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

The Zero HIV Social Impact Bond

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Commissioning Better Outcomes Evaluation

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Foreword

By Samantha Magne, Knowledge and Learning Manager at The National Lottery Community Fund

You are about to read the probing, summing-up of a key story in the Commissioning Better Outcomes (CBO) Journey. It will give you an in-depth look at a key Social Impact Bond (SIB) within CBO's community of initiatives commissioned by local public services.

A SIB is the art of using social investment to combine de-risking commissioners through Payment by Results (PbR), with the de-risking and sustaining of contracted delivery providers through the provision of capital. **Elton John Aid's Foundation's** (EJAF) **Zero HIV** story reveals some highs and lows of applying the SIB concept – and explains how far its commissioners, providers and investors got, in their own unique context, in making, managing, and demonstrating the difference their intervention aimed to achieve. The story concludes by revealing their journey's legacy. It explains its importance for the broader 'so what?' and 'what next?' picture of outcomes-based approaches to commissioning.

This stuff matters because everyone involved cares about the quest to make pursuit of outcomes the heart of what they do. We all set out with big ambitions; the prize was SIBs would help public and social organisations overcome administrative and financial constraints blocking early action on entrenched social needs. To make that happen, ideas about how bringing public, social and private sectors' interests to the table were required, to get money flowing where it was needed.

You will see it is not easy to pull off and maintain the robustness of SIBs' driving logics. And whilst our top-up offer has been a significant draw to the quest, ranging from sometimes leveraging much larger co-funding for innovation, to encouraging more attention on performance for existing work, such incentive can also work to distort the picture of demand for PbR and capital. There are important lessons to take home, whether you are interested in this social policy area or the evolution of outcomes-oriented approaches to commissioning. As SIBs morph into new outcome mechanisms, be alert to the strengths and weaknesses of their logic.

This SIB's story illustrates just one of several ways CBO SIBs attempted to configure their approaches to managing money, relationships and learning for achieving and being accountable for better outcomes. We suggest you pick out successes and cautionary tales at two levels - the intervention's delivery and the SIB mechanism's configuration - noticing where these intertwine.

There are rich pickings in the report. CBO, as a catalytic co-commissioner paying for results, has taken away key reflections including:

Policy Takeaways:	Intervention Approach	SIB Structure & Effect
Highlights	The key success lay in using opt-out testing to drive the agreement and cooperation within the NHS's internal market. Improved analysis of records also enabled providers to make or re-establish contact with HIV patients who had been what is referred to as 'lost to follow up'. This was crucial to identifying and connecting non-self-presenting HIV patients with relevant medical and social support from the NHS and VCSEs. At the project's hub, EJAF led strong data management across providers, keeping them sighted on the benefits of the opt-out system. Coinciding with the timing of the HIV Commission, the SIB was, along with other conventionally funded initiatives, instrumental in persuading government to provide £20m for adoption of the opt-out testing system in high HIV prevalence areas.	The PbR approach placed a high reward price on providers successfully identifying HIV patients. This provided a different kind of financial signal (compared to the price-point of individual opt-in tests) and has helped as part of the effort to showcase the value to the NHS of a system-wide opt-out testing package. The Board of the Special Purpose Vehicle, set up to manage the project, benefitted from the collective expertise of Trustees from across the NHS, Public Health, the private sector, and Charitable Foundations. The return on capital to its carefully chosen investors (including established grant-makers) was capped, keeping investment costs deliberately low at 2.2%.
Lowlights	Although later there was debate over the merits of a counterfactual (the test of what impact would have occurred without the intervention and given other confounding developments such as the wider availability of treatment), no counterfactual was included when the SIB was designed. This impacted on NHS and Public Health clinician's retrospective sense of confidence about the significance of the project. However, their caution about the project's impact could be seen as paradoxical, given the simultaneous NHSE (NHS England) decision to nonetheless roll out opt-out testing. This might suggest the need for clearer theory of change among stakeholders about what really leverages influence over NHSE commissioners.	The SIB's PbR premise (i.e., payment on a results basis, from the benefitting agencies, in return for its transformational impact) was thwarted by a 'wrong pocket' problem: • NHSE participated in the SIB as an observer, but despite being the party standing to gain from its impact, did not engage as a payor. It was inhibited by two of the outcome triggers, whose design risked leaving it exposed to a revolving door of lost and found HIV cases. • Instead, Local Public Health was expected to pay, despite not benefiting from NHSE financial gains of reducing untreated HIV. Consequently, only one Borough made outcomes payments, but these were all repaid by EJAF, less a pre-set fixed contribution of £150k, similar to the price of one of the community services they had grant aided. • With the complexity of the evolving fund flows through the SIB, and with EJAF providing much of the capital investment itself, EJAF was left effectively grant-funding a substantiative share of the provider costs alongside CBO PbR payments, as well as performance management costs.

Policy Takeaways:	Intervention Approach	SIB Structure & Effect
Questions	What kind of 'evidence' matters to different commissioners, and what provides them with enough confidence to influence their decisions? What will the financial or relational structuring in the new Integrated Care System need to look like if it is to sustain the systemic opt-out and follow up approach? As the evaluators note, it might be challenging to implement a similar project on a cost per outcome basis. Inherently, in a scheme to eradicate a disease, in proportion to success it becomes increasingly more difficult for providers to deliver interventions, if these are paid for based on a declining pool of available outcomes. That being the case, what do NHSE commissioners need to do to ensure follow-through of effort at the end of the taper to zero HIV? As Lambeth have been looking at Alliance Contracting as a relational tool in other areas of cross-systems impact, will the Public Health and NHS stakeholders in this area use a similar approach for maintaining collaboration?	What can be learned by all of us from the journey that led to this complicated arrangement, about the dangers of any SIB moving to launch without all its intended commissioners already on board? When should parties reconsider use of PbR, if it becomes apparent that not all parties to a wrong-pocket problem in the system are actively involved or in relevant roles, not least in the context of seeking to catalyse change in complex NHS internal markets? When working with a range of providers in a collective system-wide intervention and when lacking a counterfactual to account for other confounding factors, how suitable is the PbR premise of *conditionally withholding payments subject to proof of impact?* What can be observed from other opt-out schemes about what may make for a simpler, but equitable, way to manage resource flows or to validate and apportion rewards? At the heart of this story can deeper learning points be drawn by us about providing influential and collaborative underpinning for a strategic charity's outcome-focussed mission and catalytic objectives? What arrangements might have made it simpler for EJAF to leverage proportionate buy-in from commissioners for its opt-out-testing theory of change? And what future roles might we usefully play alongside VCSEs in cross-sector health systems, to transform collective use of data and resource?

We recommend you look out for the evaluation's in-depth reviews of 8 other CBO SIB journeys and, the final programme-level report. It will combine important insights about the realities, politics and economics of deciding how to commission for better outcomes and point to 'where next.'

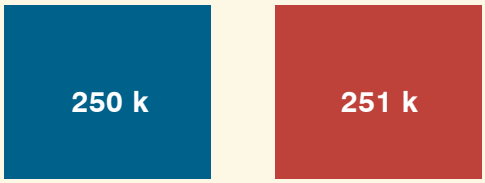
We are sharing these reports on The National Lottery Community Fund's social investment page. They are also available the Government Outcomes Lab (GO Lab) website – sign up there for updates!

1.0 Executive Summary

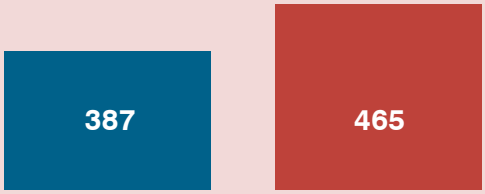
Project focus and stakeholders	
Commissioner(s):	Elton John Aids Foundation (EJAF) London Borough of Lambeth
Service provider(s):	3 NHS Acute Trusts 4 GP Federations 6 VCSE community providers
Intermediary or Investment Fund Manager	None – project managed by Zero HIV Community Interest Company
Investor(s):	Big Issue Invest Comic Relief Red Shed Fund VIIV Positive Action Fund EJAF
Intervention:	Opt-out testing for HIV with associated support and encouragement to be tested and enter treatment
Target cohort:	People unaware they are living with HIV or 'lost to follow up' and not in treatment
Period of delivery	Oct 2018 – Dec 2021

Project achievements

Service user supported (tested)



Outcomes achieved (people in treatment)



Payments and Investment	Plan[1]	Actual[2]
Engagement and outcome payments	£3.04m	£3.69m
Investment committed	£1m	£1m
Investment return	£15,000	£17,573
Internal Rate of Return (IRR)[3]	1.5%	1.76%
Money Multiple[4]	1.02	1.03

1 'Plan' means the amounts included in the CBO grant award as substantially renegotiated (with lower targets) in September 2020. Planned refers to the Median targets agreed with the CBO team during that renegotiation

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

3 IRR is essentially a way of converting the total returns on an investment (for example profits made by a business, or in this case total outcome payments) into a percentage rate, calculated over the length of the investment and varying according to cash flow – i.e. how quickly and soon payments are made. IRR calculations are complicated, but in simple terms the earlier you get the money back the higher the IRR, because IRR takes account of the 'cost of money'.

4 Money Multiple (MM) is another way of measuring returns. It is simpler than IRR and expresses the total returns as a simple multiple of the amount initially invested. Unlike IRR, MoM does not vary according to when payments are received For more information on both IRR and MM see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957374/A_study_into_the_challenges_and_benefits_of_the_SIB_commissioning_process._Final_Report_V2.pdf

1.1 Introduction

The Commissioning Better Outcomes (CBO) Fund is a social impact bond (SIB) programme funded by The National Lottery Community Fund, which aims to support the development of more SIBs and other outcomes-based commissioning[5] (OBC) models in England. The National Lottery Community Fund has commissioned Ecorys and ATQ Consultants to evaluate the programme. A key element of the CBO evaluation is nine in-depth reviews, and this review of the Zero HIV SIB is one of these. It is the final review of this project and aims to draw overall conclusions about the success of the Zero HIV project, its value for money, and the lessons that we think can be learned from it for other projects.

The main aim of the in-depth reviews, and of the evaluation as a whole, is to assess whether there is a 'SIB effect' – that is whether the key elements of the project that are unique to or have greater emphasis in a SIB model – notably the use of payment by results (PbR)[6], capital from social investors, and enhanced performance management – had an effect on the way that the project was designed and implemented, and the impact that it achieved.

1.2 Zero HIV project overview

The Zero HIV SIB was driven by the Elton John AIDS Foundation (EJAF) which designed, implemented, managed and part-funded the project. It drew on extensive research and pilot projects by EJAF into the barriers to people living with HIV being successfully tested and diagnosed, and thus entering treatment. If people are diagnosed and treated early it has huge social benefits to their health and financial benefits to the NHS in reduced and avoided treatment costs.

The aim of the project was to deploy a SIB structure to fund the delivery of HIV testing and associated support to people in the South London Boroughs (LBs) of Lambeth, Southwark and Lewisham (LSL). It was targeted at people who were either living with HIV and had not been diagnosed, or had been previously diagnosed but were not in care and had become what is technically known as 'lost to follow up' (LTFU).

The design of the project aimed to ensure that people who lived in areas of very high diagnosed HIV prevalence would be offered an HIV test in a wide variety of settings according to their needs. This included those most at risk: target groups were men who have sex with men (MSM) and people of black African heritage (BAH). In health settings (especially hospital A&E Departments and GP surgeries) the aim was to offer so-called opt-out testing (with a presumption that the patient would be tested unless they refused) to a much broader range of people rather than just those in the target groups.

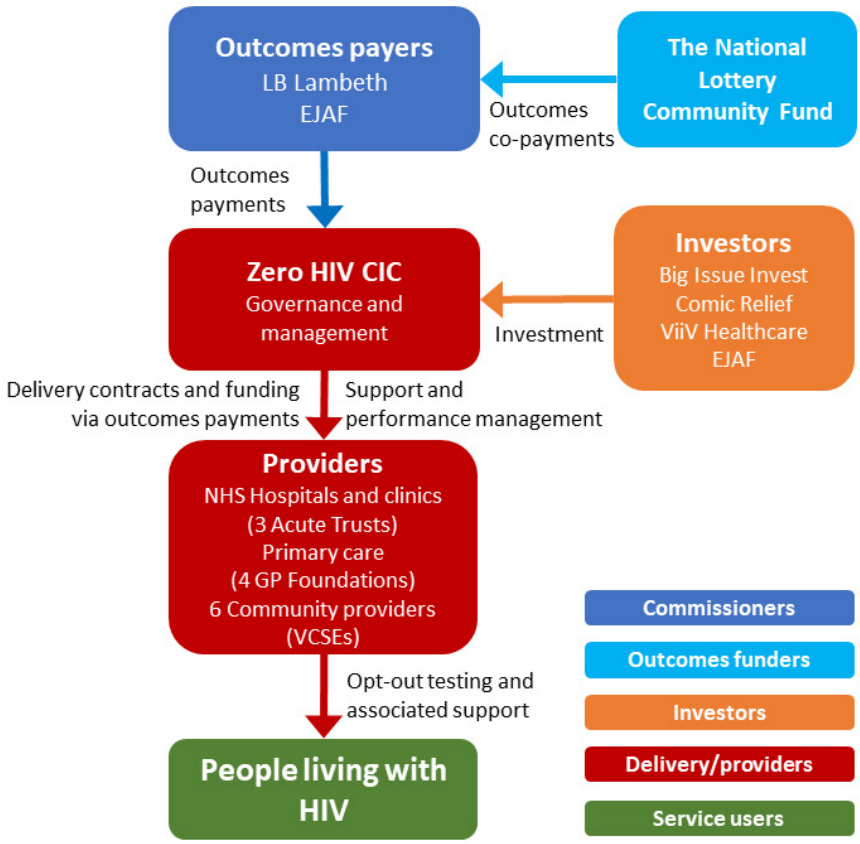
The operational structure of the project is shown in overview and in much simplified form in Figure 1 overleaf. We describe it in more detail in section 3.1 and Figure 2 therein. In summary:

- Testing and other services were offered in a range of settings by providers including hospitals, GPs, and community organisations. Unusually for UK SIBs, therefore, the providers were a mix of public sector and Voluntary, Community and Social Enterprises (VCSEs). The services provided included both encouragement to get tested and, where appropriate, counselling and follow up for those whose test was positive. There were also special 'audit and recall' contracts with hospitals and HIV clinics for those who had become LTFU. These services aimed actively to identify those LTFU through data analysis and then contact them with a view to persuading them to re-enter treatment.

5 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.

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

Figure 1: **Zero HIV Project Structure (Simplified – see full structure in Section 3.1)**



- Providers were contracted to deliver services via the Zero HIV Community Interest Company (CIC). This was set up by EJAF and investors as a separate entity and as a vehicle both for the management and support of provider performance, and to provide overall governance of the project. The CIC paid providers according to the number of outcomes they achieved, with separate outcome metrics and payments for those identified as living with HIV for the first time, and those returned to treatment after being LTFU for more than 12 months. Payments were negotiated individually with each provider and varied within a range from £4,750 – 6,000 per outcome, with providers being paid in advance for a defined number of outcomes to help them manage their cashflow. Total funding of each provider varied widely according to the scale of testing and opportunities to identify those not in treatment, with the bulk of funding focused on public sector providers.
- The Zero HIV CIC in turn received payments for outcomes achieved from one local commissioner, LB Lambeth and from The National Lottery Community Fund, via the CBO programme, as co-commissioner. Unusually, the bulk of outcome payments were made by EJAF, which stepped in to make outcome payments when other local commissioners (LBs Lewisham and Southwark, and their coterminous Clinical Commissioning Groups or CCGs and NHSE England) decided that they could not afford to support the project (see below).
- The CIC raised capital from a range of investors to support its start-up, and provide it with sufficient funds to cover its own costs and provide advance payments to providers until they could start to achieve outcomes. Investors included EJAF itself, Big Issue Invest, Comic Relief via its Red Shed Fund, and a private health care provider specialising in HIV services, ViiV,

via its Positive Action Fund. The investment structure was innovative compared to many UK SIBs, in that the investment was tiered, with investors being paid out in turn as more outcomes were achieved. The last investor to have their capital repaid was EJAF itself. EJAF was thus effectively providing "first loss" finance and reducing the risk for other investors. This meant that investors could invest at a lower rate of return, and investors more used to providing grant funding (Comic Relief and ViiV Positive Action) were able to provide repayable capital.

1.3 What has happened in practice?

As we reported at length in our first review of this project[7], it took time to develop and implement. Most of this was due to the need to identify and contract with providers; agree the investment structure and engage investors; and engage commissioners with a view to them agreeing to pay for outcomes.

Providers were engaged and contracted to deliver outcomes in stages. When the project started, in October 2018, it comprised only contracts to deliver opt-out testing in Emergency Departments in two NHS trusts, plus audit and recall of LTFU in one of them. Contracts with two GP Federations to deliver opt-out testing in GP surgeries, and with two community providers (one a consortium of three VCSEs) followed in the first half of 2019.

Further contracts were added in 2020 and 2021, including specific audit and recall contracts with two hospitals, and contracts with two more GP Federations, and two further community providers. In total the project has delivered through a range of 13 providers across primary and secondary care and in the community, giving it the ability to reach people living with HIV across a multiplicity of settings. In the community, VCSE providers were chosen to ensure targeted coverage of the most vulnerable and at-risk communities, including MSM, people of BAH, and the Latin and South American community.

The biggest challenge faced by the project was in engaging commissioners to the extent that they were prepared to pay for outcomes:

- The project intended to persuade seven organisations to make payments – the three LA public health departments and their respective CCGs in LSL, and NHS England (NHSE); however only LB Lambeth had committed to make outcome payments before the project started. The project therefore asked for co-commissioning payments from the CBO to be front-loaded in the expectation that it could bring on board further commissioners as outcomes payers once the project had proved its impact.
- By the end of the second year this had not happened, and the Zero HIV CIC agreed with the CBO programme to change the scope and duration of the project. This was mainly because it had been unable to engage commissioners as outcome payers but also because it was anticipated that the government would make additional funding available for testing before the original contract completed. It was thus important that the results of the project were available, in expectation that they would support the case for such funding.
- The effect of these changes was to reduce the key target of engaging or re-engaging more than a 1000 people in treatment to 387, based on a contract duration of just over three years rather than nearly six[8], ending in December 2021. CBO also agreed to increase its proportion of total payments to 30%, primarily to ease the transition to wider NHS funding – though such funding was not guaranteed.

The project also faced the challenge of the COVID-19 pandemic and associated restrictions, as we reported in depth in our second in-depth review[9], which focused entirely on the impact of COVID-19 and associated

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

8 Individual contracts started at different times, but overall the project ran for a total of 39 months compared to an original intended duration of 69 months

9 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-2.pdf?mtime=20220224150943&focal=none

restrictions. We found that the Zero HIV SIB did not have to make adjustments to its contract structure, in common with a third of CBO-funded projects (seven out of 21 in total). This was partly because the operational impact on some strands of service and intervention was not that severe (see below) and partly because advance payments to providers were sufficient to enable services to be maintained.

The operational impact of COVID-19 varied according to the type of intervention and its settings. The most directly impacted were the community providers, who were largely unable to deliver services at all because the social and commercial venues in which they provided testing were closed. Primary care was also affected because fewer patients were seen face to face, reducing opportunities for engagement and testing; and GPs were restricted in ordering routine blood tests. Testing in hospitals was much less affected, since a large number of patients continued to attend emergency departments (albeit for different reasons) and could still be tested. The LTFU audit and recall services were also able to operate largely as normal because they did not require face to face contact to carry out the necessary audit of cases, and could complete follow-up contact work by phone or email.

So despite wide variation by provider and strand, the overall performance of the project remained strong through COVID-19.

Overall, and judged against the revised targets agreed with the CBO team the project has been a success. It narrowly exceeded (by just over 1,000) its Median target to test 250,000 people, and more comfortably exceeded its Median target to engage or re-engage 387 people in treatment, achieving 465 outcomes according to end of grant data.

Total outcome payments were close to plan with 99.6% of planned payments made by EJAF, LB Lambeth and The National Lottery Community Fund from the CBO fund. Total delivery spend was very close to and slightly higher than plan (£2.74m compared to £2.72m) although provider delivery costs were more than a fifth higher than planned, offset by lower management and investment costs. Comparing outcome payments with total costs shows a significant surplus of £953k within the Zero HIV CIC of income over costs. This surplus was returned to EJAF at the end of the project.

Outcome performance was strong enough for all investors to be fully repaid, with capped interest, by December 2020 – twelve months before project conclusion. Interest bearing loans ended in February 2020. The final payment to investors was made in December 2020 and would have been earlier if the last transfer had not been delayed by the investor. According to the CBO project data the SIB achieved an overall money multiple (i.e. total capital plus returns as a multiple of total investment) of 1.03, which is consistent with the blended interest rate of 2.2% agreed at the start of the project.

Stakeholders we interviewed for this evaluation also judged the project a success, although not all attributed this to the SIB mechanism, rather than to the simple availability of more funding for HIV testing and support. There was no dedicated funding for such testing available when this project was devised (though as we note below more funding has now been made available, in part because of the success of this project). In summary:

- Nearly all service providers across all delivery strands had a positive experience, but providers had mixed views about the importance of the PbR mechanism that was built into outcome payments. Providers of ED testing did not think it was very important, but our second review found the LTFU audit and recall contracts in hospital clinics would have been difficult to make work without a substantial payment per outcome to justify the cost and effort involved.
- Commissioners had similarly mixed views, with some judging the PbR mechanism very important, while others (including NHSE) thought that the PbR mechanism made no difference, especially in the clinical settings, and what mattered was blanket funding for large scale testing.
- Some commissioners also observed that it was difficult to judge the effectiveness of the SIB because there was no baseline or comparison group against which to assess the additional outcomes achieved by the

project or their attribution to the intervention, and some claimed that this was a reason why they had been reluctant to fund the project.

- Investors were very positive about the project because it aligned with their social objectives, they were fully repaid well before the end of the project, and two of the investors (Comic Relief and ViiV) were given the opportunity to provide repayable finance when they were more accustomed to making straight grants. Investor stakeholders also played a prominent role in the Zero HIV CIC Board, providing innovation and challenge throughout the project.
- EJAF senior stakeholders were delighted with the impact of this project and in particular the way that it was able to act as a proof of concept for successor funding, and potentially other projects (see below). EJAF also echoed the view of provider stakeholders that the project being a SIB had galvanised action and support and created its own momentum. In addition, EJAF strongly welcomed the support that the project attracted from the CBO programme and acknowledged that this was an important factor in the success of the project.
- As a Foundation used to putting money to work through grants, EJAF did however see downsides to the SIB mechanism. There was frustration at the complexity of the SIB design and implementation process and the time it took to make progress, and particularly at the reluctance of most commissioners – despite significant engagement effort and discussion – to agree to pay for outcomes.
- The National Lottery Community Fund shared this frustration. While it remains very supportive of this project and a CBO stakeholder was a member of the Zero HIV CIC Board, The National Lottery Community Fund was disappointed that the project was scaled back when it transpired that only LB Lambeth was prepared to make any contribution to outcome payments.

1.4 Successes, challenges and impacts of the SIB mechanism

The evidence suggests that the fact that this project was designed, constructed and delivered as a SIB had the following benefits:

- ***Galvanising action and momentum***. There was a clear view across multiple stakeholders that the SIB had an effect simply by being branded a SIB, creating a level of enthusiasm, excitement and 'buzz' that it would not have had if a conventional project (though this did not persuade more commissioners to agree to make outcome payments).
- ***Improved project governance***. Stakeholders argued that the project would not have had a Board of this calibre, or possibly a Board at all, if it had not been constituted as a SIB and governed via a CIC that acted as the delivery vehicle and prime contractor for the project. The project therefore benefited from a degree of additional intellectual and knowledge capital, as well as financial capital, thanks to its SIB structure.
- ***Additional performance management*** Stakeholders across providers and the CIC Board were strongly supportive of the role of the project and performance management team within the CIC. While performance management was expensive in absolute terms (see below) the costs of a dedicated team seem to have been justified by results. Outcomes per month rose from an average of 6.5 in October 2019, when the dedicated Social Impact Consultant started to work with providers, to 13.3 in February 2020.
- ***Incentivising providers via the PbR mechanism.*** As we note above not all stakeholders thought that the PbR element was important, and there appears to have been a change of view since our first review, when most stakeholders thought that a high, outcome-based payment for HIV detection would be critical to

the project's success. We now conclude that this was less important overall, but that it was still a significant factor for some of those delivering interventions in the community, and the two hospital trusts that initiated and agreed stand-alone audit and recall contracts in mid-2020.

- ***Innovative investment structure***. The use of an innovative, tiered investment structure under which EJAF would effectively provide 'first loss' capital had two key benefits. First, it catalysed investment by two parties who had a tradition of grant making rather than investing (Comic Relief and ViiV Positive Action Fund). Secondly, it encouraged and enabled investors to seek lower rates of return, thus reducing the blended interest rate on all loans to only 2.2%.
- ***Improved data systems.*** While we would expect any complex project to put in place good management and reporting systems, the project used some of the SIB capital to put in place a bespoke data collection and reporting system that was widely praised by stakeholders across all three reviews, and had significant and important features that were needed only for an outcomes project, and affordable only because of the SIB funding.

On the downside, the SIB approach and structure led to a number of disadvantages and challenges:

- ***Lack of engagement of commissioners as outcome payers.*** The single biggest challenge faced by the project, which had major knock-on effects, was that it was unable to persuade local commissioners other than LB Lambeth to commit to fund the project. This ultimately forced the project to reset its ambitions and more than halve its target outcomes, as well as reduce its reach to service users by more than a third. Both we as evaluators in our first review and EJAF themselves attributed this to two key factors: a general shortage of funding for experimental projects of this kind; and the misalignment of the benefits of outcomes (in savings or more likely avoided costs) to those expected to fund them – often referred to in SIBs and outcomes contracts as the 'wrong pocket' problem.

  Comparison with other projects reviewed under this evaluation suggests that the second factor was critical, since in other projects in Greater London where commissioners have been more ready to pay for outcomes (notably North-West London End of Life Care Telemedicine Project[10], and the Positive Families Partnership[11]) the parties that were being asked to make outcome payments (in the first case CCGs, and in the second LBs) was also the party that stood to benefit directly and substantially from the reduced costs brought about by intervention success. A second factor in those projects, which was less evident here, was that there was leadership from local commissioners in persuading others to come on board, and the project did not start until contracts to make payment were in place. We understand why EJAF chose a different approach, but evidence from these projects and other research suggests that it is easy for commissioners to promise support, but much more difficult in the current climate for them to commit funding – and they are less likely to do so if they are not tied in contractually at an early stage.
- ***No measurement of the counterfactual.*** Commissioner stakeholders observed that there was no way of measuring how much of the impact it achieved could be attributed to the SIB and the interventions it funded, e.g. against a baseline of previous testing/detection levels or a comparison group. This applied particularly to the primary and community-based interventions, since the impact of testing in EDs (where there was no mass testing prior to the SIB) was more clear cut. While some stakeholders thought that the impact of the project was strongly evidenced in all settings, and EJAF took a number of steps to avoid poor attribution, this lack of a counter-factual must arguably be seen as a weakness of the SIB design since it appears to have reinforced the

10 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-NW-London-EOLC-telemedicine-project.pdf?mtime=20220616143105&focal=none

11 See https://www.tnlcommunityfund.org.uk/media/insights/documents/CBO-Positive-Families-Partnership.pdf

view of commissioners that they should not fund the project because they could not be confident of its impact. We note however that we did not hear this argument put to us by commissioners or other stakeholders when we were conducting our first review, and there is no evidence that any stakeholder asked for a stronger comparator to be included in the SIB design. We also note that other stakeholders disagreed more generally with this view, and pointed out that there was no alternative provision in many areas (notably for mass testing in A&E) so the counter-factual baseline was zero.

- ***Imperfect outcome metrics.*** Some provider stakeholders also observed that the outcome metrics, while clear and easy to validate, had two potential drawbacks. First, an outcome could only be claimed by one provider, even though the complexity of identification and referral of people with HIV meant that in practice more than one provider might have contributed to an outcome. Secondly, the outcome payments were one-off payments with a single trigger and no allowance for sustainment. In theory, therefore, someone could enter care and trigger a payment but then almost immediately fall out of treatment (and potentially trigger a second payment if they were then re-engaged more than 12 months later).

With the proviso that we have evaluated the performance of this project against the revised targets agreed when the project was substantially scaled back in 2020, we consider it overall to have been successful and to have been good value for money. It achieved good levels of performance compared to the reset Median scenario against both the broad measure of user engagement and testing, and the narrower treatment/re-engagement outcomes on which provider payments were based.

It also achieved most of its own key objectives, save for the important issue that it did not persuade commissioners apart from LB Lambeth to commit to outcome payments. SIB overheads were low as a percentage of total costs, although quite high in total at more than £300k, and investors took lower returns than in most SIB projects thanks to a deliberate investment strategy and structure. In addition (and despite commissioners' reluctance to fund the project) it appears to have achieved avoided costs for commissioners (through reduced treatment and levels of infection) that significantly exceed the total costs of delivery.

1.5 Legacy and sustainability

Overall, we assess the Zero HIV SIB as having a positive legacy both locally and nationally, although there has been no specific commitment to continue its outcomes-based approach.

Most importantly, there is clear evidence that its success has influenced central government policy and funding for large-scale opt-out testing for HIV. EJAF fed emerging evidence from this project for the effectiveness of such testing into its wider efforts to influence HIV testing policy at national level, and in particular into the work of the HIV Commission, whose report[12], published in December 2020, made key recommendations including that "HIV testing must become routine – opt-out, not opt-in, across the health service".

These recommendations have largely been adopted in the UK government's HIV action plan[13] for England, which committed to expand opt-out testing in emergency departments in the highest diagnosed HIV prevalence local authority areas, supported by new investment of £20m over the next three years.

It seems clear that the evidence from this project made an important contribution to both the proposal for change in this area and its acceptance by government. It also seems clear that the roll-out

12 See https://www.hivcommission.org.uk/final-report-and-recommendations/

13 See https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025

of testing is having a positive effect: in November 2022 the NHS published data showing that in the six months since the expansion of opt out-testing, 834 cases of people living with HIV and Hepatitis B or C had been newly identified, while 153 people who were LTFU had been re-engaged[14].

Locally, commissioner stakeholders reported that the Integrated care Board (ICB) had already committed to the continuation of mass opt-out testing across South-East London before national funding was announced, as a direct consequence of the evidence for the effectiveness of testing provided by the SIB.

ED testing opt-out testing had therefore already been extended in the three LSL boroughs and the hospitals that have run opt-out testing with funding from the SIB; and local NHSE commissioners had chosen also to fund the audit and recall service provided in hospitals in 2022/23. There is thus local sustainment of funding for both these interventions, based partly on the proof of concept provided by the project.

A further legacy is that this rollout has been supported by the former Zero HIV SIB Performance Manager, who was engaged by NHSE in light of his existing experience of supporting large scale testing on this project. This soft legacy of the project is particularly welcome since we have noted in other reviews that the expertise built up through projects is often lost, as staff move to other, entirely unrelated roles when projects end.

1.6 Conclusions

Overall, we judge the Zero HIV project to have been successful. It has transformed the lives of more than 450 people and proved the value of mass opt-out testing in areas of high HIV prevalence. It exceeded its Median targets for both numbers tested and numbers engaged in treatment, although these targets were lower than originally planned. This can be traced directly to the inability and unwillingness of local commissioners to pay for outcomes as the project team had hoped and expected.

We also find that it has provided good value for money overall. It has also yielded greater financial benefit to the NHS than it has cost, whether measured on immediate costs avoided, or likely longer term and much higher value.

What is less clear cut is how much of his success can be attributed to the SIB mechanism and to the use of PbR, rather than to the provision of significant additional funding for opt-out testing at scale, and focused management capacity to implement it. Similar projects (for example in Croydon) appear to have achieved good results with conventional funding, and some key stakeholders did not think the SIB and deployment of PbR made much difference. The most important such stakeholder was NHSE, which is now funding the rollout of mass testing in areas of highest diagnosed HIV prevalence (and there seems little doubt that the proven success of this project strengthened the evidence base for them doing so).

Some commissioners also thought that the project should have been designed to more clearly prove the impact of opt-out testing and associated interventions compared to business as usual, but we (and some stakeholders) do not entirely agree with this – and it appears to be a view developed with a degree of hindsight.

Stakeholders views on the benefits of the SIB appear to have evolved across the lifetime of the project. At the outset nearly all stakeholders thought that the PbR mechanism – which enabled the project to pay several thousand pounds for a treatment outcome and thus focus effort on finding those not in treatment – would be critical. Stakeholders still think it important to some strands of the project – for example the LTFU audit and recall services which would not have been viable without a high payment per cost-intensive outcome;

14 See https://www.england.nhs.uk/2022/11/nhs-hiv-testing-rollout-identifies-hundreds-of-new-cases/

but others now think the PbR mechanism was less important than they thought at the start.

Conversely, we now find that the SIB structure and the capital it provided did have significant value, which arguably could not have been achieved by EJAF grant funding alone. The SIB capital funded the additional performance management that was critical to the success of the project, as well as bespoke information systems. Investors provided expertise and know-how as well as finance, which helped the project navigate complex challenges; and investors who were grant funders were able to develop their own thinking about the benefits of repayable finance, Moreover the implementation of this project as a SIB gave it a profile and momentum that many stakeholders think it would have lacked under any other structure, even with backing from an internationally respected funder.

It is also important to draw a distinction between testing in A&E (where there does seem to be a case for simply funding testing at scale, as other projects such as Croydon also seem to demonstrate); and testing in other environments, where stakeholders did think the PbR mechanism made a difference and the ability of this project to engage multiple providers, targeting different at-risk groups, improved its effectiveness and inclusivity.

Overall, a view from some that the project has not proved the SIB effect, and of others that 'if testing is worth doing, just pay for it' means that it is not surprising that there is no strong appetite for a successor SIB or payment by results project. The project has however proved its worth in other ways, since A&E opt-out testing was continued across South East London as a result of the evidence provided by the SIB, and is now being funded at scale in high prevalence areas (and already saving lives). Moreover some of the other elements of this project (such as audit and recall by clinics, and the GP HIV champions) were retained after project conclusion in South London and consultation is in progress about extending the role of GP Champions across London.

There are many positive lessons from the project, but in our view some are not new and do not need to be repeated at length. They include the importance and value in SIBs of committed leadership and governance, of additional performance management, and of high-quality data systems.

Lessons that are new and have not been covered elsewhere in this evaluation or previous in-depth reviews include:

- ***Repayable finance can play a positive role in funding new SIBs and outcomes-based contracts.*** The majority of SIBs and outcomes-based contracts in England are now managed and funded by specialist investment fund managers. The Zero HIV SIB shows that there is still a role for one-off investment structures, designed to attract new investors, especially those more used to deploying grants and wishing to explore repayable finance.

- ***There is high risk of commissioners deciding not to pay for outcomes. This project, led by a leading funder, had strong expectations that local commissioners would pay for a high proportion of outcomes.*** When they decided not to, the project was forced to retrench, changing its funding structure and renegotiating its targets. The lesson of other projects is that commissioners are unlikely to commit unless they can see a direct financial benefit and are more likely to do so if they are contracted to pay for outcomes from the start. There was always risk in EJAF's strategy that local commissioners would decide to pay later, once the project had 'proof of concept'.

- ***Consider stronger measurement of the counterfactual.*** This is not the first SIB that we have reviewed in-depth where commissioners and other funders have observed at project conclusion that there was no robust measurement of outcomes that would have been achieved without the intervention. Establishing such a comparator should be carefully and pragmatically considered, especially if it will help prove the case to reluctant commissioners.

- ***Aim to design SIB and PbR contracts that tie outcome payments to documented evidence of impact.*** To take the logic of the points above to its conclusion, if commissioners set a high bar for payment, then SIB developers should ask them to make a contractual commitment to payment if that bar is reached. This might mean establishing and agreeing in advance a structure that links payment to agreed performance against a baseline or other counterfactual measure, rather than both parties reflecting after the fact that measurement could have been improved. In addition, outcomes payments could be linked more directly to properly validated estimates of savings or costs avoided.

2.0 Introduction

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

2.1 The Commissioning Better Outcomes (CBO) programme

The CBO programme is funded by The National Lottery Community Fund and has a mission to support the development of more social impact bonds (SIBs) and other outcome-based commissioning (OBC)[15] models in England. The Programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2024. It originally made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar OBC models in complex policy areas. It also funded support to develop robust OBC proposals and applications to the programme. The project that is the subject of this review, the Zero HIV SIB, was part-funded by the CBO programme.

The aim of the CBO programme is to grow the SIB market and other forms of OBC. It has four objectives:

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

The CBO evaluation is focusing on answering three key questions:

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

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

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

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

"Impact bonds are outcome-based contracts that incorporate the use of private funding from investors to cover the upfront capital required for a provider to set up and deliver a service. The service is set out to achieve measurable outcomes established by the commissioning authority (or outcome payer) and the investor is repaid only if these outcomes are achieved. Impact bonds encompass both social impact bonds and development impact bonds."[16]

SIBs differ greatly in their structure and there is variation in the extent to which their components are included in the contract. For this report, when we talk about the 'SIB' and the 'SIB effect', we are considering how different elements have been included, namely the payment on outcomes contract – or Payment by Results (PbR)[17], capital from social investors, and approach to performance management, and the extent to which each component is directly related to, or acting as a catalyst for, the observations we are making about the project.

2.3 The in-depth reviews

A key element of the CBO evaluation is our nine in-depth reviews, with the Zero HIV SIB featuring as one of the reviews. The purpose of the in-depth reviews is to follow the longitudinal development of a sample of projects funded by the CBO programme, conducting a review of the project up to three times during the project's lifecycle. This is the final review of the Zero HIV SIB. The first in-depth review report[18] focused on the development and set-up of the Zero HIV SIB. The second in-depth review report[19] focused on how the Zero HIV SIB responded to the challenge of the COVID-19 pandemic and the restrictions imposed as a result of it.

The key areas of interest in all final in-depth reviews were to understand:

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

The second in-depth review of the Zero HIV SIB also identified the following areas to investigate further in the final review:

- ***SIB structure and roles.*** Was the Zero HIV more (or less) effective and efficient than other SIB models? How effective was EJAF in each of the roles it undertook in this SIB? What economies of scale, if any, did in generate? What

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

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

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

19 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-2.pdf?mtime=20220224150943&focal=none

conflicts, if any, did it create? What benefits or disadvantages did it have for other stakeholders, notably commissioners? How did the drawdown, deployment and repayment of capital from investors compare to what was planned at the start of the project? And why was the project unable to attract the levels of funding originally intended from both NHSE and local commissioners?

- ***Effectiveness and value for money.*** How does The Zero HIV SIB compare to other interventions and projects? Do levels of engagement and testing prove to be significantly higher than achieved on projects which have not deployed an outcomes-based structure, such as the Leeds pilot project which EJAF itself funded? What further lessons does the EJAF SIB offer in terms of recruiting, embedding and funding SIB design capacity and expertise into commissioning bodies when developing an outcomes-focussed partnership? And does the success of this project (if so proved) influence local and other commissioners to increase funding for HIV testing and reengagement – either on an outcomes-basis, like this project, or on a conventional basis but with other learning from this project?
- ***Performance within the SIB.*** How does the performance of the different strands within the project compare? Has there been different performance within strands – for example between GP Federations that pass on outcome payments to the practice achieving the outcome, and those sharing payments with all practices? How did COVID-19 affect performance of the SIB overall and how does the extent of any impact compared with the performance of other projects funded by the CBO programme? And how and to what extent were providers across all strands able to return to business as usual during the last year of the contract and especially from June 2021 as COVID-19 restrictions started to ease substantially?
- ***Role of the CBO programme.*** To what extent did CBO outcomes payments support achievements of this SIB, did the SIB contribute to the CBO programme aims and objectives and did the SIB achieve its qualitative aims and base case financial performance as agreed with the CBO team and varied in 2020?
- ***Sustainment beyond the end of the project.*** What external factors that could affect the future sustainability of this project changed during the life of the SIB? And to what extent did the SIB provide evidence that could be used to influence national or policy in relation to HIV testing and reengagement, and with what outcome?

For this final review, the evaluation team:

- undertook semi-structured interviews with representatives from all the main parties to the project, as detailed below. These were conducted between March and December 2022;
- reviewed performance data and monitoring information supplied by the project stakeholders to The National Lottery Community Fund; and
- reviewed key documents and additional data supplied by project stakeholders.

Those interviewed for this review included:

- stakeholders within the Elton John AIDS Foundation (EJAF) which initiated, managed and part funded the project;
- members of the Board of the Zero HIV Community Interest Company (CIC) which provided governance of the project;
- local commissioners of the project from Lambeth, Lewisham and NHS England (NHSE);
- Stakeholders from a range of provider organisations across the three settings within which HIV testing and other support services were provided, including NHS Foundation Trusts, GP Federations and community organisations;
- All the investors in the project; and
- The National Community Lottery Fund, which provided support for the project from the CBO programme.

In conducting this review, we also dovetailed our fieldwork with a separate service evaluation of the Zero HIV SIB carried out by Kings College London (KCL). This evaluation[20] (referred to in this report as the KCL Service Evaluation) had a different and complementary focus to our review, and at the request of key stakeholders we worked together to ensure that there was no unnecessary duplication of effort, by jointly interviewing some stakeholders. In addition, we have drawn in this report on key findings from the KCL Service Evaluation, including on the impact of the services on different socio-economic groups and the views of service users.

2.4 Report structure

The remainder of the report is structured as follows:

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

20 Fraser, A ., Coultas, C ., & Karamanos, A . (2022) Service Evaluation of the Elton John AIDS Foundation's Zero HIV Social Impact Bond intervention in South London: An investigation into the implementation and sustainability of activities and system changes designed to bring us closer to an AIDS free future. Final Report, King's College London. See https://www.kcl.ac.uk/business/assets/research/psmo/Service-Evaluation-of-the-Elton-John-AIDS-Foundation's-Zero-HIV-Social-Impact-Bond-intervention-in-South-London.pdf

3.0 Zero HIV SIB overview

This section provides an overview of the Zero HIV SIB and its structure, describes how it was developed and implemented, and explains key elements of the SIB including its contracting, payment and investment structure.

In summary:

- the Zero HIV SIB was driven by EJAF, which designed, implemented, managed and part funded the project.
- The project aimed to deploy a SIB structure to fund the delivery of HIV testing and associated support to people in South London who were living with HIV and had not been diagnosed, and to re-engage in treatment those who had been diagnosed but had since fallen out of treatment.
- Testing and other services were offered in a range of settings by providers including hospitals, GPs, and community organisations, who were paid on results according to those they identified and got into treatment, or re-engaged in treatment.
- Outcome payments were made by the London Borough of Lambeth, by EJAF and by The National Lottery Community Fund via the CBO programme.
- Social investment to fund payments to providers, and central governance and performance management from the Zero HIV CIC, was raised from a range of social investors through an innovative 'tiered' investment structure.

3.1 Set up and key stakeholders

The Zero HIV SIB has a complex structure which reflects the number of parties involved across the health commissioning and delivery system in South London, as well as its funding and investment structure. Figure 2 overleaf shows the overall structure. The key stakeholders and their roles were as follows (please see subsequent sections for further details of contracting, payment and investment arrangements).

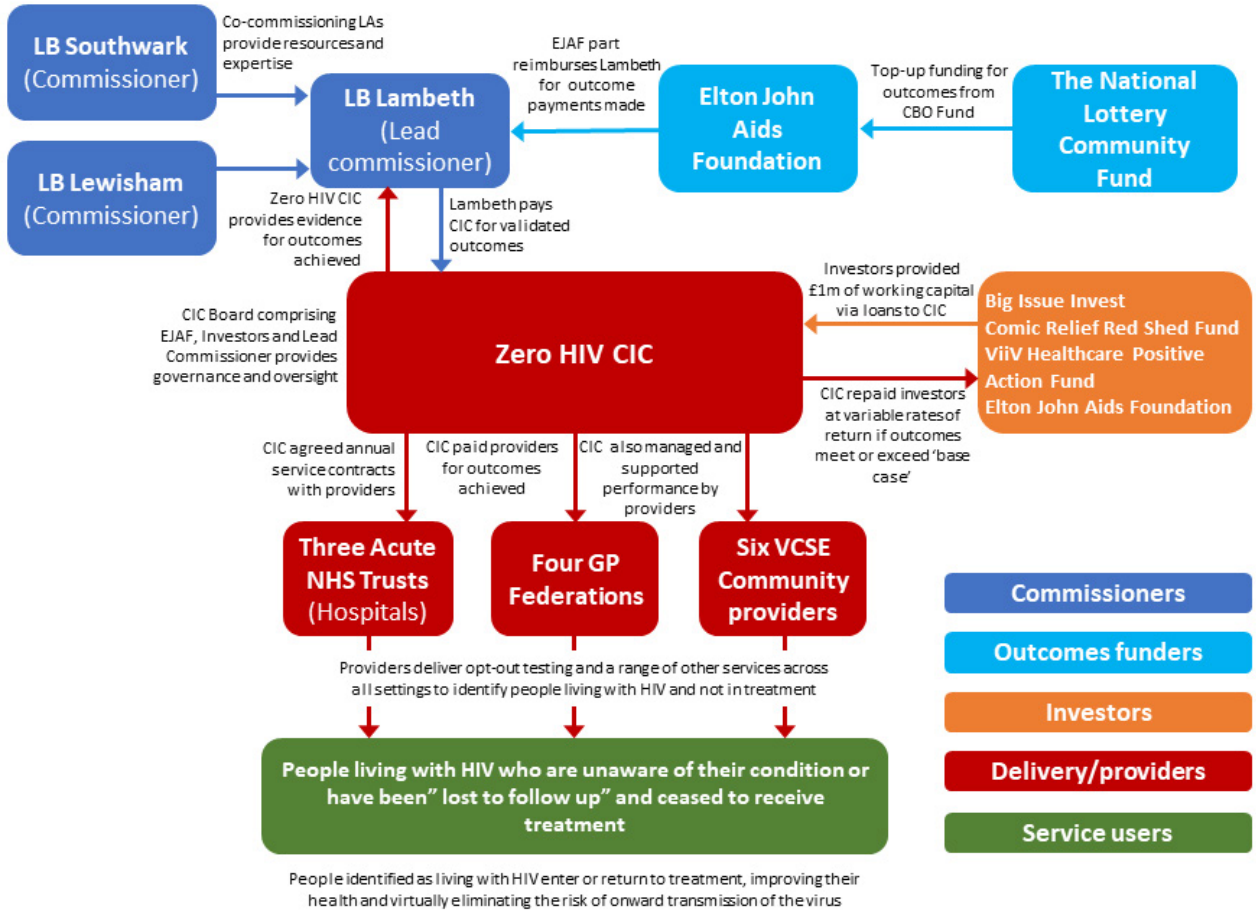
- The main contracting party and delivery body was a Community Interest Company, Zero HIV CIC, whose Board included representatives from EJAF, investors in the SIB, and the London Borough of Lambeth (LB Lambeth) as the lead local public health (PH) commissioner. The CIC selected and contracted with the service providers, and managed their performance.
- The SIB had four investors, including EJAF itself, Big Issue Invest (BII), Comic Relief, via its Red Shed Fund, and ViiV Healthcare, via its Positive Action Fund. The investment from these parties was 'tiered,' with each investor receiving a different return and being paid out sequentially according to the total number of outcomes achieved.
- Technically, there were seven commissioners: the three London Boroughs of Lambeth, Southwark and Lewisham as PH commissioners; the three coterminous Clinical Commissioning Groups (CCGs) as local commissioners of some health services for those living with HIV; and NHS England (NHSE) as a national commissioner of other HIV services in England.
- In practice, however, only the three Local Authorities (LAs) were directly involved, with the CCGs nominally being co-commissioners because there are joint commissioning and staffing arrangements for health services in the three Boroughs covered by this project (and across London as a whole). In addition, NHSE took learning from this project (and was involved in discussions about future funding after the SIB concluded) but was not an outcomes payer.
- All three LAs were active in supporting the project, but only LB Lambeth contributed to outcome payments.
- LB Lambeth acted as lead commissioner for this project and commissioned on behalf of

Lambeth, Southwark and Lewisham (LSL). It held the contract to pay for outcomes with the Zero HIV CIC, and made outcome payments to the CIC in the first instance.

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

In practice, therefore, the majority outcomes payer was EJAF itself, with the Foundation making most payments alongside LB Lambeth, and The National Lottery Community Fund funding a proportion of payments as co-commissioner via the CBO programme. This unconventional structure meant that EJAF was acting as both an outcomes-payer and an investor, which is highly unusual and possibly unique in UK SIBs.

Figure 2: **Zero HIV SIB structure and operational flows**



3.2 The intervention model

As we noted in previous reviews of this project, the Zero HIV SIB did not fund a single defined intervention delivered by one or more providers, but a range of interventions and services in different settings. The KCL Service Evaluation makes a similar observation, and notes that: *"Rather than one 'intervention'… the actors involved in commissioning and delivering HIV services through the Zero HIV SIB programme felt they were delivering a suite of 'interventions'. Some of these have a strong existing evidence base and have been recommended in existing guidelines whilst others are more organisational and pragmatic. Some were new and developed as part of the Zero HIV SIB programme whilst others were already in existence in some or other settings."*

In addition, and as we describe in more detail in section 4 of this report, the range of services and interventions delivered through the SIB expanded as the Zero HIV CIC added new contracts for further services over the life of the project.

The SIB included the following five main strands of intervention (see sections 3.2 and 4.1 for further details of specific providers):

1. Two NHS Foundation Trusts (FTs) provided HIV testing and associated support for people who presented at hospital, usually when they attended Accident and Emergency (A&E). Testing was offered on an opt-out basis (i.e. people were automatically tested unless they specifically asked not to be) with the aim of identifying undiagnosed HIV and getting people into treatment.

2. Three NHS FTs provided specific services to identify and re-engage in treatment those who had been previously diagnosed with HIV and had since fallen out of the system (technically known as "lost to follow up" or LTFU). While some who were LTFU would be identified when they presented at hospital, this strand comprised a separate intervention delivered mainly through sexual health clinics and based on what is termed 'audit and recall'. This comprised analysis of records to identify people who were LTFU and then actively aiming to contact and re-engage them, e.g. by telephone or email, rather than wait until they visited hospital or a sexual health clinic.

3. Four GP Federations (two from the start and two added later) provided similar opt-out testing of people who visited their GP. Intervention by GPs was led and supported by 'Champions' – see further details below.

4. The same Federations provided a similar service to identify and re-engage people who were LTFU through audit and recall, rather than wait until someone visited their GP.

5. Four VCSE providers[21] (two from the start, representing four organisations in total, and two added later) were contracted to reach out to people at risk of HIV within the community and encourage them to be tested, working in particular with high-risk groups or specific communities – notably men who have sex with men (MSM), men of Black African heritage (BAH) and the South American community.

The services delivered by the providers varied according to their type and role, and are summarised in Figure 3. In overview, the hospital and GP providers were:

- Ensuring tests were built into routine practice on an opt-out basis, while allowing patients to decline to be tested if they wished.
- Reviewing test results and liaising with patients, and offering them support to enter and stay in care if needed.
- Engaging with practitioners, increasing their awareness of HIV prevalence and risk, and technical understanding of HIV, and thus enabling and encouraging them to offer testing. In hospitals, this engagement and awareness raising role was carried out by

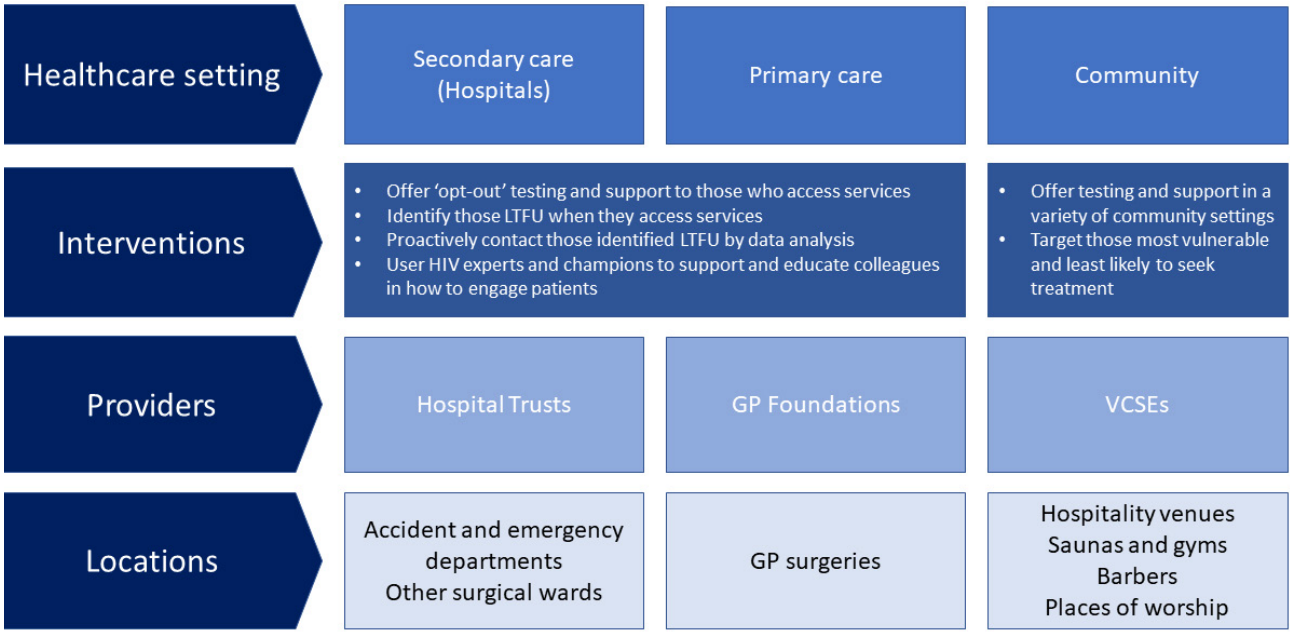
21 The original contracts were with Naz Project London and Metro Centre Ltd, on behalf of the GMI Partnership comprising Metro, Positive East and Spectra. The Zero HIV CIC later added contracts with African Advocacy Foundation, In October 2020, and Aymara Social Enterprise, in early 2021,

clinical specialists such as HIV consultants. In primary care this role was supported by 'HIV GP Champions', who were themselves GPs with an interest in HIV and were funded by the Zero HIV CIC to spend a small amount of time engaging more widely with colleagues and supporting this project's implementation. Some of these Champions were in place from the start and others came on board later.

Separately hospital and GP providers were identifying those who have been LTFU by audit and recall as described above, although only one hospital trust was doing this at the start of the project.

The community providers had a similar role in promoting and delivering testing, and providing support to those newly diagnosed or identified as LTFU to accept or return to treatment. They did so in a range of community settings appropriate to the groups which they were supporting – for example clubs, bars and saunas for MSM, and barbers' shops and places of worship for men of BAH. Community providers also provided outreach, seeking to engage communities as they went about their daily lives.

Figure 3 – **Provider settings and roles**



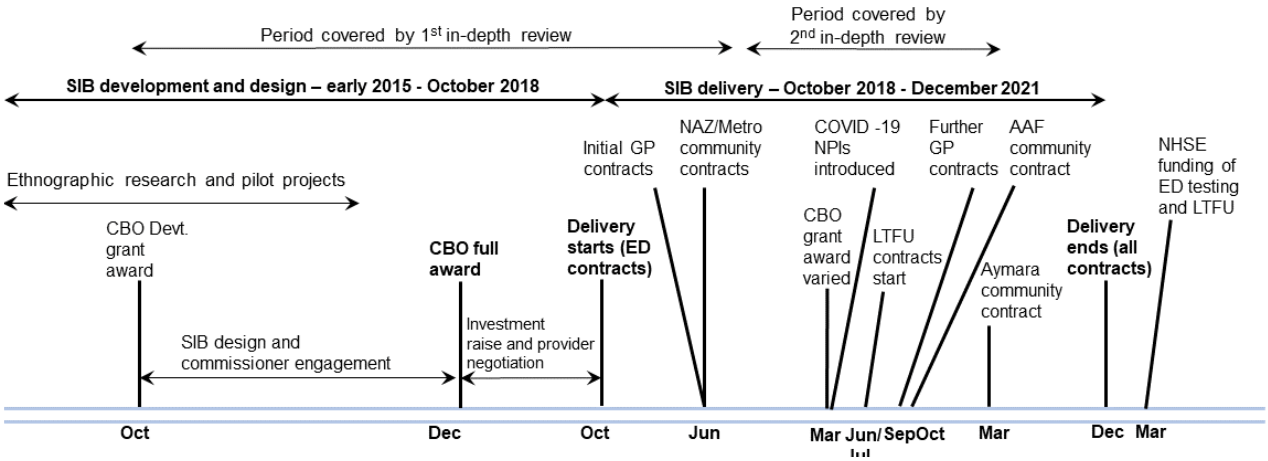
3.3 History and development

This section explains the rationale for a SIB approach to the HIV testing issue and summarises the process of developing the SIB, engaging different commissioners and stakeholders, and raising investment. Further details of this process can be found in the first review of the project already referenced above. Figure 4 provides a summary of the overall development and implementation timeline, including post-contract events described further in section 4 of this report.

3.3.1 Overview and rationale for the SIB

The Zero HIV SIB was largely conceived and driven by EJAF. EJAF is the largest non-government funder of support to the prevention and treatment of HIV and AIDS in the UK, and one of the largest independent AIDS charities in the world. According to its 2021 annual report[22] EJAF has, since 1992, funded more than 3,000 HIV projects in over 90 countries, reaching more than 100 million people with lifesaving information and services, and saving an estimated five million lives.

Figure 4: **Zero HIV SIB timeline**



The rationale for this project was that there are huge benefits, both for the health of individuals and financially to the health system, if people living with HIV can be diagnosed and treated with anti-retroviral therapy (ART). In summary:

- ART is now so effective that HIV has been redefined from an acute to chronic illness, and there is a very high likelihood that those receiving ART will be able to live a long and healthy life. The benefits of treatment are much greater if people with HIV are diagnosed early, since a late diagnosis means that the virus has already started to damage the immune system and poses the greatest threat to the health of those with HIV.
- The benefits of getting people living with HIV into effective treatment and retaining them in care are much greater than their individual health and wellbeing, because effective treatment reduces the risk that the infected person can pass on the virus to another to almost zero.
- Aside from the health benefits, there are major financial benefits for the health system through avoidance of the costs of treatment both for those whose HIV goes undetected and those who may be infected through onward transmission. There is no recent independently validated estimate of the scale of such benefits, but EJAF's own calculation, based on work by specialist consultants, is that they amount to an estimated

22 See https://www.eltonjohnaidsfoundation.org/wp-content/uploads/2022/06/40370_EltonJohn_Foundation_Interactive.pdf

£220,000 per person, based on £140,000 of cost avoided through treatment, and £80,000 avoided by reduced onward transmission. Other estimates from a range of clinical research studies estimate the costs of care to be in a range from £73,000 to £404,000 per person, with the lower figures making assumptions about the extent to which proprietary drugs will be replaced by generics in the future[23].

- Despite these benefits and huge strides made in the treatment of HIV and AIDS in the UK, there remains a challenging issue of people who remain undiagnosed or stop receiving treatment. Although 95% of people living with HIV are aware of their diagnosis, and 99% of these are in treatment, the UK Health Security Agency (UKHSA) estimate[24] that 5,150 people living with HIV in the UK remain undiagnosed.

3.3.2 Research and pilot activity

In the face of this challenge EJAF started to explore ways in which it could address the problem of undiagnosed HIV[25]. In 2015 it commissioned ethnographic research from McKinsey with support from NHSE. This focused on the three LSL South London boroughs which had the highest prevalence of undiagnosed HIV , and a high population from the two highest risk groups (MSM and BAH). The research found that current testing rates were negligible (less than 3%) and ran counter to NICE guidance that testing should be routine in emergency settings in areas of high HIV prevalence. The research showed this to be due to various factors including poor awareness of the high prevalence of HIV in the area; a perception that the process of offering a test, and associated counselling and engagement of the patient, was too complicated and time-consuming; a view that testing someone who had visited hospital or their GP for another reason was inappropriate; and staff feeling underqualified to address these issues.

The research suggested that universal testing, with appropriate support for clinicians who had to offer and administer it, would have the biggest impact on current diagnosis rates, and in 2016 EJAF ran two pilots to test this in both hospital and primary care settings:

- A trial at Kings College Hospital of 'opt-out' testing where an HIV test was routinely carried out on any patient who required blood tests when attending A&E, unless they refused consent. It showed that an opt-out policy would increase testing rates and successfully identify patients carrying the virus, including some groups (for example older patients) who would not normally be considered high risk.
- A pilot of screening for HIV, alongside Hepatitis B and C, when a patient first registered with a GP in Leeds. This was co-funded by EJAF and PHE and had more mixed results, with some practices achieving testing rates of more than 60%, but others having very low rates of testing.

3.3.3 Exploration of a SIB approach

In parallel with the ethnographic research and before these pilots, EJAF had in 2015 started to explore whether there was a way that it could use social investment to support a project in this area. It saw a number of benefits from a SIB approach:

- Additional funding. The SIB offered the chance to try something new and highly responsive and to bring new money to the effort at a time when funding within hospitals and primary care was severely compromised.
- Payment by results. The ethnographic research, later confirmed by the primary care pilot,

23 See https://www.aidsmap.com/about-hiv/how-much-does-hiv-treatment-cost-nhs#:~:text=In%20the%20UK%2C%20the%20most,or%20generic%20drugs%20are%20used

24 HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 Report, UKHSA, December 2021

25 At the time at which the research was undertaken the prevalence of diagnosed HIV per 1,000 people aged 15-59 was 16.22 in Lambeth, 11.88 in Southwark and 7.84 in Lewisham, compared to an average rate across England of 2.27.

indicated that simple funding for testing was not enough – there needed to be a combination of greater incentives to GPs to offer testing, and support to changing behaviour and practice. As we explore below, the key to this, in EJAF's view, was the shift from payment for HIV testing activity to payment for HIV detection outcomes.

- Encouraging collaboration and innovation between healthcare providers. As we observed in our first review, there was evidence for the effectiveness of increased testing in both acute and primary settings and for successful projects that aimed to target high risk groups in the community. The SIB provided the opportunity to prove the effectiveness of high levels of testing across all pathways. As EJAF observe in their own end of project report:[26]

"The funding method also gave incentives for providers to innovate. It enabled the gathering of demonstrable evidence of effectiveness of HIV testing and reengagement work. It brought fragmented and overlapping initiatives by different organisations together in one, coherent and targeted framework, paying for outcomes across providers, thus resolving the disconnection and disincentive between where resources were spent (LAs) and where benefits accrued (NHS)"

A further important driver was the opportunity to apply to the CBO programme for funding to support the development and implementation of the SIB. EJAF applied for development funding in 2015 and was awarded a development grant of £80,613 in October 2015. An interesting feature of this SIB is that the bulk of this funding was used to fund an in-house lead to drive the project forward. This project lead was recruited from a social investor, and played a key role in the development and implementation of the project.

3.3.4 Commissioner, provider and investor engagement

3.3.4.1 Commissioner engagement

The original aim of the project was for all the six local commissioners, i.e. both LAs and CCGs in the three London boroughs, to contribute to the project as outcomes payers. Despite commitment to the project, however, only LB Lambeth ultimately agreed to invest in the project, with the other commissioners unable to do so due to financial constraints. Furthermore, Lambeth were able to contribute only a proportion of outcome payments (£50,000 per year) and it appears that there was at one time a risk that the project would not proceed because it did not have commissioner financial support. In the end. EJAF itself (the Foundation not the Zero HIV CIC) agreed to reimburse the bulk of outcome payments. Thus Lambeth agreed to verify outcomes and make outcome payments in the first instance; they were then reimbursed for a high proportion of these payments by EJAF.

It was also intended that NHSE would make a contribution to outcome payments but they also declined to do so due to financial constraints. A key feature of this project, therefore, is that it does not have public agencies providing a high proportion of outcome payments: the majority of payments are made by EJAF and by the CBO programme. It is however important to note, as stakeholders have made clear to us through previous reviews and as we explain in section 3.1 above, that all local agencies (three LAs, three CCGs and NHSE) are commissioners in the wider sense of being engaged in and contributing to the project, and taking learning from it.

The CBO programme also agreed to support

26 The Elton John AIDS Foundation 'Zero HIV' Social Impact Bond. Final report on investment, implementation, and impact. March 2022. See https://www.tnlcommunityfund.org.uk/media/insights/documents/EJAF-Zero-HIV-Report-March-2022.pdf?mtime=20230406143703&focal=none

the project as a co-commissioner in November 2017. The CBO awarded the project funding of £1,652,917 which at the time constituted 23% of projected outcome payments for a project that was initially funded for two years, but was planned to be extended to a total of around six years. As we explain in section 4, this was subsequently changed to a three-year (to be exact 39-month) project.

This award was more than agreed at in principle award stage (£1.17m), in January 2017, because the scale of the project as proposed had increased. At in-principle stage there were only three commissioners proposed (Lambeth LA and CCG, and NHSE) but this had expanded to include the LAs and CCGs for both Southwark and Lewisham, so there were now seven commissioners proposed. The proposed user engagement increased from 353,888 to 493,000, and the number expected to achieve the primary outcome of entering or returning to treatment increased from 1,050 to 1,250. Investment was expected to be £2m.

3.3.4.2 Initial provider contracts

During 2018, the Zero HIV CIC put in place contracts with providers in all settings to deliver the interventions. As explained above the Zero HIV CIC was effectively prime contractor and entered into subcontracts to deliver interventions with relevant providers. The number of providers, and the services provided, grew over time with different and more providers engaged to deliver services. In addition, some interventions (ED Testing and some LTFU audit and recall) started earlier than others.

Unlike the majority of SIBs, therefore, there was no 'big bang' moment when all services from all providers went live. The initial providers in all three settings (all of whom were in place when we conducted our first review of this project, in late 2019) and the dates when their contracts became operational, were as shown in Table 1 below. As this shows a large proportion of the funding was focused on testing in health sector settings, and especially in hospital EDs and clinics.

Table 1: **Initial service providers 2018-19**

Provider	Setting	Date Operational	Services/interventions	Funding
Kings College Hospital NHSFT	Secondary care	October 2018	Emergency Department opt-out testing	£475,000
University Hospital Lewisham (Lewisham and Greenwich NHSFT)	Secondary care	October 2018	Emergency Department opt-out testing and LTFU audit and recall	£678,500
Lambeth Health Ltd (GP Federation)	Primary	June 2019	Testing in GP surgeries at registration or subsequent attendance and LTFU audit and recall	£180,000
One Health Lewisham (GP Federation)	Primary	June 2019	Testing in GP surgeries at registration or subsequent attendance LTFU audit and recall	£175,000

Provider	Setting	Date Operational	Services/interventions	Funding
Naz Project London	Community	June 2019	Community engagement in testing or reengagement of those LTFU, with a focus on BAH	£150,000
Metro Centre Ltd, on behalf of the GMI Partnership comprising Metro, Positive East and Spectra	Community	June 2019	Community engagement in testing or reengagement of those LTFU with a focus on MSM	£90,000

3.3.4.3 Investor engagement and contract negotiation

During 2018 the Zero HIV team also engaged with investors and put in place the investment structure outlined above and described in more detail in section 3.4.2.2 below.

EJAF stakeholders consulted during our first review of this project told us that the set up and contracting process took much longer than expected and was frustrating to both those directly engaged in it and to other key stakeholders – for example, the leadership team of EJAF. Part of this appears to have been due to challenges in finding the right investors, which according to stakeholders took much longer than expected. In addition, the sheer number of contracts was an issue, as EJAF states in its end of project report:

> "The contracting phase was very time intensive, partly due to the variety of contracts to be negotiated. These included the LB Lambeth commissioning contract between the CIC and LB Lambeth, the funding agreement between EJAF and LB Lambeth, the funding agreement between The National Lottery Community Fund and EJAF, and contracts between the CIC and the providers, many of which were extended. Significant time was spent with NHS trust data protection teams agreeing appropriate data protection security was in place".

In addition, the initial investment of £1m was only half what was expected at the time that the project was approved for funding by the CBO team and The National Lottery Community Fund, when total investment was predicted to be £2m.

Prior to going live EJAF also put in place a bespoke information system, developed in Power BI by Maclaren Consulting, to manage the collection of outcomes data and its subsequent reporting and visualisation. This system and McLaren Consulting were, according to EJAF, key in persuading Trusts and providers that the necessary data controls and protection would be in place.

3.4 Payment mechanism and outcome structure

3.4.1 The payment mechanism

Under their contracts to deliver services, all providers were paid for the achievement of two outcomes:

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

Beyond this simple structure the payment mechanism had the following features:

- Under the contracts providers were entitled to receive an initial lump sum payment which covered a defined number of outcomes – effectively a 'minimum order' for outcomes.
- These advance payments varied as a proportion of possible total payment and were not recoverable if the agreed number of initial outcomes was not achieved. Once the number of outcomes set out in this initial payment was exceeded, each provider was paid per outcome achieved. As we note in section 3.4.2.2 below, this was the mechanism by which providers were able to access working capital to cover their operating costs until they started to receive outcome payments - otherwise they would have faced cashflow difficulties. This mechanism was more important to the community-based VCSE providers than the NHS providers (who did not face the same cashflow pressures) though all providers made use of this facility and would have been concerned that they received enough outcome payments to cover costs in due course.
- To qualify for an LTFU re-engagement payment the patient was required to have been:
  - out of treatment for more than 12 months – measured by having had no care visit for more than twelve months, or
  - having stopped treatment more than 12 months ago based on the date of their last dispensed anti-retroviral drugs; or
  - recently released from prison or an institution and had no regular HIV care provider.

The contracted outcome payments varied by provider and precise figures per provider are not available, but we understand that they were in a range between £4,750-6,000 per outcome achieved. The SIB and its underlying payment by results mechanism thus converted a small payment for each test and associated support (ranging from less than £10 to around £50 including support) into a much larger payment for each new case identified or re-engagement made. Total payments to providers were £2.32m and amounts paid to each provider varied from £15,000 to £678,500 in total.

At the time of our first review this conversion of a small payment per transaction into a large payment per outcome was viewed by stakeholders as being key to the success of the SIB as a whole, because it created a much greater and more targeted incentive for providers to identify those needing treatment rather than simply test at scale. As we explore in sections 4 and 5, opinions on this had diverged by the end of the project.

3.4.2 Investment and financial risk sharing

3.4.2.1 Overview

The way that social investment was raised, drawn down to fund the project, and passed through to providers is interesting and has some similarities to another project that we have studied in depth as part of this evaluation, namely the Mental Health and Employment Partnership (MHEP). In overview:

- Social investment was raised from four investors and was provided in the form of loans, repayable at varying rates, to the Zero HIV CIC.

- The CIC used this capital to fund its own operations (mainly governance, and project and performance management) and also make outcome payments (including 'on account' payments as described above) to providers.
- The Zero HIV CIC received payments in turn for validated outcomes from commissioners – i.e. Lambeth, who made all 'local' payments in the first instance, and The National Lottery Community Fund, who made co-payments. Section 4 analyses outcome payments made in more detail, but in summary Lambeth paid £2.6m and The National Lottery Community Fund paid 1.1m on behalf of the CBO programme. These payments were lower than originally planned, due to the project running for around three years rather than six as originally envisaged (see section 4).
- As already explained above, Lambeth was reimbursed for all but £150,000 (£50,000 per year) of its total payment by EJAF.
- The Zero HIV CIC drew on the payments to reimburse investors, plus interest in line with the tiered structure described further below.

3.4.2.2 Investment structure

As already outlined above the SIB had four investors, including EJAF itself, Big Issue Invest (BII), Comic Relief and ViiV Healthcare. Investors therefore included one established social investor (BII), and three organisations that were relatively new to investing and usually provided grants rather than repayable finance. Of these EJAF was, as mentioned above, keen to explore social investment, Comic Relief had set up its separate Red Shed Fund similarly to explore social investment and repayable finance, and ViiV Healthcare invested from its Positive Action Fund, which was dedicated to community support, previously in the form of grants.

All four investors made a loan to the Zero HIV CIC for fixed amounts and agreed rates of interest to a total value of £1m. This was half the amount originally forecast as needed to finance the SIB, which was £2m.

The amounts invested by each party and the interest they would receive if paid out in full are shown in Table 2.1 below. This table also shows how the investment was 'tiered;' and the order in which investors would be paid out as outcomes were achieved and payments to the CIC made by commissioners.

Returns were capped at the rates shown and could not exceed these even if outcomes were higher than forecast. If outcomes were lower than expected investors would be at risk of not receiving back all their capital – with the highest risk falling on those due to be paid out last, i.e. Comic Relief and EJAF. At the Median scenario agreed with the CBO team at renegotiation, planned overall return was £15,000 on investment of £1m or 1.5%.

This structure was devised by EJAF, with support from BII. It aimed both to encourage new investors to support the project and to keep returns low. It achieved the latter by explicitly offering the opportunity to investors on the basis that the investment would be tiered and EJAF would be paid out last – thus EJAF was effectively underwriting the deal and acting as a kind of 'first loss' investor[27]. In other words, even if performance was below forecast the other investors would be less likely to lose out. As the agreed rates of return show the project achieved this objective – though in part these investors would have naturally been likely to accept lower/nil returns since they were used to funding through non-repayable grants – so even the return of capital without or at very low interest was a relative gain, giving them the opportunity to reinvest that capital elsewhere.

The exception to this was BII, who could not have invested from its specialist fund for SIBs and outcomes contracts (the Outcomes Investment Fund) at a 2.75% return (because of minimum levels of return set by its key investor in that Fund, Big Society Capital). It therefore invested from its own balance sheet via its lending portfolio.

27 'First loss' refers to capital which is used to catalyse investment by others. One definition is 'socially and environmentally driven credit enhancement provided by an investor or grant maker who agrees to bear first losses in an investment in order to catalyse the participation of co-investors that would not have otherwise entered the deal." See https://missioninvestors.org/resources/catalytic-first-loss-capital-research-and-case-studies#:~:text=Catalytic%20first%2Dloss%20capital%20refers,have%20otherwise%20entered%20the%20deal.

Table 2: **Zero HIV investment structure**

Order of pay out	Investor	Amount loaned	Capped interest
1	ViiV	£300,000	0%
2	Big Issue Invest	£200,000	2.75%
3	Comic Relief	£400,000	4%
4	Elton John Aids Foundation	£100,000	0%
	Total/Average	**£1,000,000**	**2.2%**

3.4.2.3 Risk sharing with providers

In some SIBs, the risk of outcomes being achieved is borne entirely by the investors, usually via a Special Purpose Vehicle (SPV) that manages contracts and funding flows. In such cases the SPV receives all the outcome payments from commissioners and co-commissioners and then fully funds providers to cover their delivery costs.

As outlined above this SIB had a different structure and the SPV (in this case the Zero HIV CIC) shared outcomes risk with providers, who were paid partly via a fixed, non-repayable sum (based on an agreed minimum number of outcomes) and then a variable payment based on outcomes.

This has similarities to some of the other SIBs we have reviewed in depth as part of this evaluation, including Ways to Wellness (where providers are reimbursed their costs, but only if they achieve an agreed volume of referrals) and MHEP (where the SPV paid providers in a similar way to this project – i.e. via a fixed 'on account', non-repayable sum with variable payments on top). An important difference, however, is that the payment in the MHEP model was based on user engagements, and was a much lower payment per output compared to the outcome payments made to providers under this project (around £1,000 in total compared to £4,750-6,000 here).

There was therefore some risk to providers if outcomes had fallen short of expected performance (even though they received a substantial fixed payment) and they were sharing such risk with the CIC and, through it, with the source investors. However, providers seemed broadly happy to accept this risk and be confident in their ability to achieve the requisite level of outcomes to cover their costs, as we explore further in sections 3.4.4 and 4.3 below.

3.4.3 Performance management and governance

Overall governance of this project was provided by the Zero HIV CIC Board which actively managed the project, reviewed performance and provided strategic direction. The Board had senior representation from a range of key stakeholders including the investors, the lead commissioner, and EJAF, and was chaired by an independent non-executive who themselves had direct, senior experience of social investment and impact management. Stakeholders consulted for this and previous reviews spoke highly of the role played by the Board in bringing together a team with substantial experience and

knowledge, and thought that it played a key role in the success of the project – effectively, as we explore further in section 4.3, the project benefited from intellectual as well as financial capital.

The CIC also managed the performance of the SIB and for the majority of its life (from early 2020 until March 2022) there was a SIB Performance Manager in place with long experience of project and performance management and a good understanding of both the health system and the VCSE sector's role within it. They were supported by a Social Impact Consultant (seconded to the project from McKinsey) who was involved from August 2019. This team had a number of roles including liaising with providers on a regular basis to review performance and identify and resolve any issues, reporting to the CIC Board, renewing provider contracts (which were reviewed and renewed annually), negotiating additional contracts with new providers, and liaising with commissioners including The National Lottery Community Fund.

In addition the CIC directly funded and employed the GP Champions.

An important point about the governance and structure of this project is that the Zero HIV CIC was set up and owned by EJAF, but was a separate entity. Performance management staff were thus employed by the CIC to whom they were accountable, not to EJAF. In addition, while the arrangement by which EJAF was acting as both an investor and co-commissioner/outcome payer was unusual, it was not paying itself: EJAF the foundation (and a major funder of HIV/AIDS projects worldwide) was funding the Zero HIV CIC, a separate project vehicle.

3.4.4 Comparing the Zero HIV SIB with other CBO projects

The CBO evaluation team has developed a framework for analysis to compare the SIB models across the nine in-depth review projects. This draws on the SIB dimensions set out by the Government Outcomes Lab[28], adding a sixth dimension related to cashable savings. The aim here is to understand how SIB funding mechanisms vary across CBO, and how they have evolved from their original conception. Figure 5 uses this framework to compare the Zero HIV SIB with the average positioning for the CBO in-depth review projects across six standard dimensions (Annex 1 describes the framework and the different dimensions that exist within it). This assessment is based on the design of the SIB mechanism at the launch of the project, as outlined above. Although there were some operational and contractual changes post-launch, as we outline in section 4.1, these did not alter the positioning of the Zero HIV SIB against these dimensions.

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

For further information on how these categories were formulated, and the rationale behind them, see the Third Update Report from this evaluation.[29]

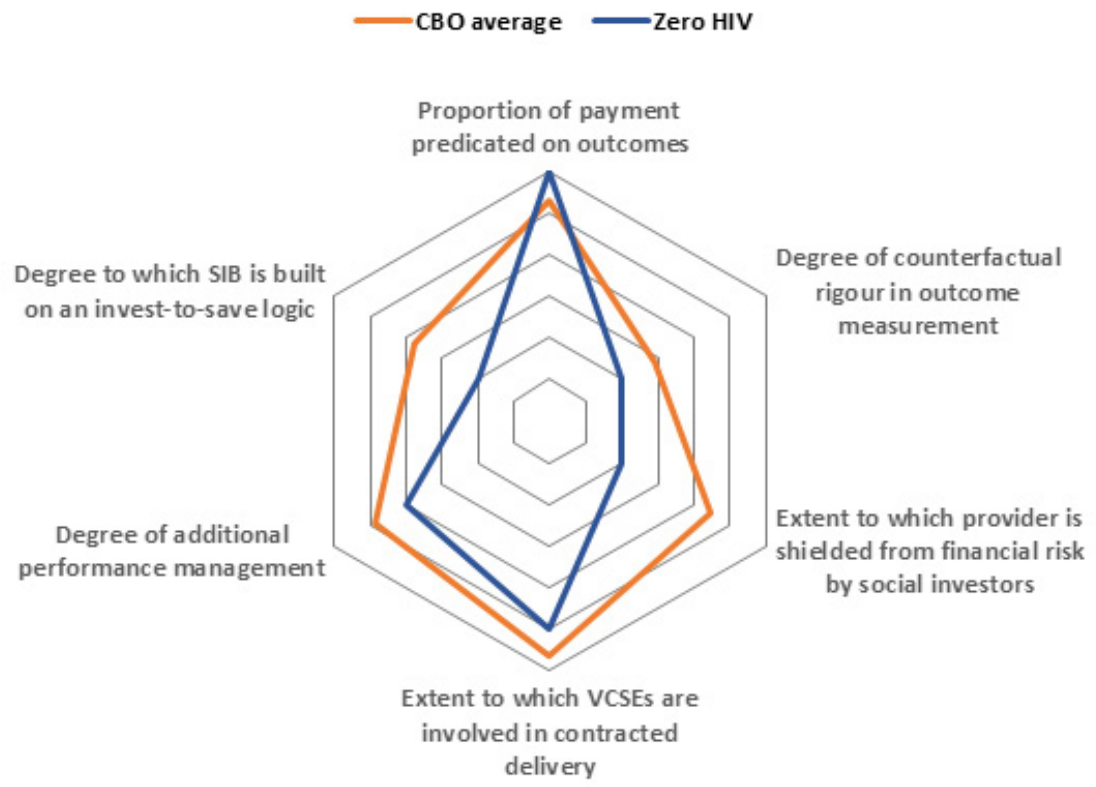
The positioning of the Zero HIV SIB against the framework shows the following:

- **Outcomes payment model:** The PbR model was based 100% on payment for outcomes achieved. Commissioners (EJAF, LB Lambeth and The National Lottery Community Fund) paid the Zero HIV CIC only when outcomes were achieved. This is typical of the CBO projects that feature as in-depth reviews: two thirds (six out of nine) of the projects have 100% of payments attached only to outcomes. In the remaining three projects (Mental Health Employment Partnership, West London Zone and Be the Change) commissioners also paid for engagements / outputs. In addition, and unusually, the CIC in turn paid providers based on outcomes achieved, albeit with a high proportion of payment paid as a lump sum (although even if this were not the case it would not affect the positioning of the project which is based on how commissioners paid).

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

29 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-3rd-update-report.pdf?mtime=20220616134448&focal=none

Figure 5: **SIB dimensions in the Zero HIV SIB and other CBO in-depth reviews**



- **Validation method:** Although payments were made for all outcomes achieved, there was no impact evaluation to ensure that outcomes were attributed to the intervention. This again is typical of SIB models in CBO, and only one of the nine in-depth review projects features measurement against a defined comparison group. As we note in section 4.3 and section 5, some stakeholders were critical of the fact that the project did not have a comparison group, baseline or other measure of the 'counterfactual' against which they could judge whether and to what extent the SIB and its payment structure had made a real difference. EJAF's own end of project report notes this as a potential weakness, commenting that:

"The SIB did not use a counterfactual methodology, which meant that there would be some difficulty in establishing for some interventions what might have happened had the SIB not been in place, such as HIV testing in primary care".

However, EJAF also point out that:

"In practice, the impact of PrEP[30] during the SIB's operational period, COVID-19 and the declining pool of undiagnosed as the work progressed, meant that this would not have been a reliable measure of the SIB's impact."

In other words, even if there had been a comparison group or baseline in place, EJAF believe its findings would have been confounded by other factors. We consider this further in section 5 of this report.

- **Provider financial risk:** As we have already outlined above, the providers contracted by the Zero HIV CIC to deliver interventions were not entirely protected from financial risk, and shared that risk with the CIC and the investors. This is a feature of four of the nine in-depth reviews, with the other five constructed so that the provider was entirely protected from financial risk, which was borne by the SPV or other body managing the project on behalf of investors. The way in which risk is shared varies from project to project and in this case the shared risk was largely that the providers would be unable to achieve enough outcomes to cover their costs. It is however fair to say that the substantial 'on account' payments that providers received would have mitigated much of this risk since those payments should have covered all or a high proportion of their fixed costs. In addition, although there was some risk that variable outcome payments would not cover variable costs, the size of each outcome payment made this risk relatively low. An indicator of the relatively low risk borne by providers is that the CIC did not have to modify payment terms during COVID-19, when community providers (those most at risk if outcomes fell short) were largely unable to engage with target communities – see section 4.1.3 for further details of the impact of COVID-19.
- **VCSE service delivery:** Four VCSEs (since the GMI Partnership covers three organisations) were providing community-based service delivery from June 2019, and two further VCSEs were contracted to deliver services later. This is typical of the in-depth reviews, all nine of which involve delivery by one or more VCSEs, although it is unusual for public sector providers (in this case NHS Trusts and GP Federations) also to be involved in service delivery. Indeed as measured by funding for delivery at inception, public sector provision accounted for the majority of the project (£1.5m out of £1.75m). For this reason, the project is assessed slightly differently to a project where all delivery is by VCSEs.
- **Performance management:** This dimension measures whether the performance management of the contract was external to service providers, rather than providers managing their own performance. As explained above performance management was provided by dedicated staff employed by and accountable to the CIC, and therefore it was external. This is a model found in five of the nine in-depth review projects, although the nature of the performance management team and its degree of separation from other parties to the contract varies. In this case we assess the performance management as external but not completely so, since it was external to and overseeing the sub-contracted providers, but did not sit outside the prime contractor, the CIC. Two of the other four projects or families of projects were designed so that performance would be managed internally by the provider, and in the final two families/projects there was a mix of external and internal performance management.

30 PrEP or pre-exposure prophylaxis is a drug (based on Antiretrovirals normally used to treat HIV) that can be taken by people before or after sex to reduce the risk of contracting HIV. The reason it would have potentially confounded measurement againt comparison group for this project that it became free on the NHS for high risk groups, via sexual health clinics, on 15 March 2020.

- **Degree to which project is built on an 'invest-to-save' logic:** As explained earlier, there are known to be substantial avoided costs to the NHS if people living with HIV are diagnosed quickly, both because their treatment costs are lower and because they reduce their risk of passing the virus to others. However, it is not apparent that those commissioning the SIB were driven by the likelihood of such financial benefits, for two reasons. First, as we identified and discussed at some length in our first review, the 'savings' from improved treatment do not accrue to the commissioner that is expected to pay for testing, since the primary beneficiaries of earlier treatment and reduced transmission are CCGs, while the cost of testing falls primarily to Public Health commissioners within LAs. Secondly, the vast majority of outcome payments were made by EJAF and The National Lottery Community Fund, neither of whom saw any direct benefit from the financial impact of the SIB. The project did however aim to draw attention to the benefits of the intervention to commissioners. In its 12-month report to the CBO at the end of its second year the project reported that:

"We calculated 'costs avoided' to the health care system of engaging people living with HIV in care and publicised this through presentations and the HIV Commission report to ensure commissioners understand the benefits of these interventions."

4.0 What has happened in practice?

In this section we describe:

- How the Zero HIV SIB changed between launch and completion, including contractual changes and how it adapted to the impact of the COVID-19 pandemic.
- How the project performed overall according to CBO data and some local project data.
- The different views of the SIB mechanism and experiences of working within a SIB of key stakeholders, where not already included in earlier sub-sections.

4.1 Contractual and operational changes

For the most part the Zero HIV SIB ran over its contract life as intended, with no changes to the overall structure, outcomes framework and payment mechanisms outlined above. The project did however adapt and change in three areas:

- The award of grant from the CBO fund was renegotiated.
- The Zero HIV CIC added new providers and contracts to those in place at the start of the project, as set out in section 3 above.
- The project had to adapt operationally (but not contractually) to the impact of COVID-19 and associated restrictions.

4.1.1 Renegotiation of CBO award

As outlined in section 3, EJAF and the Zero HIV CIC originally intended to run this project for up to six years. It was awarded CBO programme support of £1,652,917 on this basis, linked to agreed targets (known as scenarios) for user engagement (essentially the number of people who would be tested or successfully contacted where already known to be HIV positive) and outcomes (people engaged or re-engaged in treatment and triggering an outcomes payment – see section 3.4.1). The CBO award provided more support in the early years of this planned six-year period and EJAF apparently expected that local commissioners (who as explained in section 3 had declined to fund the project, apart from Lambeth) would start to do so as CBO support diminished. Essentially, key financials for each commissioner were forecast across the award, with CBO funding being front-loaded over the first three years. Breakpoints were also included in the award to review commissioner engagement.

By late 2019 it had become apparent to EJAF and the Zero HIV project team that local commissioners other than Lambeth would not be able to fund the project, and Lambeth also informed the project that it would be able to support it only for three years. In addition there were indications that NHSE was starting to consider the provision of more funding for opt-out testing for HIV, and it would be helpful for evidence from this project to be available more quickly. EJAF therefore decided that it should run the project over a shorter period than originally planned and until December 2021 (i.e. 39 months or just over three years from launch of ED opt-out testing, and around 2½ years from the point at which GP Federations and community providers started delivery).

We discuss the challenges EJAF faced in engaging commissioners in more detail in section 5.2.1 of this report, but as part of its discussions with CBO regarding the award adjustment EJAF ascribed the lack of financial commitment to three factors:

- The complexity of the HIV commissioning landscape and financial flows.
- Pressure on NHS financial resources.
- Difficulty in releasing savings from acute

health budgets when there is a near insatiable demand upon their services.

We identified these same factors in our first review of this project.

These changes required a renegotiation of both funding and associated target scenarios with The National Lottery Community Fund, in line with the break points agreed in the CBO award, the lack of commitment by local commissioners, and the benefit of the project delivering early results that would feed into discussion about a wider roll-out of opt-out testing. EJAF requested an adjustment in June 2020 and in September 2020 The National Lottery Community Fund agreed to a revised award of £913k based on adjustments to the planned scenarios as shown in Table 3 below.

Table 3: **Original and revised CBO award terms and target scenarios.**

Item/scenario	In-principle award January 2017	Original award November 2017	Revised award September 2020
Total CBO grant award (Median scenario)	£1.100.000	£1,200,000	£913,496
Users entering treatment (Outcome A)			
High scenario	1050	1250	467
Median scenario	672	942	387
Low scenario	235	471	307
Users engaged/tested (Outcome B)			
High scenario	353,888	493,000	300,000
Median scenario	283,111	395,450	250,000
Low scenario	141,555	197,725	200,000

As Table 3 shows, the revised project entailed a scale back in ambition from the original proposal approved by the CBO in December 2017, with a significant reset of the contract and consequent changes to contract volumes and targets.

4.1.2 Addition of new providers and sub-contracts

The second development was that the Zero HIV CIC added further services and contracts in addition to those commencing in October 2018 (for ED testing by hospital trusts) and in June 2019 (for interventions by GP Federations and community VCSE providers). The main additions were:

- Additional contracts for hospital trusts to undertake audit and recall of those LTFU starting in mid-2020 (these were due to start in April 2020 but were delayed due to the impact of COVID-19 – see section 4.1.3)
- Two additional contracts with GP Federations starting in September 2020; and
- Two additional contracts with VCSE providers starting in late 2020 and April 2021.

Table 4 below summarises the additional contracts made, their start date and the type of intervention/target cohort.

The Zero HIV CIC also extended contracts with all providers. All contracts were renewed annually throughout the project but they were renewed each year on exactly the same terms, with the only change being to the minimum and maximum targets agreed for the following year.

New contracts appear to have been added due to a mix of the CIC's own efforts to extend the reach of the project (e.g. into primary care in all three London Borough areas) and other providers taking the initiative to extend services and propose contracts to the CIC. The latter appears to have been the process for the targeted audit and recall contracts in hospital trusts, and both additional community contracts.

Again, we would note that, in common with original contracts, the bulk of funding was to public service providers, which is unusual relative to most CBO-funded projects.

The addition of further community contracts appears partly to have been designed to ensure good coverage across specific vulnerable groups. In summary Metro and its GMI subcontractors provided testing in community settings (bar, sauna, street), especially focused on MSM; NAZ (and later, Aymara) provided testing in community settings (restaurants, faith communities, barbers shops) for Latin Americans and those engaged in Latin American networks; and African Advocacy provided testing in community settings (barber shops, hair salons, nail salons) for BAH service users.

Throughout the negotiation of contracts (both at launch as described in section 3 and subsequently as described above) the Zero HIV CIC benefited from legal support from Freshfields Bruckhaus Deringer LLP. This support was estimated by stakeholders to have an equivalent value of more than £500,000.

Table 4: **Additional provider contracts made during the life of the SIB**

Provider	Setting	Date Operational	Services/interventions	Funding paid to provider[31]
St, Thomas' Hospital (Guy's and St Thomas' NHSFT)	Secondary care	June 2020	LTFU audit and recall by sexual health clinics	*£259,781*
Kings College Hospital NHSFT	Secondary care	July 2020	LTFU audit and recall by sexual health clinics	*£209,781*
Improving Health Ltd (South Southwark GP Federation)	Primary	Sept 2020	Testing in GP surgeries at registration or subsequent attendance and LTFU audit and recall	*£35,000*
Quay Health Services (North Southwark GP Federation)	Primary	Sept 2020	Testing in GP surgeries at registration or subsequent attendance LTFU audit and recall	*£35,000*
African Advocacy Foundation	Community	Oct 2020	Community engagement in testing or reengagement of those LTFU, with a focus on BAH	*£20,000*
Aymara Social Enterprises	Community	April 2021	Community engagement in testing or reengagement of those LTFU, with a focus on MSM and the South American community	*£15,000*

4.1.3 Changes in response to COVID-19

Our second in-depth review of this project focused on the impact of the COVID-19 pandemic and associated restrictions on this project, so please refer to that report[32] for a full account of the impact COVID-19 and lessons for other projects from it.

The timing of COVID-19 and the imposition of associated Non-pharmaceutical Interventions (NPIs) was potentially challenging for the project, since NPIs (specifically so-called Lockdown 1 – the most restrictive in the UK) were first imposed in March 2020 and arrived almost exactly in the middle of the overall contract period. As EJAF itself commented in its second annual report to the CBO:

31 This is the amount paid, which in one case includes prepayment for an outcome not subsequently achieved

32 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-2.pdf?mtime=20220224150943&focal=none

"The most significant challenge faced thus far in the Social Impact Bond is the emergence of COVID-19. As the virus spread to the UK, hospital clinicians, primary care GPs, and healthcare leadership across organisations turned their focus to the new pandemic. The urgency of the COVID-19 response drew needed capacity and resources away from HIV care. April and May 2020 were especially difficult, with key clinicians reassigned to COVID-19 wards and outcomes experiencing a steep drop-off."

We summarise the main impacts of COVID-19 and the response of the project below.

4.1.3.1 Impact on contractual relationships and 'supplier relief'

An important finding is that this project did not need to make any significant contractual adjustments to provide what was termed 'supplier relief'. At the outset of the pandemic, in March 2020, the Cabinet Office issued a Procurement Policy Note (PPN)[33]. This provided information and guidance on how all public authorities should respond to contract disruption. It also sought to ensure service continuity through COVID-19, by providing supplier relief through urgently reviewing their contract portfolio, and informing suppliers at risk that they would continue to be paid as normal (even if service delivery was disrupted or temporarily suspended); and supporting supplier cash flow through approaches such as forward ordering, payment in advance/prepayment, interim payments and payment on order (not receipt).

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

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

We found that the Zero HIV SIB did not have to make such adjustments[34] in part because the operational impact on some strands of service and intervention was not that severe, and in part because the forward payments to suppliers described in section 3.4 were sufficient to enable services to be maintained. This applied even among the most adversely – affected community VCSE providers, who were unable to operate at all for long periods, as described below. Some of these providers were however able to avoid significant issues only because they had other contracts on which they were granted supplier relief, and were able to furlough some staff, which gave them enough cashflow to maintain services.

4.1.3.2 Operational impact

The operational impact on the project was mixed and dependent to a large extent on the type of intervention and its settings and delivery mechanisms:

- The most directly impacted were the community providers, who were largely unable to deliver services at all during lockdowns, because the social and commercial venues in which they engaged with people living with HIV (such as night clubs, gyms and barbers shops) were completely closed. Services did adapt where they were able to do so, but the scope for this was limited.

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

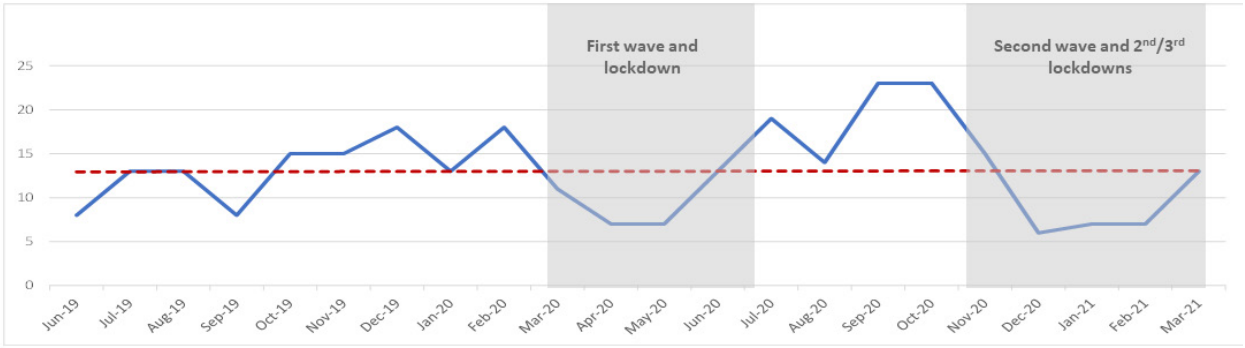
34 It is worth noting that relatively few CBO projects had to make significant adjustments due to COVD-19, and this project was one of seven that made no adjustment at all.

- GP Federations and individual GP practices were also adversely affected because fewer patients were seen face to face, reducing opportunities for engagement and testing; and GPs were in any case only allowed during COVID-19 restrictions to order urgent blood tests, not routine ones (and therefore could not automatically add HIV testing to such tests). GPs were however able to carry on tracing those who were LTFU and persuading them to return to treatment, as they had done pre-COVID-19.
- Testing in hospitals was much less affected, since a large number of patients continued to attend emergency departments and could still be tested. The main effect of COVID-19 was that more attended A&E because they had or believed they had COVID-19, and far fewer attended for other reasons. COVID-19 did affect the capacity of the hospitals to deliver testing – in part because some key staff were redeployed to COVID-19 wards, and in part because staff themselves were ill with COVID-19, or were forced to self-isolate. However, it does not appear that these impacts were sufficient to impair the ability of the services to deliver a steady flow of outcomes.
- In addition, the LTFU audit and recall services were able to operate largely as normal because they did not require face to face contact to carry out the necessary audit of cases and follow–up contact work by phone or email. COVID-19 meant that the new audit and recall contracts with Kings College, and Guy's and St. Thomas' hospitals did not start on time (in April 2020) and were delayed until June/July when lockdown 1 started to ease, and all the services faced the capacity issues encountered in A&E. Once they were operational they performed strongly, however, and were able to tap into a reservoir of potential re-engagement outcomes in their early months, and especially during the summer and autumn of 2020.

So despite wide variation, the overall performance of the project remained strong. Indeed, measured on outcomes alone, the project maintained a consistent level of performance from the point at which all the original services went live (in June 2019) until the end of the second lockdown (in March 2021). As Figure 6 shows, the trend across this period was exactly flat, with dips in performance during both lockdowns offset by a strong uptick in performance, especially from the LTFU audit and recall contracts, in between.

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

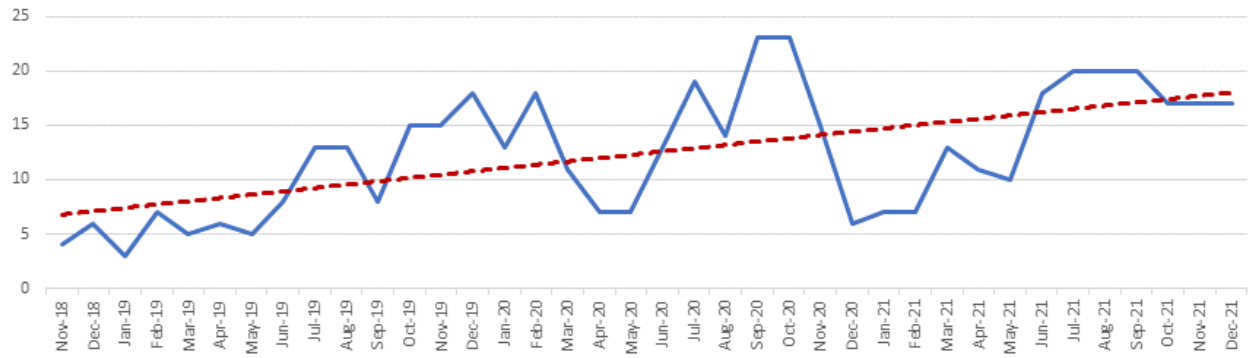
Figure 6: **Outcomes achieved per month before and through COVID-19**



Source: EJAF outcomes data

Our second review did not cover the impact of COVID-19 beyond the end of the second lockdown (which was progressively eased between April and July 2021) and stakeholders confirmed that it continued to have an impact until the end of the project – notably in affecting the capacity of staff in hospitals and access to services in GP practices. However, the impact on the project was significantly lower than previous lockdowns, partly because the settings in which community providers operated were fully open from July 2021. Outcome performance beyond March 2021 until the end of the project, as reported to the CBO team, confirms this, with a clear upward trend and increase in average outcomes per month, by the end of the project – see Figure 7 below.

Figure 7: **Outcomes achieved per month to end of project**



Source: EJAF outcomes data, CBO End of Grant (EoG) data

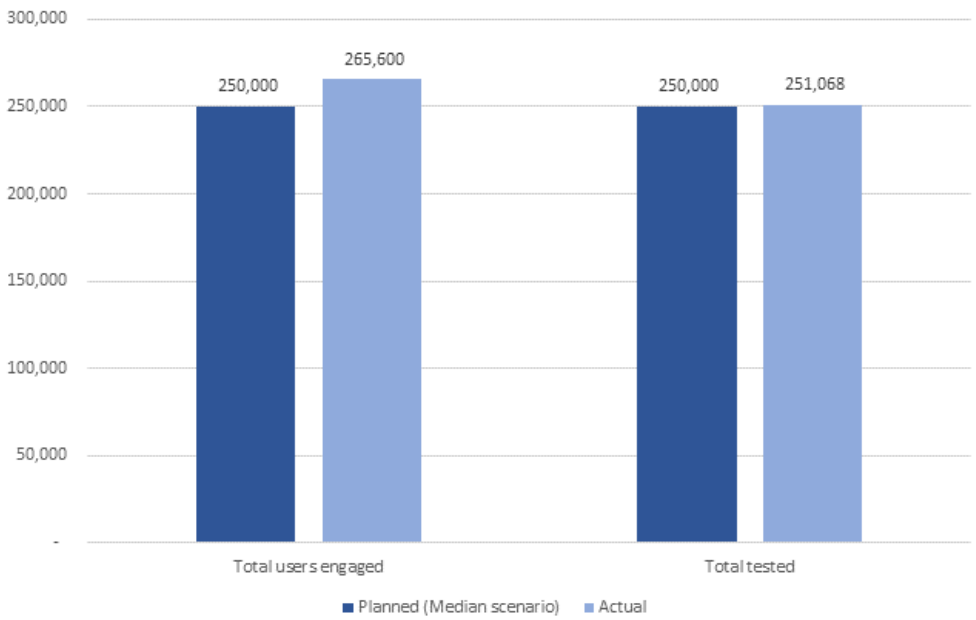
4.2 Project performance

This section summarises how the project performed compared to plan as agreed with the CBO team. In all cases we are comparing actual performance against the Median scenario agreed when the CBO award was renegotiated in 2020, based on just over three years' project duration, rather than the original scenario agreed at project start – which assumed a six year project and therefore higher targets for both outcomes and spending.

4.2.1 Volume targets

Figure 8 below shows how the project performed in terms of total service users engaged and achieving the broad outcome (Outcome B) agreed with the CBO team – which was simply that the service user was tested. As this shows the project narrowly exceeded the renegotiated Median target to complete 250,000 tests.

Figure 8: **Service user engagement and testing**

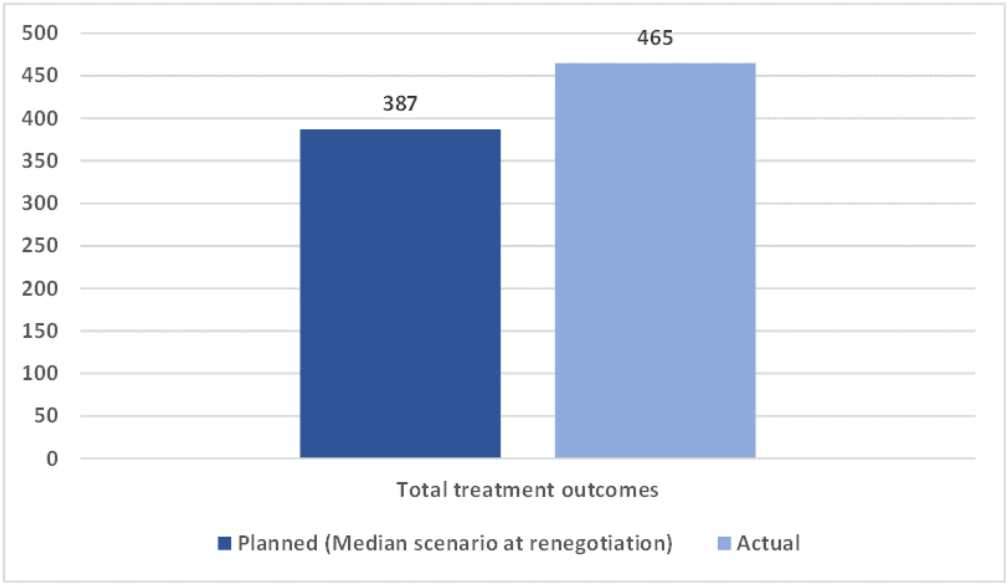


Source: CBO End of Grant (EoG) monitoring information

4.2.2 Outcome performance

Figure 9 below shows how the project performed against its renegotiated target for the core Outcome A – i.e. the number of people identified as HIV positive and entering treatment, or re-engaged after being out of treatment for more than 12 months. As this shows the project achieved 465 outcomes. This comfortably exceeded the Median scenario agreed at renegotiation and was very close to the High scenario (467 outcomes).

Figure 9: **Total outcomes (people entering or re-engaging with treatment)**



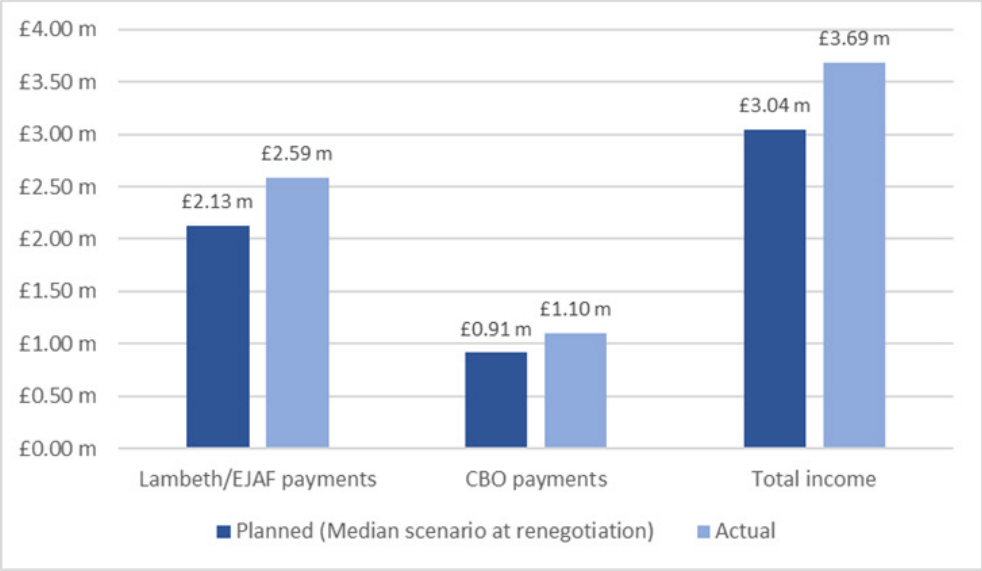
Source: CBO EoG monitoring information

4.2.3 Commissioner payments

Figure 10 shows total commissioner payments and how they break down between local commissioners (EJAF and Lambeth) and the CBO programme. Lambeth contributed £150,000 to local outcome payments, in line with plan at renegotiation.

Since they naturally mirror outcomes achieved, total outcome payments also comfortably exceeded the Median scenario at renegotiation and were close to plan at High scenario.

Figure 10: **Commissioner and co-commissioner outcome payments**

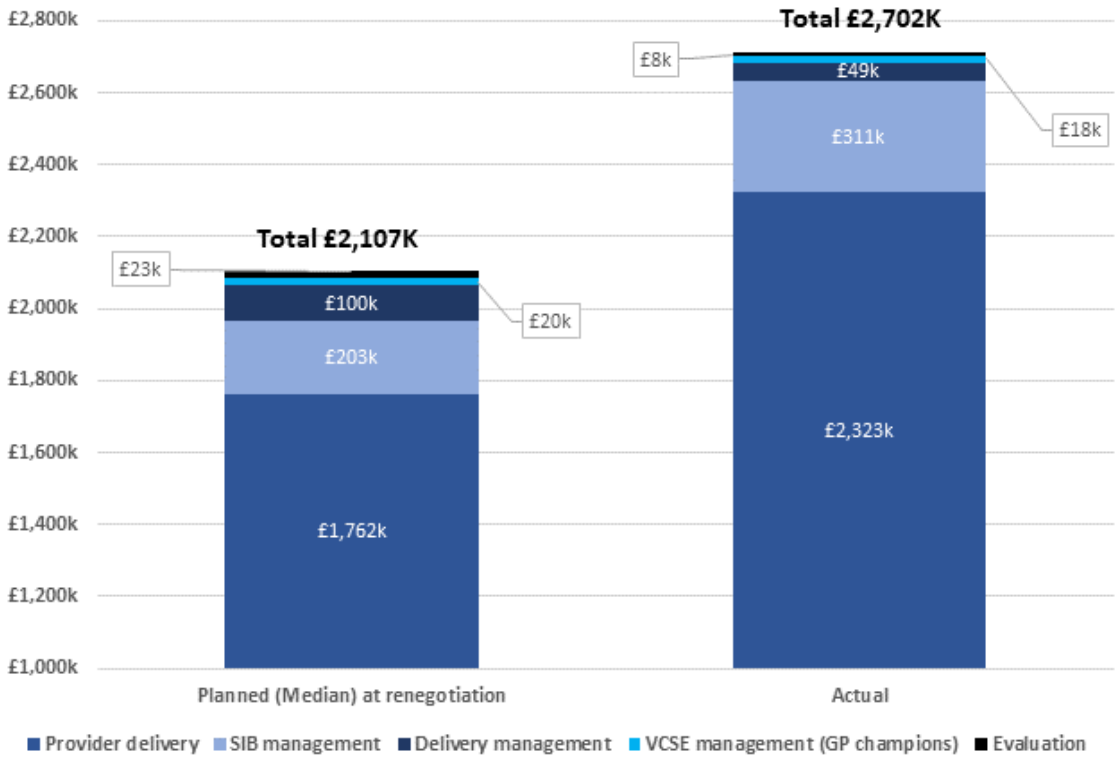


Source: CBO EoG monitoring information

4.2.4 Total and planned delivery costs

Figure 11 shows total delivery costs, including SIB management by the Zero HIV CIC team and delivery management by the VCSE providers, and a small amount of spend on local evaluation. As this shows total spend was higher than Median scenario at negotiation (£2,702k compared to £2,107k) with the difference being almost entirely due to additional spend on direct delivery. Comparing outcome payments with total costs shows a significant surplus of £953k within the Zero HIV CIC of income over costs. This surplus was returned to EJAF at the end of the project.

Figure 11: **Planned and actual delivery costs**



Source: CBO EoG monitoring information

4.2.5 Investment returns

As explained above the project raised an initial £1m in investment and according to stakeholders all of this was drawn down by the CIC to cover its own operating costs and enable it to make advance payments to providers as described in section 3.4. We understand that not all the capital was required because as outcomes started to be verified and payments made, there was sufficient income within the CIC to recycle these payments to cover future costs – a frequent scenario found in most SIB structures. Overall, outcome performance was strong enough for all investors to be fully repaid by December 2020 – twelve months before project conclusion – with interest (£2.6k) slightly above Median scenario baseline projections (maximum interest was capped at 2.2%). Interest bearing loans ended in February 2020. The final payment made in December 2020 would have been earlier if the last transfer had not been delayed by the investor. According to the CBO project data the SIB achieved an overall money multiple (i.e. total capital plus returns as a multiple of total investment) of 1.02

4.2.6 Savings and avoided costs

Finally, one measure of project performance considered by the CBO is whether the SIB achieves target savings made or costs avoided by commissioners (even though as we acknowledge above 'invest to save' was not a key driver in this case, especially once commissioners declined to fund outcome payments).

On this scenario the project significantly exceeded Median and achieved almost exactly 100% of its High scenario target at renegotiation – £5.67m compared to £5.7m, or 99.6%. Net savings to the local commissioners (mainly EJAF) were £1,983k, short

of Median scenario but still a significant net benefit equivalent to a benefit cost ratio (BCR) of 1.54[35] . We have not been able to validate these estimates but they seem conservative compared to the total costs calculated to be avoided by each person entering treatment of £220k per person noted above – which would generate avoided costs of more than £96m. This may be accounted for by the estimates made by the project for the end of grant return to the CBO being much more directly related to immediate and short-term benefits (and completely excluding any benefits due to reduced transmission, for example).

Even these conservative estimates suggest that engagement in treatment has strong positive value, which casts an interesting light on the reluctance of local commissioners to invest in outcome payments – an issue that we discuss further in section 5 of this report.

4.3 Stakeholder experiences

This section summarises stakeholders' views on – and experiences of – working within the project, and being involved in a SIB.

4.3.1 Service provider experience

We consulted service providers across all delivery strands through the second and third reviews and nearly all had a positive experience, although much of that positivity was related to the fact that targeted funding had been made available through the SIB for services and interventions that they wanted to expand or test – rather than the effect of the SIB in itself.

Providers did however observe that the fact that this was a 'Social Impact Bond' was itself important and created momentum for and excitement about the project– an interesting finding which we have observed in some other reviews (for example the Reconnections SIB). Stakeholders did not believe that the 'buzz' and excitement created by this would have been present if the project had been conventionally funded. All providers were aware that this was a SIB and tended in general to understand the overall principles and mechanics of a SIB approach – which we have not always found to be the case across in-depth reviews.

Providers had mixed views about the importance of the PbR mechanism that was built into outcome payments. Providers of ED testing did not think it was very important, but our second review found that it was a factor in the LTFU audit and recall contracts that were initiated by the sexual health clinic consultants in 2020, and concluded that it would have been difficult to fund these services without a substantial payment per outcome which justified the cost and effort of the necessary tracing work.

Some community providers also valued the additional incentive that they had to seek out those who had disengaged from treatment. In addition, the GP champions working across and with the individual practices in each GP Federation also thought the funding was an important spur to action. As one commented, *'We would say to GPs – hey you need to do this because there's real money attached to it'*

Some clinical providers were clearly motivated solely by a passion for doing the right thing for patients. In addition, one community provider responded throughout all three of our reviews that PbR was not a key driver for them and they would have been equally motivated by conventional block funding. The same provider also thought they had lost money overall although they had still found involvement in the project a positive experience:

35 The Benefit Cost Ratio (BCR) is recommended in the Treasury Green Book as a way of assessing the value for money of an intervention. It is defined as the ratio of the present value of benefits to the present value of costs. See Green Book 2022 section 5.54. In this case note that the actual BCR may be slightly different because cost and savings data from EJAF have not been converted to net present value, as the Green Book stipulates

"I keep being told that we should have made a massive profit. I don't think we were massively overspent but I think we didn't quite break even. So we didn't do enough outcomes for that to be the case so in that way we are like slightly ambivalent about it money wise but I think it was good programme wise and I think it helped us work in a different way and we were happy to be part of it."

Community provider

Community providers also found the impact of COVID-19 more challenging, since as noted above and explored in depth in our second review, they were unable to deliver any services because the settings in which they provided outreach – such as hospitality venues frequented by MSM – were shut down by COVID-19 restrictions. Even when restrictions were lifted community providers reported that they could not fully recover and 'things were slow', because MSM and other target communities did not return to venues in pre-COVID numbers.

Some community providers also praised the flexibility that the outcome-based structure gave them to do what they thought was best, contrasting this with input driven contracts which sometimes over-specified – e.g. requiring them to do a specified numbers of tests with MSM and only MSM. One reported that this flexibility had enabled them to shift their focus away from MSM and towards specific ethnicities who were culturally disinclined to be tested and/or stay in treatment. They observed that MSM had higher awareness of the risk of HIV and were more inclined to be tested, and therefore widespread testing in this community would be less effective. As this provider commented:

This is the way to reach people who are invisible, most of the service users we reach have immigration problems, have many issues so they are very difficult to reach. I was talking about this with someone who goes to Soho to do testing. They go and do 900 tests. all negative – why does this happen? Everyone is aware of the issue, everyone is testing and if they are negative they are taking PrEP. We need to go where the problem is and go into small communities and this is a beautiful way to work because if I don't find them I don't get money and I can prove everything I do.

Finally, providers praised the role played by the Zero HIV CIC project and performance management team which was directly funded by the capital raised for the SIB – an issue we explore further under SIB benefits in section 5.1.1 below.

4.3.2 Commissioner experience

Commissioner stakeholders also had mixed views about both the impact of the SIB and of the PbR mechanism. One local commissioner (though not contributing to outcome payments) thought that the PbR mechanism, and high payment per outcome, was very important to the success of the project because it was easier to prove what had happened and who had caused it.

Because the SIB only pays for outcomes the onus on the provider is all about very very clear demonstration of outcome and very very clear demonstration of attribution. I've worked on other sorts of SIBs where the outcomes are softer and attribution is a total nightmare….Its's a very clear outcome that you can attribute to the intervention.

LA commissioner

Conversely NHSE commissioner stakeholders (who also did not pay for outcomes) thought that the PbR mechanism made no difference, especially in the clinical settings, and that the important point was the availability of targeted funding for blanket opt-out testing, and to a lesser extent LTFU audit and recall. Commissioner stakeholders observed that audit and recall was already part of the role of clinics but as noted above it is not sufficiently well funded to make it worthwhile – i.e. at least some targeted funding for audit and recall work needs to be specified in Foundation Trust contracts, otherwise it will be a low priority. NHSE stakeholders also referred to the issue of 'busyness' being as important as funding in some settings such as A&E – that is, hard-pressed clinicians dealing with a medical emergency will find it difficult to give time to other issues such as HIV testing unless specifically incentivised (or contractually required) to do so.

Some commissioners also observed that it was difficult to judge the effectiveness of the SIB because there was no baseline or comparison group against which to assess the additional outcomes achieved by the project or their attribution to the intervention. The KCL Service Evaluation makes a similar observation, that '…the absence of robust baseline data for key outcomes or a commitment to a counterfactual evaluation design means it is not possible to attribute outcomes to specific interventions'. This was viewed as more of an issue in primary care than in hospitals, since as another commissioner observed there was, prior to this project, virtually no HIV testing in ED in some hospitals. As this commissioner observed:

"In Lewisham testing wasn't happening so the baseline is zero in that context so that's easy enough. Whereas primary care yes I think it's difficult to prove that you aren't paying money for old rope to be honest, stuff that would have happened anyway …..and if you look at the payment structure where you are paying for every outcome well that's odd because primary care were certainly finding people with HIV before."

The issue of whether there could or should have been a measure of the counterfactual is complex and we explore it further in section 5.1.2.

4.3.3 Investor experience

Understandably, investors in the SIB reported a positive experience. All had been paid out in full and with interest where appropriate, and had been repaid back sooner than expected, despite there being some risk if outcomes had been lower than forecast, especially to Comic Relief Red Shed who invested the most and were paid out second last under the tiered structure (see section 3.4.2.2). Both investors with a history of conventional grant funding (Comic Relief Red Shed and ViiV Positive Action Fund) were pleased that the project had demonstrated the potential of repayable finance, while enabling them to continue to fund important social and health outcomes.

The established social investor, BII also had a positive experience and stressed in both the first and third reviews that it had been committed to this project and had chosen to invest via its lending portfolio because it could not have done so via its specialist Outcomes Investment Fund – which requires a higher rate of return. BII also played an important role in the design of the project, as other investors acknowledged, helping EJAF devise the tiered structure and engage with investors.

4.3.4 EJAF/Zero HIV CIC experience

As explained above, both EJAF (as a leading funder of HIV prevention and treatment) and the Zero HIV CIC (as the vehicle through which this project was governed and managed) played a key role in this project. From the former perspective, EJAF senior stakeholders were delighted with the impact of this project and in particular the way that it was able to act as a proof of concept for successor funding, and potentially other projects – we explore this further in section 6 of this report. EJAF stakeholders also echoed the view of others that the project being a SIB had galvanised action and support and created its own momentum. In addition, EJAF strongly welcomed the support that the project attracted from the CBO programme and acknowledged that this was an important factor in the success of the project.

As a Foundation used to putting money to work through grants EJAF did however see downsides to the SIB mechanism. There was frustration (identified during our first review) at the complexity of the SIB design and implementation process and the time it took to make progress. This is a factor we have observed across many SIBs but one which may have been particularly irksome to EJAF because of its unfamiliarity with NHS and local authority commissioning processes (and indeed CBO grant award processes, which added a further level of unfamiliar complexity).

More importantly, EJAF as a Foundation was frustrated by the reluctance of commissioners – despite significant engagement effort and discussion – to agree to pay for outcomes (with the partial exception of LB Lambeth). As noted earlier, EJAF attributed this to a combination of simple shortage of funding and to the complexity of funding mechanisms for HIV testing, prevention and treatment – we discuss this further in section 5.1.2 of this report.

Stakeholders thought that the potential conflicts of interest in EJAF having multiple roles were managed effectively. The governance of the project was arranged so that the Zero HIV CIC was a separate entity with its own budget, and key staff – notably the SIB performance management team – were employed by the CIC not by EJAF. The Foundation was therefore making payments to a separate body – not to itself. In addition, no other stakeholder raised any concerns with regard to EJAF's multiple roles – indeed they welcomed the support that EJAF had provided to keep the project viable. As we explored in depth in the first review, arguably the biggest concern with EJAF's position was it rendered some of the SIB infrastructure unnecessary[36] – we thought that EJAF could have funded providers directly, still with a payment by results element, and achieved much the same outcomes. However EJAF stakeholders strongly refuted this, and though that the SIB had given them multiple benefits that could not otherwise have been achieved.

Stakeholders in the Zero HIV CIC had a positive view of the way it was governed and managed. We interviewed CIC Board members as stakeholders in their own right, and there was strong support for and belief in the active role the Board had played in driving the project, reviewing performance and applying experience and knowledge to solve issues and problems. Some identified this as a clear benefit of the SIB model – i.e. the SIB brought together a range of people with expertise that would not otherwise have been available (such as investors) and created a governance structure that would not have been in place for a conventional project, They observed that it would be important to replicate this, albeit with different people, if a similar project were initiated elsewhere.

36 See pages 47-48 of the first review

"I've had a lovely time on the Board – it's been brilliant because it's gone well. But if it had been going wrong, we would have had I guess at that point four or five people who had some experience [and] a group of people who were interested in trying to solve it and frankly that didn't happen, but if it had just been EJAF you wouldn't have had that collective brainpower in the room…. And I guess there's now a group of us who know a little bit more about this you know each time you do a different impact bond you know a little bit more than you did before hand and a key thing for me is what comes next"

CIC Board stakeholder

The performance management team were also positive about the project and believed that it would not have been so successful if it had not had their involvement in driving it forward and acting as an external change agent. As noted above other stakeholders, especially providers but also commissioners agreed, and we discuss this further in section 5.1.1.

4.3.5 The National Lottery Community Fund experience

The CBO team who assessed the project for The National Lottery Community Fund were supportive of the project and recommended an initial award of £1.65m, which as noted above in section 3.3.2 was less than originally requested by EJAF (£2m) but more than agreed at in principle award stage (£1.17m) because the scale of the project had increased.

There was therefore some disappointment that the project was later scaled back – first when only half the projected investment was raised and more importantly, when it transpired that only LB Lambeth was making any contribution to outcome payments, although all the other local agencies technically remained 'commissioners'.The chain of events here is unclear, but it appears that EJAF had applied to the CBO in the expectation that it would be able to bring the other commissioners on board as outcomes payers, but later found that it was unable to do so.

At the time of in-principle award EJAF named both LB Lambeth and NHSE as commissioners, and at final award it named six local commissioners (both LAs and CCGs from each of the three areas) as well as NHSE. At the end of the first year of the project EJAF was still reporting strong engagement with all commissioners but by the end of the second year it was naming only LB Lambeth as a local commissioner, so it appears that at this point it had concluded (or been told) that other commissioners would not contribute. This meant that EJAF had to step in as an outcomes payer in order to maintain the project, as reported earlier[37], and led to 'break point' discussions with the CBO team that meant that, in due course, the CBO award had to be renegotiated and the project reset at lower levels of outcome. CBO stakeholders commented that they learnt from this experience and required grant claimants to provide more detail in claims as to the amount each commissioner was paying.

That said The National Lottery Community Fund remains very supportive of this project and a CBO stakeholder was a member of the Zero HIV CIC Board. This gave The National Lottery Community Fund direct access to the project and enabled them to contribute to relevant issues. This stakeholder was strongly supportive of the project and the impact it has achieved as well as its potential wider and longer-term impact on HIV testing and treatment in England (see section 6). As this stakeholder observed:

37 Though as also noted earlier EJAF's gross contribution of £2.4m eventually became a net contribution of £1.4m once the surplus on the project was repaid.

"The biggest thing for me is that the way they structured the outcomes is the right way. They saw that the way that it had been paid before didn't work, and not only that then linking it with the learning that they needed to then have his amazing influence that they've now had. That for me is mind-blowing that that could have a fundamental change across the whole of government policy because the SIB was able to do this thing as scale, was able to look at how you fund things differently, just blows my mind."

4.3.6 Service user experience

As explained in section 2 of this report we made a conscious decision at the outset of this review not to do separate user research to that already planned as part of the KCL Service Evaluation. The KCL report contains useful case studies of service user/ patient experience in both secondary and primary care, which are included in Boxes 1 and 2 below.

As these case studies indicate, service users did not have specific insights into the impact of the SIB mechanism, which appears to have been almost entirely invisible to them, as might have been expected. Service users were specifically asked if they were aware of the project being both the Zero HIV project and 'a Social Impact Bond' SIB and confirmed that they were not. One service user was however aware that this project was aiming to prove the effectiveness of testing and support the case for wider funding by government, commenting that:

"...there was a point where I think the government were going to take over some of the funding and [my GP] said that we're really fighting for this at the moment"

Box 1: **Secondary Care Patient Experience: Bennie's Story**

Bennie has lived in London for many years A couple of years ago, he was not feeling well – so he went to his local ED One of the ED doctors organised for him to have an HIV test in the ED, despite him having very few HIV risk factors: *'[The doctor] asked me, have I ever been tested for STDs or HIV, and I said, no, and they said, did you mind, I said, I don't, because obviously, I didn't think anything of it.*

He was admitted to hospital from the ED and thought nothing more of the HIV test Two days after his admission, he was visited on the ward by the HIV team: *'So, they came in and they said that I tested positive, and obviously, they gave me all the support and stuff '*

Bennie spoke very highly of the support he received from the HIV clinical staff describing themes: *'Very, very supportive. [the nurse] held my hand, and it was, I mean… we are kind of friends when I go [to the clinic] for my blood test. It's like family… they told me everything, they explained everything. I mean, I cannot thank them enough… every time you go [to the clinic] it's just like, they don't look at you like you've got disease; they look at you like you just come in and say, hello, good morning, how are you? The nurses know, and even when they take the blood test, everyone is so friendly, you just do want to go there, literally.*

'Bennie is fully supportive of opt-out testing in ED: *'I think they should do it [test for HIV]automatically, that should be just a normal, standard thing, because like I said to you, I don't know when and how… I mean, I think I know how, but I still, I'm not 100% sure, and if they didn't do that, then I was still living and probably been much more ill than I am now, so there should be standard tests like they shouldn't ask, they should just do it.*

'Bennie had heard of EJAF and had an understanding that they were involved in some way but felt that the service functioned as a standard NHS one. He was keen that the service continue beyond 2021 and that the NHS fund the service.

He was keen to pass on the following message about education for schoolchildren and for HIV testing to be increased and normalised for everyone: *'I think that [schools] should have someone to actually come in to talk to them about HIV, how you catch it or how not to catch it, just to make them aware… To avoid it and to help them understand that if you do get it, it's not the end of the world, but it's better for them not to get it.'*

Source: KCL Service Evaluation

Box 2: **Primary Care Patient Experience: Suzie's Story**

Suzie returned to London having lived away from the capital for a few years and registered as anew patient at her new local GP surgery At the end of her new patient check-up the nurse asked Suzie if she'd take an HIV test: *'as I was just leaving the surgery [the nurse], really nicely, asked me would I be prepared to take an HIV test and I thought, well, yeah why not. Now had I been in a hurry that day, I wouldn't have taken that test, it would have been one of those things where I would have said 'look, do you know what, next time I'm coming in I'll have that', but you know that day never happens does it…'*

Suzie had very few HIV risk factors, but, very unexpectedly, the test came back positive Suzie was referred to her local hospital to see the HIV specialist team the following week That week spent waiting for the appointment was hard However, once she met the specialist team, led by the local consultant she felt in safe hands: *'I've got a lot of faith in [the HIV consultant] because you know when you meet someone and you kind of click and you know that they're going to go above and beyond and she's very much like that.*

'Suzie's HIV was diagnosed before she developed any symptoms She was put on to treatment and is able to live a fully functioning life She is an advocate for Primary Care opt-out HIV testing: *'you can't force people to have it, but if anyone said to me 'what would you advise me to do', my advice will be always to have the test, because in the extremely unlikely event – and it is extremely unlikely– then you will get treated. So, I can't see a negative in it at all.*

Suzie suggested a good analogy for the inclusion of HIV testing in new patient appointments might be the following: *'it's like checking a car, taking it in for a service and not checking the brakes isn't it, you know, we're going to check everything but we're not going to check the brakes. It's got to be done, hasn't it?*

Suzie was not aware of how the service was funded – or the involvement of EJAF or the nature of the SIB – for her, the experience was one in which the NHS provided an excellent, well integrated care pathway: *'A really, really good NHS [service], you know, when the NHS is at its best kind of thing.'*

Finally, Suzie stressed: *'one thing that I think could be changed and there should be more public awareness of taking this test and put over in such a way 'look, this is not something you should be scared of, this is something that you might need'… [furthermore] It will save the government money in the long run, if they can get everybody on treatment, the cost of HIV treatment will come down'.*

Source: KCL Service Evaluation

5.0 Successes, challenges and impacts of the SIB mechanism

This chapter discusses the overall learning, in terms of the successes, challenges and impacts, of funding the Zero HIV project and its interventions as a SIB, compared to funding this project through another mechanism (such as fee for service or PbR). It also addresses overall value for money, as judged by both stakeholders and, so far as possible, independently by us as evaluators.

5.1 Benefits of the SIB mechanism

The evidence suggests that the fact that this project was designed, constructed and delivered as a SIB had the following benefits.

5.1.1 Galvanising action and momentum

There was a clear view across multiple stakeholders that the SIB had an effect simply by being branded a SIB, creating a level of enthusiasm, excitement and 'buzz'. that it would not have had if a conventional project. Awareness of the SIB and its principles was especially high among providers and individual project strand leaders – for example hospital consultants – and stakeholders we interviewed consistently referred to it as 'the SIB' rather than 'the project' – to a degree we have not found in other projects, where many providers do not have such high awareness and recognition. The exception to this is service users, who were not aware of the project as a SIB as we observe above.

The SIB Project Leader, who was recruited to the project in 2020 also observed that they would not have been attracted to the role if it had been a conventional project, commenting that *"it was a new challenge and I wanted to learn about SIBs. I'm not sure I would have applied without that as I had been in more senior roles previously".*

This galvanising effect is an unusual but not unique finding, identified also in the in-depth review of the Reconnections project and, to a lesser extent, in the first review of the HCT Travel Training SIB. In those cases there was a galvanising effect for commissioners, who wanted to be outcomes payers in part because of the reputational value of being involved in a SIB. This was not the case here, since the 'buzz' created by the SIB was not sufficient to persuade some local commissioners to contribute to its funding; it appears mainly to have encouraged and motivated service providers.

5.1.2 Improved project governance

Stakeholders argued that the project would not have had a Board of this calibre, or possibly a Board at all, if it had not been constituted as a SIB and governed via a CIC that acted as the delivery vehicle and prime contractor for the project. The project therefore benefited from a degree of additional intellectual and knowledge capital, as well as financial capital, thanks to its SIB structure. Senior stakeholders on the board thought that this was important, and enabled the project to overcome major challenges. As one Board member observed:

"This has worked. The project has pulled it off. It was super complex, costly, complicated, frustrating, COVID-hit, and it was dealing with the NHS just in case you've forgotten. It's extraordinary that despite every one of those hugely difficult obstacles this has actually worked. Why has it worked? Because we had the right stakeholders round the table, we had the right people involved. [and] because SIBs are change management agents, they incentivise people to go for outcomes and that means they become better at adopting work practices – even in the relatively conservative world of the NHS"

5.1.3 Additional performance management

Stakeholders across providers and the CIC Board were strongly supportive of the role of the project and performance management team within the CIC, especially after it was strengthened and added to when the Social Impact Consultant came on board in August 2019, and then when the SIB Performance Manager was appointed in early 2020. Results tend to confirm this, with outcomes per month rising from an average of 6.5 in October 2019 to 13.3 in February 2020 after the Social Impact Consultant started to work with providers.

The SIB also funded the Project Leader who played a pivotal role in extending the scope of the project and working closely with the various providers across all strands.

Additional performance management of this kind is found in several of the SIBs that we have reviewed, though in this project, unlike some others, the performance management was dedicated but not acting solely or mainly on behalf of the investors. Rather it appears to have been protecting the interests of the CIC as a whole, and also acting as an external change agent – for example in both encouraging and responding to new provider sub-contract opportunities, and working more widely with policy makers and funders to create longer term action around HIV eradication in the UK (See section 6).

5.1.4 Incentivising providers via the PbR mechanism

This is a weak effect since as noted in section 4.3 above views on both the importance and scale of impact of the PbR mechanism were mixed, with some providers and commissioners viewing it as important or very important, and others viewing it as largely irrelevant. The extent to which they viewed it as important (or not) did not appear to correlate directly with type of provider or to have anything to do with the amount paid per outcome or the total amount of funding for each type of provider.

We note that many stakeholders thought that the PbR mechanism would be very important at the time of our first review and we agreed, assessing the conversion of activity-based payment for HIV testing into outcome-based payment for HIV detection – at a high payment per outcome – as critical to the project's success. We now think this was less important overall, but still a significant factor for providers in two strands: some of those delivering interventions in the community, and the two hospital FTs that initiated and agreed stand-alone audit and recall contracts in mid.2020. As we noted in our second review, the latter contracts were also important to the resilience of the project as a whole through COVID-19.

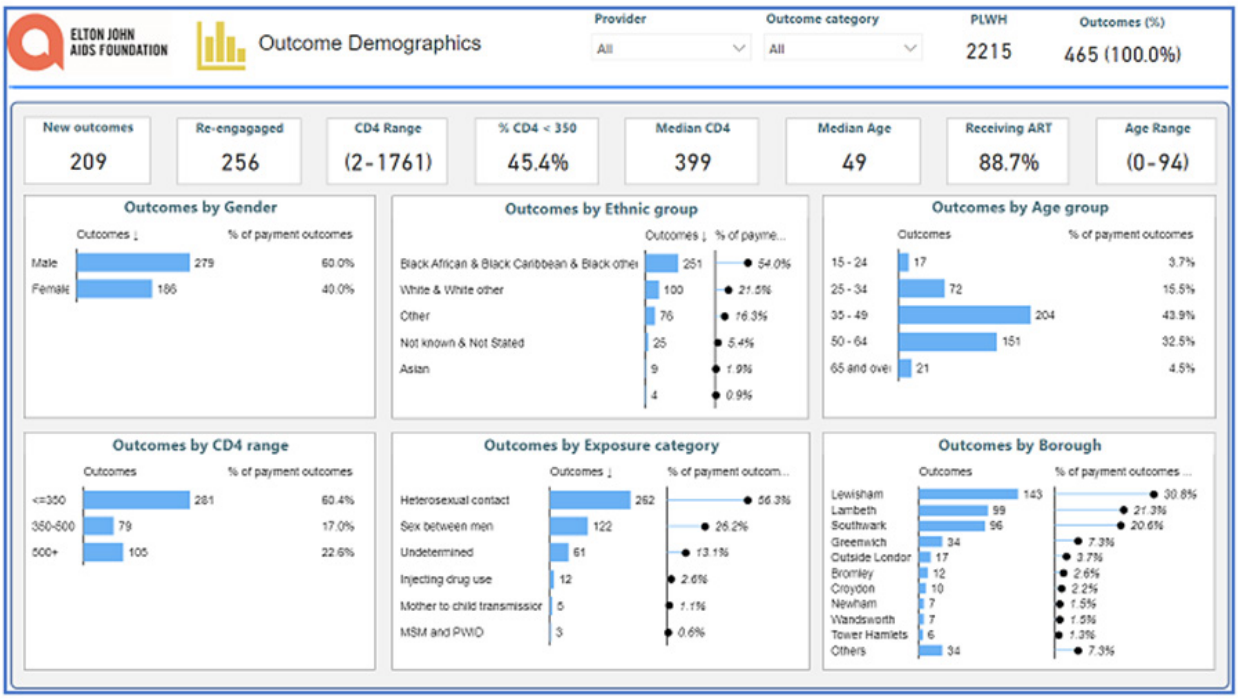
5.1.5 Innovative investment structure

The project used an innovative, tiered investment structure which was devised by the EJAF in-house design team and BII. It attracted investors on the basis that EJAF would be paid out last and therefore would effectively provide 'first loss' capital that would catalyse investment by other parties. This had two key benefits. First, it encouraged investment by two parties (Comic Relief and ViiV Positive Action Fund) who had a tradition of grant making rather than investing, but wanted to explore repayable finance. Secondly, it encouraged and enabled investors to seek lower rates of return, thus keeping overall costs down: the blended interest rate on all loans was only 2.2%.

5.1.6 Improved data systems

The project used some of the SIB capital to put in place a bespoke data collection and reporting system that was widely praised by stakeholders across all three reviews. This benefit is sometimes overplayed in SIBs, since all complex projects require good data collection and reporting tools, but interviews with both users and, for this review, the designer of this system suggest that the system had significant and important features that were needed only for an outcomes project, and affordable only because of the SIB funding. Notably the system had high standards of data management and security (which were critical to securing buy-in to the project from NHS stakeholders); functionality to control the recording of individual outcomes which ensured validation and prevented double counting of outcomes by more than one provider; and flexible and user-friendly reporting and data visualisation - see example screenshot below in Figure 12.

Figure 12: **Screenshot from Zero HIV system**



Source: Zero HIV end of project report

5.1.7 Other claimed benefits

Across both our first review and this one, stakeholders referred to another benefit of the SIB which we view as not proven, or not clearly attributable to the SIB and therefore a SIB effect. This was that the SIB enabled (in EJAF's own words) 'an integrated model of HIV care' through 'A place-based, collaborative model'. In our first review we had no doubt that the project had stimulated a 'whole system' approach to HIV testing across different healthcare settings and referral pathways, and that this approach was vital to the success of the project. However, we thought then, and still believe now, that it may not have been necessary to deploy a SIB mechanism to make such collaboration happen: the influence and leadership of EJAF, and the experienced stakeholders with which it worked, might have been sufficient to make this happen under a different model, including a conventional grant or contract structure, funded directly by EJAF.

EJAF dispute this and argue that it would have been difficult to bring on board commissioners through conventional approaches, and that the SIB model was critical to engaging commissioners and getting their commitment to the approach. However, the SIB as enabler and motivator of action is not disputed, as we explain in section 5.1.1.

What is less clear is whether the SIB funding made this happen, especially as it did not persuade commissioners other than Lambeth to commit funding of their own. Moreover, it is clear that commissioner stakeholders remain sceptical about the value of the SIB approach, although they do not dispute the value of opt-out testing, especially in Emergency Departments. This is reflected in decisions made since the SIB concluded about future funding, as we explore in section 6 of this review.

5.2 Disadvantages and challenges of the SIB mechanism

The evidence suggests that the project had the following significant drawbacks.

5.2.1 Reluctance of commissioners to become outcomes payers

The single biggest challenge faced by the project, which had major knock-on effects, was that it was unable to persuade local commissioners other than LB Lambeth to commit to fund the project. We explored this issue in some depth in our first review, and noted that it appeared to be due largely to two factors;

- A general shortage of funding and tightening of budgets which left little or no headroom for experimental projects of this kind.
- The misalignment of the benefits of outcomes (in savings or more likely avoided costs) to those expected to fund them – often referred to in SIBs and outcomes contracts as the 'wrong pocket' problem. The structure of funding for HIV testing and treatment in England is extremely complex, with multiple parties expected to pay for different activities. The most important misalignment is that Public Health departments within LAs are expected to fund testing, while the benefits of increase detection, earlier treatment and reduced transmission, accrue to others – notably CCGs, NHSE and hospital trusts.

In our first review we identified it as a benefit that this project had overcome this problem – it had acted as an integrator, enabling collaboration between services and allowing them to ignore silo-based thinking – but only by providing substantial external funding, from EJAF itself and from the CBO programme. Only Lambeth contributed at local level, and even Lambeth contributed only £150k against an original plan that assumed the borough would contribute £489k. It is clear that there was much frustration that other local commissioners would not contribute – especially as the CCGs would benefit directly from avoided costs in hospitals. Moreover, the reported costs avoided exceeded outcome payments by a considerable margin – even in the short term – and would in theory grow over time.

This inability to bring on board local commissioners had a major impact on the project, forcing it to reset its ambitions and more than halve its target outcomes, as well as reduce its reach to service users by more than a third. While the project might be counted a success, therefore, it was not as successful as it could and perhaps should have been.

It is interesting to compare the experience of this project with other CBO-funded projects that we have evaluated in-depth and which depended on the engagement of multiple commissioners, One such is the North-West London End of Life Care (EOLC) Telemedicine Project[38] which engaged multiple CCGs as outcome payers, led by Hammersmith and Fulham CCG, to fund improved end of life care and reduce unplanned hospital admissions. Another is the Positive Families Partnership (PFP)[39] which has engaged multiple London Boroughs to fund Multisystemic Therapy and Family Functional Therapy to reduce the number of children entering local authority care. The drivers of successful commissioner engagement as outcome payers in both these projects are complex, and we should be cautious of making simplistic comparisons, but there appear to have been two key factors evident in both these projects which were not as prominent in the Zero HIV project:

- Commissioners were engaged and committed early in the SIB design process, and their involvement was catalysed by public sector agencies. In the EOLC Telemedicine Project a total of seven commissioners were signed up and committed to contribute to outcome payments during the design stage of the project, with Hammersmith and Fulham CCG playing a leading role in supporting engagement. In PFP five boroughs were part of the original consortium that committed to make outcome payments, facilitated by the Greater London Authority's convening role in bringing together London Boroughs. As we note earlier, EJAF aimed to engage commissioners from an early stage but chose to go ahead with the project without their commitment, in the hope/expectation that they would commit later once the project had provided 'proof of concept'. This was almost certainly a riskier approach than not proceeding until commissioners were contracted to make outcome payments.
- There was much clearer alignment of financial benefits from improved outcomes to the outcomes payers. In both projects, stakeholders told us during the reviews that they had been motivated by the financial benefits – from reduced non-elective hospital admissions for the CCGs that paid for the Telemedicine Project, and from fewer children being looked after for the LBs that paid for PFP. In PFP this also motivated other LBs to join the programme later. In other words, the 'wrong pocket' problem was less prevalent – the financial benefit largely went into the right pocket.

In light of this we think that EJAF and the Zero HIV CIC might have anticipated the difficulty of persuading commissioners to commit to become outcomes payers after project inception, and either designed the project solely around those prepared to commit from the start, or waited until more commissioners were contracted to pay before inception. We are also tempted to suggest that EJAF was slightly naïve, since we noted in our first review that a senior commissioner stakeholder made it clear that it was never likely that LA public health commissioners would fund the project, and there is substantial learning from other research[40] about the risk in outcomes-based projects of commissioners engaging but ultimately declining to commit, especially when the project has been initiated by providers or other third parties.

There is however little that EJAF could have done about the misalignment of financial incentives, which meant that those being asked to pay for outcomes (public health commissioners) were not the primary beneficiaries of savings from reduced hospital admission or shorter hospital stays (CCGs). It is also entirely valid to observe that the commissioning

38 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-NW-London-EOLC-telemedicine-project.pdf?mtime=20220616143105&focal=none

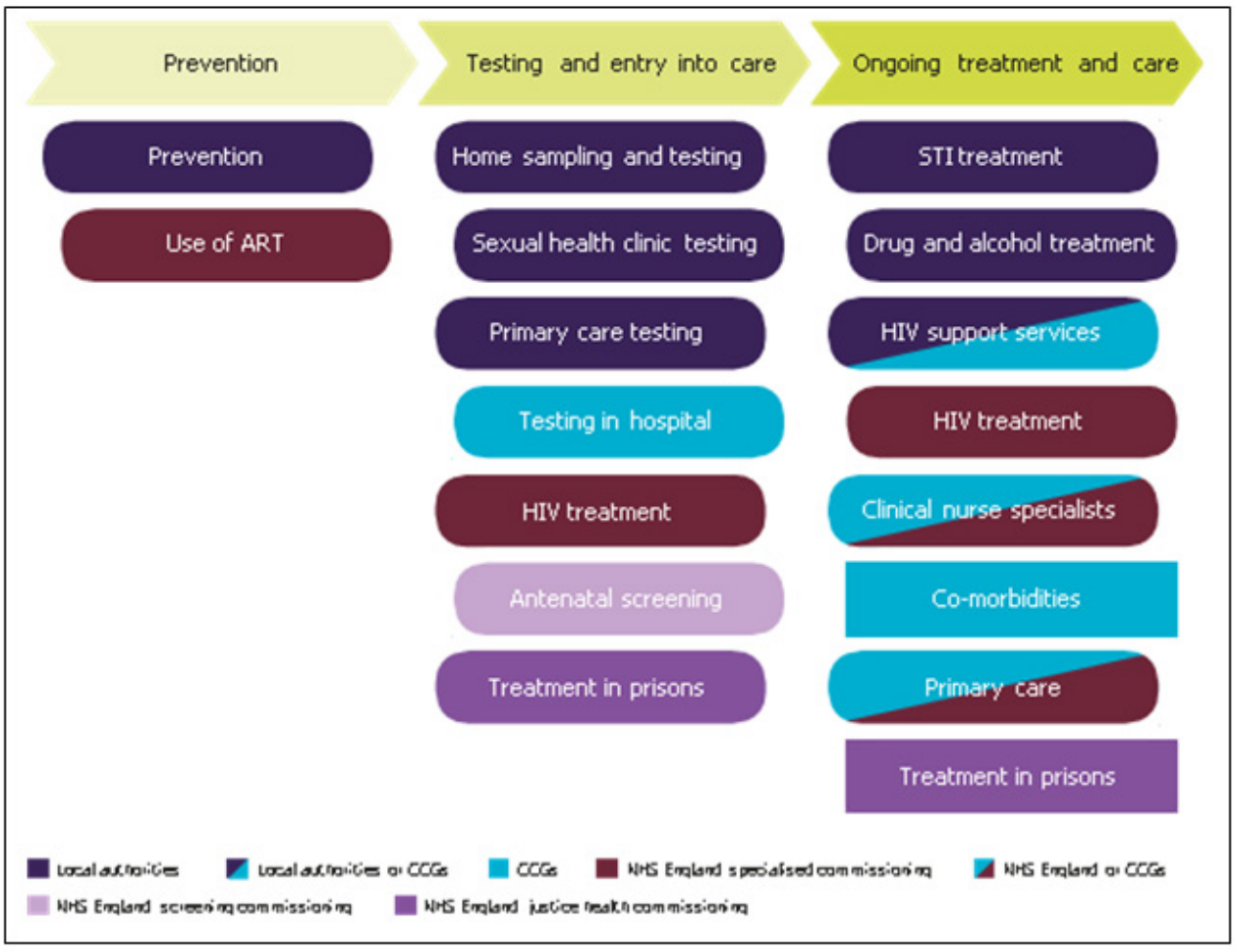
39 See https://www.tnlcommunityfund.org.uk/media/insights/documents/CBO-Positive-Families-Partnership.pdf

40 See for example Evaluation of the Social Impact Bond Trailblazers in Health and Social Care Final report. Frasr et al, 2018. Available at https://golab.bsg.ox.ac.uk/documents/SIBS_Evaluation____final_report.pdf

and funding structure for HIV testing and treatment was, and largely remains, extremely complicated. The commissioning landscape as it was throughout the Zero HIV project is illustrated in Figure 12 below, taken from a King's Fund report in 2017. What some stakeholders did observe to us is that they hope that this misalignment will be less pronounced, and the incentives on commissioners to act together to improve HIV outcomes will be improved, following the introduction of Integrated Care Systems (ICS) in July 2022. However there is some scepticism that ICS will achieve all that is expected of them.[41]

In view of these factors and especially the complexity of the commissioning landscape, we should be wary of attributing the commissioner commitment issue solely to the SIB. If EJAF had tried to catalyse conventional funding for the same suite of interventions, it would in our view almost certainly have faced similar issues.

Figure 13: **The HIV Commission Landscape in England**



Source: The future of HIV services in England: King's Fund, 2017

41 See https://www.nao.org.uk/wp-content/uploads/2022/10/Integrated-Care-Systems-Funding-and-accountability-for-local-health-and-care.pdf

5.2.2 No measurement of the counterfactual

Both commissioner stakeholders whom we consulted, and the KCL Service Evaluation noted that the project was not constructed and designed so that there was a way of measuring how much of the impact it achieved could be attributed to the SIB and the interventions it funded. This is because it did not set a baseline of previous testing/detection levels or establish a comparison group in order to assess what would have happened anyway – i.e. the counterfactual. EJAF's own end of project report acknowledges this as a weakness, especially in primary care where testing and audit and recall should previously have been part of business as usual (albeit competing with numerous other priorities, even before COVID-19 exacerbated the challenge).

However, EJAF also argues that even if there had been a comparator in place it would have been confounded by other factors such as the introduction of free PReP via sexual health clinics (see section 3.4.4). This point arguably reinforces the importance of a comparator being in place, however, since the availability of PReP would apply in both the treatment and control group, and enable a clearer understanding of where the interventions had made a verifiable impact beyond that of PrEP. In addition the availability of PReP is likely to have been a significant confounder only for the MSM cohort; it would not have been a major factor for other cohorts, where use of PReP would likely be low and reluctance to be tested would likely have been greater.

Furthermore, it is clear that EJAF did everything that it could to ensure attribution without there being a counterfactual in place, while acknowledging that multiplicity of funding would not make this easy to achieve. In its first annual report to the CBO programme team, the project reported that:

"Our outcome funder contracts and service provider contracts explicitly state that service users must be found through interventions incremental to existing service provision. This implies that people brought into care which use existing methods independently of the SIB cannot count as SIB outcomes. This has been generally straightforward, but cases have been more complex when there are instances of service provision which increased capacity of an existing programme. For example, Metro (on behalf of the wider GMI partnership) used our funding to implement increased targeted HIV testing among MSM. They had already been providing a lower amount of testing through alternative funding. For this reason, we worked diligently with their team and Lambeth Council, who commissioned the alternative funding to ensure that there was no "double counting" of outcomes and we were only compensating for distinct work."

However, EJAF also acknowledged that funding from the Fast Track Cities initiative (which provided conventional funding for expanded HIV testing in London) would make attribution more difficult, commenting that:

"If a project is funded that overlaps with existing provider work, it will be challenging and potentially impossible to disaggregate which outcomes came from the SIB and which came from Fast Track. This could overestimate the SIB's effectiveness. For this reason, we are actively

working with providers to ensure that any new projects are fully discrete from SIB activities."

We also note that some commissioners did not believe that a rigorous counterfactual measure was important, especially in ED where, as we note in section 4.3.2, there was effectively no testing prior to the funding provided by this project and (in one setting) the pilot that EJAF funded before it. It also seems to be beyond doubt that the Zero HIV project made a positive contribution to increased detection of HIV and identification of those LTFU, even though the project cannot be certain that all outcomes can be attributed to its interventions.

The main impact of there not being a counterfactual measure appears to have been to reinforce the view of commissioners that they should not fund the project because they could not be confident of its impact, and therefore this must be counted an important weakness of the SIB design. We would note however that we did not hear this argument put to us by commissioners or other stakeholders when we were conducting our first review, and it does not appear that it was a reason why local commissioners chose not to fund the project in the first place. Had commissioners made the use of a comparison group a condition of funding outcome payments (or agreed to make payments linked in some settings to achievement of outcomes only above a defined baseline, thereby guaranteeing a minimum contribution) we think this argument would now carry more weight.

5.2.3 Imperfect outcome metrics

While not as important as the issues above some provider stakeholders pointed out to us that the outcome metrics, while clear and easy to validate, had two potential drawbacks:

- The contracts and validation mechanisms were designed so that an outcome could only be claimed by one provider. This created some minor issues and occasional disputes about who was entitled to claim an outcome payment – for example if both a community provider and a sexual health clinic had contributed to successfully re-engaging someone LTFU.
- The outcome payments were one-off payments with a single trigger – in simplified form, there was a single payment for the first entry to treatment of someone not previously diagnosed, or for the renewal of treatment for someone LTFU for more than 12 months. These are imperfect metrics because they make no allowance for sustainment. In theory, someone could enter care and almost immediately fall out of treatment (and potentially trigger a second payment if they were then re-engaged more than 12 months later). Similarly, an LTFU patient could be re-engaged, then fall out of treatment for 12 months, and then be re-engaged again. This also makes it extremely difficult to validate any savings or other financial benefits attributed to re-engagement.

As is often the case in SIBs and PbR, there is a trade-off between simplicity and precise alignment of incentives in metric design, but if undertaking a similar project we think both these issues could be relatively easily addressed – the first by allowing for the sharing of payments where appropriate; the second by replacing a single 'bullet payment' with two or more smaller payments payable over time to reward sustainment. Such smaller payments would have implications for provider cashflow, but these could be built into the SIB design and finance structure, with more capital raised (if needed) and larger forward payments made to providers.

5.3 Value for money of the SIB mechanism

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

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

5.3.1 Economy

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

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

It is however still important that costs are as low as they can be while being consistent with this overriding objective, and it is clear that economy was an important issue at various points within this project, and that EJAF and the Zero HIV CIC took steps to keep cost down where appropriate.

First, Table 5 below summarises the costs incurred by the project, based on the EoG information submitted to the CBO team within The National Lottery Community Fund. As this shows the total SIB overheads – i.e. additional cost of this being constructed and managed as a SIB, were 13% of total costs. This is relatively low by the standards of the projects that we have reviewed in-depth and which have reached end of grant, though we should be cautious of inferring too much from comparison of very different projects.

EJAF sought to keep costs as low as possible (without jeopardising outcome performance) in two main ways:

- It acted effectively as first loss investor, and therefore sought investment at lower rates of return than are usual in SIB investment structures, as explained in section 3.4.2.2 above.
- It sought competitive bids from providers for initial contracts (especially community providers) and sought to negotiate specific outcome payments with each provider. It also renewed contracts annually, maintaining a degree of pressure on providers to deliver.

We should also note that SIB management costs in total (at £311k) accounted for 11% of total costs, higher than the CBO benchmark of 10% and higher than the average for all CBO projects at the time of writing, which is 8%. Management costs were thus considerable in absolute terms and were also lower than they would otherwise have been due to pro bono legal support to the project, which according to stakeholders had an equivalent value of £670,342. The main reason why total SIB overheads at 13% are relatively low, while SIB management costs at 11% are relatively high, is that the investment structure was successful in keeping investment returns low in comparison to other projects.

Table 5: **Total project costs**

Type	Description	Amount	% of Total
Core delivery costs	**Delivery by providers**	£2,323,062	84.9%
	Delivery management	£49,371	1.8%
SIB costs	**SIB Management**	£310,619	11.4%
	Investment costs	£17,573	0.6%
	Tax	£9,041	0.3%
	Other costs (GP Champions)	£18,469	0.7%
Other	**Evaluation**	£7,984	0.3%
	Total	**£2,736, 119**	

Source: Cost information submitted by Zero HIV CIC to The National Lottery Community Fund.

5.3.2 Efficiency

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

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

As we note in section 4.2, this project delivered high levels of user engagement and testing of service users. It exceeded the Median scenario on both measures and therefore had reasonably good reach. Against that, the project arguably set an unrealistic target for user testing that was exactly the same as its user engagement target – despite the fact that some users were bound to decline to be tested even on an opt-out basis, and therefore some attrition was inevitable.

Comparing the total costs shown above with the total number of service users engaged and tested as shown in Figure 6 and section 4.2.1 (251,618), the average cost per test across all settings was £10.87. This seems reasonable compared to the average costs of HIV testing derived from work by the Health Protection Agency in 2011, and reproduced in a study into the economic benefits of HIV testing by the National Institute for Health and Care Excellence in 2016[42]. This study gave costs for HIV testing in the main settings (including total staff and resource costs) of between; £3.11 and £12.15 in hospital settings, £6.35 and £8.32 in primary care settings and £20.93 and £46.72 in community pilots. When updated for inflation (using the latest GDP deflator released March 2023) these costs rise to those shown in Table 6 below.

42 HIV testing: increasing uptake among people who may have undiagnosed HIV Economic assessment: resource impact of recommendations. National Institute for Health and Care Excellence 2016 https://www.nice.org.uk/guidance/ng60/documents/economic-report

Allowing for the high level of support given to patients and service users by this project and of course additional SIB costs, we would expect costs per test to be at the upper end of these ranges. Even so, the overall cost per test for this project is below the high-end cost of hospital testing, and close to the cost of primary care testing, despite a substantial proportion of test being in the more expensive community setting. It is also close to the low end for average cost of testing, and less than half the highest average cost, although we should be cautious of comparing with average costs since the split of tests between settings will not be even, with more tests likely to have been provided in the less expensive hospital and primary settings.

Overall therefore, It is reasonable to conclude that the cost per test for this project was good value for money, despite the additional SIB costs and a higher level of support to those tested than many comparators.

Table 6: **Average costs of HIV testing**

Setting	Lowest cost per HIV test	Highest cost per HIV test
Hospital	£3.98	£15.53
Primary Care	£8.12	£10.64
Community	£26.76	£59.73
Average	£12.95	£28.64

Source: HPA Data reported in "HIV testing: increasing uptake among people who may have undiagnosed HIV Economic assessment: resource impact of recommendations", National Institute for Health and Care Excellence 2016, updated to 2022/23 prices

5.3.3 Effectiveness

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

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

Overall, the project exceeded Median scenario on all key indicators as agreed at renegotiation and was close to High scenario on some measures, as explained in detail in section 4.2 above. It also exceeded internal targets according to EJAF's own end of project report. We should however caveat that the project was significantly scaled back from its much more ambitious targets at earlier stages – where it planned to achieve 1050 outcomes at the time of in-principle award of grant by the CBO, and 1,250 at the time of full award.

We have also been unable to evaluate in detail whether and to what extent the SIB achieved better performance than similar opt-out testing projects that were funded conventionally elsewhere, and without either a SIB or outcomes-based payment structure. This is largely because robust data on comparable projects is not easily available.

There is however some evidence that other projects have been very effective, for example the introduction of opt-out testing in Croydon University Hospital. While this does not appear to have been independently evaluated, according to an internal press release43 more than 38,000 patients were tested between May

43 See https://www.croydonhealthservices.nhs.uk/trust-news/croydon-initiative-leads-the-uk-by-testing-38000-emergency-patients-for-hiv-2711/

2020 and July 2021 and *"As a result, the Trust was able to offer more HIV care and support to patients in the first eight months than had been possible in the previous two years combined. Those being newly diagnosed as HIV-positive in Croydon now need dramatically shorter hospital stays, from an average of 34.9 days down to only 2.4 days after the program was implemented."*According to an unverified case study44, the same programme led to 25 new HIV diagnoses in the first year of testing, which would appear to compare well with EJAF's own performance (128 diagnoses across two hospitals over the whole contract period), although we cannot be certain that we are comparing like with like. We also note that this project only trialled opt-out testing in A&E – it did not attempt the holistic approach, across multiple pathways, deployed by the Zero HIV project.

Under Effectiveness we also assess whether the project has achieved its stated objectives (in addition to the broader CBO objectives, against which we assess the project in section 7.2 below). Our assessment is that the project mostly achieved these objectives, as identified in our first review, as follows:

- ***A strategic interest in deploying EJAF's and its collaborators' funds as social investment to support testing an outcomes-based approach across all major health pathways.*** This has been largely achieved – notably by ensuring that the project addressed all health pathways and brought resources together to ensure a joined -up approach. The major caveat again is that, as previously discussed it only engaged some commissioners tangentially – they did not engage directly as outcomes payers, as EJAF intended and expected.
- ***An intention that investors would fund "first class performance management'.*** This sems to have been wholly achieved, as reported in section 5.1.3.
- ***There would be an in-built focus on outcomes that passed most (but not all) of the PbR risk onto providers, to improve performance.*** Again, the project was deliberately constructed to achieve this and it seems to have worked well, with providers comfortable with the risk they were bearing.

5.3.4 Equity

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

There is useful data from both EJAF's own SIB management system and from the independent KCL Service Evaluation on whether and to what extent the SIB was able to deliver services equitably and address known inequalities in the health system as regards HIV detection and treatment. The main inequalities are that there is in general a likelihood that those in lower income groups or areas with greater deprivation will be less likely to be diagnosed, and that white people are more likely to be diagnosed than those from ethnic minorities.

To some extent the project had an in-built bias at the community level in favour of disadvantaged groups, since it aimed specifically to address BAH and other ethnic minorities. However, the data suggest that the project also addressed some structural inequalities across all health pathways and intervention strands.

EJAF's own data (as reported in its end of project report) indicates that:

- ED HIV testing through the project appeared to be effective at addressing health inequalities by reaching black and minority ethnic groups with Black African, Black Caribbean and Black Other community members accounting for 55% of all new HIV diagnoses identified by ED testing. This proportion is larger than that of the newly diagnosed population in London (31%) and

44 See https://cdn.pepperapps.io/diagnostics-cms/public/62f2858db043c862d2da5839?signature=eyJhbGciOiJkaXIiLCJlbmMiOiJBMTI4Q0JDLUhTMjU2In0..wMSqBDRSluRhr-yVkUzD-w.RBf_XZV6q-X-6mVXEhBpr5cdUfEvUO-sEzTtyi7eiDNJ6jmt875wrs6OLcDdg2oghoxaEn_KABFrz8g0X-U_qrufY1vxGxJ32_7dOe72FZsrRDy9PmCKUE46hDkLLGdO_AmxvXe5r9HEFthhlUzVxHRteecYT_0Q4PVn1xmX5s3LYYsHtT47MB0tM1X9DhqK.3oxPQufC7093ot4t_Mco8w

in the UK (30%), as reported in Public Health England's 'Spotlight on London' (2018)[45] and UKHSA's 2021 HIV data tables[46] respectively.

- There is a strong correlation with those found through ED HIV testing and those living in areas of multiple deprivation, with over 60% living on the lowest three deciles of the Indices of Multiple Deprivation in England.
- Primary Care HIV testing was also very effective at addressing health inequalities through reaching people currently not engaged by services where HIV testing occurs, or who might not take a HIV test because of stigma, such as Black African, Black Caribbean and Black Other community members, who were 70% of all new HIV diagnoses in this setting. This figure is higher than the SIB's ED HIV testing (55%), and greatly exceeds the percentages of this community newly diagnosed in either Public Health England's 'Spotlight on London' figures at 31%, or UKHSA's national figure of 30%.

The KCL Service Evaluation is more cautious about the limitations of the data but it observes that:

- Of a total of 153 people who were reengaged through hospital clinic audit and recall work 71% were from Black African, Black Caribbean and Black Other communities, which suggests that LTFU work is particularly helpful in reaching people from this community, who may have left care because of HIV stigma as well as other life challenges.
- In the community, providers that targeted Latin American community members were especially successful, contributing 32 new outcomes and one reengagement, suggesting that this is a community that was particularly underserved through current arrangements.
- Overall, Black Africans were almost twice and Black Caribbeans more than three times as likely as White British to be re-engaged.

In summary it seems that there is evidence that the project has treated communities fairly and has addressed some imbalance in the current testing system, especially against some ethnic minorities. In part this appears to be because the Zero HIV CIC deliberately contracted with a range of providers to ensure it was able to address specific needs. As already noted, the CIC contracted with community providers to ensure good coverage of key demographics including MSM, BAH and the South American community; but EJAF also thought that the wider spread of provision across multiple pathways was equally critical to ensuring the inclusivity of the project. As they explained in their second annual report to the CBO team:

"One of the primary benefits of engaging across four major provider types (hospital ED, hospital clinics, GP federations, and community groups) is the diverse effects on local communities and networks across the three target boroughs (Lambeth, Southwark, and Lewisham). These organisations have different local connections and existing service users they can reach. The decentralized mode of service delivery allows each of our 10 providers to focus on the communities where they already have trust (e.g. a GP engaging with someone who is already her patient; a Latin American specialist discussing HIV in a room of peers). While service users are not engaged at the project management level, listening to their

45 Spotlight on sexually transmitted infections in London, 2018 data, See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/827676/2019_08_Lon_STISpot2019.pdf

46 HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1037215/hiv-2021-report.pdf

stories, concerns, and feedback is an essential component of the way that our service providers build trust, bring people into care, and continuously improve the services that they are delivering."

5.3.5 Overall cost effectiveness

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

Overall, we conclude that the project has been value for money. It achieved good levels of performance compared to planned Median scenario against both the broad measure of user engagement and testing, and the narrower treatment/re-engagement outcomes on which provider payments were based. It also achieved most of its own key objectives, save for the important issue that it did not persuade commissioners to commit to outcome payments apart from LB Lambeth. SIB overheads were reasonable as a percentage of total costs, although management costs were quite high in total at more than £300k (and at 11% higher than the CBO average of 9%). These costs were offset by investors taking lower returns than in most SIB projects, thanks to a deliberate investment strategy and structure.

In addition (and despite commissioners' reluctance to fund the project) it appears to have achieved avoided costs for commissioners that significantly exceeded total delivery costs.

EJAF's own end of project report analyses total outcomes and their cost by intervention setting and type (new diagnosis and re-engagement) and gives the broad assessment shown in Table 7 of costs per outcome.

Table 7: **Cost per outcome for different settings and outcome types (EJAF analysis)**

Setting	Outcome type	Cost per outcome
Secondary Care	New diagnosis (ED testing)	£5,200 - £6,300
	Re-engagement (Audit and recall)	£3,000
Primary Care	New diagnosis (GP testing)	Under £10,000
	LTFU re-engagement (Audit and recall)	Under £10,000
Community	New diagnosis	Under £10,000
	LTFU re-engagement	Under £10,000

Source: The Elton John AIDS Foundation 'Zero HIV' Social Impact Bond: Final report on investment, implementation, and impact. EJAF, March 2022

We have done our own, slightly different analysis of cost per outcome by contract type, based on CBO end of Grant data on delivery costs per provider and contract, and pro rata allocation of all other costs, including SIB overheads. The results of this analysis are shown in Table 8 below. As this shows our assessment of costs per outcome is similar, though this analysis and EJAF's are not fully comparable. Overall, we calculate that average cost per outcome is £6,104 on EJAF's outcome figure, and £5,884

based on the CBO data. decision process for BII was a relatively short four-month period from end to end. Although there were other social investors reviewing the MHEP opportunity at the same time, BII found the proposal attractive and was in a position to make a rapid investment committee decision.

Table 8: **Costs per outcome for different settings (Evaluator analysis)**

Setting	Delivery costs	Other costs pro rata	Total costs	Total outcomes	Cost per outcome
Hospital ED testing	£1,144,401	£203,483	£1,347,884	177	£7,615
Hospital clinic audit & recall	£465,859	£82,833	£548,692	153	£3,586
Primary care	£370,523	£65,882	£436,405	84	£5,195
Community	£342,279	£60,860	£403,138	51	£7,905
Total	£2,323,062	£413,057	£2,736,119	465	£5,884

Source: CBO EoG data on costs per provider, EJAF data on total outcomes by setting and contract type, ATQ analysis

On either EJAF's own assessment or ours, what is clear is that the costs per outcome are very good value for money compared to the costs of HIV remaining undiagnosed and/or a person not being in treatment. As noted in section 3.3.1, EJAF's own research estimates the cost of undiagnosed HIV at £220,000 per person, and other estimates put the costs in a range from £73,000 to £404,000 per person. Even if we take the lowest of these figures, with no update for inflation, the Benefit Cost Ratio (BCR)[47] is 12.4 based on our figures (average outcome costs £5,884) and 7.3 based on each outcome costing a maximum of £10,000 as per EJAF figures.

In other words, the system gets back between £7.30 and more than £12 for every pound spent by the project on outcomes. If we take the narrower analysis of costs avoided by the project over its lifetime, as reported to the CBO and discussed in section 4.2.6 above, we find a total cost avoided (for 465 outcomes) of £12,979, compared to a cost per outcome of £6,283, so the BCR is still a strong 2.06.

In summary, therefore, and on any measure, the total outcomes achieved by the project appear good value for money compared to the current and potential benefits to the NHS and wider health system.

47 The Benefit Cost Ratio is recommended in the Treasury Green Book as a way of assessing the value for money of an intervention. It is defined as the ratio of the present value of benefits to the present value of costs. See Green Book 2022 section 5.54. ff.

6.0 Legacy and sustainability

Overall, we assess the Zero HIV SIB as having a positive legacy both locally and nationally, although there has been no specific commitment to continue its outcomes – based approach and only tentative plans to undertake a similar SIB elsewhere. We outline below what we know about what the SIB has achieved by way of sustainment and what might happen in the future.

6.1 National policy commitment

EJAF fed emerging evidence for the effectiveness of opt-out testing for HIV at scale into its wider efforts to influence HIV testing policy at national level. The most visible manifestation of this is the HIV Commission, which brought together EJAF and the other major UK-based HIV/AIDS charities, the Terence Higgins Trust and National AIDS Trust, to explore how to achieve the long-term aim of ending new HIV transmissions and HIV attributed deaths in England by 2030.

The Commission's report[48], published in December 2020, made three key recommendations that:

- England should take the necessary steps to be the first country to end new HIV transmissions by 2030, with an 80% reduction by 2025.
- Government must drive and be accountable for reaching this goal through publishing a national HIV Action Plan in 2021.
- HIV testing must become routine – opt-out, not opt-in, across the health service.

These recommendations have largely been adopted with the UK Government publishing its HIV action plan[49] for England in December 2021. This plan broadly accepted the recommendations of the HIV commission and, most directly, committed that:

"National Health Service England and NHS Improvement (NHSEI) will expand opt-out testing in emergency departments in the highest prevalence local authority areas, a proven effective way to identify new cases, and will invest £20m over the next three years to support this activity."

It seems clear that the evidence from this project made an important contribution to both the proposal for change in this area and its acceptance by government.

We also note that the NHSEI Director who will be responsible for rollout of this new testing programme in London is the London-based NHSEI stakeholder involved in the Zero HIV project from its inception and interviewed for this review. In addition, he has engaged the former Zero HIV SIB Performance Manager (whose contract ended in March 2022) to support the roll out in London. The latter, soft legacy of the project is particularly welcome since we have noted in other reviews that the expertise built up through projects is often lost, as staff move to other, entirely unrelated roles when projects end. In addition, the involvement in NHS delivery of stakeholders with prior experience of the SIB, is likely to mitigate any loss of impetus and momentum that might otherwise have occurred as interventions move to mainstream funded. Conversely, lessons learned from the SIB will benefit Trusts and hospitals adopting opt-out testing for the first time.

In November 2022 the NHS published data showing that in only six months since the expansion of opt out-testing, 834 cases of people living with the HIV, Hepatitis B or Hepatitis C had been newly identified, while 153 people, who were previously diagnosed, but were not receiving NHS care, were also identified[50].

48 See https://www.hivcommission.org.uk/final-report-and-recommendations/

49 See https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025

50 See https://www.england.nhs.uk/2022/11/nhs-hiv-testing-rollout-identifies-hundreds-of-new-cases/

6.2 Local funding commitment

Partly as a result of the new national funding, ED testing opt-out testing is being extended in the three LSL boroughs and the hospitals that have run opt-out testing with funding from the SIB. In addition, local NHSE commissioners have chosen also to fund the audit and recall service provided in hospitals in 2022/23. There is thus sustainment of funding for both these interventions, based partly on the proof of concept provided by the project.

In addition, there has been sustainment of the role in primary care of the GP champions, who were funded by the SIB until December 2021 to provide support to individual GPs in carrying out testing. Funding of the champions was taken on by local commissioners, and extended initially until the end of March 2022, with an expectation that this role could be retained in the longer term. According to one local commissioner, the SIB has provoked a discussion about extending the role of GP champions for HIV testing across London, and consultation on this was in progress in April 2023.

6.3 Prospects of a further SIB or outcomes-based contract

What is less clear is whether there will be, or needs to be, any sustainment of the SIB mechanism or its underlying payment by results approach. The national and local funding that will be available for opt-out testing will not be linked to outcomes, and appears to reflect an NHSE view that such an approach is not needed. It also reflects a view that the introduction of Integrated Care Systems (ICS) in the NHS[51] will reduce the challenge of joining up funding streams. The key NHSE stakeholder observed that

> 'The reality of finance in hospitals is that even if finance is targeted in a particular way, there's no guarantee that the funding will get to where it needs to be. So the big thing we want to be doing as we go forward into ICS is saying that, well actually If anything is obvious in terms of what you should be doing as part of putting specialist and CCG funding together, its funding ED testing in every A&E you have.'

As noted above local commissioners had mixed views of the value and importance of the outcomes-based mechanism, though commissioners will no doubt continue to fund community-based testing as they did before the SIB was implemented. What will be interesting in the future is whether some of the community providers ask to be paid on outcomes because they prefer the flexibility it offers to input-based approaches. Again, as we note in section 4.3.1 above, some valued the increased flexibility that outcome – based payment offers, while others preferred more traditional funding.

There is also uncertainty about whether the other key feature of the SIB – the financial and intellectual capital that it provided from investors and via the CIC Board, will be replicated elsewhere. While nothing is decided, there does appear to be some interest in EJAF replicating the approach, possibly in the United States, and a recent blog[52] for Brookings by the Social Impact Consultant who was part of the project team for the Zero HIV SIB comments that:

51 According to the NHS (see https://www.england.nhs.uk/integratedcare/what-is-integrated-care/) Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Following several years of locally led development, recommendations of NHS England and NHS Improvement and Royal Assent of the Health and Care Act (2022), 42 ICSs will be established across England on a statutory basis on 1 July 2022.

52 See https://www.brookings.edu/blog/education-plus-development/2022/05/24/problem-to-program-to-public-policy-how-outcomes-based-financing-strengthened-englands-health-system/

"The learnings from this SIB could be extended to other pay-for-success and outcomes-based models. …. For example, this design could be applied in the United States where it would be challenging to do a traditional SIB with local government, as many parties have payment responsibility for HIV testing and care services. Private insurers and managed care organizations may be especially worthwhile partners in this context, particularly those with demonstrated commitment to address health equity and social determinants of health."

Overall we conclude that the sustainment of the SIB mechanism is not a major issue, since the primary objective of the project was to prove the effectiveness of opt-out testing at scale, with testing of the effectiveness of a SIB or PbR approach being at best a secondary objective. Moreover as the proportion of the population living with HIV continues to fall it would become more challenging to pay for treatment/ LTFU outcomes rather than for testing in any case, since there will be fewer unidentified cases to find.

7.0 Conclusions

7.1 Overall conclusions and evaluative insight

When asked to sum up their view of the Zero HIV SIB as part of fieldwork for this review, a senior stakeholder who sat on the Board of the CIC, and has long experience of both HIV prevention and Public Health, offered the following observation:

> "Have we proven whether SIBs deliver HIV outcomes, I would say no. Have we proved whether injecting a quite substantial sum of cash into a local health economy will deliver extra HIV outcomes, I would say yes. Have we proved whether injecting that sum of money into different interventions has been successful, in the sense that they can be easily compared in terms of quality or value for money, I would say the jury is out."

This seems a useful, if understandably slightly simplistic summary, of the Zero HIV SIB and of the views of stakeholders we consulted.

As a project our assessment is that the Zero HIV SIB has been successful, delivering strong performance against both its broad target for user engagement and testing, and its narrower target for hard outcomes achieved – where according to data reconciled with the CBO team it achieved 465 outcomes and exceeded the Median scenario – though we would again note that it did so only against a significant scale-back of its original outcomes targets once it renegotiated targets across a shorter contract period than originally envisaged.

We also find that it has provided good value for money across all criteria and overall. It has also yielded greater financial benefit to the NHS than it has cost, whether measured on immediate costs avoided, or likely longer term and much higher value. The costs of delivery and per engagement/test also seem reasonable, even with the additional costs of SIB delivery and management included.

Stakeholders were also in strong agreement that the project had proved the value of key interventions, notably opt-out testing in ED departments, and targeted audit and recall of those LTFU, managed through sexual health clinics. At the time that we conducted fieldwork for this review it was already clear that government was likely to commit to funding ED testing, and that this project had influenced that decision. But there was more scepticism about the value of audit and recall, and there is understandable satisfaction among the designers and managers of this project that this too has been funded, at least for 2022/23.

Views on the value of the SIB mechanism and whether there was a significant SIB effect are more mixed, with wide variation. At the time of our first review, we thought that the payment by results mechanism was very important, while the capital provided by investors was less so. While the SIB was then in its early stages, we argued that the conversion of a low payment per test into a high payment per person diagnosed and treated (or re-engaged if LTFU) appeared to be critical to the success of the project. This was because it aligned incentives and provided a strong stimulus to providers to identify those that the project really needed to reach. Conversely, we thought the availability of funding from investors was less important, and that similar results might have been achieved if EJAF had simply decided to fund the project directly without the overhead and complexity of a SIB structure.

As we review the project as a whole, our views have shifted and we now assess the outcomes structure and payment mechanism as arguably less important, and the SIB itself more important, than they seemed in the project's early stages. Opinions on the importance of the payment by results mechanism diverged widely, and some stakeholders thought that it had been important. As we noted in our second review, it also appears to have had some influence on the success of the LTFU audit and recall contracts, which depended in part on a high payment per outcome to make the effort and resource required to achieve each outcome viable – though even here there was a view that the injection of substantial cash – to paraphrase the stakeholder above – was also a major factor.

But other stakeholders did not think it had made a significant difference, or been necessary. Crucially, those deciding whether to fund hospital based opt-out testing did not, with one stakeholder commenting that:

'Our aim is to change the whole system, so I'm not attracted to the funding mechanism. If it's worth doing, just pay for it directly.....

Conversely, we find that the SIB structure and the capital it provided did have significant value, which arguably could not have been achieved by EJAF grant funding alone. First, it funded the additional, high class performance management that EJAF thought was essential to the success of the project, as well as bespoke and highly regarded information systems. Secondly, it provided expertise and know-how as well as finance, which helped the project navigate complex challenges. Finally, the implementation of this project as a SIB gave it a profile and momentum that many stakeholders think it would have lacked under any other structure, even with backing from an internationally respected funder.

In addition, the SIB had benefits for its investors in developing their own thinking and views about the benefits of repayable finance, and in enabling traditional grant funders to contribute to a successful and high profile project through social investment.

Overall, however, local commissioners were always reluctant to fund the project and still are, arguing that it has failed to prove that all its impact can be attributed to the SIB. As one stakeholder noted:

"Every result has been counted and we don't have a baseline or a comparison group. I know there is a lot more testing than would have happened otherwise, but I couldn't stand in front of a clinician (who will pull it apart to the nth degree) or my Director of Finance and state with certainty that the SIB made all the difference."

As we note in section 5 of this report, we think there is some validity in this criticism but it does not apply equally in all settings, and there appears to be an element of hindsight in this objection being put to EJAF and the Zero HIV team at the end of the project rather than at the start. If it was essential to commissioner buy-in that the project proved its additionality, then this was not evident during our first review; the main argument for commissioners not becoming outcomes payers was that resources were heavily constrained, and that Public Health commissioners would never be in a position to fund testing on this scale, whether outcomes-based or not.

Overall, a combination of this view that the project has not proved the SIB effect, and the view of key stakeholders that 'if testing is worth doing, just pay for it' means that it is not surprising that there is no strong appetite for a successor SIB or payment by results project in South London (though EJAF may be right to explore whether the

same or a similar combination of finance, expertise and energy could achieve similar results outside the UK).

Another factor that might mitigate against future projects of this kind in the UK (or at least in England) is the declining number of people who are HIV positive and undiagnosed. EJAF's own end of project report puts forward 'the declining pool of undiagnosed as the work progressed' as one reason why a counterfactual measure might not have been reliable. In addition, the UK government's HIV Action Plan observes that: "As new infections reduce, they become harder to find, so we will need to continually adapt and evolve our strategy, tailoring our efforts to new groups and need". If that Action Plan succeeds, it will reduce the number of people first diagnosed in England from 2,860 in 2019, to under 600 in 2025.

In light of these trends, we think it might be challenging to implement a similar project, even in areas of high prevalence, since it will become more difficult for providers to deliver interventions paid for from a declining pool of available outcomes. Indeed, it is possible that the Zero HIV project might have found it challenging to achieve its original target of 1250 outcomes over six years, rather than around 460 outcomes over three.

7.2 Achievement of CBO objectives

The CBO programme has one overriding aim and four more detailed objectives.

The overriding aim was *to grow the SIB market in order to enable more people, particularly those most in need, to lead fulfilling lives, in enriching places and as part of successful communities.*

Against this aim we assess the Zero HIV SIB as **largely successful**. It implemented a complex project using a SIB model, attracted new investors into the market, and delivered good outcomes for people who otherwise faced poor quality of life, including long-term illness and death. It also had community-wide reach, and successfully brought together public and VCSE providers. It did not persuade commissioners to fund a similar project once it ended, but it did help persuade the government to invest more widely in opt-out testing in areas of high HIV prevalence, which is in our view a much more important outcome.

We have assessed the Zero HIV SIB against the four more detailed CBO objectives as follows:

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

  Partly achieved. There is evidence that commissioners had a better understanding of SIB structures and their strengths and weaknesses at the end of the project than they did at the start, but they remain largely sceptical of the benefits of SIBs and PbR and did not appear likely to apply what they have learnt to projects in the foreseeable future.

- *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*

  Fully achieved. The project proved the value of earlier and better intervention to address a persistent and apparently intractable issue, and contributed to a change in national policy to address that issue in the longer term.

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

  Mostly achieved. The SIB and EJAF's prime contractor role within it provided the opportunity for both new VCSE providers in the community and NHS providers, notably hospital sexual health

clinics, to get involved in service delivery in new and innovative ways and/or address additional hard to reach cohorts, such as the South American community, and those who had disengaged from treatment and were very reluctant to re-engage due to stigma and disadvantage.

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

  Fully achieved. The project has contributed widely to learning both about the challenges it faced in developing a SIB within the English health system and the challenges of intervention in the HIV prevention and treatment policy area. According to CBO end of grant data it has participated in a total of 80 learning events over its life and in addition to active participation in this evaluation, has separately commissioned the KCL Service Evaluation to provide a rounded and complete view of its effectiveness as both a SIB and as a service model.

7.3 Lessons for other projects

While there are many positive lessons from the project, some are not new and do not, in our view, need to be emphasised at length. They include the importance and value in SIBs of committed leadership and governance, of additional performance management, and of high-quality data systems.

One new lesson that has not emerged from previous in-depth reviews is that ***repayable finance can play a positive role in funding new SIBs and outcomes-based contracts***. The majority of SIBs and outcomes-based contracts in England are now managed and funded by specialist investment fund managers, managing and deploying funds from a range of investors. The Zero HIV SIB shows that there is still a role for one-off investment structures, designed to attract new investors. The main attraction appears to be that investors more used to deploying grants with no expectation of repayment, do not need to make a target return and may be content simply with the return of some or all of their capital. This is a lesson both for those looking to raise finance, and those seeking to deploy it, and seeing investment as a potential alterative to grants.

Of equal if not more importance, in our view, are lessons to be learned by this project's relatively few weaknesses, two of which have been highlighted at several points throughout this review and are to be found in other projects that we have reviewed, including the HCT travel training SIB and the MHEP family of projects. These are that:

- ***Projects that are not led by commissioners are at risk of commissioners deciding not to pay for outcomes.*** Like many projects which are led by providers or specialist intermediaries, this project, led by a funder, had strong expectations that local commissioners would pay for a high proportion of outcomes. This was understandable given the prevalence of undiagnosed HIV in the relevant London Boroughs, the history of funding for community testing provision, and the strong case, on both social and financial grounds, for commissioner funding of improved outcomes. A strong theme from our own and other research, as we note earlier, is that commissioners are often willing to engage in discussions and even detailed negotiation about making outcome payments without ultimately being willing to do so. The risk of this is clearly higher when resources are highly constrained, and the evidence is that any SIB developer should factor unwillingness to fund outcome payments into their risk analysis with both high likelihood and high impact. The lesson of other projects such as EOLC Telemedicine and PFP is that commissioners are unlikely to commit unless they can see a direct financial benefit and are more likely to do so if they are contracted to pay for outcomes from the start. There was always risk in EJAF's strategy that local commissioners would decide to pay later, once the project had 'proof of concept'.

- ***Any project seeking to prove its effectiveness to sceptical commissioners should consider stronger measurement of the counterfactual.*** This is the fourth SIB that we have reviewed

in-depth where commissioners and other funders have observed at project conclusion, to varying degrees, that they are not convinced of the effectiveness of the intervention(s) and/or of the SIB mechanism because there was no robust measurement of outcomes that would have been achieved without the intervention. Establishing such a comparator whether through a separate assessment or an historic baseline, is both difficult and potentially expensive. However it should be carefully and pragmatically considered, especially if it will help prove the case to reluctant commissioners.

There is an obvious link between these two learning points and we venture a new lesson which takes the logic of the points above to its conclusion. ***If commissioners are reluctant to commit to payments, we would suggest that SIB developers should press them to indicate clearly what level of evidence they need to be convinced***, and aim to tie them to that. In other words, if commissioners set a high bar for payment, then SIB developers should ask them to make a contractual commitment to payment if that bar is reached. This might mean establishing and agreeing in advance a structure that links payment to agreed performance against a baseline or other counterfactual measure, rather than both parties reflecting after the fact that measurement could have been improved. In addition, outcomes payments could be linked more directly to properly validated estimates of savings or costs avoided,

This approach might not have worked for this project because of the misalignment of cost and benefit, and complex HIV commissioning structure that we discuss earlier. It might however work for other projects, especially now that Integrated Care Systems (ICS) have replaced CCGs with the express aim of better joining up health and care funding and provision at local level. NHSE and local commissioner stakeholders we consulted during this review were cautiously optimistic that ICS would solve some of the 'wrong pocket' issues that have held back commissioner commitment to this project since the start.

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

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

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