CORE

Metadata, citation and similar papers at core.ac.uk

Provided by LSHTM Research Online

Tan, Stefanie; Fraser, Alec; Giacomantonio, Chris; Kruithof, Kristy; Sim, Megan; Lagarde, Mylene; Disley, Emma; Rubin, Jennifer; Mays, Nicholas (2015) An evaluation of Social Impact Bonds in Health and Social Care: Interim Report. Policy Innovation Research Unit (PIRU).

Downloaded from: http://researchonline.lshtm.ac.uk/2391521/

DOI:

Usage Guidelines

Please refer to usage guidelines at http://researchonline.lshtm.ac.uk/policies.html or alternatively contact researchonline@lshtm.ac.uk.

Available under license: Creative Commons Attribution Non-commercial http://creativecommons.org/licenses/by-nc/3.0/

PIRU POLICY INNOVATION RESEARCH UNIT

An evaluation of Social Impact Bonds in Health and Social Care

Interim Report

Stefanie Tan, Alec Fraser, Chris Giacomantonio[1], Kristy Kruithof[1], Megan Sim[1], Mylene Lagarde, Emma Disley[1], Jennifer Rubin[1], and Nicholas Mays

Policy Innovation Research Unit (PIRU), Department of Health Services Research and Policy
London School of Hygiene and Tropical Medicine, and RAND Europe[1]

PIRU Publication
2015 - 12

For further details, please contact:

Mylene Lagarde
Policy Innovation Research Unit (PIRU)
Department of Health Services Research & Policy
15-17 Tavistock Place
London WC1H 9SH
Email: mylene.lagarde@lshtm.ac.uk
www.piru.ac.uk

© Copyright 2015. Not to be reproduced without permission.

PIRU POLICY INNOVATION RESEARCH UNIT

An evaluation of Social Impact Bonds in Health and Social Care

Interim Report

Stefanie Tan, Alec Fraser, Chris Giacomantonio[1], Kristy Kruithof[1], Megan Sim[1], Mylene Lagarde, Emma Disley[1], Jennifer Rubin[1], and Nicholas Mays

Policy Innovation Research Unit (PIRU), Department of Health Services Research and Policy London School of Hygiene and Tropical Medicine, and RAND Europe[1]

March 2015

Acknowledgements

We would like to thank the members of staff in all the Trailblazer projects who kindly agreed to give up their time to be interviewed in this initial stage of the evaluation. Thanks to the three anonymous peer reviewers for their comments. Thanks are also due to our advisory board members, Pauline Allen, Sarah Caldwell, and Mildred Warner, for comments on the draft interim report and to Alex Pollitt who provided comments on Chapters 4 and 5 of this report as part of RAND Europe's ongoing quality assessment process.

Disclaimer

Chapters 1, 2, 3, and 6 were written by the LSHTM members of the research team. Chapters 4 and 5 were written collaboratively by the LSHTM and RAND Europe teams; only these chapters have undergone RAND Europe's internal quality assessment process.

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health. The views expressed are not necessarily those of the Department.

Table of contents

Summary 5

1. Introduction 6

2. Methods 12

3. Literature review on social impact bonds 15

4. Overview of SIB Trailblazers 26

5. Early findings from interviews 59

6. Discussion 72

References 77

Appendix: Further profile information on the Trailblazers 86

Summary

This interim report describes the progress of the nine 'Trailblazer' projects that received funds from the Social Enterprise Investment Fund in 2013 to investigate the feasibility of setting up Social Impact Bond (SIB) projects in health and social care in England. The findings discussed in this report are based on a literature review of the SIB literature and on documentary analysis and qualitative interviews with key informants involved in UK SIB development undertaken between May and November 2014.

The Trailblazers cover a variety of health and social care issues and are in different stages of development. As of December 2014, two projects were operational, and five projects were still in negotiation. Two Trailblazers will not become SIBs as one project has been fully funded by a public commissioner and the other was terminated before the contractual stage. This report details the diversity of models and approaches to SIB development across the nine Trailblazer projects.

The literature review finds that little empirical data about SIBs has been produced to date. There is a much larger academic, policy and 'grey' literature focused on the theoretical impacts of SIBs in funding and providing public services. Early empirical fieldwork data align closely with the existent literature.

Key findings from the documentary analysis and interviews in the nine Trailblazers are that SIBs require complex negotiations amongst multiple actors and organisations that have not worked together before. There may often be delays in agreeing SIB contracts and accessing requisite development funding to aid SIB development. SIB negotiations currently appear to have high transaction costs. Some health and social care SIBs are motivated by a desire to develop innovative services, whilst others focus on scaling up established service models delivered elsewhere or at smaller scale. SIBs have a significant impact upon how activity and outcome data are collected – frequently leading to more extensive and considered techniques of both data capture and analysis. However, informants expressed concerns around how to attribute outcomes to services. Learning points from two of the first operational SIBs in health and social care include, firstly, the importance of establishing clarity of data requirements and then building internal or external capacity to do this; and secondly, the importance of extensive collaborative working between all parties to ensure operational success despite the requirement to tender services.

1. Introduction

Interest in Pay-for-Performance (P4P) mechanisms, linking part of remuneration to achieving certain performance targets, has recently grown in health care and other public services, especially in the UK. For instance, payment-for-performance (P4P), also sometimes termed 'payment by results' in England, was mentioned 15 times in the UK Government's 2011 Open Public Services White Paper. The term 'payment by results' can be confusing as 'Payment by Results' is also the term used in the English NHS to refer to the prospective payment for hospital care based on activity, not on performance targets.

Social Impact Bonds (SIBs) have been introduced even more recently as a new type of P4P contract to fund the delivery of public services frequently through third sector organisations. These contracts involve three parties: public sector commissioners; social investors; and service providers, and often a fourth party, an intermediary. In a nutshell, in a typical SIB contract, public sector commissioners partner with private for-profit or Third Sector social investors to fund interventions that seek to tackle (usually complex) social problems (e.g. associated with rough sleeping, frail older people with multiple long term conditions, youth offending, etc.). More specifically, charities and/or private investors cover the upfront costs necessary to set up the interventions implemented by service providers, while the commissioner commits to pay rewards if pre-defined desired outcomes are later reached. Intermediaries are often involved in developing the intervention, providing advisory services (intermittent or through the life of the contract) and liaising with investors to secure project funding. In many cases, a Special Purpose Vehicle (SPV), or a subsidiary company, is established whose operations are used for the exclusive acquisition and financing of the service, and to receive investments and make outcome payments. The SPV can also issue contracts to service providers to deliver the intervention.

The term Social Impact Bond can be confusing as these contracts are not really bonds, since the return on capital or investment is not guaranteed. If they were bonds in the accepted sense, investors should be guaranteed to get their initial investment back at the end of the defined period, with any interest in proportion to the effectiveness of the intervention funded with their investment. Instead, Social Finance, a prominent intermediary in the SIB field in the UK, describes a SIB as "a hybrid instrument with some characteristics of a bond (e.g. an upper limit on returns) but also characteristics of equity with a return related to performance" (Social Finance 2014). The fact that there is no guaranteed return on investment is perhaps one reason why most of the investors in SIBs so far have been charities or foundations, often with pre-existing commitment(s) to a particular area of social service. Such schemes can appear simply as a new mechanism for public commissioners to shift the risk of funding interventions that might not be successful onto other players.

In the more ambitious SIB schemes, the pay-out to investors is, in theory, derived, wholly or in part, from savings to government if the intervention succeeds (e.g. if people are helped back to

work and cease to be reliant on welfare benefits) rather than on the basis of an estimation of the value to society of the improved outcomes – as happens in less ambitious SIB schemes. The government commissioner agrees to pay a proportion of any savings to the investors as profit and/or return on capital (returns on their investment).

Under a SIB mechanism, there is no requirement for the service provider to enter into a performance-related contract. This means that unlike in P4P schemes, the risk does not have to be borne by service providers, but is borne by the investors instead. Nevertheless, in practice, some SIB schemes include a P4P component for service providers as well. Ultimately, even though there might be an attempt from the public funder to shift some of the risk to private investors, the government is likely to bear at least some risk, for example, if the SIB-funded intervention fails or makes things worse and clients of those interventions end up using other public services more.

SIBs have been widely promoted in the last five or so years in England for many reasons. In particular, SIBs are presented as a new financing mechanism that:

- "[attracts] *new investment*" from private social investors (Social Finance website 2014) since it *"promises returns to private investors if social objectives are met"* (Economist 2013).
- "*remove[s] the risk that interventions do not deliver outcomes from the public sector"* (Social Finance website 2014) and *"enable[s] a re-allocation of risk between the two sectors"* (Rotheroe et al 2013).
- allows the implementation of new and innovative programs that have potential for success, but often have trouble securing government funding and thereby *"fund[s] innovation in service delivery"* (Rotheroe et al 2013).

England is emerging as a pioneer in the use of private finance to deliver social services through SIBs. The first SIB was launched at the Peterborough Prison in 2010, and SIBs have since been presented as the answer to some of England's most intractable social problems including, for example, recidivism, youth unemployment and substance abuse (HM Government 2009). As health and social care systems face the challenges of rising demand (due to an ageing population) and severely constrained resources, social investors and financial intermediaries see the sector as one of the main areas of growth and opportunities. The demand for social investment in the UK has been estimated as likely to reach £1billion by 2016, a third of which is expected to be in the field of health and social care (Boston Consulting Group 2012).

The simultaneous introduction of such an innovative funding mechanism and entry of new actors (i.e. social investors and financial intermediaries) in the field of health and social care is likely to present opportunities for the future financing of services, but might also present potential risks associated with the contracting out of public services, for example, in relation to the sustainability of service delivery and what happens if ventures 'fail'. There is also the issue of the transaction costs as SIBs appear more complex than traditional mechanisms with the added risks associated with complexity in financing. In this context, it is important to critically

assess the development of the first SIBs in the area of health and social care, in order to contribute to the research literature focused on the value-added and feasibility of further SIB models in health and social care, and to inform the way in which they might be designed and managed in the future.

Evaluation

In the field of health and social care, nine projects (briefly described below in Table 1.1, see Table 4.1 for a more detailed description of all projects), collectively known as the SIB 'Trailblazers', received seed funding from the Government's Social Enterprise Investment Fund (SEIF) in 2013. This was to undertake an analysis whether to implement a SIB and, if so, to set it up. The SEIF was originally set up in 2007 by the Department of Health in order to facilitate the development of the social investment market in health and social care. In many cases SEIF funding allowed projects, often led by service providers at the invitation of commissioners, to gain access to intermediaries, new actors offering advisory services, not unlike management consultancies with specialist knowledge in SIB development, who have provided assistance in the design and negotiation of potential SIBs. Thus in most cases, intermediaries have been working with providers and commissioners to share the development work involved in the SIB as far as is possible within the requirement to tender SIB-funded services.

The Essex Multi-Systemic Therapy SIB did not receive SEIF funding but had received cross-Government funding, including from Department of Health, prior to the SEIF awards and is thus included in this report for completeness and learning. At the time of writing, the nine projects in Table 1.1 have advanced to varying degrees, At the time of the report, just two projects are operational SIBs, five remain in negotiation, while one has been wholly funded by the public commissioner and one other will not proceed to become a SIB due to lack of commissioner support. The Trailblazers vary in their geographical location, scale or type of interventions to be delivered (e.g. from providing innovative interventions to support isolated older people in the community to scaling up proven programmes targeting delinquent youths).

Table 1.1: Overview of 9 SIB Trailblazers and Essex, as at December 2014

Project	Objective	Progress
Sandwell	Integrated community-based end of life services	Under negotiation
Cornwall	Early interventions for a cohort of 1000 frail older people with LTCs at risk of emergency admission.	Under negotiation
East Lancashire	Provision of patient-specific tailored health and social care interventions to reduce isolation, unemployment and poor quality of life	Will not be a SIB (government funded)
Leeds	Setting up a 75-bed nursing facility and creating a community of care delivering nursing care to a mix of high-needs people.	Project abandoned
Manchester	Multidimensional Treatment Foster Care for Adolescents programme (MTFC-A) providing behavioural interventions for 95 children aged 11 to 14 years	Signed and in progress
Newcastle	Improve the self-management of long-term conditions through social prescribing (i.e. non-medical interventions in the local community to foster sustained healthy behaviours)	Under negotiation
Shared Lives	Alternative to care homes for people in need of support: carers share their lives and often their homes with those they support	Under negotiation
Thames Reach	Personalised service pathway for a cohort of 415 entrenched rough sleepers.	Signed and in progress
Worcester	Early intervention and self-care programmes for isolated individuals.	Under negotiation
Essex[1]	Multi-Systemic Therapy (MST), which delivers family therapy in the home through highly qualified therapists delivered to 380 children on the edge of care or custody	Signed and in progress

[1] The Essex SIB is included here for completeness and learning but is not a SIB trailblazer and is being evaluated fully by the Office for Public Management.

The Department of Health's Policy Research Programme has commissioned an independent evaluation of these Trailblazer projects from the Policy Innovation Research Unit at the London School of Hygiene and Tropical Medicine, in partnership with RAND Europe, to explore their potential benefits and costs in health and social care.

Aims and objectives

The objectives of the evaluation of the Trailblazers are to:

(1) Develop a conceptual framework to help understand the potential role and effects of SIBs compared with other approaches to paying for public services. This component will help orientate the subsequent empirical parts of the project.
(2) Describe and assess the development of the nine SIB Trailblazers in order to identify obstacles and enabling factors in finalising SIB contracts.
(3) Describe and characterise the signed SIB contracts in order to unpack the implications in terms of incentives and risk-sharing arrangements for the different parties
(4) Assess, if feasible, in a second phase, whether and how the SIB contract mechanism enables achievement of better outcomes than alternative funding mechanisms, and if so, to explore the ways through which such benefits appear.

The evaluation comprises four components:

1) Conceptual work that builds on existing economics, public finance and public administration literature, as well as on a description of existing SIBs, to develop a typology of the different possible ways in which SIBs can be designed, in order to assess their theoretical implications in terms of the incentives faced by providers, investors and service commissioners, together with the risk-sharing arrangements. This component of the work will also seek to compare SIBs to other approaches to funding health and social services.
2) Building on this analysis, the project describes the way in which the projects have progressed towards the design of a SIB, and what challenges have emerged during that phase. This work relies on document review and qualitative interviews with key stakeholders from each of the three parties involved in the preparatory phase of SIBs (private investors, service providers and commissioners). The research will also seek to quantify the amount of work and time involved in this preparatory phase of SIBs, in order to quantify transaction costs.
3) The third component will comprise an in-depth analysis of the SIB contracts that are signed as the project progresses. It will rely mostly on the analysis of the contractual documents signed by all parties, and possibly on interviews with service providers and private investors to get a more precise understanding of the contractual arrangements, as well as some general understanding of services delivered. The information obtained will allow us to unpack the implications in terms of incentives and risk-sharing arrangements for the different parties, and to locate each of the existing SIBs within the typology defined in objective one.
4) The final component, to be undertaken in a second phase of the project from 2015, will seek to assess whether, and if so why, SIB funding mechanisms enable providers and thus

commissioners to achieve better outcomes and at what cost. To address this question, we will look for opportunities to compare quantitatively social and health care outcomes and costs of interventions funded through SIBs to those of a similar intervention (ideally, delivered by the same provider) funded through a traditional funding mechanism (i.e. with no social investor and/or no performance-based funding mechanism). Qualitative work will also be carried out to understand the reasons for any differences in performance (management, process, etc.) by the service provider under the two different funding mechanisms. The detail of this phase of the project is heavily dependent on how far the SIBs progress during this time.

The study began in January 2014 and is currently scheduled to end in December 2015 after 24 months. This interim report covers most of components 1 and 2 of the evaluation with the exception of comparing SIBs with other forms of payment for health and social care (component 1), and estimating the costs of establishing SIBs (component 2). Chapter 3 presents the early conceptual framework and literature on SIBs, while chapters 4 and 5 present results from documentary analysis and semi-structured interviews focused on how the Trailblazers have progressed.

2. Methods

Overview

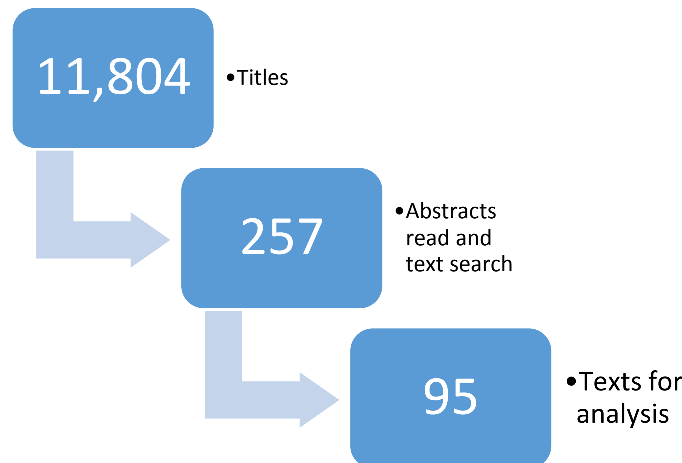
This interim report covers the first 11 months of the evaluation period (January 2014-November 2014). Data collection started in May 2014 due to delays in securing ethical approval and local research governance approvals. The first year of the evaluation has comprised the following:

- a literature review of SIBs from publications in the existing economics, public finance and public administration literature and from academic, governmental and commercial sectors (Chapter 3);
- collation of basic information on the SIB Trailblazers from their plans and other documents;
- semi-structured interviews to discuss the development of each trailblazer with:
    - Service providers involved in SIB design and delivery
    - Commissioners in health and social care (CCGs and local authorities)
    - Financial intermediary organisations involved in the development and design of SIBs in health and social care and others involved in SIB development (e.g. legal specialists)
    - Social investors and
    - National policy advisers (e.g. in the Cabinet Office).

Literature review

The terms “social impact bond” and “social AND impact AND bond” were used to search the following electronic databases: *CINAHL, Cochrane Library, EMBASE, ERIC, Ethos, Global Health, GreenFILE, Health Systems Evidence, HEED, HMIC, IBSS, NBER, NCJRS, NICE evidence search, Open Grey, PubMed, Scopus, Social Policy & Practice, Web of Science, Google Scholar*. These databases were chosen because they are openly available via the LSHTM library service. A criticism of this search approach is that it did not include non-UK terms for SIB-like projects – for example – ‘pay-for-success bonds’ or ‘health impact bonds’ which are sometimes found in the North American and Australian literature. However, the explicit aim of this review is to focus on the empirical and theoretical treatment of ‘Social Impact Bonds’ in the academic and non-academic policy literature. There was no time limit placed on the search and all languages were included – however, no non-English language papers were found. Figure 1 below describes the search process.

Figure 2.1: Overview of selection process for review



Interviews

Semi-structured interviews were undertaken with service providers, commissioning bodies, financial and consulting intermediaries and social investors involved in the development of the SIB health and social care Trailblazers. We conducted 36 interviews between May and November 2014 with service providers (n=11), commissioners (n=6), investors (n=2), intermediaries (n=11) and others involved in SIBs (n=6), e.g. staff at the Cabinet Office. We undertook interviews in all nine Trailblazers and the Essex SIB.

Initial interviewees were identified through SEIF applications, the Department of Health and the Cabinet Office, and subsequent interviewees were identified using the 'snowball' method. The topic guide for the semi-structured interviews aimed to understand informants' reasons for becoming involved in SIBs and the SIB Trailblazers; the (proposed) contractual model in the trailblazer; identification of the target population, outcomes and measurement issues; expectations of taking part in a SIB trailblazer; the negotiation process; identifying investors; and lessons for future SIBs.

Interviews were transcribed and data were analysed using NVivo 10. Interview data were analysed thematically. The research team designed an initial coding framework using deductive and inductive logic. First level coding was based on themes from the evaluation's research questions, interview topic guide and the key issues drawn from the literature on SIBs and payment for performance. The research team discussed initial themes before agreeing main themes and sub-themes for further analysis. The researchers at RAND and LSHTM who had been responsible for field work at different Trailblazers remained in frequent contact to reflect upon and refine the coding framework throughout the analytical process.

In Chapter 5, we present early findings from the semi-structured interviews by themes. In this Chapter, quotes from interviewees are presented to illustrate a broader theme that emerged. In each case the role of the interviewee is presented according to their role

(provider, commissioner, intermediary, investor), but quotes may have been modified to preserve the anonymity of the speaker.

Ethical approval

Ethical approval to undertake the study was granted by the research ethics committee of the London School of Hygiene and Tropical Medicine. We obtained local research governance permission from the CCG for each Trailblazer, where relevant.

3. Literature review on social impact bonds

Introduction

The aim of this review is to explore the publicly available empirical and theoretical literature relating to SIBs. At present, there is very little empirical data available on the implementation and evaluation of SIBs. In contrast to the scarcity of empirical data on SIBs, this review highlights the range of more and less theoretically driven sources from academic and non-academic authors. The review begins by locating SIBs within the larger literature on payment for performance (P4P) before moving into an analysis of the larger literature in order to set out the thinking associated with the development of SIBs across different policy sectors and countries. It also seeks to examine what the empirical literature suggests about what SIBs are in practice, how they function, and what the results of early SIBs show.

SIBs can be considered as a variant of payment for performance, with a focus on outcomes based contracting. At a theoretical level, SIBs are expected to ameliorate many perceived shortcomings of previous performance-based contracting programmes, such as the use of externally imposed targets, through a focus on locally developed solutions by service providers to meet the needs of marginalised populations with entrenched social problems. Given the limited empirical evidence on SIBs, it is instructive to look towards the payment for performance (P4P) literature, and what is known about P4P in public services, locally-designed and/or outcomes-based performance payment schemes to understand some issues around design and measurement. Payment for performance (P4P) programmes have been introduced widely across high to low-income settings over the past 10 years but there remains little convincing evidence that they are a better approach to funding public services.

There is limited empirical evidence in favour of introducing P4P schemes that are reimbursed entirely on outcomes, which is problematic when extended to SIBs, whose main benefits have been their exclusive reimbursement on outcomes. The majority of the evidence finds some positive effect or no evidence of impact following the introduction of a P4P scheme. There is limited evidence on the impact of performance- or outcome-based payments on provider behaviour at the organisational level (Shen 2003; Magrath and Nichter 2012; Songstad, Lindkvist et al. 2012; Chimhutu, Lindkvist et al. 2014), or negative impacts, though most literature suggests that there is some evidence of gaming and adverse selection (Van Herck, De Smedt et al. 2010). The development of metrics can also be contentious as Petersen et al (2006) suggest that design is important and recommend using a mix of absolute and relative incentives for process and outcome measures to disincentivise gaming. It is also difficult to demonstrate gaming, this is likely due to limited contexts for comparison, with one systematic review recommending that more research is needed that seeks to monitor unintended consequences as non-incentivised aspects of performance are likely to suffer or fall after the introduction of a P4P programme. There are few studies looking at the economic efficiency of P4P programmes and little evidence on cost-effectiveness (Petersen, Woodard et al. 2006; Van Herck, De Smedt et al. 2010; Emmert, Eijkenaar et al. 2012). Just one study was found that aimed to separate the effect

of broad health system funding increases from the impact of a new P4P programme (Basinga, Gertler et al. 2011).

SIBs are often advocated as a locally-developed solution to entrenched social problems however it is notable that there is also conflicting evidence on whether locally designed P4P schemes are best. A study of US hospitals with strong P4P incentives found limited impact, and suggested that individually tailored programs may be more effective (Werner, Kolstad et al. 2011) while a study on the UK's CQUIN program found local input was important but of limited use at the design stage as outcome setting is a technical process that "involves defining indicators, agreeing thresholds, and setting reward levels" which many local commissioners were unprepared for (Kristensen, McDonald et al. 2013).

SIBs are expected to bring greater rigour and accountability to performance management, especially for service providers and public commissioners. Similarly, in P4P programmes, measurement is repeatedly highlighted as a crucial aspect for the success of a P4P programme. Broadly, there was agreement that there should be information systems to facilitate prompt and reliable transfers of performance management systems (Van Herck, De Smedt et al. 2010; Werner, Kolstad et al. 2011; Roland and Campbell In press) but there often arise issues around constant monitoring and evaluation needs, such as the disruption of work and refocusing of staff time on administrative work rather than with service recipients (Chimhutu, Lindkvist et al. 2014; Feng, Ma et al. 2014). There remain issues with risk adjustment, for example, it can be statistically confusing and hard to convince providers of the credibility of indicators, and requires a large enough sample size to yield sufficient reliability (Eijkenaar 2013).

Any application of evidence from P4P should note that the literature offers limited insights on best processes for the optimal design of locally-responsive interventions as much of the empirical evidence on P4P in health looks at nationwide payment reforms, for example, the impact of outcomes-based incentives on the quality of secondary (Petersen, Woodard et al. 2006; McDonald, Harrison et al. 2007; Powell-Jackson, Yip et al. 2014) and primary care (Gravelle, Sutton et al. 2010; Kantarevic and Kralj 2013; Feng, Ma et al. 2014; Roland and Campbell In press), introducing payments for quality improvement in primary care (Doran, Fullwood et al. 2006) or nursing homes in the US (Werner, Konetzka et al. 2013)).

Despite the mixed, and often limited, empirical evidence P4P initiatives remain popular among policy makers and governments seeking to improve efficiency, effectiveness and value for money in health care and social services (Roland 2012; Lagarde, Wright et al. 2013). SIBs are appealing as a policy instrument that should ensure that governments only pay for successful programming but there remains a dearth of evidence for the assertion that SIBs will lead to improved outcomes (Disley, Rubin et al. 2011; McHugh, Sinclair et al. 2013; Disley, Rubin et al. 2014; Sinclair, McHugh et al. 2014).

Nature of the literature

Of the 95 texts identified for analysis, 61 were classified as 'non-academic' and 34 were 'academic,' The 'non-academic' reports and policy papers were produced by organisations such as charities, consultancies, social investment facilitators, governments and think tanks,

which often highlight the potential of SIB development relative to specific interventions. This 'grey' literature is reviewed alongside work on SIBs produced in academic settings that draws on various (frequently conflicting) theoretical approaches to reflect upon the applicability of SIBs to policy questions. The academic literature is wider in scope and offers a more critical approach to the subject than the grey literature.

The reviewed English language literature was produced between the years 2010 and 2014. It discusses the use of SIBs in policy areas as diverse as crime and justice including probation, health, education, social care (both of young and older people), social work, local and national government, law, management and taxation. The majority of academic sources dedicated to SIBs are from, and discuss the applicability of SIB models to, the US. This primary US focus is complemented by a secondary interest in English developments, as might be expected, given that the first SIB projects were set up in these two countries. The majority of non-academic sources identified in the review come from England – followed by those from the US, once more reflecting the relatively developed nature of SIBs in these two countries compared to others internationally. Given the nascence of the SIBs literature, the guiding principles around inclusion and exclusion have erred towards the side of inclusion rather than exclusion provided that the papers refer to SIBs at least three times – this was judged to be more important than formal peer review for example (as an inclusion criterion for 'academic' papers), which would have reduced the number of sources for analysis substantially.

The non-academic sources published by individual charities, or umbrella groups for charitable organisations, emphasise how SIBs may offer strategic opportunities for charitable organisations to innovate, collaborate and capitalise upon the changed economic and policy context following the banking crisis of 2008 (Fitzpatrick & Thorne, 2011; Griffiths & Meinicke, 2014). Documents produced by management consultancies highlight how SIBs represent a new market for philanthropic and socially minded investors, and, whilst referring to potential pitfalls, are generally positive about the potential for both improvements in social outcomes and returns for investors if the new policy arena is managed effectively. This is particularly so with reference to specific, measurable interventions targeted at difficult to reach populations (Callanan et al, 2012; Martin, 2013). There is also a burgeoning literature produced by organisations that act as facilitators, or intermediaries in the development of SIB projects. This literature stresses the value of partnership working for innovation and the importation of 'market discipline' into the public sector and among charitable providers (Cohen, 2011). The majority of authors share a keen interest in the importance of outcomes' measurement and effective ways to capture this (Social Enterprise UK, 2013). The UK government has further produced a significant literature over recent years – in particular from the Cabinet Office - extolling the potential virtues of SIBs and emphasising how innovation, transparency, collaboration and prevention may be enhanced by SIBs which transfer risk from the public sector to the private sector in order to further the goals of 'social justice' for 'vulnerable' populations (HM Government, 2011; 2013). The literature produced by various think tanks tends to be more developed in theoretical terms, and as with the academic literature, represents a more diverse and sometimes critical approach to the development of SIBs (Whitfield, 2012).

The majority of academic papers do not provide empirical evidence generated by SIBs. Of the purely theoretical papers, many focus upon how SIBs may impact on public policy. Some of these papers are supportive of the potential role that SIBs may play in policy improvement and particularly in developing better preventive programmes (Bafford, 2014; Cox, 2011) whilst others are critical (McHugh et al, 2013; Sinclair et al, 2014). A second stream of papers focus on the real or potential impacts of SIBs in the field of probation – particularly in the UK (Deering, 2014; Fox and Albertson, 2011; 2012), perhaps reflecting the reforms to probation services with the increased use of performance-related contracts and the influence of the Peterborough Prison SIB on wider thinking on reducing reoffending. There is a third category of papers narrowly focused on the applicability of SIBs to health policy and preventive funding centred on the US (Crowley, 2014; Fairfax-Clay, 2013; Trupin, 2014). These tend to be short, speculative and of limited value. A fourth category, once more US-dominated, focuses on banking, finance and tax law, and questions how SIBs might require changes to regulatory frameworks to become effective, and how government might need to reform the tax system to incentivise increased private investment in potential SIBs. There are a small number of papers that engage with both theory and empirics. These endeavour to collect and present qualitative data on SIBs – notably Warner (2012; 2013) and Jackson (2013). Finally, Disley et al (2011) and Disley and Rubin (2014) provide strong qualitative data on the Peterborough SIB specifically – quantitative analysis of which is provided by Jolliffe and Hedderman (2014). The few available empirical studies will be reviewed at the end of this chapter, preceded by a summary of the main themes that emerge from the theoretical and discursive literature, with particular emphasis on potential areas of tension related to SIBs and public policy.

Themes in the theoretical literature

A number of recurring themes identified in the theoretical sources are discussed in detail below. Central to this thematic development is the role of *values* for those writing about SIBs. This permeates the discussions around other key themes which include: the contested nature of *measurement* in SIB development; the management of *risk* in SIB contracts; and how this is closely linked to aligning *financial incentives* to agreed outcomes. Finally, the paradoxical claims made for SIBs as potentially both drivers of *innovation* and mechanisms to *scale-up* proven interventions, are explored.

The role of values

There is a tension in the theoretical literature focused on SIBs between those authors who assert the benefits of introducing market-influenced incentives to tackle ingrained social problems and those who emphasise the potential problems with doing so. These different perspectives may be understood as expressions of competing *values.* SIBs may be seen as tools to challenge traditional policy failures by proposing new solutions to ingrained social problems. Many of these social problems traditionally come under the purview of the public sector (e.g. probation services) or charitable provision (e.g. addiction support services) – or fall between the two (e.g. loneliness in old age) and thus may have been traditionally under-funded and perhaps weakly delivered. Another key aspect of SIB delivery for many of its champions is to instil private sector management techniques to remedy for the historic

shortcomings of public sector and charitable provision. This is linked to a belief in the superiority of competitive tendering and value for money auditing systems (Power, 1999). Cohen (2011) argues that the advances made in mainstream business in the 1980s and 1990s by venture capital and entrepreneurship can be replicated through social enterprise and impact investment in social services to reform public service provision. Callanan and Law (2012) in a report produced by *McKinsey & Company* emphasise that social innovation occurs "at the intersection of the public, private, and social sectors." For many advocates of SIBs, SIBs offer a mechanism to improve the ways in which non-profit organisations collect data and measure their performance (Bafford, 2014; Cox, 2011). For these authors, SIBs offer an opportunity to challenge cultures of public and third sector underperformance through an engagement with, and appropriation of, private sector management practices.

However, a counterview is offered by authors who suggest that there are potential dangers in the importation of private sector values and techniques into public policy. This is partly ideological, with critics viewing SIBs as an extension of neoliberal logic into government policy (Warner, 2012; 2013; Whitfield, 2012; McHugh et al, 2013; Malcolmson, 2014; Sinclair et al, 2014). Beyond this broader defence of public values in face of private sector encroachment, these authors highlight a number of specific problems associated with the extension of private values into public service delivery via SIBs. Warner (2012) emphasises the 'openness' of public sector contract making and contrasts this with the closed nature of private sector contracts that frequently remain hidden from scrutiny due to concerns of commercial confidentiality. She suggests that a degree of government, or public sector control, or oversight is essential in order to ensure legitimacy in relation to these contracts – there is a suspicion that private sector investors or providers may place the profit motive above the interest of a target population. Issues of accountability like this are developed further by Baliga (2013) who highlights how US prison privatization has been characterized by perverse outcomes associated with payment for performance contracting and suggests that SIB contracting may offer a solution by harnessing the altruistic nature of charitable organisations as a bulwark against corporate abuses. Other authors fear that the competitive ethos and performance management regimes imposed on charitable organisations by private financiers through SIB models may lead to a diminution of the ethical goals of charitable organisations or act as a 'smokescreen for privatisation' of service provision (McHugh et al, 2013; Whitfield, 2012). Other concerns raised relate to phenomena such as tunnel vision, 'gaming' and other perverse behaviour associated with targets and payment for performance regimes in general (Bevan and Hood 2006; Roland 2012).

Measurement

SIBs open up a multitude of questions relating to regimes of measurement. The expressed focus on outcomes is emphasised in positive terms across the literature. Perhaps reflecting a rejection of the 'target culture' which pervaded public service delivery in the Blair and Brown governments (Fox and Albertson, 2011), alongside the embrace of the evidence based ethos of '*what matters is what works'* (Deering, 2014), a focus on measured outcomes is portrayed as a significant advantage of SIB design (Social Finance, 2011). In many ways the focus on outcome measurement may be seen to unite both champions and critics of SIBs, and function as its major strength in policy terms, though some authors do

caution about the difficulties of accurate measurement in the field of social policy, and the need for extensive thought around the most effective ways to do so (Warner, 2012; 2013). This insight feeds into broader questions of attribution and the complexity of outcome measurement (Sinclair et al, 2014). McHugh et al (2013) posit that welcome as the focus on programme outcomes undoubtedly is, there is a danger that SIBs may rely upon an oversimplified approach to evaluation. This can misinterpret the contingent factors such as the dynamics of the target population, the context in which the intervention takes place and changes over time, all of which need to be understood as part of complex social change mechanisms affecting outcomes. The need for extensive, ongoing evaluation to ensure that SIBs 'work' is emphasised by most authors (Cox, 2011; Burand, 2013; Leventhal, 2013; Warner, 2012; 2013; Social Finance, 2011). Fox and Albertson (2011) suggest that the complexity of SIBs might mean that they remain a niche policy tool – in that the demonstrable benefits of SIBs may only accrue if interventions are 'scaled-up'. However, they suggest that 'scaling-up' brings with it challenges which may hinder the effectiveness of the original intervention. They also argue in a further paper (Fox and Albertson, 2012) that if programmes offer demonstrable benefits, then it may make more sense for commissioners to fund them directly without the additional transaction costs linked with SIBs. SIBs may therefore represent a pioneering activity that may be followed by more traditional funding arrangements, rather than leading to further SIBs. Demel (2013) suggests that commissioners ought to think carefully before opting for SIBs as there may be other innovative financing models that can achieve results more effectively and efficiently. She argues that the increased number of actors involved in SIB delivery will likely increase transaction costs, therefore it is important to be clear about what value the added skills, expertise and knowledge of the respective actors will bring above and beyond other commissioning models.

Risk and financial incentives

A key element in the theory of the SIB mechanism is the transfer of risk from the state to private investors and sometimes also to providers (Mulgan et al, 2011). This is attractive to governments and commissioners for a number of reasons. Many sources (both grey and academic) highlight the changed economic circumstances following the banking crash of 2008 (Early Intervention Foundation, 2014; Dodd and Moody, 2011; Jackson, 2013) and the space this apparently opens up for innovative forms of financing of social interventions (Young Foundation and NESTA, 2011; HM Government, 2013). It is interesting to note that many authors link the relevance of SIBs with the context of austerity without necessarily making the link between austerity and the possibility of greater cautiousness on the part of potential investors – nor of commissioners in how they use their limited funds.

In an English policy making context, SIBs also offer charitable organisations a chance to capitalise on a new set of opportunities following the election of the coalition government and the Prime Minister's advocacy of the Big Society. This aligns with the Government's assertion that 'social investment can deliver social justice objectives' (HM Government, 2013). SIBs may impact upon charitable organisations in a number of ways. Firstly, it is argued that, because SIBs can encourage a diverse range of service providers to deliver public services, they allow charities (both large and small) the potential to become more deeply involved in service provision, and secondly, it is argued that, as the contracts are

frequently granted for more than one year, this allows stability for charities to build up their capacity in service provision, rather than having to pursue a series of short term contracts to survive (Social Enterprise UK, 2013).

For some writers, the ability of SIBs to transfer risk opens up a policy space for innovative practice which SIBs may be well placed to exploit (Fox and Albertson, 2011; Jackson, 2013; Leventhal, 2013), whilst others take a very different view and emphasise that SIBs may be best used to capitalise on proven interventions and the 'scaling-up' of these (Trupin, 2014; Crowley, 2014; Burand, 2013). 'Scaling-up' is seen as problematic, however, by Jackson (2013) who suggests that the contextual factors which may be important in proving the value of a concept in one area may be different elsewhere, thus hindering simple replication. There is no consensus in the literature on whether SIBs are best suited to innovation or 'scaling-up' – rather, different authors draw on competing logics to make contradictory claims. A distinction between the English and US approaches appears to be that American proponents of SIBs in the literature emphasise the potential for 'scaling up' projects, whilst in England, SIBs proponents more readily highlight the innovative nature of programmes (Goodall, 2014). This distinction may have significant implications for an understanding of how risk and financial incentives are developed in the two countries. Nevertheless it is certainly the case that the SIBs so far developed in the US tend to be small-scale pilots despite the rhetoric of some American proponents of SIBs

Whilst, as highlighted above, government agencies and SIB proponents such as Social Finance and the Young Foundation in the UK emphasise the transfer of risks from the state to private investors, a number of authors (particularly in the US) focus on questions around how the risk to investors can be made sufficiently attractive to incentivise them to invest in the nascent market. Bafford (2013) argues that the risks for investors need to be minimised in order to encourage their involvement. Cox (2013) calls for the tax system to reward the SIB investors more effectively. Burand (2013) likewise calls for action to realign the relationship between debt and equity for SIB investors, as does Leventhal (2013) who also emphasises the need for a dedicated intermediary partner to help minimise investor risk. Dagher (2013) explores the potential legal and tax implications for non-profit organisations of being involved in SIBs. Pauly and Swanson (2013) suggest that the value of SIBs and its calculation of risk are likely to be heavily contextually-specific. Shiller (2013) makes the case that to be more attractive to investors, investors should be able to 'short' the bond – however, this kind of secondary marketization of SIBs is cited as a potential danger elsewhere on the grounds that it increases complexity and risk in an already complex and risky activity (Warner, 2012). This focus on taxation policy and regulation appears to be of greater concern to American authors than their UK counterparts, though there are areas of shared interest.

Having discussed some of the key thematic elements emanating from the theoretically focused SIBs literature, the next section examines empirical studies of SIBs.

Empirical studies

It is important to place the health and social care Trailblazers within the wider context of operational SIBs. Whilst much has been written about the potential of SIBs in both the grey literature as well as increasingly by academic researchers, the existent SIB projects themselves are still at an early stage. Table 3.1, below, details the fourteen SIBs currently up and running in the UK. The majority of these projects focus on tackling issues of youth unemployment and are linked to the Department of Work and Pensions. The second main area of focus relates to programmes that 'strengthen families,' including two of the Trailblazer projects (Essex and Manchester). There is also the Peterborough SIB to tackle recidivism and another trailblazer aimed at reducing rough-sleeping.

Table 3.1: SIB projects in the UK

SIB	Social Issue	Location	Status
Links4Life	Increasing education, employment and training for young people	London	Operational
Triodos New Horizons	Increasing education, employment and training for young people	Merseyside	Operational
Advance	Increasing education, employment and training for young people	Birmingham	Operational
Living Balance	Increasing education, employment and training for young people	Perth	Operational
Employer Hub & Nottingham Futures	Increasing education, employment and training for young people	Nottingham	Operational
3SC Capitalise	Increasing education, employment and training for young people	Cardiff & Newport	Operational
Energise Innovation	Increasing education, employment and training for young people	Thames Valley	Operational
Teens & Toddlers Innovation	Increasing education, employment and training for young people	Greater Manchester	Operational
Prevista	Increasing education, employment and training for young people	London	Operational
Multi-Systemic Therapy (MST)	Strengthening Families	Essex	Operational
It's All About Me (IAAM) Adoption	Strengthening Families	National	Operational
Multi-Dimensional Treatment Foster Care – Adolescents (MTFC-A)	Strengthening Families	Manchester	Operational
Team Parenting	Strengthening Families	Birmingham	Unclear
One Service	Tackling Recidivism	Peterborough	Operational
Rough Sleepers	Reducing Homelessness	London	Operational

Source: Goodall, 2014; Cabinet Office http://data.gov.uk/sib_knowledge_box/map

Outside the UK, there are a number of other operational SIB projects. Firstly, in the area of education and training for young people, there is the *Utah High Quality Pre-school Programme* in the USA, *Buzinezzclub Rotterdam* in the Netherlands, *Duo for a Job* in Brussels, Belgium, and *Juvat* based in Augsburg, Germany. In the 'strengthening families' category, there is the *Sweet Dreams* project in Saskatchewan, Canada, and two Australian projects based in New South Wales – the *New Parent and Infant Network* and the *Benevolent Society Social Benefit Bond.* Finally, there are three US projects focused on tackling recidivism: the *Adolescent Behavioural Learning Experience* and *Increasing Employment and Improving Public Safety,* both in New York City, and, in Massachusetts, there is the *Juvenile Justice Pay for Success Initiative.* On top of these, there are reportedly over 100 more SIBs in development (Goodall, 2014).

Despite the rise of SIB projects both in the UK and abroad, so far there is little empirical research published detailing the operation of the UK SIBs The lack of data is partly due to the small number of operational SIBs and the normal time-lag required to evaluate such socially complex projects – it may take a number of years to be able to collect the data to show whether a project has been successful given the long-term nature of many of these interventions. A small number of authors have begun to report empirically on SIB development, however. For example, though not a study of the functioning of any actual projects, Jackson (2013) draws on empirical qualitative data from over 100 interviews with international community development specialists and impact investors and suggests that there are important issues that need to be better understood with relation to SIBs – particularly related to measurement practices. Firstly, he suggests the current focus is on SIB design – with much less attention on 'down-stream' issues of attribution and measurement complexity. However, this will become ever more important as SIBs mature. Secondly, the effects of SIBs tend to be measured at the population level, but this fails to shed much light on the changes that occur at the individual, or household level – more research is needed here in order to increase understanding of how SIBs may (or may not) improve both overall and individual outcomes.

Warner (2013) interviewed architects of the (operational) Rikers Island recidivism SIB and the Alexandra City pre-school SIB aimed at increasing pre-school place uptake (in development) in Virginia USA, alongside documentary analysis of these two projects and that of the Peterborough SIB. She focused her analysis on the actors involved in SIB development and noted how SIBs increase the numbers of these and the complexity of the relationships between these actors – requiring intermediaries to manage the contracts for services once let. She also highlights the importance of philanthropic investment, albeit from a very large charitable foundation, despite the focus on attracting private investors highlighted elsewhere. She notes the innovative nature of the SIB model and its relation to outcome payments, highlighting the importance of the proven nature of the three respective interventions. She concludes:

> *"What is clear from this analysis is the governance processes in design and implementation are critical. SIBs are very complex. Goal alignment, network management, evaluation design to ensure core outcomes are measured, and risk management for investors, government, and clients are challenges that raise the*

transactions costs of SIB schemes. SIBs are being promoted for two primary reasons: to bring rigor to social service interventions and to attract private finance to areas where public investment is lacking. While such evaluation rigor is critical for structuring the private investment scheme, it may undermine developmental evaluation approaches which encourage critical reflection and ongoing program innovation" (Warner, 2013)

The most extensive empirical analyses of an operational SIB are provided by Disley et al (2011) and Disley and Rubin (2014) who focus on the early implementation and mid-phase experience of the Peterborough SIB in two RAND reports for the Ministry of Justice in England. The first of these draws upon 22 qualitative interviews with actors involved in setting up the SIB and offers a number of important findings. These include the need for good coordination and oversight from Government Departments to establish the initial SIB, and the importance of intermediary expertise to manage contracts and financial aspects as well as 'softer' relational skills to keep all actors engaged. The social motivation of investors is also cited as significant – the Peterborough project was not about fast returns for investors, but engaged socially motivated investors with an interest in more than a financial return. They note that tax rules may have acted as a barrier to investment in this case (Disley et al, 2011).

The second report, three years later, once more uses qualitative methods including 39 interviews to reflect upon the design, implementation and operation of the Peterborough SIB. Again, the authors offer a number of learning points including the freedom that providers have to innovate and be flexible around delivering aspects of the service to offenders. They find that small-scale providers felt liberated by not chasing short-term contracts and were therefore better able to focus on the quality of service delivery. Improved data collection and sharing were seen in positive terms – in the future it would be advisable to account for this in contracts – as there had been some confusion early on as to who was responsible for collecting and analysing specific pieces of data (Disley and Rubin, 2014).

Jolliffe and Hederman (2014) used propensity score matching to evaluate the effectiveness of the Peterborough SIB as part of the quantitative evaluation of the programme for the Ministry of Justice. The study matched 936 offenders released from Peterborough with 9,360 released from other prisons on 36 out of 38 variables. This was complicated by difficulties in accessing the requisite data – they note that it took '11 months to agree the sample and obtain all the data needed to begin analysis' (Jolliffe and Hedderman, 2014). This was linked to problems of data quality, including missing data on the type of offence in the routine systems. Social Finance and the Ministry of Justice had different views about who had (and should have) been helped in the Peterborough SIB, which had implications for who was included in the Peterborough sample and also implications for the control group. The first cohort analysis showed an 8.39% reduction in reoffending rates compared to the control group. This was insufficient to trigger payment (the goal being 10%), but the project was on target for the three-year goal of a 7.5% reduction in reoffending when it was ceased earlier this year due to wider Government policy changes (Ministry of Justice, 2014). Peterborough remains the most researched and best understood SIB, however there is no

published evidence relating the costs of setting up and running the SIB with the costs in a control group, so there is still no cost-effectiveness evidence on SIBs compared with other methods of paying for public services.

Conclusion

This review has thematically analysed the growing theoretically-focused SIB literature produced mainly in the US and the UK over the past four years emanating from both academic and non-academic sources. Key themes include the competing rationales of public and private values in policy making, new approaches to measuring performance and outcomes in particular, and considerations of risk and financial incentives. The review also showed the comparably small number of empirical studies of SIBs. The empirical studies highlight the high transaction costs of SIBs, the complexity of data monitoring and measurement as well as the ability for SIB delivery to offer space for innovation to service providers and improved outcomes as exemplified by the first outcome findings from the Peterborough SIB.

4. Overview of SIB Trailblazers

This chapter describes the main characteristics of the Trailblazers and provides an overview of development in each site (more details are given in the Appendix). The chapter is based on fieldwork conducted between May 2014 and November 2014. A finding of the early fieldwork is the range of variation in progress made by, and design of, projects since receiving initial SEIF funding. Projects (except Essex) received their initial SEIF grants between December 2012 and March 2013.

All efforts have been made to verify the information in this chapter as accurate as of December 2014. Information reported here has been found in official documentation or reported by interviewees. It is recognized that many of these initiatives have since changed in scope or structure, and updated information on each initiative will be made available in the final report. Please also note that certain relevant information relating to these SIB initiatives cannot be reported here where such information is not yet in the public domain.

Two Trailblazers and Essex have signed contracts and commenced operation while the majority have made progress in service design and discussions on the SIB, but remain at the SIB negotiation phase between commissioners, intermediaries, providers and funders. Two others will not become SIBs.

Table 4.1 below provides a summary of the nine Trailblazers plus Essex.

Table 4.1: Summary profile of health and social care SIB Trailblazers as of December 2014

Project	Provider	Commissioner	Location	Interventions/objectives	Outcome metrics	SIB already in place	Evaluator
Sandwell	Marie Curie Cancer Care[1]	Sandwell and West Birmingham CCG	Birmingham	Integrated end-of-life care services	Increase in proportion of patients dying in their usual place of residence; decrease in unplanned emergency admission rate in final month of life	In tender process	Not yet determined
Cornwall	Age UK[1]	Cornwall County Council	Cornwall	Early interventions for a cohort of 1000 frail older people with LTCs at risk of emergency admission.	Reduced A&E admissions, improved well-being (Edinburgh and Warwick mental well-being scale)	No	Not yet determined
East Lancashire	Green Dreams	NHS East Lancashire CCG	East Lancashire	Provision of patient-specific tailored health and social care interventions to reduce isolation, unemployment and poor quality of life	This project is currently still funded by East Lancashire CCG, yet PbR options are being considered. Outcomes likely include reducing isolation and returning to work or education	No	n/a
Essex	Action for Children	Essex County Council	Essex	Multi-Systemic Therapy (MST), which delivers family therapy in the home through highly qualified therapists delivered to 380 children on the edge of care or custody	Days saved in care as the primary outcome metric. Other outcome metrics include improved school attendance, decreased offending and improved emotional wellbeing	Yes	OPM
Leeds	Deep Green	Leeds CCGs (3)	Leeds	Setting up a 75-bed nursing facility and creating a community of care delivering nursing care to a mix of high-needs people.	Not specified in details in the presentation – "complex metrics" used, many outcomes, incl. money saved for the government by the interventions.	No	n/a
Manchester	Action for Children	Manchester City Council	Manchester	Multidimensional Treatment Foster Care for Adolescents programme (MTFC-A) providing behavioural interventions for 95 children aged 11 to 14 years	Number of children moved from residential care to foster placements. 'Bonus' outcome metrics: improved school attendance, better behaviour and wider wellbeing.	Yes	Implementat ion has been evaluated, SIB will be evaluated internally
Newcastle	Changing Lives, First Contact Clinical, HealthWORKS Newcastle and Mental Health Concern	NHS Newcastle West CCG	Newcastle West	Improve the self-management of long-term conditions through social prescribing (i.e. non-medical interventions in the local community to foster sustained healthy behaviours)	Achieved Improvement of the outcomes on the Wellbeing Star and savings for secondary care acute usage	No (expected to start in April 2015)	In consideratio n
Shared Lives	Identified STC (for Manchester; to be determined for Lambeth)	Manchester City Council (Lambeth Council for Lambeth)	Manchester (Lambeth to follow)	An alternative to care homes for people in need of support: carers share their lives and often their homes with those they support	Number of new Shared Lives care placements established	No (Manchester expected April 2015; Lambeth expected for summer 2015)	Not yet determined
Thames Reach	Thames Reach Housing Association	Greater London Authority	London	Personalised service pathway for a cohort of 415 entrenched rough sleepers.	Reduction in rough sleeping, move to stable accommodation, sustained reconnection, reduced A&E admissions, progress to employment, education or volunteering.	Yes (Nov. 2012- Nov 2015)	DCLG
Worcester	Age UK Herefordshire and Worcestershire	Worcester county council, Worcester CCGs (3)	Worcestershire	Early intervention and self-care programmes for isolated individuals.	Reduction in self-reported loneliness (using UCLA-9 scale)	Bid under review by commissioner	Written into tender

[1] Defined as lead provider or commissioner according to SEIF documents. Subject to change pending results of competitive tender.

Sandwell

The Sandwell SIB seeks to improve outcomes for End of Life Care (EOLC) patients living in Sandwell and West Birmingham through a redesigned integrated patient pathway that delivers care through a coordination hub designed to improve communication between service providers, patients and carers. This SIB will use two metrics to measure outcomes and determine outcome payments: an increase in the proportion of service users who die in their usual place of residence, and a reduction in the rate of emergency admissions in the final month of life. Alongside the SIB funded element, the EOLC service redesign also incorporates non-SIB funded services such as palliative care, hospice care, support services and specialised nursing, to be commissioned through a national tender process and block contract.

The Sandwell and West Birmingham Clinical Commissioning Group (CCG) serves a population with high levels of deprivation. In 2012, a CCG-initiated project identified EOLC redesign as a CCG priority given high levels of fragmentation in service delivery. At the same time, the NHS Confederation and public sector legal specialist firm Bevan Brittan LLP were in separate and unrelated discussions to develop a health and social care SIB which led to negotiations with Marie Curie Cancer Care (MCCC) and Social Finance, and a successful application for Social Enterprise Investment Funds (SEIF) to support the development of an EOLC programme based on a SIB. Staff at the Sandwell and West Birmingham CCG saw potential for alignment between the CCG's needs and the SEIF proposal. In 2013, the CCG and the other project consortium members, including MCCC, NHS Confederation, NHS Clinical Commissioners, Bevan Brittan LLP and Social Finance started work to review the service design of EOLC in Sandwell and West Birmingham.

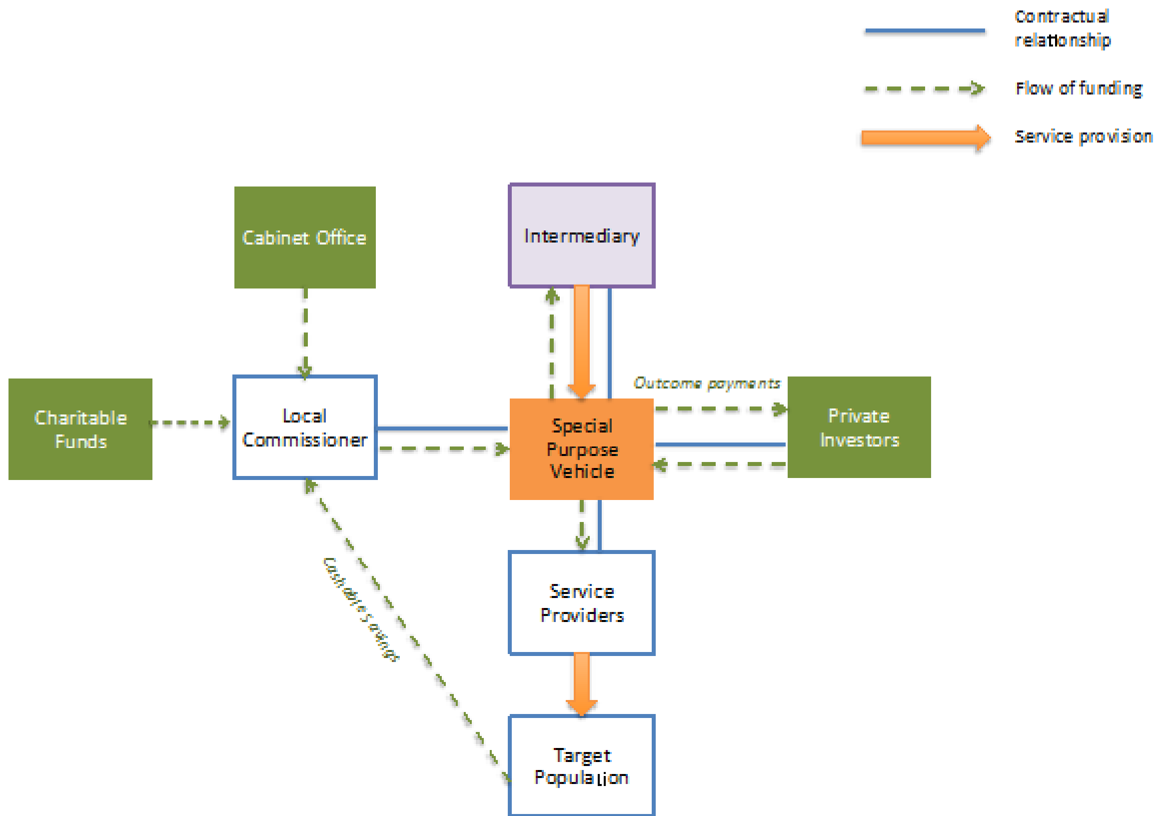
From July 2013 to May 2014 the CCG, Marie Curie, Bevan Brittan LLP and Social Finance worked collaboratively to engage stakeholders through a series of public events. The project team reviewed the relevant literature and developed potential care models and funding arrangements for a new EOLC service in Sandwell and West Birmingham. Once the new service model was agreed, Social Finance and Marie Curie withdrew from the collaboration in order to work on a joint bid to provide the SIB-based service once it was put out to tender. A decision on the chosen provider to deliver services funded through the SIB is expected in February 2015. Until then, it is unclear who the likely investors will be, how the SIB will be designed (i.e. with/without an SPV, although the project proposal favours an SPV) and what the agreed investor rates of return might be. It is expected that the rate of return will be no higher than 5% following CCG and local authority Joint Health and Overview Scrutiny Committee concerns about potential negative public perceptions of services being funded to generate private profit in this area (Sandwell and West Birmingham CCG, 2014) .

Table 4.2: Main characteristics of the Sandwell SIB

Timeframe	
(expected) Start date	01/09/2015
(expected) End date	31/08/2018
Parties involved	
Service provider	Numerous bids including MCCC, local NHS and non-NHS providers
Commissioner	Sandwell & West Birmingham CCG
Intermediary	Social Finance (with MCCC); Bevan Brittan LLP (with CCG)
Investors	This will depend upon who wins contract, but investors approached already include Bridges, Big Society Capital, LGT Venture Philanthropy, Barrow Cadbury, NESTA
Focus of the SIB	
Type of target population	Patients requiring EOLC
Size of target population	1000 EOLC patients per year
Problem tackled by the SIB	Lack of an integrated EOLC care pathway leading to poor communication between service providers, patients and carers. In turn, this has been shown to lead to unplanned emergency admissions for patients in the last month of life and increased numbers of deaths in hospital when patients had preferred to die at home
Type of services proposed	1. A coordination hub which coordinates packages of EOLC across all local providers 2. A rapid response service on duty 24/7 to help people in the community
Geographic remit	West Birmingham and Sandwell
Outcome-based component of the SIB	
Outcome metrics	The precise outcome targets and payment level will be set through the commissioning and procurement process. The metrics proposed are: 1. Increase in the proportion of service users who die in their usual place of residence across a service user cohort of 1000 patients per year. 2. Reduction of emergency admissions in the last month of life against an agreed baseline of 710 patients per year.
Type of target	1. An increase in the number of people dying in usual place of residence from 320 to 625. This represents a 30.5 percentage point increase across the service user cohort of 1000. 2. A reduction in the number of non-elective emergency admissions from 710 to 473. This represents 33% fewer emergency admissions against the agreed baseline of 710.
Data collection to measure outcomes	The precise data collection and outcome measurement processes are yet to be clarified. However it is assumed that data on A&E admissions will be drawn from Hospital Episode Statistics (HES) data.
Is the provider payment based on outcomes?	1. £465 per death in usual place of residence (Big Lottery/Cabinet Office would pay c.30% of total outcomes payments) 2. £2,560 per avoided emergency admission. This is 95% of the cost of an average non-elective emergency admission for this cohort
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	Not yet identified
Is there a contract between commissioners and service providers?	Not yet identified
Is there a contract between investors and service providers?	Not yet identified
Is there an SPV?	Yes, proposed
Investment	
Investors already on board	Not yet identified
Size of each contribution	Not yet identified

Sources: This table is based on fieldwork sources and Sandwell & West Birmingham CCG and Marie Curie Cancer Care (April, 2014) *Social investment in end of life care initiative: Stage 3 report*

Figure 4.1, Proposed SIB model, Sandwell



Cornwall

The proposed SIB is to be used to reduce dependence on public sector health and social care services by engaging voluntary sector organisations (VSOs) to deliver personalised care packages for patients with high service use and multiple long-term conditions. This is a collaborative service model developed between voluntary sector organisations and local commissioners in health and social care, initiated by Age UK Cornwall and the Isles of Scilly, in 2010. The project aims to develop a proof of concept model of integrated health and social care services that improves patient outcomes and produces measurable cost savings, specifically in secondary acute care.

There have been two pilot projects, in Newquay, and Penwith, Cornwall, to test the service model. Both were accompanied by an independent evaluation by the Nuffield Trust. In Newquay and Penwith, the target populations (n=50 and n=1000, respectively) were identified using a risk stratification model to identify patients with high use or at high risk of readmission to hospital. The target population then received personalised service packages to enable better self-management of chronic conditions and less reliance on formal caregivers, including district nursing services. These pilots were funded with bridge funding from Age UK's national office, various philanthropic grants, and a local endowment. Social Finance has held an advisory role at intermittent points in the process, primarily around the identification of measurable outcomes that could appeal to external investors, if and when a SIB model is used. The Penwith pilot has ten main outcome measures; of these, it is likely that any future SIB's payable outcomes will be a reduction in avoidable admissions to A&E, and an improvement in self-reported well-being based on the Edinburgh and Warwick mental well-being scale (Tennant et al 2007).

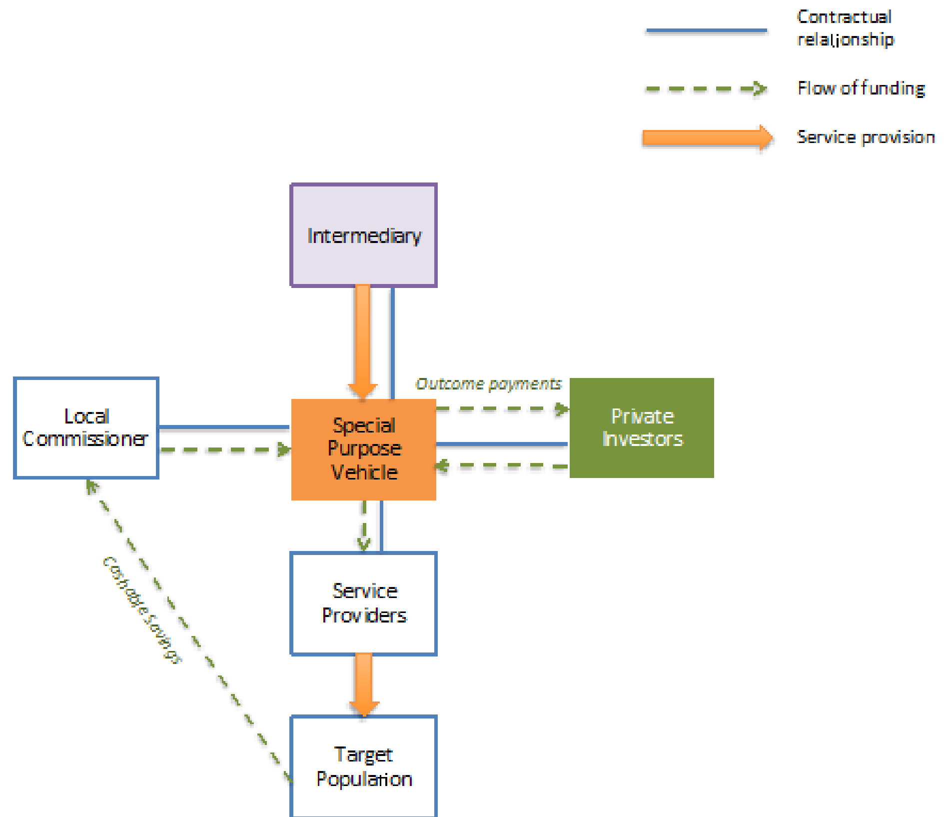
The Trailblazer team recently received a grant from the Cabinet Office's Social Action Team to pilot this service at a new site in the East of Cornwall. It is undecided how this project will be funded, and negotiations are currently underway to discuss whether this will become a SIB contract or whether alternate sources of bridge funding will be procured (as with Newquay and Penwith). In Cornwall, the lead service provider, Age UK and its national office remain supportive of SIBs as a funding mechanism. If Cornwall's proof of concept is established, it could be a basis for Age UK to gain long-term funding for preventive services using the SIB model in other CCGs around the country.

Table 4.3: Main characteristics of proposed Cornwall SIB

Timeframe	
(expected) Start date	To be determined
(expected) End date	To be determined
Parties involved	
Service provider	Age UK Cornwall and the Isles of Scilly in partnership with other local VCS organisations in Cornwall
Commissioner	NHS Kernow
Intermediary	Support from Social Finance on model development, limited to advisory/consultancy role
Investors	To be identified
Focus of the SIB	
Type of target population	Older individuals with multiple long term conditions, high service users, low mobility, high risk of avoidable admission to A&E.
Size of target population	1000 patients
Problem tackled by the SIB	Reduce dependency on statutory health and social care, especially acute hospital services, through increased use of voluntary sector services to reduce costs.
Type of services proposed	Introducing personalisation in health and social care through greater engagement with the voluntary sector
Geographic remit	Pilot project with 1000 people in Penwith, West Cornwall. Forthcoming project with 1000+ people in East Cornwall.
Outcome-based component of the SIB	
Outcome metrics	Reduced avoidable admissions to A&E; improved well-being, measured with the Edinburgh and Warwick mental well-being scale (7 attributes, 5 point scale).
Type of target	To be defined based on Penwith project data, available in late 2014
Data collection to measure outcomes	Data on A&E admissions will be drawn from Hospital Episode Statistics (HES) data. Well-being data will be drawn from questionnaires, likely administered by service providers.
Is the provider payment based on outcomes?	To be determined
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No
Is there a contract between commissioners and service providers?	No
Is there a contract between investors and service providers?	No
Is there an SPV?	Yes, proposed.
Investment	
Investors already on board	Informal discussions held
Size of each contribution	N/A

Sources: this table is based on fieldwork information.

Figure 4.2, Proposed SIB model, Cornwall



East Lancashire

The Green Dreams Project was initiated in Padiham in 2010 and as of February 2015 operates across thirteen GP surgeries in East Lancashire without a SIB funding mechanism (Green Dreams Project n.d.; Green Dreams Project CIC, 2013). It currently serves half of the adult patient population (approximately 130,000 registered patients) in East Lancashire and receives around seventy referrals from GPs each month.

The Green Dreams Project provides local, community-based solutions in East Lancashire to unemployment, isolation and reduced quality of life. As such, it aims to reduce isolation and to increase (returning to) education and work. This is achieved by linking Green Dreams project managers with individual GP practices who provide one to one support to patients. The project managers provide a 'triad of care' in which they 1) provide tailored coordinated care; 2) combine health with social care needs; and 3) create opportunities for patients to get involved in community activities (Green Dreams Project CIC, 2013). The intervention is aimed at individuals over 18 years of age with "knock on effects for their children and other dependents and family members" (College of Medicine n.d.).

In 2010, original grant funding was received from Innovate Now North West, which was used to pay the first project worker for the first year. In 2011, the Green Dreams Project collaborated with the Lancashire Care NHS Foundation Trust (LCFT), which seconded four people to Green Dreams to become project managers. Since 2011, Green Dreams has been funded by NHS East Lancashire CCG. Other funding for specific projects includes the Social Value Fund and the Prince's Charities (SEIF PbR Application, 2013, internal document).

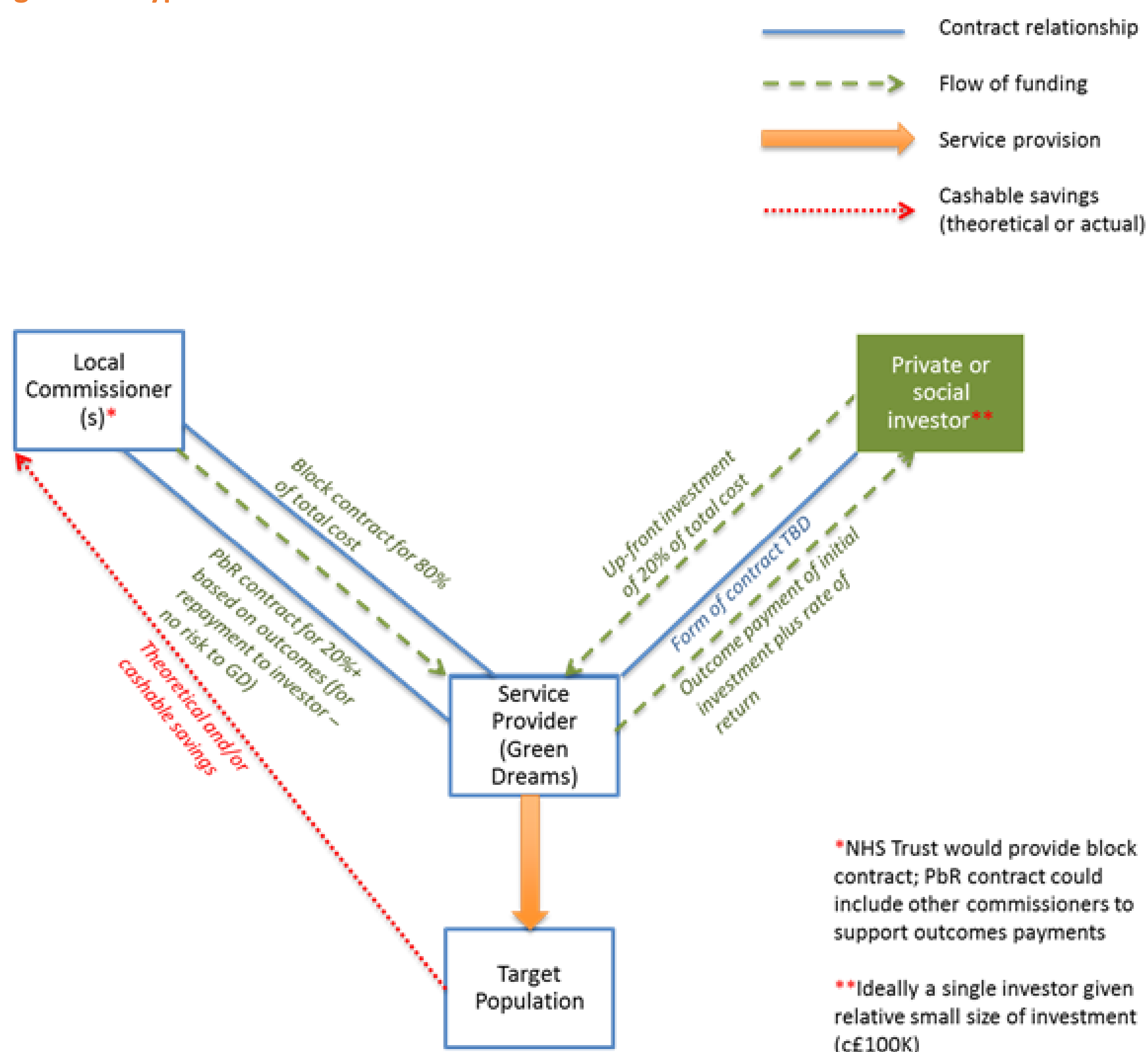
In 2013, the commissioner, NHS East Lancashire CCG, recognised that not all patient outcomes were health outcomes and thus other departments could be funding the project as well. As such, the Department of Health asked the Green Dreams Project to look for payment by results opportunities. With SEIF funding, Local Partnerships and other partners stepped in to narrow down Green Dreams' outcomes, to create a robust way of measuring outcomes and to look at SIB and PbR mechanisms as options for future funding. They presented their findings and alternate options for funding models (SIB and PbR) to the Local Commissioner in October 2013. It was agreed that key outcomes included reducing isolation and returning to work or education. Furthermore, a subset of outcomes included, amongst others, changes in housing, debt and benefits. In addition, medical and physical outcomes were also taken into account, such as mental health and healthy eating respectively. Following these discussions, an online monitoring system was developed in which 72 outcomes for each patient could be measured. The monitoring system has been in place since August 2014.

During the presentation in October 2013, Green Dreams advocated for a 'hybrid' PbR model, which could possibly be funded by a SIB mechanism, where one commissioner would commit 80% of the necessary funding (a 'block contract') while the other 20% would be set up as a PbR model (which could be funded up front by a private or social investor) (Green Dreams Project CIC, 2013). If the outcomes would be achieved, the same or other commissioners would pay the remaining 20% back to the investor, including a return. Following this presentation the commissioner committed to funding the Green Dreams

Project for one more year, with the caveat that they did want to consider the hybrid model in the future. As of March 2015, the Green Dreams Project is still commissioned and funded by East Lancashire CCG, and is therefore not currently funded through a SIB or PbR mechanism. However, the project is still considering PbR options for future funding while the commissioner has agreed to continue funding until other funding is secured.

Note: There is no table summarising this trailblazer because The Green Dreams Project had not yet developed a SIB or related payment for outcomes model when data collection ended. Instead, Local Partnerships did develop a potential payment for outcomes approach, and the diagram below is adapted from this approach. Since a respondent indicated that a non-SIB PbR mechanism is the most likely option to be taken forward at some point, this PbR model is presented in the diagram instead of a SIB.

Figure 4.3 Hypothetical PbR model[1]



[1] The research team developed this diagram in collaboration with respondents involved in the development of the PbR model

Essex

In 2010, Social Finance began working with Essex County Council (among other local authorities) to gauge their interest in developing a SIB for use in children's services. As a result, Social Finance conducted feasibility work with Essex County Council, after which it was decided that Multi-Systemic Therapy (MST) would be funded through a SIB mechanism. Subsequently, a competitive procurement process took place after which Social Finance was awarded a contract by Essex County Council to develop and implement the SIB (Essex County Council and Social Finance 2012). Over the following year, the SIB mechanism was developed through dialogue and co-production between Essex County Council, Social Finance and other parties. This was coordinated by a project board and included seeking legal advice about the provision of services under a SIB model.

In November 2012, Essex County Council became the first local authority to commission and to award a SIB for the provision of an MST service aimed at children in or at-risk of going into care (Griffiths and Meinicke 2014). MST has been provided in the UK for several years without SIB financing. It provides family support through therapeutic assistance in order to rebuild relationships as well as through practical assistance (Barclay & Symons, 2013b). The Essex SIB went live in April 2013 and will be operational for five years, with outcome-related payments made over eight years (Cabinet Office 2013; Essex County Council & Social Finance [no date]). After a procurement process as led by Social Finance, Action for Children was commissioned to provide MST services, with an 'Evolution Fund' running alongside the MST funding. This Evolution Fund was created to provide flexible funding for the MST programme (Cabinet Office 2013). As such, it acts as a reserve fund that holds money not originally allocated at the start of the SIB and is intended as a discretionary budget to reinforce achievement of positive outcomes across the tracking period. An SPV, Children's Support Services Ltd, was established to manage the SIB, the contracts with the investors (subscription and loan agreements), the service provider (service contracts), and the commissioner (outcomes contract) (Cabinet Office 2013; Barclay & Symons 2013b). A total of £3.1m of investment was secured from investors including Big Society Capital and Bridges Ventures. The evolution Fund is also part of the investment and was provided by the investors. The base case returns to investors are expected to be eight to twelve per cent derived from outcome payments based on the average number of days in care saved. Essex County Council pays for these outcomes up to a cap of £7m (Cabinet Office 2013). For each individual, during a period of 30 months from commencement of the MST (excluding MST Therapy days), the number of days spent in care are measured. On a quarterly basis, payments are made to the investors based on the average number of days spent in care across the cohort compared to a historic benchmark comparison group.

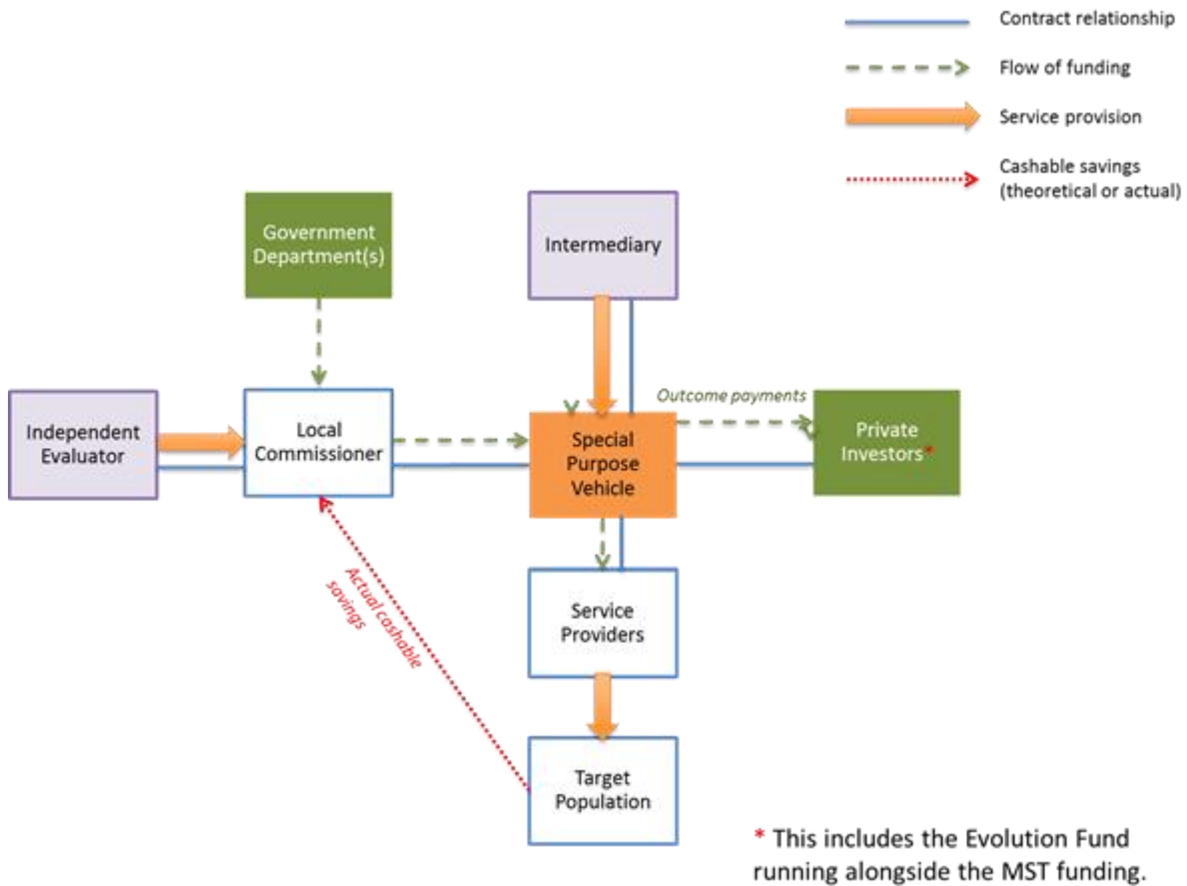
Table 4.4: Main characteristics of the Essex SIB

Timeframe	
Start date	April 2013
End date	Operational for five years, with payments made across eight years
Parties involved	
Service provider	Action for Children
Commissioner	Essex County Council
Intermediary	Social Finance
Investors	Big Society Capital, Bridges Ventures, Barrow Cadbury Trust, the Tudor Trust, Esmée Fairbairn Foundation, King Baudouin Foundation, Charities Aid Foundation and Social Venture Fund.
SPV	Children's Support Services Ltd
Independent evaluator	OPM
Focus of the SIB	
Type of target population	11-16 year olds at the edge of care/custody
Size of target population	380 young people over a five-year timespan (thereby diverting around 100 children from care)
Problem tackled by the SIB	There was a gap in addressing the specific needs of adolescents at the edge of care through service provision. Essex experienced an increase in numbers of looked after children, costing £65m annually
Type of services proposed	Multi-Systemic Therapy (MST)
Geographic remit	Essex
Outcome-based component of the SIB	
Outcome metrics	- Primary outcome metric: savings of days in care - Other metrics: school attendance, emotional wellbeing and reduced reoffending
Type of target	Average number of days spent in care
Data collection to measure outcomes	At the end of each measurement quarter, the average number of days spent in care is compared with historical case file data. This historical data is collected prior to the SIB, covering 650 cases tracked over 30 months.
Is the provider payment based on outcomes?	Yes. A maximum of £7m in outcome payments over the contract term.
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No. The commissioner and the SPV have an outcomes-based contract.
Is there a contract between commissioners and service providers?	No. There are service contracts between the SPV and the provider.
Is there a contract between investors and service providers?	No. The investors fund the SPV and have agreements with the SPV.
Is there an SPV?	Children's Support Services Ltd
Investment	

Investors already on board	Yes
Size of each contribution	In total, there is £3.1m of secured funding, including: - £825,000 from Big Society Capital - £825,000 from Bridges Ventures

Sources: this table is based on fieldwork information as well as the following references: Cabinet Office 2013; Barclay & Symons 2013a; Barclay & Symons 2013b; Big Society Capital 2013; Bridges Ventures 2013; Essex County Council & Social Finance [no date]; Social Finance [no date b].

Figure 4.4, SIB model, Essex



Leeds

The Leeds SIB trailblazer was developed by Deep Green Care Community Interest Company (CIC) and aimed to deliver active case management for a cohort of 70-100 patients between the ages of 18-64 with very complex needs due to physical health conditions. The proof of concept proposition intended to use an existing nursing facility with between 20-35 beds alongside a mobile community nurse specialist team to deliver an integrated care service for patients which would allow admissions to the facility for intermediate care, avoidance of admissions to hospitals and improved outcomes for patients living at home as well as those who become unable to live at home as an alternative to standard residential homes. It was premised upon the development of an outcomes based arrangement with local commissioners in the Leeds and West Yorkshire area drawing on a SIB investment instrument to raise working capital for the service and link improved health outcomes to financial success (Halfpenny and Hotchkiss, 2014 p3).

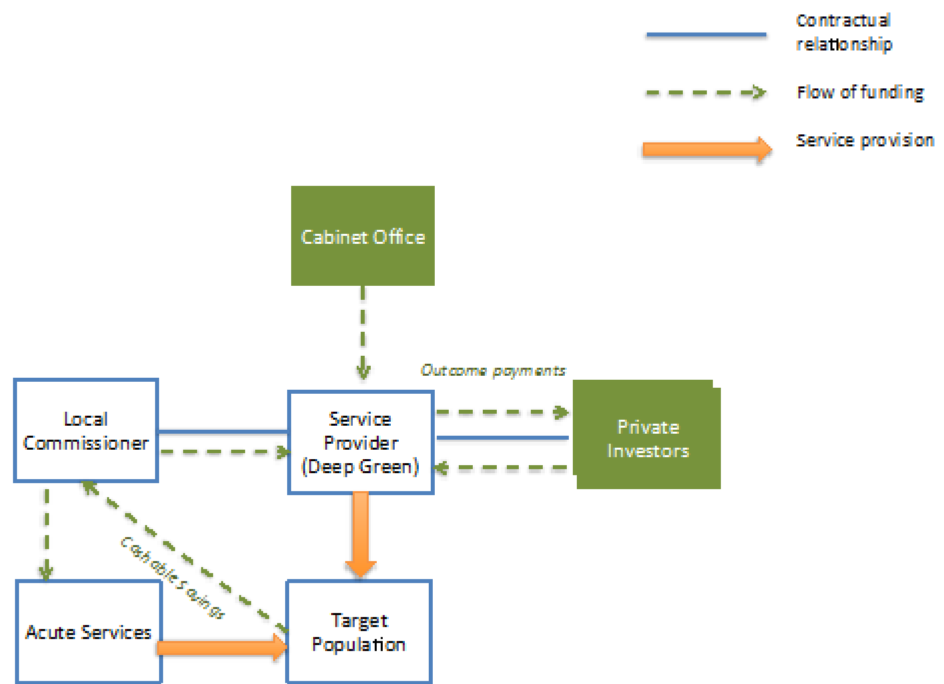
This was a purely provider instigated and led initiative that received SEIF funding in May 2013. There was no commissioner input at any stage in project design and development. Deep Green was driven by the personal vision of its founder, a nurse and public health consultant who, following the diagnosis of a brain tumour in 2005 reflected on the need for specialised nursing and rehabilitative care for other patients with similar afflictions as she made her recovery. She developed the Deep Green care model alongside a business partner with experience of the social enterprise market in the North West of England. Deep Green were offered the opportunity to develop a building on a large site in South West Leeds but in order to progress with this, they first needed to establish a proof of concept at a smaller site. Whilst Deep Green successfully developed a service delivery model throughout 2013, achieved Cabinet Office backing and finance, and independently engaged a social investor, they failed to achieve crucial support from the three relevant local CCGs necessary to secure further funding from the Big Lottery Fund, required to move the project further along. The CCGs felt the project did not fill a gap in existing service provision and that Deep Green lacked sufficient experience as a service provider and were seen as a high-risk investment. Deep Green therefore ceased their attempts to develop a SIB in Leeds in the summer of 2014 (FSquared Ltd, 2014).

Table 4.5: Main characteristics of the Leeds SIB

Timeframe	
(expected) Start date	Not applicable
(expected) End date	Not applicable
Parties involved	
Service provider	Deep Green CIC
Commissioner	Leeds North CCG, Leeds South and East CCG, Leeds West CCG
Intermediary	No specialist SIB intermediary (limited advice taken by Social Finance), but two different Management Consultancies and legal advice sought from Capsticks LLP
Investors	Interest from Bridges and others – but nothing formalized
Focus of the SIB	
Type of target population	18-64 year old patients with very complex needs due to physical health conditions
Size of target population	70-100 patients
Problem tackled by the SIB	Improve intensive rehabilitation for patients with long term neurological conditions (e.g. multiple sclerosis, Parkinson's, Huntington's, epilepsy, congenital conditions, Acquired Brain Injury, with physical manifestations, Spinal Injury, learning disabilities with complex physical needs, people requiring mechanical ventilation / other highly technical support, young physically disabled) who require have need for nursing support
Type of services proposed	Active case management including at-home nursing service with mobile nurses overseeing care delivered by family, friends and hired care, backed up by a nursing care facility as an alternative to hospital admission when patient condition deteriorated and for post-hospital Intermediate Care and rehabilitation, in addition to long term residential care and respite.
Geographic remit	West Yorkshire (Leeds, Bradford, Wakefield, Calderdale, Kirklees)
Outcome-based component of the SIB	
Outcome metrics	Reduction in hospital admissions for each patient
Type of target	Admissions avoided 0.8-1 per cohort member
Data collection to measure outcomes	Before and After (based on 3 years historical GP clinical systems data)
Is the provider payment based on outcomes?	Final value (was) to be negotiated with commissioners
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No
Is there a contract between commissioners and service providers?	No
Is there a contract between investors and service providers?	No
Is there an SPV?	No
Investment	
Investors already on board	Informal discussions held
Size of each contribution	Not applicable

Sources: this table is based on fieldwork information as well as the following references: Halfpenny, P and Hotchkiss, J. (2014) *Deep Green Care Community CIC Business Plan: proof of concept stage 2014-2018,* and FSquared Ltd (2014) *Deep Green Care Community CIC: Developing a provider led Social Impact Bond*

Figure 4.5, Proposed SIB model, Leeds



Manchester

In 2011, Manchester City Council invited Social Finance "to conduct a feasibility study into potential new interventions to safely reduce the numbers of children in residential care, improve outcomes, reduce costs" (Cabinet Office [no date], no page), thereby considering SIBs as a funding mechanism.

Social Finance advised Manchester City Council on an intervention that would provide an intensive fostering service for adolescents aged 11-14, an intervention called Multi-dimensional Treatment Foster Care - Adolescents (MTFC-A), as an alternative to local authority residential care for those young people that meet the criteria (Social Finance [No date c]). In brief, within Multi-dimensional Treatment Foster Care, foster carers are trained to provide MTFC in order to help addressing children's emotional and behavioural difficulties (Action for Children [no date]). The one-year MTFC programme includes encouraging the development of academic skills, setting boundaries, supporting the establishment of contact with pro-social peers and maintaining close supervision of the child (Cabinet Office [no date]).

As a result, the Manchester City Council commissioned an MTFC-A intervention to move at least 95 children aged 11-14 with behavioural and emotional issues from local authority residential care to more stable, family-based placements (Roberts 2013). Action for Children was selected as the service provider from amongst the bids received.

Within the process, Social Finance "provided Manchester with hands-on experience in developing new ways of bringing private and philanthropic sector investment into projects for social good" (Cabinet Office [no date], no page). Furthermore, throughout the SIB development process, Social Finance has an on-going advisory role.

The Manchester City Council SIB was signed between the commissioner and Action for Children in February 2014 and will run for eight years, with services delivered over five years (Griffiths and Meinicke 2014). Because Manchester City Council determined that it could not discharge its statutory safeguarding duties to an SPV, but could to Action for Children, no SPV was put in place for this SIB. Instead, Action for Children is in a contractual relationship with both the commissioner and the investors, but no contractual relationship exists between the investors and the commissioner.

Risk is distributed across all partners in this SIB, including the service provider. Action for Children will receive additional payments for improvements on the same metrics as the investors.

In the first year, up to eight young people will be placed into the programme, and if successful, this will increase to 16 people from year two (Cabinet Office [no date]). Over the lifetime of the SIB, 95 children in total are expected to go through the programme. Outcome payments are made on the basis of getting and keeping children out of residential care (Cabinet Office [no date]). Furthermore, 'bonus' outcome metrics include improving young people's outcomes (e.g. school attendance, behaviour, and positive activities) (Cabinet Office [no date]).

The contract value is around £8m in total (for five years), with Bridges Ventures investing £1.2m (Action for Children [no date]; Bridges Ventures 2014). Top-up payment will come from the Cabinet Office Social Outcomes Fund grant that contributes up to nine per cent of the outcome payments (Roberts 2013). The Cabinet Office contribution to outcome payments will be proportionally higher in the early years of the programme and then will decrease over time, averaging nine per cent over the period of the SIB.

An independent evaluation of the implementation of the initiative has been completed. No independent evaluation is planned for the operation of the initiative, but an internal evaluation by the commissioner is ongoing.

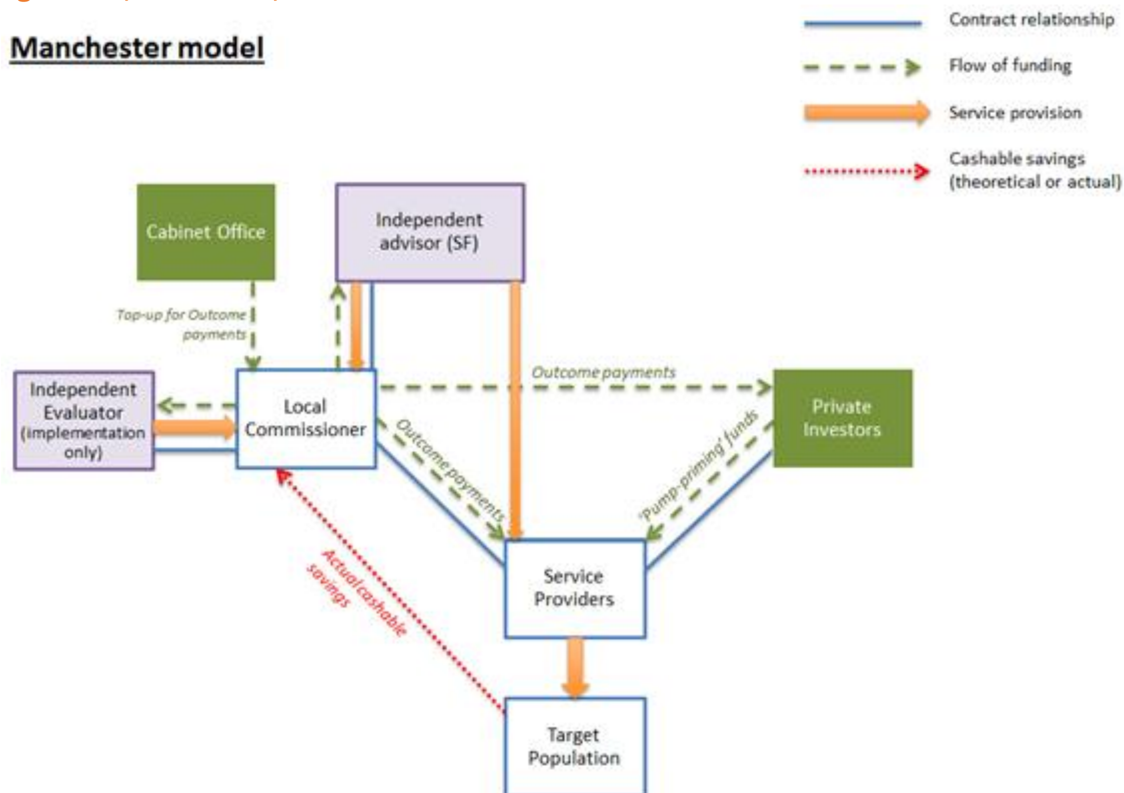
Table 4.6: Main characteristics of the Manchester MTFC-A SIB

Timeframe	
(expected) Start date	October/November 2014
(expected) End date	After 8 years (services delivered over 5 years)
Parties involved	
Service provider	Action for Children
Commissioner	Manchester City Council
Intermediary	None, although there is an on-going advisory role for Social Finance.
Investors	Bridges Ventures
Independent evaluation	Name could not be confirmed (evaluation completed during implementation phase). Internal evaluation ongoing during the course of the intervention.
Focus of the SIB	
Type of target population	Children aged 11-14 years with highest level of need who are placed in residential care and have challenging behaviour.
Size of target population	Approximately 95 children during the five years of the programme.
Problem tackled by the SIB	High social and financial costs of high numbers of young people in residential care.
Type of services proposed	Multi-dimensional Treatment Foster Care—Adolescents (MTFC-A)
Geographic remit	Manchester
Outcome-based component of the SIB	
Outcome metrics	Number of children moved from residential care to foster placements. Bonus outcome metrics: improved school attendance, better behaviour and wider wellbeing.
Type of target	Absolute targets. Young person engaged in MTFC-A programme, moved out of residential placement, achieving all wellbeing outcomes Benchmark is data on 11-14 year-olds in residential care from 2007 to 2008.
Data collection to measure outcomes	This information has been extrapolated from outcome payments information: - Number of young people who are on the MTFC programme and hence not requiring residential care - Number of weeks programme graduates remain in family setting, and - Wellbeing measures (to be recorded at graduation from MTFC and 12 months after graduation)
Is the provider payment based on outcomes?	Payment is based on outcomes, predominantly on the basis of getting and keeping young people out of residential care.

	'Bonus' outcome metrics include improving young people's outcomes (e.g. school attendance, behaviour, and positive activities).
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No, actual.
Is there a contract between commissioners and service providers?	Yes, actual
Is there a contract between investors and service providers?	Yes, actual.
Is there an SPV?	No, actual
Investment	
Investors already on board	Yes
Size of each contribution	The Bridges Social Impact Bond Fund will provide £1.2m working capital for the scheme.

Sources: this table is based on fieldwork information as well as the following references: Action for Children 2014; Action for Children [no date]; Cabinet Office [no date]; Bridges Venture [no date]; Griffiths and Meinicke 2014; HM Government [no date]; Roberts 2013; Social Finance [no date a]; (Social Finance [no date c]).

Figure 4.6, SIB model, Manchester



Newcastle

In 2011, the Voluntary Organisations' Network North East (VONNE), with other interested parties, learned about SIBs after a presentation by Social Finance. Following this presentation, VONNE came together with other people and chief executives from voluntary organisations to discuss this topic. Subsequently, VONNE made £5,000 available to gauge interest in a SIB for the North East of England. A few individuals with experience in (social) investment conducted this exercise and found that there was an appetite for addressing long-term health conditions in the area.

A CCG in the west of Newcastle upon Tyne put forth a proposal to develop a SIB to improve long-term health conditions (LTCs) through social prescribing, defined as "the use of non-medical interventions to achieve sustained healthy behaviour change and improved self-care" (VONNE 2014b). The intervention promotes physical activity, healthy eating and social interaction (for example through taking part in local activities. A steering group was convened to seek out SEIF funding to support the initial development stages of the project. The steering group included representatives from VONNE, the NHS Newcastle West CCG (NWCCG), the Cabinet Office and organisations that work with or represent the Voluntary and Community Sector (ACEVO, CapitaliSE and Business Mind Social Purpose). In addition to SEIF funding, other development funding included £15,000 by ACEVO and £150,000 in technical assistance funding by the Big Lottery Commissioning Better Outcomes Fund (VONNE 2014b).

In December 2013, the steering group became a sub-committee when the SPV, Ways to Wellness Ltd (WTW) was established (VONNE 2014b). Ways to Wellness is a charitable foundation with an operating arm, in which the charity foundation (consisting of independent directors) controls the operating arm and has the purpose to disseminate good practice about social prescribing for people with LTCs. The operating arm, which consists of a paid board of directors, is responsible for the delivery of the SIB, holding the contract with the commissioner, and for managing the providers. Parties in the board of directors include, among others, someone from Newcastle West CCG and VONNE.

In June 2014, after a procurement process, four providers were appointed to deliver the social prescribing service under a two-year contract, with tasks including employing and managing the so-called Link workers who support patients with long-term conditions through social prescribing (VONNE 2014a; Ways to Wellness 2014).

Commissioned by the NWCCG, Big Lottery Fund's Commissioning Better Outcomes and the Cabinet Office's Social Outcomes Fund (see below for role Big Lottery Fund and Cabinet Office), Ways to Wellness will be funded through a SIB. In the first year of the SIB, the program is expecting 1,091 successful referrals. It is assumed that a proportion of patients will disrupt their placements and drop off a program resulting in 866 patients on the program. Over the course of the seven year CCG contract, base case assumption is 11,141 successfully engaged beneficiaries. Outcome payments are paid out based on the achievement of agreed outcome metric targets. Social investment is secured from Bridges Ventures and the Newcastle Healthcare Charity. This is a full risk investment and there is no fixed coupon or secured level of return.

Two metrics were selected in order to measure outcomes of the intervention: achieved Improvement of the outcomes on the Wellbeing Star and savings for secondary care acute usage. The Wellbeing Star is a patient-recorded metric through which progress in eight areas of a patient's health and wellbeing is measured. Patients in the WTW programme will complete the Wellbeing Star every six months, with typically four stars (spanning 21 months) to be completed per patient. Furthermore, secondary care costs measured include inpatient and outpatient usage and Accident and Emergency usage. With support from a tool called RAIDR (Reporting, Analysis and Intelligence Delivering Results), which extracts data from GP IT systems, secondary care data from the WTW cohort will be compared with secondary care data from a control group in Newcastle North and Newcastle East. Throughout the first six years, the Big Lottery Fund (up to £2m) and the Cabinet Office (up to £1m) will provide payments based on improvements on the Wellbeing Star only (WTW internal document). The commissioner will pay for both outcomes on the Wellbeing Star and outcomes in terms of secondary care costs from year two-three onwards (WTW internal document).

The SIB is expected to be operational in April 2015 and intends to run for seven years (VONNE 2014a; Ways to Wellness 2014; VONNE, 2014c).

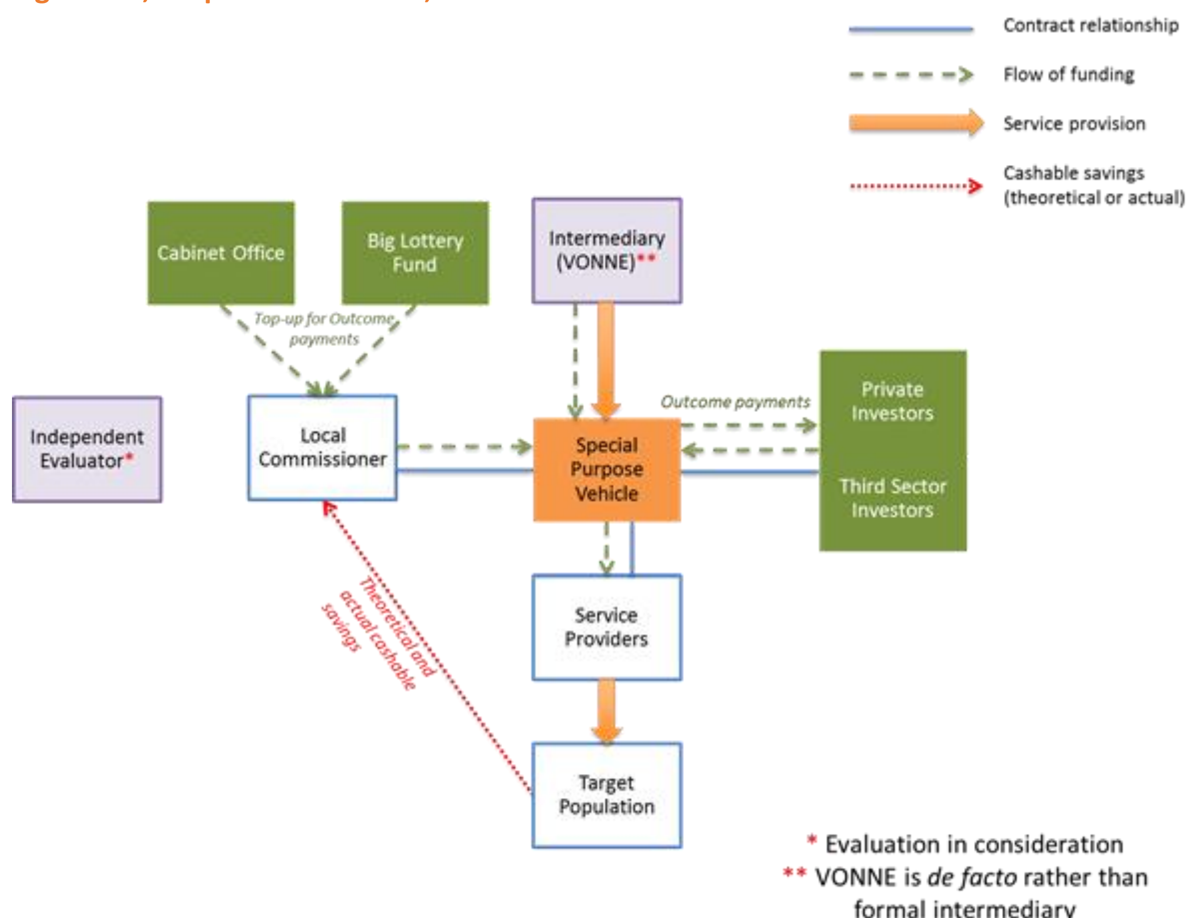
Table 4.7: Main characteristics of the Newcastle SIB

Timeframe	
(expected) Start date	April 2015
(expected) End date	2022
Parties involved	
Service provider	Changing Lives, First Contact Clinical, HealthWORKS Newcastle and Mental Health Concern
Commissioner	NHS Newcastle West CCG
Intermediary	There is no formal intermediary; VONNE initiated and helped setting up WTW, later being part of the operating arm of WTW, together with other parties
Investors	Bridges Ventures and Newcastle Healthcare Charity
SPV	Ways to Wellness Ltd
Focus of the SIB	
Type of target population	People with long-term health conditions
Size of target population	866 engaged clients in the first year; 4,100 expected in year ten (cumulative live patients on the program)
Problem tackled by the SIB	Long-term health conditions (LTCs)
Type of services proposed	Social prescribing (through Link workers)
Geographic remit	Newcastle West
Outcome-based component of the SIB	
Outcome metrics	1. Achieved Improvement of the outcomes on the Wellbeing Star 2. Savings for secondary care acute usage
Type of target	Improved health and wellbeing and a reduction in use of secondary care.
Data collection to measure outcomes	1. Wellbeing Star 2. Secondary care data of the WTW cohort will be compared with secondary care data from a control group cohort in Newcastle North and East CCG. A tool called RAIDR will be used to extract data from GP IT systems.
Is the provider payment based on outcomes?	Payments to the providers are partially outcome-based. Proposed payments to providers will have three components: 1. Base payment: based on the number of Link workers as commissioned by Ways to Wellness to employ. 2. Referral payment: first part (£125) for every patient referred and accepted as a client; second part (£100) on completion of Wellbeing Star 6 months after referral. 3. Continuation payment: payment of £50 at 15 months after referral and every 6 months thereafter during engagement of client. This payment will be performance based.

Contractual relationships (specify actual or proposed)[2]	
Is there a contract between commissioners and investors?	No. Proposed model is that Ways to Wellness holds contract with social investor.
Is there a contract between commissioners and service providers?	No. Proposed contract between CCG and Ways to Wellness.
Is there a contract between investors and service providers?	No. There will be a contract between Ways to Wellness and providers, as Ways to Wellness procures the services.
Is there an SPV?	(actual) SPV Ways to Wellness Ltd
Investment	
Investors already on board	Yes
Size of each contribution	- Bridges Ventures: £1.65m
	- Newcastle Healthcare Charity: £50,000

Sources: this table is based on fieldwork information as well as the following references: VONNE 2014a; Ways to Wellness 2014.

Figure 4.7, Proposed SIB model, Newcastle



[2] All based on Ways to Wellness procurement prospectus (Ways to Wellness 2014)

Shared Lives (Manchester, Lambeth)

Shared Lives is a service where individual carers share their family and community lives with the disabled adults and older people in need of care, supporting them in daily life. In practice, this can mean that an individual is a regular daytime or overnight visitor to his or her carer's household, or that the individual moves in with the carer (Shared Lives Plus 2012a). People who use Shared Lives find a sense of belonging with their carer; other potential social benefits of these people being active, valued citizens are still emerging (Shared Lives 2012a). Shared Lives is used by about 15,000 people altogether in almost every area of the UK (Social Finance 2013b). Most local authorities manage or commission a Shared Lives service, but this service is often small-scale and directly managed by local authorities. Supported by the Cabinet Office, Social Finance, Shared Lives Plus and Community Catalysts worked with four local authorities—Lambeth, Leeds, Manchester and Newham—to develop a model to expand Shared Lives using social investment. This work found that expanding Shared Lives can provide significantly greater value for money than many other forms of care (Incubator@community catalysts 2013).

Community Catalysts, MacIntyre, Social Finance and Shared Lives Plus have partnered together to establish a Shared Lives Incubator. The incubator aims to support the success of Shared Lives schemes that receive social or other investment for an agreed period (usually 3-5 years) (Incubator@community catalysts 2013).

After independent procurement processes in Lambeth and Manchester, preferred providers for delivery of the services have been identified and are in process of being confirmed. It is expected that the SIB in Manchester will go live in April 2015, and it is expected that the Shared Lives SIB in Lambeth will start in June 2015.

It seems unlikely at present that the SIB model will be set up in Leeds and Newham as local authorities have chosen to re-evaluate the appropriate means to provide Shared Lives care in their respective areas. Therefore, Table 4.8 below is primarily based on the developments in Manchester (and where possible Lambeth). Additionally, two further sites at locations yet to be determined are currently being considered within this SIB initiative, with an intention of providing the SIB-based Shared Lives service across four locations. All four sites would intend to reach up to 250 individuals in total, with outcome payments made based on the number of new Shared Lives care placements established (Jupp and Shirley, 2015).

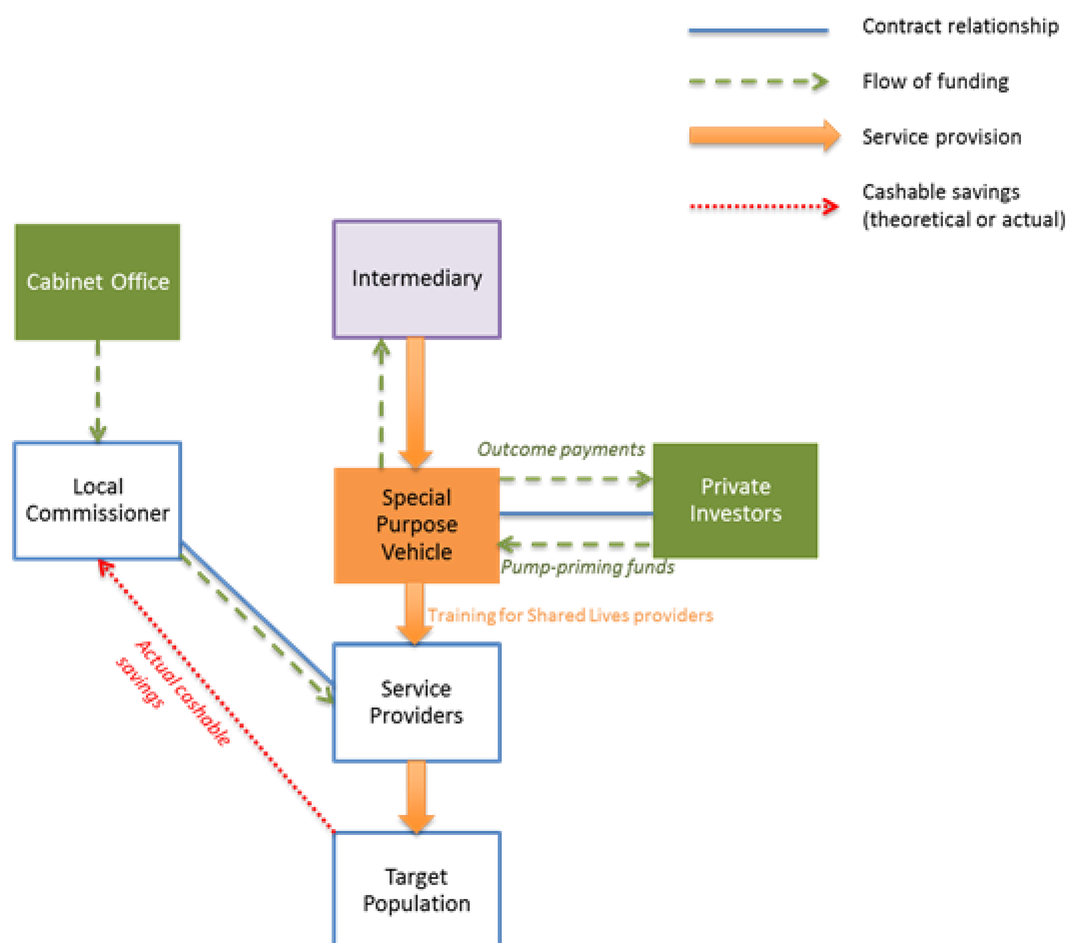
Table 4.8: Main characteristics of the Shared Lives SIB

Timeframe	
(expected) Start date	Manchester: April 2015 Lambeth: June 2015
(expected) End date	2020 for both
Parties involved	
Service provider	Identified STC
Commissioner	Manchester: Manchester City Council; Lambeth: Lambeth Council
Intermediary	Social Finance, as part of the Shared Lives Incubator. Social Finance will have a performance management role when the scheme is live.
Investors	Big Society Capital, Esmeé Fairbairn foundation, John Ellerman Foundation
SPV	Shared Lives Investment Fund (SF supports this SPV)
Focus of the SIB	
Type of target population	Disabled adults and older people in need of care
Size of target population	Up to 250 individuals across four schemes
Problem tackled by the SIB	Lack of community care options for vulnerable adults; high cost of existing forms of care.
Type of services proposed	An alternative to home care and care homes for people in need of support, with support instead provided through living with a host family. Shared Lives offers personalised, quality care where carers share their lives and often their homes with those they support.
Geographic remit	Lambeth and Manchester plus two others TBD to replace Newham and Leeds.
Outcome-based component of the SIB	
Outcome metrics	Number of new Shared Lives care placements established. A university has been commissioned to develop a broader outcome measuring tool.
Type of target	Delivery of stable long term placements for individuals. Other outcomes might be improvement of independence of vulnerable adults and reductions in difficult behaviour.
Data collection to measure outcomes	1. Each local commissioner will provide a benchmarking of performance of local services 2. Benchmarking against national adult social care services Measurement will be conducted by providers.
Is the provider payment based on outcomes?	Yes.
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	(actual) No
Is there a contract between commissioners and service providers?	(proposed) Yes
Is there a contract between investors and service providers?	(proposed) Yes

Is there an SPV?	(actual) Shared Lives Investment Fund
Investment	
Investors already on board	Yes - £1.1M to cover four areas.
Size of each contribution	Size of investment is between £200,000 to £350,000 per provider.[3]

Sources: this table is based on fieldwork information as well as the following references: Lambeth Corporate Procurement Team 2013; Shared Lives Plus 2012b; Social Finance 2013a; Social Finance 2013b; The London Borough of Lambeth 2014.

Figure 4.8, Proposed SIB model, Shared Lives



[3] Exact size of investments to be confirmed.

Thames Reach

The Thames Reach SIB seeks to reduce rough sleeping and improve social outcomes for a named cohort of 415 people in the Greater London area by delivering an intensive, personalised set of services through outreach navigators. The Department for Communities and Local Government (DCLG) and the Greater London Authority (GLA) initiated the project in 2012 with the goal of reducing homelessness in London through social investment. At the onset, commissioners invited Social Finance and the Young Foundation to conduct a feasibility study as to whether SIBs were appropriate for use in a rough sleeping intervention, and at a later date, to identify outcome metrics for measuring success. Social Finance and the Young Foundation drew on data from the Combined Homelessness and Information Network (CHAIN) to develop a social benefit model with the following outcome metrics: a reduction in rough sleeping, as recorded by street outreach teams; a move to settled accommodation (not a hostel) with tariffs paid out if sustained for 6, 12, and 18 consecutive months; reconnections with home country; to be in employment or training (e.g. obtaining NVQ2, volunteering for 8+ hours a week, being in part or full time employment); and, a reduction in visits to A&E. The subsequent GLA tender invited service providers to present a service designed to meet these five outcome metrics where bidders identified their own target levels. Social Finance assisted the DCLG and GLA, in an advisory role during the tender process, and was not involved in the development of any bids for the contract.

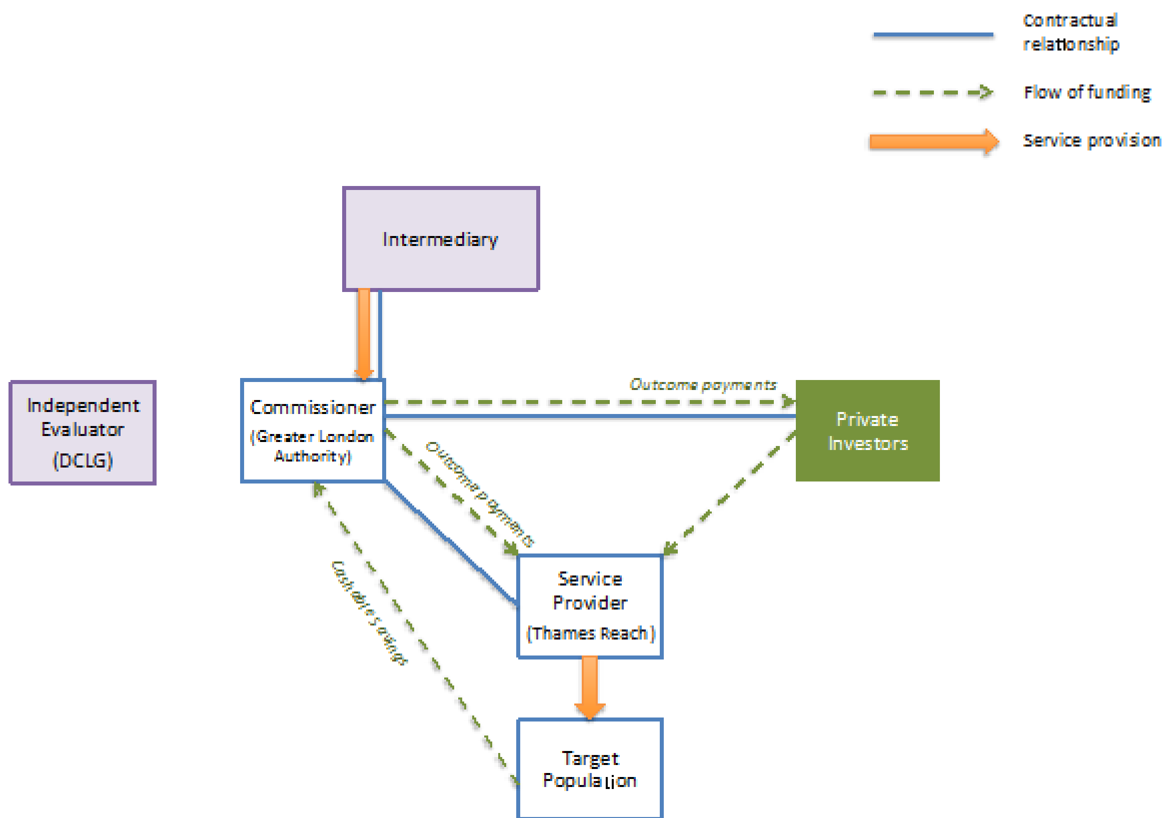
The GLA commissioned two provider organisations, Thames Reach and St. Mungo's Broadway to deliver concurrent SIBs, estimated at £4.5 million across both providers. This evaluation only looks at the Thames Reach SIB as they received SEIF funding. The SIBs were launched in November 2012 and will run for three years. The DCLG will pay outcomes until February 2016. Each provider has a cohort of 415 individuals identified as entrenched rough sleepers. Neither organisation has disclosed their payment tariffs or rate of success in achieving outcomes. The target population was identified as any individuals seen sleeping rough more than six times between July-September 2012, based on CHAIN data. Thames Reach, the lead service provider, chose to also invest directly in the SIB alongside several other socially-minded investors, including the Big Issue and the Monument Trust among others. The GLA and Thames Reach signed a contract where Thames Reach is reimbursed entirely by results.

Table 4.9: Main characteristics of the Thames Reach SIB

Timeframe	
(expected) Start date	November 2012
(expected) End date	November 2015, outcomes to be paid until February 2016
Parties involved	
Service provider	Thames Reach
Commissioner	Greater London Authority (GLA)
Intermediary	Social Finance and the Young Foundation developed the service specification and measurement metrics for use prior to tender
Investors	Big Issue, Thames Reach, Monument Trust, others
Focus of the SIB	
Type of target population	Rough sleepers in the greater London area
Size of target population	415 named individuals
Problem tackled by the SIB	Homelessness
Type of services proposed	Navigators monitor cohort closely. Work with service recipients to develop personalised approach tailored to individuals (e.g. assist to find housing, swimming lessons etc.)
Geographic remit	Greater London Area
Outcome-based component of the SIB	
Outcome metrics	Reduction in rough sleeping; moved to settled accommodation; reconnected with accommodation abroad; increased employment; reduction in use of A&E.
Type of target	Absolute targets. Reduction in rough sleeping paid out on quarterly basis, other outcome metrics paid out on (continued) achievement at 6, 12, and 18 months
Data collection to measure outcomes	Reduction in rough sleeping based on historical cohort Other outcomes paid out on information submitted to CHAIN database, audited by project officer at GLA
Is the provider payment based on outcomes?	Yes, the provider is reimbursed entirely by results.
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No
Is there a contract between commissioners and service providers?	Yes
Is there a contract between investors and service providers?	Yes
Is there an SPV?	No
Investment	
Investors already on board	Yes
Size of each contribution	Final value was negotiated with commissioners and investors, payment amounts not disclosed. Not disclosed.

Sources: this table is based on fieldwork information and Department for Local Communities and Government 2014.

Figure 4.9, SIB model, Thames Reach



Worcester

Age UK Herefordshire and Worcestershire (Age UK H&W) have worked in partnership with Social Finance to develop a service model to reduce loneliness among older people through increased social engagement. The SIB is a targeted intervention to reduce loneliness, and thereby lead to improvements in health outcomes (for example, a reduction in depression, or delayed onset of dementia). It is expected to benefit service recipients as less socially isolated individuals are expected to remain more active (therefore reducing likelihood of non-communicable diseases linked to sedentary lifestyles such as diabetes, stroke, coronary heart disease, and increased frailty and disability). The SIB will engage a cohort of 5,000 people, out of 20-30,000 lonely older people in Worcestershire over three years. The target population may be identified and recruited through GP referrals, bereavement records or identified by local organisations. Service recipients will receive help to attend desired local activities, for example, to join a gardening club or befriending service with young people, through time-limited support from a trained volunteer. Access to more specialist services will also be available such as transport, language & cultural support. This proposed service expects that increased social engagement will lead to a reduction in use of health care services (decrease in visits to GP or A&E and delayed entry to residential care). Outcomes will be measured by a reduction in loneliness as measured by the R-UCLA loneliness scale (psychometric tool, 4 attributes, 3 point scale) at 0, 6 and 18 months after joining the service (Russell 1996).

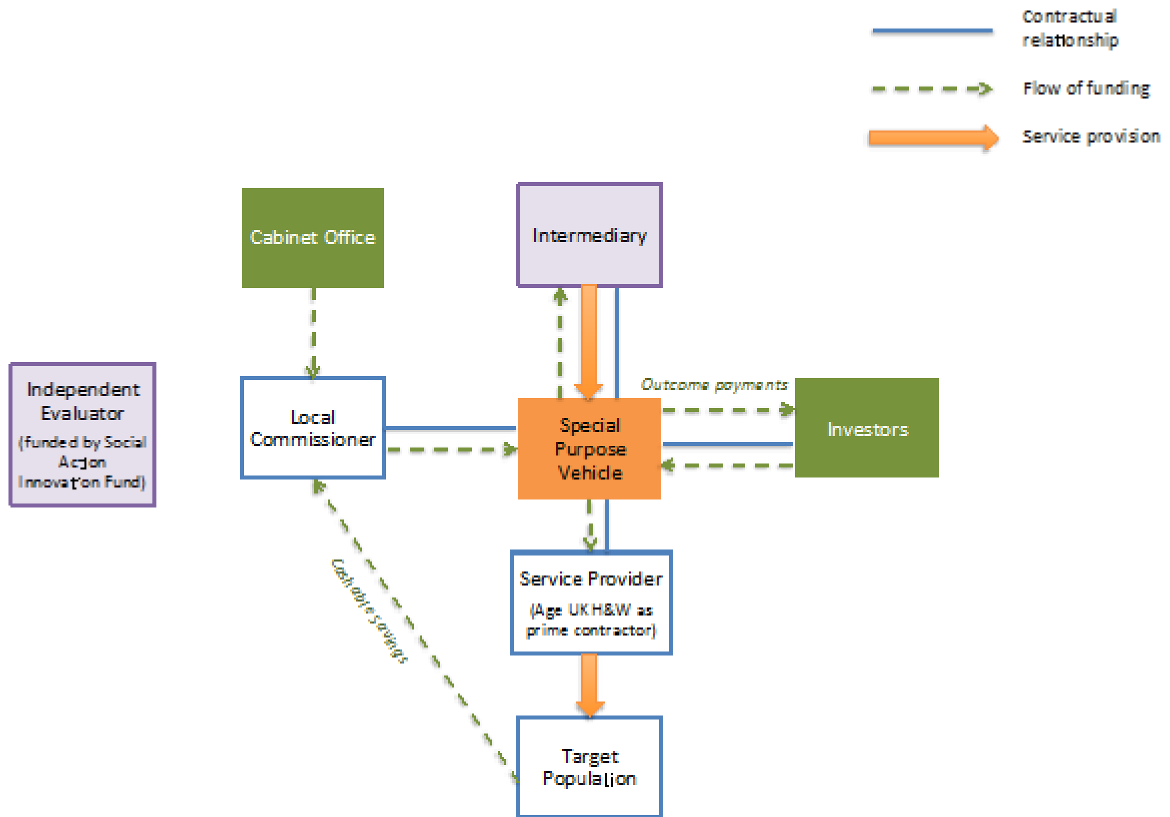
Worcestershire Council, Redditch and Bromsgrove CCG, South Worcestershire CCG, and Wyre Forest CCG were involved with the project as part of their Well-Connected Programme bid to become a national Integrated Care Pioneer. The local commissioners were interested in Identifying potential interventions to tackle complex social issues affecting older people, and to assess the potential benefits and savings emerging from these interventions. To address this, they invited Social Finance to conduct a pre-feasibility study for a SIB, in partnership with Age UK H&W. The proposed SIB and cost-benefit model was presented and agreed, in principle, by the commissioners in November 2013. There was a long delay between the agreement to commission a project targeting social isolation and the tender release in September 2014. This was attributed to the novelty of SIB procurement. As Social Finance was heavily involved in service design, they were considered unable to act as neutral intermediary to expedite the procurement process. Social Finance has partnered with Age UK H&W in its SIB bid and are awaiting the outcome of the competitive tender. Bids were submitted on 31 October 2014 and the preferred bidder will be announced in February 2015. Until then, it is unclear who the likely investors will be, how the payment structure will be designed (i.e. whether Age UK H&W enter a risk-sharing agreement with prospective investors) and what the agreed investor rates of return will be.

Table 4.10: Main characteristics of the Worcestershire SIB

Timeframe	
(expected) Start date	April 2015
(expected) End date	April 2019
Parties involved	
Service provider	Age UK Herefordshire and Worcestershire
Commissioner	Worcestershire Council, Redditch and Bromsgrove CCG, South Worcestershire CCG and Wyre Forest CCG, and Cabinet Office contributions to outcomes payments
Intermediary	Social Finance, co-designer
Investors	Nothing formalised as commissioners will announce preferred bidders in February
Focus of the SIB	
Type of target population	Lonely older people
Size of target population	5000 individuals
Problem tackled by the SIB	To reduce loneliness and social isolation among older people
Type of services proposed	To develop personalised service packages to engage individuals with local community activities (e.g. befriending services, gardening club etc.)
Geographic remit	Worcestershire
Outcome-based component of the SIB	
Outcome metrics	Reduction in loneliness using R-UCLA loneliness scale (4 attributes, 3 point scale)
Type of target	Relative to individual's answer to survey at 0, 6 and 18 months after intervention
Data collection to measure outcomes	Not yet defined
Is the provider payment based on outcomes?	To be negotiated
Contractual relationships (specify actual or proposed)	
Is there a contract between commissioners and investors?	No
Is there a contract between commissioners and service providers?	No
Is there a contract between investors and service providers?	No
Is there an SPV?	No
Investment	
Investors already on board	Informal discussions held
Size of each contribution	N/A

Sources: this table is based on fieldwork information.

Figure 4.10, Proposed SIB model, Worcester (if using SPV)



5. Early findings from interviews

Introduction

This chapter presents interim thematic findings from interviews with service providers, commissioners, intermediary parties and investors involved in the ten SIB Trailblazers in health and social care. Overall, the Trailblazers are notable for their diversity of providers, in service objectives, commissioning arrangements, levels of intermediary support, and target populations. While the projects are wide ranging, there were some commonalities in the often lengthy negotiation processes, motivations for pursuing a SIB contract and issues around the measurement and attribution of SIB interventions. Most of our findings relate to the early SIB contract process as five of the Trailblazers remain in development, but we offer some lessons where possible on two of the operational SIB projects (Essex, Thames Reach) and other insights where a SIB will not proceed (East Lancashire, Leeds).

Negotiations

Establishing the feasibility of a SIB requires extensive negotiation processes between commissioners, service providers, and financial intermediaries to agree on a policy problem, identify a potential solution, design the intervention's outcomes and payment schedule, and determine what the best way to fund the service is. If a SIB is identified as a potential funding route, further negotiations follow between commissioners, obliged to follow rules around competitive bidding and procurement, service providers and intermediaries. At the end of this process, an often lengthy tender process ensues, ending in a single preferred bidder, who may or may not be the organization that took part in the initial planning process. These complexities are due in part to the novelty of the SIB model and to unavoidable issues in new forms of commissioning.

Difficulties in the negotiation process

Negotiations around SIB development are complicated by SIBs' diversity of objectives and intervention types. The interviews identified three common hurdles in the negotiation process. Firstly, some Trailblazers offer innovative approaches to service delivery (for example, Worcester and Leeds), while others are proven programmes (for example, Essex and Manchester use interventions with a robust evidence base) where what is innovative is the funding mechanism (e.g. pursuing a SIB). The differences in intervention types means that experiences from other SIBs in terms of, for example, performance measurement, outcome payment thresholds and values, are rarely transferable between SIB-funded initiatives. This in turn means that SIB stakeholders must approach each negotiation *de novo* rather than being able to build on existing practice or experience. This first difficulty in a sense underpins the second and third difficulties, which relate to general lack of familiarity with the SIB commissioning and negotiation processes.

A second common difficulty was that SIB contracts require commissioners and service providers to collaborate with many new actors, such as intermediaries, lawyers, specialists in social investing, and external investors (private or socially motivated). For commissioners, SIBs are a new contract type and there are no set processes or checklists for completion, especially on how best to accommodate the new actors. While the Cabinet Office has provided a template contract and guidance document since April 2012, in practice, internal commissioning processes had to be adapted to for each Trailblazer as new hurdles were encountered. The presence of multiple commissioners (e.g. CCGs and a local authority) also presented additional administrative challenges, for example in obtaining sign-off from all parties on the final recommendation of the preferred service provider. For the Trailblazers, an additional complication was the organisational turbulence and new commissioning landscape that followed the Coalition government's NHS reforms. This time period coincided with many of the Trailblazers' early negotiations with commissioners. For example, in one SIB, procurement was complicated by a change from working alongside other organisations to develop the SIB project, to an open tendering process.

The third common hurdle was that commissioners were unfamiliar with contracting for outcomes. Many SIBs use cost-benefit models to inform the development of outcomes metrics, often on a wholly pay-for-performance basis. This approach was new to some commissioners who felt it opened up contracting systems to new forms of scrutiny:

> *"One of the problems was nobody could unpick what the finances of it all are. The existing services are so multiform and various. Some of them are from charitable organisations, some are others, some are NHS. If you were to follow a string that connected one person's money going to an organisation, some of them go through other CCGs on the way and they've got lost in the mists of time and the contracting has been ineffectively managed in many ways over the years."* (Commissioner 5)

Proponents of SIBs suggest that they encourage a new and more robust approach to data collection by both public and third sector organisations, and that this is associated with increased quality, rigour of performance management and greater transparency in client referral and selection. Related to this, one site indicated that the payment by results mechanism helped define and monitor outcomes better. In Manchester, where an established intervention is being used, the increased focus on how the service was being provided was expected to lead to greater adherence to the intervention model. The interview data suggests that SIB development does indeed open up traditional service contracts, and the operational assumptions they are based upon, to a new level of examination. This process is often led by intermediary organisations and new potential providers. However, the 'untangling' of the existing relationships can be slow and difficult.

Determining a fair rate of return for investors presented an added complexity to negotiations between multiple actors. Some informants felt it was important to establish rates of return that were attractive enough to interest private or social investors. Nevertheless, they also must be sufficiently modest to avoid antagonising public commissioners and local politicians who may harbour suspicions of the motivations of those potential investors. In a few interviews, health commissioners expressed concerns about joining private investors in a SIB contract based on actual, or perceptions of, negative

experiences with the Private Finance Initiative (PFI) - commonly viewed as a financing mechanism where the public sector has paid out excessively large returns to the private sector (Vecchi et al 2013).

Although none of the SIBs are delivering statutory services, a final complication resulting from multi-actor negotiation was whether SIBs might put target populations at risk. Because what is being funded or invested in are public services for 'vulnerable' populations, local politicians such as members of Joint Health Overview Scrutiny Committees may be involved in discussing potential issues, which in turn may complicate and further delay these already complex negotiations.

Development funding

Interviewees from several sites emphasised the importance of development funding for the work towards the launch, service design and development stages to support staff throughout the negotiations. A factor that appears to be significant in some sites relates to delays in securing development grant funding from the BIG (Big Lottery Fund) once a decision to proceed with a SIB contract has been made:

> *"It's not unique to it but it is quite a recurring thing with SIBs, partly around the complexity but partly because of the grant funding that a number of them work under, the need to go back to Big Lottery/Cabinet Office or whatever funding. And that is a process that takes time, it's difficult… Once there's the option of grant funding to support it, the reality is the commissioner's not going to do anything else because it won't do if it knows that someone else is willing to pay for it. That's just a process so it's not worse than not having it but as soon as it's there, it's going to be the only thing they go for because they're not going to say we want speed over money. It ends up being quite a burden for progress."* (Intermediary 10)

The wait for further BIG funds is one (of numerous) factors that has delayed the Sandwell SIB. The CCG there found the procedure to access these funds complicated, bureaucratic and time consuming. BIG funding requirements also quite strongly affected the development of the Leeds SIB as the providers had to prove they had commissioner support in order to access further funds before the negotiations had reached a stage at which the CCG were ready to agree to give support. This truncated the period that the Leeds providers had to convince the commissioners about their project. Many respondents recognised that this may be a function of the novelty of the SIB funding process, which over time may be overcome.

Tendering processes have been more complicated than usual for some commissioners. Additionally, there is a sense from informants (providers, intermediaries and commissioners) that the timeframes allocated for tendering, bidding and signing contracts were too optimistic in many cases. For example, the Manchester SIB faced significant delays linked to managing the legal framework around legal duties (held by Manchester City Council) for safeguarding children. The complication was that these legal duties could not be discharged through a Special Purpose Vehicle (SPV) as planned, but had to go through the provider.

The role of the intermediary

The SIB development process has introduced intermediaries as key actors, since they offer to bring experience in SIB development, expertise in the identification of outcomes, skills in data analysis, and links to potential investors, to the commissioning process. In the SIB Trailblazers, progress toward SIB design and contract negotiations have required close working between commissioners, providers and intermediaries to ensure that a proposed service or intervention will be of value to the target population and that outcomes are based on robust, locally agreed assumptions. As a result of this process, the roles and boundaries between actors tend to become blurred, complicating and delaying the negotiation process.

In most cases, intermediaries play a key role in design and negotiation by using their prior experience to aid commissioners (and in some instances, providers) with the feasibility and modelling work integral to getting a SIB contract out to tender. A few informants suggested that there was an unexpected turn in some of the SIB processes, where the intermediaries, having delivered this preparatory work, could opt to bid for a role in the delivery of these services. From the perspective of other actors, this had the potential to represent a conflict of interest, particularly if the intermediary had worked closely with a particular provider to design a service or intervention to address a commissioner-defined problem. In such cases, the intermediary and provider would hold an advantage (e.g. greater knowledge about commissioner motivations for a proposed service) over other potential providers. A few commissioner informants felt that intermediary organisations (and providers) involved in early SIB design, who then chose to bid for services were not always as open as possible with them through the process. In at least two cases, intermediaries withdrew from an advisory role in the development of the SIB (that had been highly valuable for commissioners) after the preparatory phase to assist a provider in bidding for a contract. Though this was done to minimize a perceived or actual conflict of interest, it could, in turn disrupt SIB negotiation and development processes:

> *"Then we have this awkward period of switching over to the other sides, where we cut off all ties with the local authority, because it wouldn't be proper, even just before procurement, to have any contact with them or to be talking about things like this. Having said that, because we've done most of the development work, I… think there are still a few questions for example, to be ironed out, which we haven't [solved] in doing this and we knew that that was the next step that we haven't done that, so I think that caused issues for the commissioner not being able to speak to us, because we know that there are limitations to the study and we know what needs to be done."* (Intermediary 7)

The appearance of potential conflicts of interest during SIB development resonated across many of the Trailblazers. In spite of this, intermediary organisations were widely seen as crucial to the effective development of SIB projects in health and social care, according to interviewees. A number of informants suggested that the process of developing a SIB contract would be very difficult without the input of intermediary organisations. Commissioners appreciated the analytical skills that intermediaries brought to the process,

alongside project management and negotiating expertise. Providers appreciated their support in identifying payable outcomes and their links to potential investors.

Some informants highlighted the lack of choice in terms of experienced intermediaries, attributing this to the immature nature of the social investment market. This limits the degree of competition for intermediary services, with potential impacts upon the costs of their services. A further critical point raised by informants related to the commercial sensitivity of the details of the SIBs and their contracts which would be of considerable value to other potential intermediaries and other potential SIB projects, and the impact of information asymmetries associated with protecting commercially sensitive information on the contractual negotiations:

> *"I think there's an element of it's a business model for some of the intermediaries as well. There's definitely an element there. There's maybe not as much sharing there because there's a need to protect your business."* (Government 2)

A key finding so far is that many of the Trailblazers have encountered difficulties and delays related to the development and negotiation of SIB contracts. Many informants have reported high transaction costs, specifically around the costs of additional staff, lengthy negotiation processes, advisory services, of obtaining seed funding and grants from the Big Lottery Fund, for example. There was a distinction between provider- and commissioner-led SIB project negotiations. The majority of the trailblazer SIBs were commissioner-led or received a high degree of input or support from intermediaries, with one exception, the provider-initiated and led SIB in Leeds. The Leeds project will not progress to a SIB and negotiations ceased in October 2014 for two main reasons: commissioners did not believe that the project would fill a significant gap in existing services; and the potential service provider lacked sufficient experience (e.g. as service providers, they lacked a track record of success or failure, facilities, and regulatory clearances from the Care Quality Commission). The provider felt it was unable to garner sufficient commissioner support for the project. The Leeds SIB received less specialist intermediary input than many other projects which may also have impacted upon the difficulties faced in the negotiation process.

This leads to two important conclusions at this stage. Firstly, early and ongoing engagement between commissioners and providers was critical to successful negotiations; secondly, trailblazers seeking to implement an unproven, innovative model of care for health and social care system faced more barriers to successful negotiations. This is explored further in the subsequent section on motivations to pursue a SIB.

Motivations

Commissioner-driven yet allowing service innovation

For the most part, the development of the Trailblazers was commissioner-driven and motivated by the desire to develop innovative services in response to difficult social problems (Thames Reach, Worcester), improve integration (Sandwell), or remedy inefficiencies in existing provision (Cornwall). Other strong motivations included the desire to expand existing services (Essex, Manchester, Shared Lives).

Some commissioners were drawn to SIBs as a funding mechanism because a shift to 'payment by results' (PbR) appeared to be the direction of travel for future commissioning, and SIBs offered a risk-free way to explore this shift because in many cases, the financial risk of implementing or scaling up interventions was borne by investors. Others felt SIBs allowed commissioners to avoid up-front costs, create financial savings, or were an appropriate policy response to shrinking budgets in social care. For example, the Thames Reach SIB was the GLA's first payment for outcomes contract, although the DCLG is paying, and offered a new financing mechanism while attempting to transfer commissioning risk to providers and investors. A number of informants suggested that commissioners' interest in SIBs was associated with the drive to foster innovation. This trend was welcomed by service providers who felt traditional funding streams, for example, from grant-giving organisations or block contracting, encouraged the delivery of programmes focused on short-term, narrow, process measures of successful service delivery. In contrast, SIB contracts were seen as allowing service providers to pursue preventive interventions with predetermined measures of success over longer periods of time. However, it should be noted that the impacts of preventive programmes are often hard to quantify. For example, it is difficult to demonstrate the effectiveness of a programme that prevents a child from entering foster care if this outcome may not be able to be confirmed for several years and if there is no counterfactual or even a baseline for comparison. Additionally, SIBs and payment for outcomes would also allow commissioners to take a long term perspective. As one intermediary suggested, long term and sustainable changes could not be made in people's lives through a series of short term projects (Intermediary 4).

Several Trailblazers were developed at the invitation of commissioners, who asked intermediaries to develop a service that met an identified social problem. The extent of intermediary involvement varies by project. In many early cases, the intermediary worked closely with the commissioner to develop a service design and tender document, and provide on-going assistance in selecting the winning bid(s). In such cases, SIB outcomes were identified from an intermediary's feasibility study and presented in the tender, as set out in the commissioners' bid specification document. Service providers were then free to design their intervention to meet the specified outcomes, an approach intended to enable commissioners to choose from a range of service models to meet their desired outcomes. In at least one case, the tender specified the outcome targets constructed by an intermediary to address a set of perceived problems (e.g. GLA's tender for a rough sleeping SIB intervention laid out a care pathway for the problem of entrenched rough sleeping). For this tender:

> *"[T]here was no set threshold of you must achieve this many people off the streets. It was just come to us and your bid with a price and with the outcomes you think you can achieve."* (Intermediary 7)

In other cases, the commissioner invited the intermediary to work with a service provider to develop a service design that was later put out to tender (discussed also under *The Role of the intermediary,* above). Although the commissioner instigated the process in these cases, the intermediary often took a lead role and was a named bidder for the project, such as in

Sandwell and Worcester SIBs. In these circumstances, it could be difficult to attract other intermediaries or service providers to tender bids. It is unclear if this approach limits commissioners' choice in the service models they choose to tackle the social problem they identify.

Financial freedom for service providers

Some service providers were highly motivated to take part in a SIB because SIBs were seen as offering financial freedom from shorter grant-giving cycles and process-measure-driven contracts. SIB projects focused on preventive interventions were seen as attractive because they would allow time for interventions to bed in, and for outcome metrics to determine whether the intervention was working (Newcastle).

Service providers were also drawn to the possibility of future financial gains by investing their own capital in the SIB so they could share in potential profits, or, where the provider organisation lacked financial reserves for investment in the SIB, a risk-sharing agreement could be included in the SIB contract where service providers could gain small financial payments for exceeding expectations in some outcome areas. In one site, there was much optimism that savings made 'further down the line which can then be used to pay for the Social Impact Bond and also reinvest it in further work' would benefit commissioners and help to grow the service (Provider 6).

The design of SIBs tends to stress the use of outcome over process measures and thus potentially enables greater flexibility for service providers in how they deliver services. A few service providers were motivated to implement a SIB because the outcomes contract allowed freedom to pursue the outcome in a flexible way and tailor services to the needs of individuals. For example, the SIB allowed a service organisation, traditionally limited to block contracts using process measures, to pair outreach staff with the target cohort to do:

> *"[W]hatever it takes for this person, because whatever's been done up to this point clearly hasn't worked. So it gives [outreach staff] that financial freedom' to provide any services within reason [for example, as part of one service provider's intervention, service recipients received swimming lessons or a television in response to requests for entertainment to deter a return to negative, previous behaviours]. This would not be possible without outcomes-based contracts."* (Provider 7)

The desire for more flexible funding or to move away from relying solely on statutory funding was expressed by a service provider and an intermediary (Provider 3; Intermediary 2). Other providers were interested in SIBs to demonstrate cashable savings ahead of anticipated financial cuts (Manchester, Shared Lives, Newcastle, and Cornwall).

Pilots

A small number of trailblazer projects were being developed as pilot projects for future application in a SIB. In Cornwall, there has been a substantial drive to demonstrate that a vision of personalised care plans, delivered by voluntary sector organisations, will lead to

demonstrable cost savings in secondary acute care by experimenting with the delivery of innovative, untested services:

> *"The perfect world is to get something funded by the public sector, but actually, if you're looking at doing something different, the way we were looking at doing something different, especially colleagues in Health, they'll go, "Ooh, yes, what does your evidence base look like?"* (Provider 10)

It was suggested that this could be mitigated through a SIB model as social investors and philanthropic organisations might be drawn to provide funding if there was a social good served, with the potential for future payments, in return for delivering a riskier, untested new service.

At the national policy level, it was suggested that SIBs function as a method to pilot policy projects ahead of wider roll out:

> *"I think some of their interest and this is their interest in social investment more broadly, is in finding new ways for the organisations that they work with and they're trying to support to access markets and to access funding. They know that where a foundation... what often they will do is they grant fund innovation where no one else will go. But ultimately they want that scaled up and they want that delivered across the country. The majority of the time the only way it's going to happen is if the government commissions it." (Government 2)*

In other sites, especially within social care, a SIB served as a pilot to demonstrate that an existing model could work in other areas (Manchester) or show that existing services could work on a larger scale (Cornwall, Shared Lives, Newcastle).

Perceived benefits of involvement of private financier in health and social services

A common justification for the introduction of SIBs in health and social care is the perceived need to instil 'market discipline' in the third sector. Some informants felt that voluntary sector organisations involved in SIBs would benefit from greater performance management and accountability to government and grant-giving funders, and greater rigour in demonstrating improved outcomes and better service delivery. In others, the emphasis was on the benefits of the shift to payment for outcomes. At the macro policy level, some informants regarded SIBs and related payment for outcomes as the future direction of commissioning, with one policy maker saying that:

> *"[T]he outsourcing of public services is probably unlikely to stop. A focus on outcomes is a relatively obvious thing to be doing. So I think people see generally that Social Impact Bonds could and should be playing quite a big role in public services going forward."* (Government 2)

Many of the service delivery providers involved with the Trailblazers were larger, more entrepreneurial organisations within the Third Sector with a strong interest in increasing financial flows to increase social impact. Some Third Sector service providers were keen to

embrace SIBs as a way to build capacity, with one service provider suggesting that the Third Sector was currently "not equipped to manage, to create the data and evidence that you need to have' to meet the rigour of outcome payments" (Provider 4). For others, the SIB model was seen as leading to greater rigour in performance management and accountability and greater transparency.

A few informants expressed concerns about the potential for perverse incentives and the downsides associated with other payment for performance schemes or external target setting. These informants felt that it was important that outcome metrics were designed in a way that they would not inadvertently work to the disadvantage of the target population. At the national level, one service provider felt SIBs offered a more inclusive pathway to collaborative, locally-designed service provision than previous health care reforms, characterised by top-down, externally imposed targets. At the local level, collaborative design was perceived as beneficial to providers and a departure from the logic of recent reforms in health care:

> *"That's the kind of behavioural change that you don't get through training, you don't get through regulations, you don't get through performance management, you only get by working with teams on the ground. So I think the thing that we're trying to do is create a whole system change by working the community up, so by really galvanising those 2,500 voluntary sector organisations to be the frontline for people and to enable people who have long-term conditions, are naturally those that use and consume a lot of health and social resources, to be able to give them something else than just formal care as an option."* (Provider 9)

Measurement

The importance of measurement for SIB design and delivery has emerged as a significant theme. Agreement of metrics to understand both the problem at hand and the most appropriate outcome measures is essential to SIB negotiations, with one service provider saying "the first key lesson is make certain that you get people coming together around the data… [T]he data bit is the thing that will make or break it." (Provider 10). This is a complicated process, not least because it is difficult to put monetary figures on social outcomes, as suggested by one informant.

Data analytical capacity

SIBs are expected to drive a change in Third Sector culture around data collection capacity and monitoring. Beyond payments for outcomes, other indicators that are or will be measured as part of certain SIBs include assessing whether providers are meeting volume requirements or additional outcomes for service users. There was a lack of consensus from informants around how firm or flexible agreed metrics ought to be once set. For example, informants from the Essex SIB emphasised the value of working with metrics that might change over time and informants from the Thames Reach SIB felt the outcome target might be unachievably high for some metrics like education or volunteering and fail to compensate providers for strong efforts made. In other cases, informants suggested that firmness of metrics would be viewed as an attractive element for investors.

Improving tools to measure programme effectiveness is expected to increase accountability. This shift is intended to help service providers to deliver better services for their target populations. There is also the expectation that introducing measurement of outcomes makes service providers, commissioners and intermediaries more accountable for their use of public money. In the case of the London rough sleeping SIB, for example, it was stated:

> *"[T]hat extra layer of proof has been required but only really for SIB. Other services don't have to provide evidence on the system, it's just taken that if someone records a bedded down street contact, that's because that happened. They would have to have shift notes but they wouldn't have to upload those."* (Intermediary 9).

The Essex SIB produces a monthly 'dashboard' which captures the analysis carried out by the intermediary into the effectiveness of the project, to enable early identification of underperformance on specific metrics. In Essex as well as in other sites, as noted earlier, there is a strong sense that alleged traditional failures to monitor performance (in both operational and financial terms) by public sector and charitable organisations can be alleviated by SIB-inspired reforms related to measurement and performance management. Therefore, the importance of investing in resources for data collection and analysis is stressed by many informants. Reflecting this, many SIB models include the commissioning of bespoke information management systems, which in some cases require new or specialised staff.

There is some tension around the appropriate role of intermediaries or service providers in data monitoring. If the purpose of a SIB is to improve the voluntary sector's capacity to monitor and evaluate a service, it is reasonable to expect that new funds (via SPV or direct investment) be used to scale up internal capacity and data monitoring. Another view is that SIBs introduce rigorous performance monitoring, where an external party (i.e. intermediary) should be responsible for collecting data and measuring progress against outcomes. It is unclear whether the introduction of third-party monitoring and evaluation is detrimental to service providers' efforts to scale up internal measurement capacity. Although most informants agreed that independent evaluations were important to assess the effectiveness of SIB interventions, few projects were able to incorporate an independent evaluation of either the SIB process or intervention outcomes due to financial constraints. However, at least one project currently under consideration does include an independent evaluation by a third party in the current tender specification.

SIBs vary in the amount of new and existing data to be collected; in some cases, routine data are used and compared against a historical 'before treatment' group, while others will rely on administering psychometric surveys to clients at the start and end of the project to see how clients have benefited from the service provided through the SIB. The new emphasis on data requirements has created additional pressure for some providers, but some informants held positive views about increased data collection requirements of SIBs. One informant (optimistically) proposed that having to define objectives had forced people to identify the purpose of social care (Intermediary 2).

The need for clarity in outcomes and agreement with respect to measurement, whilst absolutely key, may not be simple – especially when delivery involves joint commissioning across health and social care:

> *"[T]he problem in the health and social care sector is what we touched on earlier. Budgets and responsibilities sit in two different places. So while ...ultimately your outcome might be around reduced hospital admissions whatever, which is where your savings for the actual intervention is in the social care space. It's [about] how do you join those two things up? In theory an outcomes based approach should make that easier than actually linking up those two different bits of the health service can be really difficult… I think that is quite a big problem. It's hard enough doing a SIB with one commissioner than trying to do it across two."* (Government 2)

Differences in health care commissioning and local authority commissioning may complicate and delay negotiations around the development of methods for measurement, as, for example, respondents argued that local authorities tended to have less experience with contracting for outcomes. Because of the typical lack of data collection and measurement in social care, one informant thought that social care was lacking in comparison to health in this regard (Intermediary 2). However, another intermediary representative argued measurement structures need to be simpler in order for the SIB model to be adapted to other sites in the future, suggesting that greater complexity would hamper SIB development. Nevertheless, the ongoing economic climate was cited as a strong motivational force for CCGs and local authorities to improve the robustness of their measurement regimes to demonstrate value for money for funded projects.

Attribution

The other major measurement issue identified relates to the attribution of outcomes to SIBs. This was recognised to be of great significance across all the sites and of special concern to commissioners. Methods to prove attribution were linked to ensuring investor confidence. The Trailblazers display a diversity of approaches to the question of attribution, with some drawing on contemporaneous control groups, and others on historical control groups or measurements against a baseline (at an arbitrary point in time). Important factors that influenced these decisions related to the novelty of the intervention and contrasting experiences around the potential to access and use reliable data sources. More specifically, proposed comparisons relate to whether a trailblazer has access to expertise in evaluation design and data management to (e.g. capacity to have contemporaneous matched comparisons as in Peterborough) and funds to cover the cost of the intervention in parallel with the budget for the service itself. These choices reflect a trade-off between simplicity and robustness.

The negotiations around the outcome measurement parts of the contract are crucial in relation to the avoidance of outcome disputes at a later juncture, and, again, all relevant parties need to be equally signed up to what will be measured and how this will be done from the beginning. There are also time considerations: although SIBs may operate over long timescales in many instances, there may be a need to demonstrate effectiveness

relatively early in the life of a contract – especially given the length of the negotiations that are required to get to the start of a project:

> *"One of the challenges in arriving at a Social Impact Bond is that the time it takes to develop the partnerships, to actually go through, just even getting to the co-diagnosis stage and then going through the co-design stage is taking time. That is the challenge. Then even if you're doing one year's delivery, you're looking at somewhere between two to three years to get to a point where you might be able to demonstrate some attribution [of impact]."* (Provider 10)

A further point is that whilst proving that an outcome can be attributed to the service may be one issue, it is not necessarily clear that achieving this outcome will lead to cashable savings given the pressure on health and social care services and/or where in the system the savings become apparent. As a result, some providers questioned whether savings attributable to SIB interventions would be made available for community sector investment at a later date, or if these savings might be used elsewhere.

In one site, changes to data protection laws have made it impossible (for the foreseeable future) to access identifiable hospital episode statistics (HES) data to demonstrate the provider's actual progress against the performance metric. In this case, the commissioner had issued payments based on predicted performance targets on the proviso that this might need to be adjusted at a later date, in order to preserve relationships at the centre of the SIB – again highlighting the need for compromise.

There are two further points of interest here: firstly that small scale projects face a particular challenge in regard to providing definitive evidence of attributable results:

> *"I know that a technical problem was we've got such a small number of patients that we would really struggle to achieve a statistically significant result. We'd have to have an enormous impact and I don't believe we would have."* (Provider 4)

And secondly, that, if the goals of larger projects are particularly innovative, then building a robust evaluation into the design of the SIB is especially important, but also potentially time consuming, complicated and expensive, adding to the transaction costs associated with the SIB.

Findings from operational SIBs

The two SIB initiatives that have been established and are currently providing services – in Essex and Thames Reach, London – offer some indications as to what is required to implement a SIB in practice. The first finding relates to the importance of building data management capacity ahead of project implementation, alongside workforce development, to ensure adherence to stringent new data requirements. The second relates to the importance of collaborative working between parties and amongst service providers to ensure programme success.

In both SIBs, the importance of improving data management capacity and training at the service provider level was identified as crucial to successful implementation and later performance measurement for outcome payments. Thames Reach interviewees suggested that the project would have benefitted from an additional staff member to ensure accuracy in claims for outcome payments, for example. Small issues such as inconsistencies in date recording (DD/MM/YY versus MM/DD/YY) caused some data to go unrecorded, leading to lower than expected outcome payments in one quarter. A single database coordinator could have benefitted the team through internal capacity building and ensured that there were no data inconsistencies. In Essex, a special purpose vehicle is responsible for performance management and monitoring. Despite the presence of this third party 'regulator', there were still issues with a lack of analytical capacity and data systems, which contributed to unexpected delays and hidden costs (Commissioner 1). Moreover, other delays could be caused by lags, for instance, in availability of education data, and access to certain datasets such as police and offending data.

A second insight is the importance of collaborative project development involving all the key parties and ongoing engagement between them. In Essex, strong provider partnerships were seen as crucial to the implementation of the project, with one interviewee saying that regular meetings between the various parties helped to facilitate multi-way communication (Intermediary 1). The level of collaboration was viewed positively. In rough sleeping, Thames Reach holds quarterly meetings with commissioners, service providers and investors to share lessons and case studies about progress towards outcomes

A final insight, specific to Thames Reach, was the positive experience reported by service providers and commissioners associated with the outcome-based intervention. In Thames Reach, the main benefit of the new programme was seen as the greater flexibility in service provision enabled by the SIB provider contract. This was warmly welcomed by the providers, commissioners and investors. It appears that a combination of persistent and flexible service delivery was leading to unexpected success amongst even deeply entrenched rough sleepers. However, two parties suggested that the targets for outcome payments relating to education, employment or volunteering were set too high given the problems facing the target population and should be revised downward if these outcomes are to be used in future tenders for SIB-related services for people sleeping rough.

6. Discussion

The findings of this interim report are focused on the SIB Trailblazers' development process, especially in the early stages of negotiation and implementation. The Trailblazers vary in their objectives, target populations and progress towards a contract, but have similar motivations, experiences of negotiations and issues relating to determining and attributing outcomes.

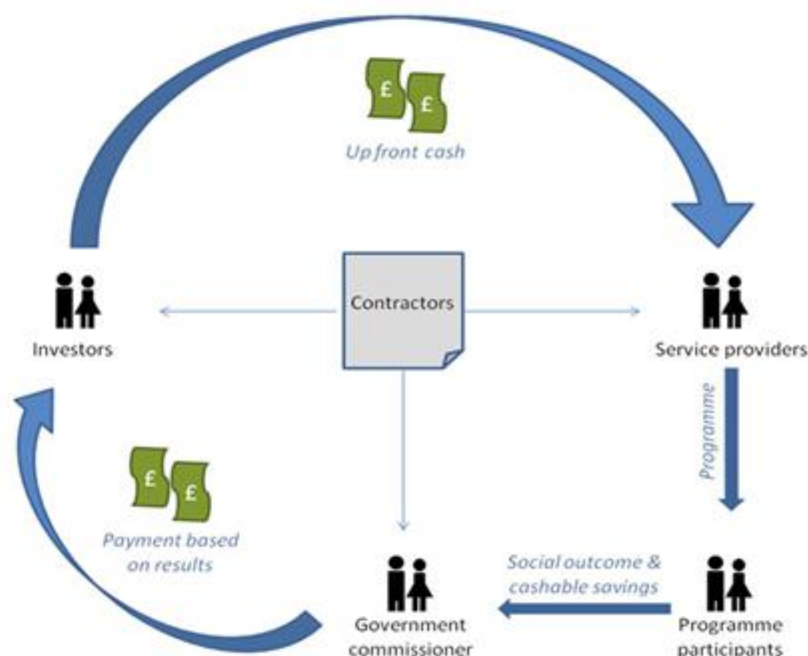
The literature review found a diverse literature on the potential application of SIBs to public policy issues. The role of public, private and not-for-profit values, potential impacts upon measurement systems alongside risk and financial incentives were central themes that emerged from this literature. Very little empirical data about SIBs exists; most of the empirical work was qualitative and mostly concerned with the Peterborough SIB. The empirical studies highlighted firstly, the high transaction costs and policy complexity in establishing a SIB; secondly, difficulties in the measurement of outcomes; and thirdly, the potential for innovative practice and improvement in outcomes.

Overview of findings from the Trailblazers

Contractual relationships vary

The SIB Trailblazers tackle a variety of health/social policy areas and have made varying amounts of progress towards a signed contract. As of December 2014 the moment, two are operational, five remain in negotiation, one was funded directly by government and one has been abandoned. Progress towards a signed SIB contract was linked to common issues around negotiation complexity, for example of delays in the commissioning process as multiple new stakeholders were brought together. There is a diversity of planned SIB models among the Trailblazers when compared to the Cabinet Office's working model (see Figure 6.1, below).

Figure 6.1: Cabinet Office diagram of how a SIB could work



Source: Cabinet Office 2014, https://www.gov.uk/social-impact-bonds

The approaches detailed in Chapter 4 of this report suggest that there is no 'typical health and social care SIB model' identified so far. Rather, proposed contractual relationships differed based on local partnerships, service provider preferences, and commissioner comfort with the model and investment sources. For example, we found that some of the models under development proposed to operate with, or, without SPVs depending on provider preferences - some received direct investment to fund a service while others used the SPV model to contract or subcontract other providers. Some SIBs appear to have 'double' P4P structures where both the financier and provider are paid, at least in part, on outcomes while others are not structured this way, with just the private investor receiving a share of profits and return on capital In several cases, different levels and sources of funding were obtained from private, public or philanthropic funds in addition to, or in lieu of, private or social investment, although an outcomes-based contract was still present.

However, the flexibility of the SIB model was often seen as advantageous by informants as it fostered local approaches to specific problems and allowed innovation in financing initiatives that might otherwise have been too risky (e.g. to test the link between social isolation and loneliness with improved health outcomes in Worcester). Nonetheless, such diversity makes generalization more difficult when proposing learning points for other future health and social care SIBs. The variety of models may do little to lessen the transaction costs and negotiation process for future SIBs.

We will learn more about the implications of these different models as more of the Trailblazers become operational. It may be that certain models show themselves as easier to manage economically, better at minimising potential conflicts of interest and/or more strongly encourage better provider performance than others.

Complexity of SIB negotiations

SIBs appear to be more complex than traditional financing mechanisms in health and social care services. There are high transaction costs due to the host of new considerations to accommodate the multiple players involved in designing and developing SIBs. Negotiations appear in many instances to be time-consuming. It is possible that there may be downstream advantages for these projects, as the effort expended to establish clear contracts can enable a smoother running process. It is also possible that future SIBs can benefit from Trailblazer learnings to minimise difficulties in future negotiation processes. The role of specialized intermediary groups appears critical to many SIB negotiations. However, this raises questions around conflicts of interest and market dominance while there are few such intermediaries. There are issues around asymmetries of information as intermediaries hold specialist knowledge and may potentially use it to inappropriately sway the negotiation process. Access to development funding is frequently important for SIB progress, but often takes a long time to obtain and may slow, or in some cases halt, the process.

The complexity of negotiations is frequently linked to the need for intense analysis of the assumptions and data on which the SIB proposal is based. This includes making such analyses widely available so all parties can test or see the assumptions in order to build trust in the models. It may include developing a deeper understanding of issues associated with an intervention than may have been the case in the past.

Motivations

Most Trailblazers are commissioner-driven, and developed in partnership with other actors with one of two goals: to develop innovative services; or, to 'scale up' existing interventions. Service providers were drawn to SIBs that offered innovative approaches, via payment for performance, for perceived financial freedom, opportunities to explore preventive care models, multi-year contracts and flexibility in delivery. Commissioners and providers were interested in exploring SIB funding because they viewed payment for performance as the route forward for public services commissioning. At the macro level, SIBs allow commissioners to pilot new service models or defer taking financial responsibility for innovative or risky projects that require testing before scaling up or disseminating.

Motivations for SIB programming varied by type of informant, with service providers and intermediaries having strong pro-social motivations. A few commissioners held less positive views about SIBs as a funding mechanism for health and social care programming. Their reservations were largely due to the transaction costs involved in setting up SIBs and in negotiating reasonable rates of return. SIBs present potential financial freedom and room for service providers to provide innovative services. Commissioners seem happy to accommodate this as they are widely seen as risk-free (although financial risk for failure is shifted to private investors, such interventions cannot be entirely risk free), though a few commissioners were wary of being complicit in the fragmentation and outsourcing of public services.

Measurement

SIBs affect the amount, type and importance of data collection and performance measurement for service providers with the intent of increasing the potential accountability of SIB projects. A shift to a focus on outcomes was welcomed by all informants and seen as a strong advantage of a SIB approach to policy making. However, in health and social care it was noted that cross-sector commissioning may complicate discussions on how to measure and what to measure. Informants had limited understanding of, and interest in, the well-known potential and actual drawbacks of payment for performance contracts in health and social care.

SIBs raise real issues of outcome attribution which the early data from the Trailblazers suggests will be an important element of ongoing research. A key finding was the often missing link between outcome attribution and likely cost savings. While it remains to be proven that an outcome can be attributed to a specific service, it was often unclear that this would yield cashable savings to ease pressure on health and/or social care budgets, or where in the system the savings could become apparent. As a result, some providers questioned whether savings attributable to SIB interventions should be made available for community sector investment at a later date, rather than benefiting private financiers,

Learning from the operational SIBs

Two of the operational SIB Trailblazers highlighted two aspects of successful implementation relevant to the other Trailblazers. Firstly, it is important to proceed with clarity around data requirements and increase internal or external capacity ahead of project launch to ensure that the outcome can be attributed to the service or intervention so successes and barriers to outcome achievement can be addressed. Secondly, collaborative working between all parties is important at every stage of the project to ensure good communication.

Priorities for future research

As the literature review for this evaluation has shown, there is a need for empirical research into SIBs, especially in health and social care, where little is known about how SIBs are likely to function. Indeed, the earliest applications of SIB projects were in the areas of recidivism or employment and training policies so we are limited in what policy lessons can be applied to health and social care. Despite a lack of empirical data on outcomes and costs of SIBs in health and social care, there has been no shortage of national and local enthusiasm for the development of further projects. To accompany this, qualitative research is needed to explore how SIB delivery affects service recipients, service providers and joint commissioners. There is also scope to explore the interactions between those actors by focusing on how their perceptions of competing values are challenged by new systems of measurement, financial incentives and conceptions of risk.

Quantitative research is also needed to explore the effectiveness of SIB projects in meeting their oft-stated goals of improving accountability, scaling up projects that work with service

providers most attuned to the needs of vulnerable populations and ensuring value for money for public commissioners and grant-giving organisations. In the US, it appears that most SIBs have been implemented in the context of a RCT. This is not the case with the Trailblazers. While the RCT is not the only appropriate evaluation technique for a SIB, it highlights the need for robust evaluations based on appropriate counterfactuals or control groups to demonstrate effectiveness. It is planned to attempt to undertake such comparative qualitative and quantitative work during the next stage of this evaluation.

References

Action for Children [No date]. *Evidence based programmes: Multi-dimensional treatment foster care* [Online]. Available at: http://www.actionforchildren.org.uk/our-services/for-professionals/evidence-based-programmes#mtfc [Accessed: 30 October 2014].

Action for Children. 2014. *UK's first social impact bond to fund foster placements for kids in care* [Online]. Action for Children News, 5 June 2014. Available at: http://www.actionforchildren.org.uk/news/archive/2014/june/first-social-impact-bond [Accessed 30 October 2014].

Allia (2013) *Future for Children Bond report.* Available at*:* http://allia.org.uk/latest-news/2013/07/17/future-for-children-bond-report/[Accessed: 03 December 2014].

Bafford, B. (2014) The Feasibility and Future of Social Impact Bonds in the United States. *Sanford Journal of Public Policy*, 3.

Baliga, S. (2013). Shaping the Success of Social Impact Bonds in the United States: Lessons Learned from the Privatization of US Prisons. *Duke LJ*, *63*, 437.

Barclay, L. and Symons, T. 2013a. *A technical guide to developing Social Impact Bonds*. London: Social Finance.

Barclay, L. and Symons, T. 2013b. *Introduction to Social Impact Bonds workshop* [Online]. Available at: http://www.local.gov.uk/documents/10180/5659908/Introduction+to+Social+Impact+Bond-+lisa+Barclay.pdf/4b504b98-3e36-4fb3-97b5-3eded504756e [Accessed 23 October 2014].

Basinga, P., et al. (2011). "Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation." The Lancet **377**(9775): 1421-1428.

Bevan, G., & Hood, C. (2006). Have targets improved performance in the English NHS?. *BMJ*, *332*(7538), 419-422.

Big Society Capital. 2013. *Essex Social Impact Bond: Early intervention with young people* [Online]. Available at: http://www.bigsocietycapital.com/how-we-invest/essex-social-impact-bond-0 [Accessed: 23 October 2014].

Boston Consulting Group. (2012). The First Billion, A forecast of social investment demand. Available at: https://www.bcg.com/documents/file115598.pdf [Accessed on 4 December 2014].

Bridges Ventures. 2013. *Bridges Social Impact Bond Fund* [Online]. Available at: http://bridgesventures.com/wp-

content/uploads/2013/12/BridgesSocialImpacBondFundSummary-one-pager-latest.pdf [Accessed: 23 October 2014].

Bridges Ventures. 2014. UK's first social impact bond to fund foster placements for children in care [Online]/ Available at: http://www.bridgesventures.com/uks-first-social-impact-bond-to-fund-foster-placements-for-children-in-care/ [Accessed 27 November 2014].

Bridges Ventures [No date]. *Portfolio – Bridges Social Impact Bond Fund* [Online]. Available at: http://bridgesventures.com/portfoliolist/manchester-mtfc-programme/ [Accessed: 30 October 2014].

Burand, D. (2012). Globalizing Social Finance: How Social Impact Bonds and Social Impact Performance Guarantees Can Scale Development. *NYUJL & Bus.*, *9*, 447.

Cabinet Office [No date]. *Manchester City Council – Children in Care SIB* [Online]. Available at: http://data.gov.uk/sib_knowledge_box/manchester-city-council-children-care-sib [Accessed: 30 October 2014]

Cabinet Office. 2013. *Essex County Council: Children at risk of going into care* [Online]. Available at: http://data.gov.uk/sib_knowledge_box/essex-county-council-children-risk-going-care [Accessed: 23 October 2014].

Cabinet Office (2014) Centre for Social Impact Bonds, map. Available at: http://data.gov.uk/sib_knowledge_box/map [Accessed 03 December 2014]

Callanan, L., & Law, J. (2012). Will social impact bonds work in the United States? *Washington DC: McKinsey on Society*.

Chimhutu, V., et al. (2014). "When incentives work too well: locally implemented pay for performance (P4P) and adverse sanctions towards home birth in Tanzania - a qualitative study." BMC Health Serv Res **14**: 23.

Cohen, R. (2011, November). Harnessing social entrepreneurship and investment to bridge the social divide. In *EU conference on the social economy* (Vol. 18).

Cox, B. R. (2011). Financing Homelessness Prevention Programs with Social Impact Bonds. *Rev. Banking & Fin. L.*, *31*, 959.

Crowley, D. M. (2014). The Role of Social Impact Bonds in Pediatric Health Care. *Pediatrics*, *134*(2), e331-e333.

College of Medicine [No date]. *The Green Dreams Project CIC* [Online]. Available at: http://www.collegeofmedicine.org.uk/innovations-projects/the-green-dreams-project-cic/ [Accessed: 24 October 2014].

Dagher Jr, P. G. (2013). Social Impact Bonds and the Private Benefit Doctrine: Will Participation Jeopardize a Nonprofit's Tax-Exempt Status.

Deering, J. (2014). A Future for Probation? *The Howard Journal of Criminal Justice*, *53*(1), 1-15.

Demel, A. (2012). Second Thoughts on Social Impact Bonds. *NYUJL & Bus.9*, 503.

Department for Communities and Local Government. (2014). Qualitative evaluation of the London homelessness Social Impact Bond: First interim report. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357785/Qualitative_Evaluation_of_the_London_Homelessness_SIB.pdf [Accessed on 3 December 2014].

Disley, E., Rubin, J., Scraggs, E., Burrowes, N., & Culley, D. M. (2011). Evaluation of the Social Impact Bond. RAND

Disley, E., Rubin, J. (2014). Phase 2 report from the payment by results Social Impact Bond pilot at HMP Peterborough. RAND

Dodd, J. A., & Moody, R. (2011). Outcomes, Not Process: Towards a New Model for European Funding in an Age of Austerity. *Journal of Contemporary European Research*, *7*(1), 120-128.

Doran, T., et al. (2006). "Pay-for-performance programs in family practices in the United Kingdom." New England Journal of Medicine **355**(4): 375-384.

Early Intervention Foundation (2014) Griffiths, A. & Meinicke, C. *Introduction to Social Impact Bonds and Early Intervention.* Available at: http://www.eif.org.uk/publications/social-impact-bonds-and-early-intervention/ [Accessed 03 December 2014]

Economist. (2013). “Commerce and conscience: a new way of financing public services gains momentum,” Available at: http://www.economist.com/news/finance-and-economics/21572231-new-way-financing-public-services-gains-momentum-commerce-and-conscience [Accessed: 3 December 2014].

Eijkenaar, F. (2013). "Key issues in the design of pay for performance programs." *The European Journal of Health Economics* **14**(1): 117-131.

Emmert, M., et al. (2012). "Economic evaluation of pay-for-performance in health care: a systematic review." *The European Journal of Health Economics* **13**(6): 755-767.

Essex County Council and Social Finance [No date]. *The Essex Social Impact Bond: financial innovation and service redesign in children’s services* [Online]. Available at: http://awards.themj.co.uk/library/media/pdfs/MJ%20Awards%20Submission%20Final.pdf [Accessed: 23 October 2014].

Essex County Council and Social Finance 2012. *First local authority social impact bond awarded to improve outcomes for vulnerable young people on the edge of care.*

Fairfax-Clay, R. F. (2013). Health impact bonds: will investors pay for intervention? *Environmental health perspectives*, *121*(2), a45.

Feng, Y., et al. (2014). 'The Tougher the Better: an economic analysis of increased payment thresholds on the performance of General Practices' *Health Econ*

Fitzpatrick, R., & Thorne, L. (2010). *A label for exclusion: Support for alcohol-misusing offenders*. Centre for Mental Health Policy Paper.

Fox, C., & Albertson, K. (2011). Payment by results and social impact bonds in the criminal justice sector: New challenges for the concept of evidence-based policy? *Criminology and Criminal Justice*, 1748895811415580.

Fox, C., & Albertson, K. (2012). Is payment by results the most efficient way to address the challenges faced by the criminal justice sector? *Probation Journal*, *59*(4), 355-373.

FSquared Ltd (2014) *Deep Green Care Community CIC: Developing a provider led Social Impact Bond*

Goodall, E. (2014) *Choosing Social Impact Bonds: A Practitioner's Guide.* Bank of America Merrill Lynch & Bridges Impact+. Available at: http://www.bridgesventures.com/wp-content/uploads/2014/10/ChoosingSocialImpactBonds_APractitionersGuide.pdf [Accessed 03 December 2014]

Gravelle, H., et al. (2010). "Doctor Behaviour under a Pay for Performance Contract: Treating, Cheating and Case Finding?*." *The Economic Journal* **120**(542): F129-F156.

Green Dreams Project [No date]. *The Green Dreams Project – Padiham Area* [Online]. Available at: http://www.greendreamsproject.co.uk/projects/padihamproject [Accessed: 24 October 2014].

Green Dreams Project. 2013. *Promotion film* [Online]. Available at: http://www.greendreamsproject.co.uk/index.html [Accessed: 24 October 2014].

Green Dreams Project CIC. 2013. *Payment by Results*. Powerpoint presentation.

Griffiths, A. and Meinicke, C. 2014. *Introduction to Social Impact Bonds and Early Intervention* [Online]. Initial report, April 2014. London: Early Intervention Foundation. Available at: http://www.eif.org.uk/wp-content/uploads/2014/04/Social-Investment-Report-final-for-publication-04-Apr.pdf [Accessed: 30 October 2014].

Halfpenny, P & Hopkiss, J. (2014) *Deep Green Care Community CIC Business Plan: proof of concept stage 2014-2018*

HM Government (2011) *Growing the Social Investment Market: a vision and a strategy.* London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61185/404970_SocialInvestmentMarket_acc.pdf [Accessed 03 December 2014]

HM Government (2013) *Open Public Services* London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200077/Open_Public_Services_2013_full_report.pdf [Accessed 03 December 2014]

HM Government [No date]. *Growing the social investment market: 2013 progress update* [Online]. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205295/Social_Investment_Strategy_Update_2013.pdf [Accessed: 30 October 2014].

HM Government (2009). Putting the Frontline First: smarter government.

Incubator@community catalysts. 2013. *Driving the development of a strong vibrant Shared Lives market.*

Jackson, E. T. (2013) Evaluating social impact bonds: questions, challenges, innovations, and possibilities in measuring outcomes in impact investing, *Community Development,* 44:5, 608-616, DOI: 10.1080/15575330.2013.854258

Jolliffe, D. and Hederman, C. (2014) Peterborough Social Impact Bond: Final Report on Cohort 1 Analysis, Qinetiq and MoJ

Jupp, B. and Shirley, T. (2015). Introduction to commissioning and procuring social impact bonds. Available from http://www.local.gov.uk/documents/10180/6927816/Workshop+-+Commissioning+and+procuring+a+SIB+(17+slides).pdf/4b48f618-87af-4d92-8aa4-c44e432f037b [Accessed on 19 February 2015].

Kantarevic, J. and B. Kralj (2013). "Link between pay for performance incentives and physician payment mechanisms: evidence from the diabetes management incentive in Ontario." *Health Econ* **22**(12): 1417-1439.

Kristensen, S. R., et al. (2013). "Should pay-for-performance schemes be locally designed? Evidence from the Commissioning for Quality and Innovation (CQUIN) Framework." *J Health Serv Res Policy* **18**(2 Suppl): 38-49.

Lagarde, M., et al. (2013). "Challenges of payment-for-performance in health care and other public services–design, implementation and evaluation."PIRU

Lambeth Corporate Procurement Team. 2013. *Officer Delegated Decision Report—Procurement*.

Leventhal, R. (2012). Effecting Progress: Using Social Impact Bonds to Finance Social Services. *NYUJL & Bus.*, *9*, 511.

Magrath, P. and M. Nichter (2012). "Paying for performance and the social relations of health care provision: an anthropological perspective." *Social science & medicine* **75**(10): 1778-1785.

Malcolmson, J. D. (2014). Social impact bonds: cleared for landing in British Columbia. *CUPE Research*

Martin, M. (2013). Making Impact Investible. *Impact Economy Working Papers Vol 4*

McDonald, R., et al. (2007). "Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study." BMJ **334**(7608): 1357.

McHugh, N., Sinclair, S., Roy, M., Huckfield, L., & Donaldson, C. (2013). Social impact bonds: a wolf in sheep's clothing?. *Journal of Poverty and Social Justice*, *21*(3), 247-257.

Mulgan, G., Reeder, N., Aylott, M., & Bo'sher, L. (2011). Social impact investment: the challenge and opportunity of social impact bonds. *Young Foundation.*

Pauly, M., & Swanson, A. (2013). *Social Impact Bonds in Nonprofit Health Care: New Product or New Package?* (No. w18991). National Bureau of Economic Research.

Petersen, L. A., et al. (2006). "Does pay-for-performance improve the quality of health care?" *Annals of internal medicine* **145**(4): 265-272.

Powell-Jackson, T., et al. (2014). "Realigning demand and supply side incentives to improve primary health care seeking in rural china." *Health Econ*.

Power, M. (1999). *The Audit Society: Rituals of verification*. Oxford University Press.

Roberts, T. 2013. *The Centre for Social Impact Bonds* [Online]. Civil Service Quarterly, 22 October 2013. Available at: https://quarterly.blog.gov.uk/2013/10/22/the-centre-for-social-impact-bonds/ [Accessed: 30 October 2014].

Roland, M. and S. M. Campbell (In press). "What's gone right and what's gone wrong with the UK's P4P scheme." *New England Journal of Medicine*.

Roland, M. (2012). Pay-for-performance: not a magic bullet. *Annals of internal medicine*, *157*(12), 912-913.

Rotheroe, A., Joy, I., & Lomax, P., (2013). Allia's Future for Children Bond: Lessons learned. Available at: http://www.thinknpc.org/publications/the-future-for-children-bond-lessons-learned [Accessed on 3 December 2014].

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of personality assessment*, *66*(1), 20-40.

Sandwell & West Birmingham CCG and Marie Curie Cancer Care (April, 2014) *Social investment in end of life care initiative: Stage 3 report*

Shared Lives Plus. 2012a. *Welcome to SharedLivesPlus Online*. Available at: http://www.sharedlivesplus.org.uk/ [Accessed 25 November 2014].

Shared Lives Plus. 2012b. *What is Shared Lives?* [Online]. Available at: http://www.sharedlivesplus.org.uk/about-us/shared-lives-about [Accessed: 29 October 2014].

Shen, Y. (2003). "Selection Incentives in a Performance – Based Contracting System." Health Serv Res **38**(2): 535-552.

Shiller, R. J. (2013). Capitalism and Financial Innovation. *Financial Analysts Journal*, *69*(1).

Sinclair, S., McHugh, N., Huckfield, L., Roy, M., & Donaldson, C. (2014). Social Impact Bonds: shifting the boundaries of citizenship. *Social Policy Review 26: Analysis and Debate in Social Policy, 2014*, 119.

Social Enterprise UK (2013) *The power of partnerships : effective working with the voluntary, community and social enterprise sector to achieve local health goals*. Available at: http://www.socialenterprise.org.uk/uploads/files/2013/06/powerpartnershiptoolkit_onlinefeb13.pdf [Accessed: 03 December 2014]

Social Finance (2011) *A technical guide to developing a Social Impact Bond: Vulnerable Children and Young People.* Avaialbale at: http://www.socialfinance.org.uk/a-technical-guide-to-developing-a-social-impact-bond-vulnerable-children-and-young-people/ [Accessed: 03 December 2014]

Social Finance website: http://www.socialfinance.org.uk/work/sibs

Social Finance [No date a]. *Comparison table of Essex and Manchester* [Online]. Available at: http://socialfinanceuk.files.wordpress.com/2014/02/essexmanchester.png [Accessed: 30 October 2014].

Social Finance [No date b]. *Impact: Essex Social Impact Bond for children at the edge of care* [Online]. Available at: http://www.socialfinance.org.uk/impact/young-people/ [Accessed: 23 October 2014].

Social Finance [No date c]. *Manchester Social Impact Bond for looked after adolescents in residential care* [Online]. Available at: http://www.socialfinance.org.uk/impact/young-people/ [Accessed: 30 October 2014].

Social Finance. 2013a. *Investing in Shared Lives* [Online]. Available at: http://www.socialfinance.org.uk/wp-content/uploads/2014/04/SF_Shared_Lives_Final.pdf [Accessed: 29 October 2014].

Social Finance. 2013b. *Publications: Investing in Shared Lives* [Online]. Available at: http://www.socialfinance.org.uk/investing-in-shared-lives/ [Accessed: 29 October 2014].

Songstad, N. G., et al. (2012). "Assessing performance enhancing tools: experiences with the open performance review and appraisal system (OPRAS) and expectations towards payment for performance (P4P) in the public health sector in Tanzania." *Globalization and health* **8**(1): 33.

The London Borough of Lambeth. 2014. *An exciting business opportunity*.

The Economist, Feb 23rd 2013 http://www.economist.com/news/finance-and-economics/21572231-new-way-financing-public-services-gains-momentum-commerce-and-conscience

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., ... & Stewart-Brown, S. (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): development and UK validation. *Health and Quality of life Outcomes*, *5*(1), 63.

Trupin, E., Weiss, N., & Kerns, S. E. (2014). Social impact bonds: behavioral health opportunities. *JAMA Pediatrics*, *168*(11), 985-986.

Van Herck, P., et al. (2010). "Systematic review: effects, design choices, and context of pay-for-performance in health care." *BMC Health Serv Res* **10**(1): 247.

Vecchi, V., Hellowell, M., & Gatti, S. (2013). Does the private sector receive an excessive return from investments in health care infrastructure projects? Evidence from the UK. *Health Policy*, *110*(2), 243-270.

VONNE. 2014a. *Policy Article: Ebulletin 11 – August 2014* [Online]. Available at: http://www.vonne.org.uk/policy/policy_article.php?offset=0&id=2268 [Accessed: 23 October 2014].

VONNE. 2014b. *Ways to Wellness FAQ* [Online]. Available at: http://www.vonne.org.uk/policy/waystowellness/ways_to_wellness_faq.php?flink=896 [Accessed: 23 October 2014].

VONNE. 2014c. *Policy Article: Ebulletin 11 – November 2014* [Online]. Available at: http://www.vonne.org.uk/policy/policy_article.php?offset=0&id=2299 [Accessed 25 November 2014].

Warner, M. (2012, September). Profiting from Public Value? The Case of Social Impact Bonds. Draft paper prepared for Creating Public Value Conference, University of Minnesota, Sept.

Warner, M. E. (2013). Private finance for public goods: social impact bonds. *Journal of Economic Policy Reform*, *16*(4), 303-319.

Werner, R. M., et al. (2011). "The effect of pay-for-performance in hospitals: lessons for quality improvement." *Health Aff (Millwood)* **30**(4): 690-698.

Werner, R. M., et al. (2013). "The Effect of Pay‐for‐Performance in Nursing Homes: Evidence from State Medicaid Programs." *Health Serv Res* **48**(4): 1393-1414.

Ways to Wellness. 2014. *Prospectus for the Procurement of Service Providers. Version 8.1, 24 March 2014*.

Whitfield, D. (2012). The payment-by-results road to marketization. *Critical reflections: social and criminal justice in the first year of Coalition government*, 22.

Young Foundation and NESTA (2011) *Growing Social Ventures: the role of intermediaries and investors – who they are, what they do, and what they could become.* Available at: http://youngfoundation.org/wp-content/uploads/2012/10/Growing-Social-Ventures-2011.pdf [Accessed: 03 December 2014]

Appendix: Further profile information on the Trailblazers

Data collection – interviews

SIB project	Providers	Commissioners	Intermediaries	Investors	Other	TOTAL
Sandwell	1	2	2			5
Leeds	3		1			4
Cornwall	2		1			3
Worcester	1		1			2
Thames Reach	1	1	1	1		4
Newcastle		1		1	3	5
Manchester	1	1	1			3
Green Dreams					1	1
Shared Lives			1		1	2
Essex	1	1	1			3
Non-trailblazer	1		2		1	4
TOTAL	11	6	11	2	6	36

SIB development

SIB project	Who initiated the SIB idea?	Is Social Finance involved (and in what capacity)?	Stage of development (as of December 2014)
Sandwell	Government agencies, Social Finance, MCCC	Yes – development of SIB and now partnership with MCCC	Out to tender
Leeds	Deep Green CIC	Small amount of advice	Terminated
Cornwall	CCG/VCS organisations	Advice on outcomes and identifying metrics	Bridge funding received from Cabinet Office's Social Action Team to extend SIB-like project into East Cornwall. Money to be used by end of this financial year.
Worcester	Worcester City Council	Yes, actively involved in co-design with service provider	Tender submitted in October 2014, preferred bidder to be announced February 2015.
Thames Reach	Greater London Authority	Yes, through advisory services to GLA	Started in November 2012
Newcastle	VONNE	No	Expected to start in April 2015
Manchester	Manchester City Council commissioned SF to conduct feasibility study	Yes. Conducted feasibility study, and on-going advisory role	Started in October/November 2014
Green Dreams	NA	NA	This scheme is not a SIB
Shared Lives	Shared Lives Plus	Yes, as part of the Shared Lives Incubator	Manchester expected April 2015; Lambeth expected to start in June 2015)
Essex	Social Finance	Yes, through advisory services	Started in April 2013

SIB focus

SIB project	Is the focus of the SIB cross-sectoral?	Does the government already fund similar services?	Are the services proposed innovative?	Are the proposed savings actual or potential?
Sandwell	No – just health	Yes	The combination is	Potential
Leeds	Yes	No	Yes	Potential
Cornwall	Yes	Yes	Somewhat	Potential
Worcester	Yes	No	Somewhat	Potential
Thames Reach	Yes	Not across all outcome metrics	Yes	Potential
Newcastle	Yes	Yes	Yes	Potential
Manchester	Yes	Yes	No	Actual
Green Dreams	NA	NA	NA	NA
Shared Lives	No	Yes	Yes	Actual
Essex	Yes	Yes	No	Actual

SIB evaluation of outcomes

SIB project	Existing data or new data collection?	Type of outcomes (relative improvement, absolute, incremental, etc)	Type of evaluation of outcomes (before/after, with control group, etc.)	Is this a robust method to attribute effects to services provided under SIB?
Sandwell	Existing data and new data	Absolute	Before/After	Yes
Leeds	New data	Relative improvement	Before/After	?
Cornwall	Existing and new data	Absolute proposed	Before/After	Pending results of Penwith
Worcester	Existing and new data	Absolute	Before/After	?
Thames Reach	Existing and new data	Absolute	Before/After, potential for control group to be constructed	?
Newcastle	Existing and new data	Absolute improvement on Wellbeing Star; Relative improvement on other outcomes	Ongoing reviews with the patient through use of a Wellbeing Star and secondary care outcomes compared to control group	No
Manchester	Existing data	Absolute	Young person engaged in MTFC-A programme, moved out of residential placement, achieving all wellbeing outcomes (wellbeing is measured at graduation and 12 months after graduation). Benchmark is data on 11-14 year-olds in residential care from 2007 to 2008	No
Green Dreams	NA	NA	NA	NA
Shared Lives	New data	Absolute	Number of new Shared Lives care placements established	No
Essex	Existing and new data	Relative to a historical control group (baseline is absolute as it is historical data)	At the end of each measurement quarter a comparison with historical case file data is made	Potentially

Contractual model

SIB project	Type of involvement of intermediary in SIB (especially support for performance management?)	Commissioners (to) contract with…	Contractual relationship between investors and service providers?	Is the service provider bearing part of the financial risk (i.e. paid partly based on outcomes)
Sandwell	Would depend on who won contract	Unclear at this stage	Unclear at this stage	Would depend on who won contract – but probably, based on documentation available
Leeds	N/A	N/A	N/A	N/A
Cornwall	Assisted with identification of outcome metrics	N/A	N/A	Unlikely
Worcester	High, co-design of service model, assistance in developing tender	Service provider and investors (to be identified)	To be confirmed	To be confirmed
Thames Reach	Provided technical assistance to commissioner only	Service provider, investors	Yes	Yes
Newcastle	VONNE acted as *de facto* intermediary and provided office space and other administrative support	SPV	No	Partially
Manchester	Conducted feasibility study, and on-going advisory role	Service provider	Yes	Yes
Green Dreams	NA	NA	NA	NA
Shared Lives	Through Shared Lives Incubator	Service provider	Yes	Yes
Essex	Advisory services	SPV	No	Yes

Who invests in SIBs?

SIB project	Size of investment	Type of investors involved (with %) – public, charities, social investors	Rate of return?	Were investors not interested / turned down?
Sandwell	Unclear	Unclear	Unclear	Unclear
Leeds	N/A	N/A	N/A	N/A
Cornwall	Unclear	?All Cabinet Office	N/A	Unclear
Worcester	Approximately £1.7m. Exact amount to be confirmed.	TBD	TBD	Not at that stage
Thames Reach	£2.5m	Thames Reach, Big Issue, other philanthropic	Not disclosed	Bridges withdrew, risk deemed too high
Newcastle	£1.7m	Bridges Ventures and the Newcastle Healthcare Charity.	This is a fully at risk investment and there is no fixed coupon or secured level of return.	Unknown
Manchester	£1.2m	Bridges Ventures: £1.2m	To be confirmed	Unknown
Green Dreams	NA	NA	NA	NA
Shared Lives	£1.1M to cover four areas.	Big Society Capital, Esmeé Fairbairn foundation, John Ellerman Foundation	To be confirmed	Unknown
Essex	£3.1m	Including Bridges Ventures: £825,000 and Big Society Capital: £825,000	To be confirmed	Unknown

The Policy Innovation Research Unit (PIRU) brings together leading health and social care expertise to improve evidence-based policy-making and its implementation across the National Health Service, social care and public health.

We strengthen early policy development by exploiting the best routine data and by subjecting initiatives to speedy, thorough evaluation. We also help to optimise policy implementation across the Department of Health's responsibilities.

Our partners

PIRU is a novel collaboration between the London School of Hygiene & Tropical Medicine (LSHTM), the Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science (LSE), and the Health and Care Infrastructure Research and Innovation Centre (HaCIRIC) at Imperial College London Business School plus RAND Europe and the Nuffield Trust.

The Unit is funded by the Policy Research Programme of the Department of Health.

Policy Innovation Research Unit
Department of Health Services Research & Policy
London School of Hygiene & Tropical Medicine
15–17 Tavistock Place, London WC1H 9SH
Tel: +44 (0)20 7927 2784
www.piru.a