

Commissioning Better
Outcomes Fund Evaluation:
In depth review

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Zero HIV Social Impact Bond

Contents

Executive Summary	4
About this report	4
Background to this project	5
How the SIB works	6
The SIB Model.....	7
What is interesting about this SIB?	8
Successes and perceived benefits of the SIB approach	9
Challenges and disadvantages of the SIB approach.....	10
Lessons learned	11
Conclusion	12

1. Introduction.....	15	2. How the SIB works	18
1.1 The CBO programme	15	2.1 The SIB model.....	18
1.2 What do we mean by a SIB and the SIB effect?	16	2.1.1 Overview and underlying logic model	18
1.3 The in-depth review reports	16	2.1.2 The business case and rationale for the SIB – Zero HIV and its benefits.....	19
1.4 Report structure	17	2.1.3 Drivers of an outcomes-based approach.....	21
		2.1.4 The Zero HIV SIB services and outcomes.....	25
		2.1.5 Rationale for a SIB approach.....	28
		2.2 SIB contracting and governance structure	29
		2.2.1 Overview and key features... ..	29
		2.2.2 Investment structure	31

3. Stakeholder experiences and views	33
3.1 Stakeholder roles and experiences	33
3.1.1 EJAF	33
3.1.2 Local authority commissioners	35
3.1.3 Providers	35
3.1.4 Investors	38
3.1.5 The National Lottery Community Fund	38
3.2 Successes	39
3.3 Challenges and disadvantages	42
3.4 Lessons learned	45

4. Conclusions	47
4.1 Conclusions to date	47
4.2 Achievement of CBO objectives	49
4.3 Areas for future investigation	50

Executive Summary

About this report

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

This report is the first in-depth review of the Zero HIV SIB. Its focus is on stakeholder experiences and learning from the design and development of the SIB up to the point at which it was launched, and the immediate challenges in the period after launch. The interviews with stakeholders whose views are reflected in this report were conducted between September and December 2019.

SIBs are a form of outcomes-based commissioning¹ (OBC). There is no generally accepted definition of a SIB beyond the minimum requirements that it should involve payment for outcomes and any investment required should be raised from social investors. The Government Outcomes Lab (GO Lab) defines impact bonds, including SIBs, as follows:

“Impact bonds are outcome-based contracts that incorporate the use of private funding from investors to cover the upfront capital required for a provider to set up and deliver a service. The service is set out to achieve measurable outcomes established by the commissioning authority (or outcome payer) and the investor is repaid only if these outcomes are achieved. Impact bonds encompass both social impact bonds and development impact bonds.”²

SIBs differ greatly in their structure and there is variation in the extent to which their components are included in the contract. This difference underlies the stakeholder dynamics and the extent to which performance is monitored in the SIB. For the purpose of this report, when we talk about the ‘SIB’ and the ‘SIB effect’, we are considering how different elements have been included, namely, the payment on outcomes contract, capital from social investors, and approach to performance management.

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

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

Background to this project

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

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

There are thus significant health and social benefits to both the person with HIV and to the wider community if HIV can be detected. These benefits increase hugely if it is detected early, since if detected late the virus has already started to damage the immune system, and poses a much greater threat. There are also major financial benefits from early detection, and still greater gains from preventing onward transmission – potentially to several people.

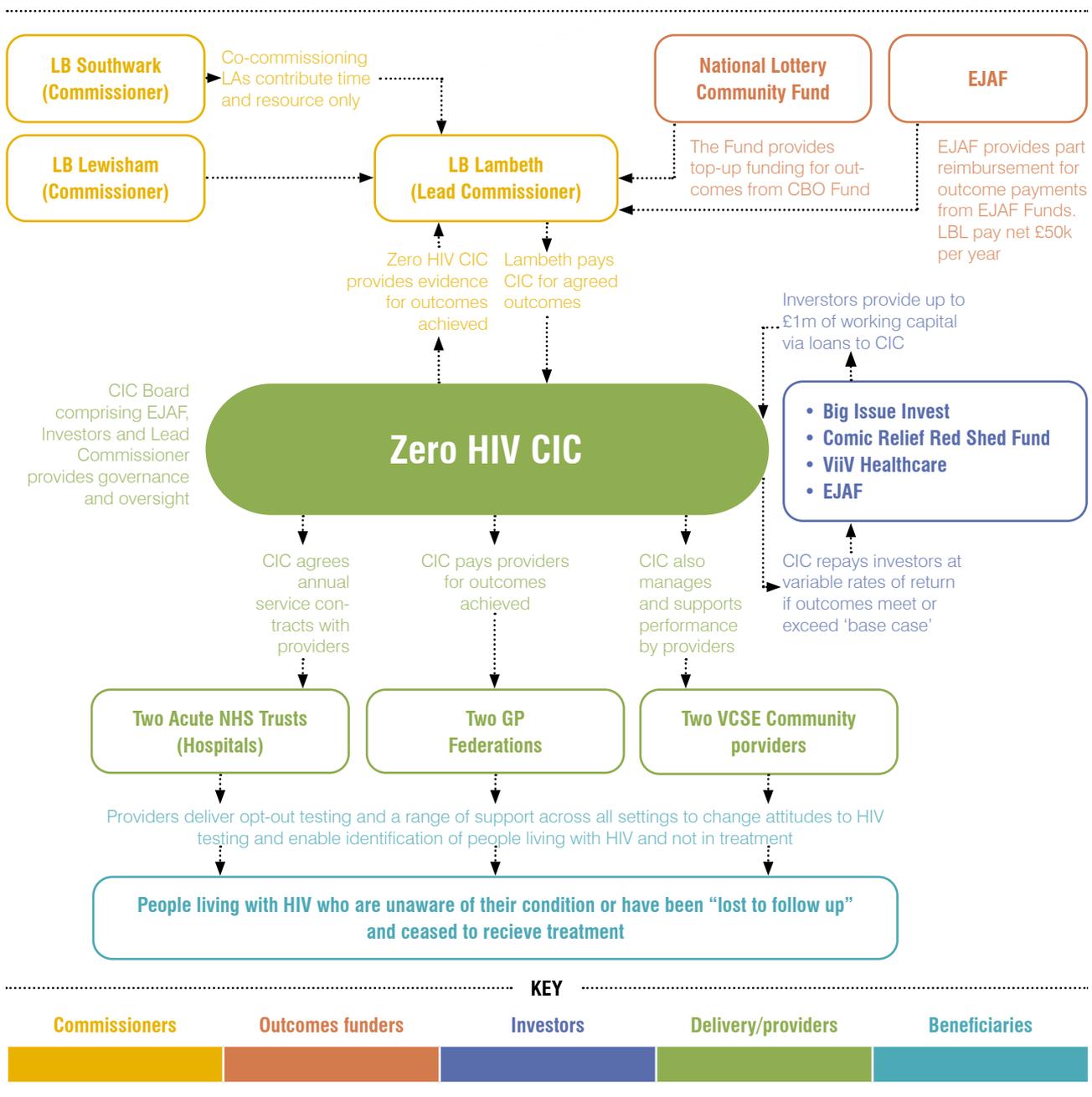
The problem the SIB addresses is that there remains a stubbornly higher number of people (estimated to be 10 - 15% of those who have HIV) who are not in treatment – either because they do not know they have the virus, or have been diagnosed but later dropped out of treatment. This problem is particularly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

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

How the SIB works

The logic behind the SIB is summarised in Figure 1 below (note that this is simplified and does not fully reflect the detailed operating and contracting structure of the SIB, which is described further in sections 2.2 and 2.3).

Figure 1 – the SIB Model



The SIB Model

The key to the success of the SIB is its clever use of an outcomes-based contracting model to incentivise all parts of the health system to identify those living with HIV and get them into treatment (or back into treatment if they are deemed 'lost to follow up'). In light of the benefits of early detection and treatment, it is already NICE guidance to test up to 100% of those at risk of HIV, but this rarely happens, and actual testing rates are habitually much lower. As EJAF's own projects and wider research shows, this is largely due to lack of funding and a reluctance among some health practitioners to offer testing to at-risk groups – even though tests cost relatively little (about £80).

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

The SIB is supported by social investment from both an established social investment fund manager (Big Issue Invest) and other investors who, at the time, had not previously invested in SIBs (Comic Relief and ViiV healthcare). Investors were attracted in part by EJAF's own commitment to be a co-investor.

The other interesting feature of this SIB is that it is part-funded by EJAF itself, since it is contributing most of the cost of the outcome payments, alongside the CBO Fund. This reflects one of the key challenges of this SIB, which was to engage and then persuade local or specialist commissioners (notably the Clinical Commissioning groups or CCGs, and Local Authority (LA) Public Health (PH) commissioners, as well as NHS England) to pay for outcomes that would ultimately benefit them – because fewer people would contract HIV and more of those that do contract it would be treated earlier. While one of the LA PH commissioners is contributing to outcome payments, the other LAs are only contributing resources and expertise, and neither the CCGs nor NHS England are making any significant contribution.

What is interesting about this SIB?

In our view this SIB is interesting because it:

- **is the first to address HIV in the UK through an outcomes-based contract.** It is also unique, in our view, among health-focused SIBs in having the potential to achieve very high impact on the condition it addresses. It does not just reduce incidence of a chronic condition; it prevents incidence of an acute and potentially fatal condition – AIDS and its associated complications.
- **is a very good and clear example of the value of contracting for outcomes** rather than outputs or activities. Arguably its most important feature is that it incentivises providers by paying them to detect people who have HIV and are not being treated, rather than taking the more usual approach of paying for a quantity of HIV tests to be conducted irrespective of outcomes achieved. However this approach is not without drawbacks to the providers, who have to cover much of their costs from variable and insecure outcome payments – see challenges and disadvantages below.
- **shows the value of a SIB model in engaging multiple stakeholders to work together.** it enables providers of healthcare to collaborate across the sector in primary, secondary and community settings. While it can be argued that such collaboration could have been achieved without using a SIB, EJAF believes that the SIB model was instrumental to engaging commissioners and to enabling the change of mindset among health practitioners that is essential to this project's success.
- **involves multiple roles for EJAF.** The multiplicity of these roles is interesting and in some respects unprecedented: EJAF has been the main initiator and developer of the SIB, a lead investor that also drove the raising of investment from other parties, and – uniquely in our experience – a co-funder of outcome payments.
- **has an unusual and innovative investment structure,** in which EJAF itself is an investor and has attracted investment not only from a mainstream social investor (Big Issue Invest) but also from Comic Relief and a private healthcare provider specialising in HIV - ViiV. The involvement of both EJAF and Comic Relief shows that charities traditionally known as grant givers are actively exploring the potential of repayable finance.



Successes and perceived benefits of the SIB approach

The use of a SIB model has:

- **Created much stronger incentives for providers** (especially in the primary care sector) to undertake testing with high risk groups, and overcome a range of objections, of varying validity, for not doing so. As already explained the SIB has done this by paying for the identification of new and 'lost to follow up' HIV patients, rather than paying for testing directly, and supporting providers to achieve the necessary change in mindset and attitudes – among both health practitioners and those at risk of contracting HIV.
- **Provided the basis for comparing this outcomes-based approach with more conventional funding approaches.** While there is no explicit comparison group built into this project, previous projects have attempted to increase HIV testing levels through conventional grant and contract funding, including some funded by EJAF itself, offering the potential to more directly assess the effectiveness and impact of this SIB.
- **Demonstrated that a complex SIB can be developed with the right in-house resources.** While this SIB did have some limited external support, most of the 'hard yards' were made by EJAF itself with leadership from a dedicated in-house manager with the right experience and skills, recruited specifically to drive the project forward.
- **Provided the impetus for changes to systems and processes** that are needed to enable large scale 'opt-out' testing of at-risk groups, and report promptly and accurately on progress and outcomes achieved. These include both changes to current systems (including workarounds where changes to laboratory systems could not be implemented) and a new reporting system which has been implemented across all providers.

There are two further claimed benefits of the SIB approach (as opposed to the project itself) about which we are more ambivalent. The first is that the external investment provides up-front funding for the providers which relieves them of cashflow pressure. However there is, as noted below, a potential longer-term challenge for providers in the outcome-based payment arrangements since, over the longer term within the SIB, providers have to bear fixed costs that might not be recovered if outcomes are not achieved.

The second is that the SIB enables 'an integrated model of HIV care' through 'A place-based, collaborative model'. There is no doubt that this project has stimulated a 'whole system' approach to HIV testing across different healthcare settings and referral pathways, and that this approach is vital to the success of the project. However it is arguably not essential to deploy a SIB mechanism to make such collaboration happen; the influence and leadership of EJAF, and the experienced stakeholders with which it worked, might have been sufficient to make this happen under a different model including a conventional grant structure. However EJAF dispute this, since in their experience it has been difficult to bring commissioners on board through conventional approaches, and they strongly believe that the SIB model was critical to engaging commissioners, especially Lambeth and the other LA PH commissioners, and getting their commitment to the approach.



Challenges and disadvantages of the SIB approach

The major challenges of the SIB to date appear to have been in the following areas:

- **Engaging multiple stakeholders.** Like many other SIBs we have evaluated, and as highlighted in other research, engaging multiple stakeholders is a major challenge of SIB development and this again appears to have been the case here. According to EJAF, the engagement challenges were exacerbated by high turnover in key stakeholders, and senior EJAF management also mentioned ‘suspicion’ of the SIB mechanism as an inhibitor of engagement. Both of these are factors that we have encountered elsewhere, and feature in other research into the enabler of and barriers to SIBs.
- **Persuading commissioners to fund outcome payments.** It appears that this SIB was intended to have a ‘conventional’ funding structure, with outcome payments being met wholly or mainly by local commissioners (and the CBO Fund as co-commissioner). However the SIB project and the opportunities it offered appear to have been enough to engage local commissioners in a constructive conversation, but ultimately not sufficient to persuade them to fully fund the project, even with CBO top-up funding. This again mirrors other projects’ experience, with NHS commissioners appearing to be very reluctant to commit current expenditure, from very hard-pressed budgets, to such projects even when they promise a very strong future payback.
- **Some potential financial risk to providers.** Service providers have received up-front funding to ease initial cashflow in the form of a fixed payment for an agreed initial number of outcomes, and these upfront payments are unrecoverable if agreed payments are not achieved. Once this payment is exhausted, however, it appears that providers are paid by the outcome, and may therefore face cashflow problems if they cannot generate enough outcomes, through identifying new HIV cases or those lost to follow up. The upfront payments were intended to cover fixed costs, leaving only variable costs to be met from outcome payments. However one provider pointed out that the ongoing running costs of the service (i.e. staff in post, costs of the HIV pathology tests and administrative costs to process outcome reports etc) are borne by the provider regardless of whether outcomes are achieved or not. They commented that, if they were doing this again, they ‘would opt for a safer contract model that did not place the risk of non-achievement of outcomes solely on the providers’. This aspect of the SIB is worth noting because the SIB model does not, as some do, relieve providers of all risk by funding them in advance throughout the contract period.
- **Risk of a sharp fall in activity when the project ends.** There is some concern that, once the project ends, there will be a demoralising return to business as usual – with limited funding on either a conventional or outcomes basis. This is an issue that we will want to consider closely in the second review – i.e. as the project progresses and the results come in, to what extent will it provide a strong evidence base that will ensure both sustainability of the project in the longer-term and its wider adoption elsewhere? As noted elsewhere in this review, EJAF believe that the SIB model will be important in achieving sustainment, because it has secured the commitment of Lambeth and other local commissioners in a way that other models have not.

Lessons learned

The main lessons from this SIB are ones that have emerged from other SIBs that we have evaluated previously, but some of these lessons bear repetition. They include:

1

SIBs take a very long time to develop. This has been a theme of nearly every SIB we have researched, and this SIB was no different, taking 3½ years to get from award of development funding by the CBO in October 2015, to “go-live” in November 2018. As in other SIBs that we have reviewed such long delays appear to arise in large part from the need to engage, enthuse and ultimately commit multiple parties, across complex and sometimes unfamiliar public sector systems. In this case it is also worth noting the additional challenges of putting in place the necessary systems and processes to make the project work. These were successfully overcome – to the project’s great credit – but it took time.

2

Stakeholder engagement is difficult. Again this is by no means a new finding, but this project highlights many familiar lessons about the importance of effective stakeholder engagement and the patience and persistence sometimes needed to get them on board. These challenges can occur on any project but are made worse in the SIB context by stakeholder turnover and churn.

3

A SIB can be developed without substantial external support, and may be better for it. As already explained above this SIB was developed largely internally, and shows how effective this can be with the right people in place.

4

Piloting prior to a SIB can help inform its development. A number of SIBs claim to be piloting new approaches, and this SIB is to an extent a pilot of outcomes-based contracting for HIV testing and diagnosis. However, in this case the SIB was itself developed in the light of previous pilots by EJAF of both opt-out testing in hospitals and HIV screening by default in primary care. The SIB can then build on the pilots, and make further changes which are more appropriate to leveraging the intended incentives of a SIB approach – in this case testing whether outcomes-based contracts are more effective than activity-based ones in the same policy area.

Conclusion

Overall, it seems clear that this is an innovative, exciting and potentially transformative project. EJAF have looked carefully at the benefits of both social investment and an outcomes-based approach and have developed a project that has many of the features of a successful project of this type.

In particular, and most importantly in our view, they have deployed the SIB mechanism to introduce payment for outcomes in a policy area where it has the potential to make a real difference and address the shortcomings of the 'conventional' approach to funding HIV prevention and testing. Notably, the focus on outcomes aims to address low levels of testing by practitioners, which had persisted despite clear policy guidance in favour of 100% testing in high prevalence areas. This has helped local providers – supported by specialists such as the HIV champion whom we interviewed – to achieve the change in mindset needed to make large-scale testing a reality, and thereby overcome both their own resistance to offering opt-out testing and beneficiaries' own reluctance to be tested.

The project has also had other successes including attracting new investors into SIBs, testing the potential benefits of traditional grant-funders deploying repayable finance, and demonstrating both the benefits and challenges of joining up provision across the health system. Many of these benefits have been achieved because EJAF has successfully leveraged its leading position as a provider of funding and enabler of support to the treatment and eradication of HIV/AIDS. EJAF also believes that engagement with social investment is useful to their strategic leadership in the sector, and has enhanced it. Their reasoning is that EJAF has significant ambition to improve the lives of people living with HIV, both in the UK and globally. Prior to this project it has utilised fundraising and grant revenue to achieve these aims. This project has enabled EJAF to successfully trial an entirely new approach to funding projects in the sector, which reduces the amount of upfront funding that EJAF would otherwise need to make available to providers, even though investors need to be repaid later. EJAF believes it could replicate this model in the UK and globally, and it will be interesting to explore this thinking further in the mid-point and final reviews.

On the downside, EJAF was unable to persuade local commissioners to make the expected major contribution to outcome payments, and is now paying for a substantial proportion of the outcomes itself, as well as effectively acting as a 'first-loss' investor. There are thus fewer benefits to this somewhat circular involvement of EJAF in the SIB model than there would have been if, alongside CBO's quasi 'co-commissioning' funding, outcomes had been paid for entirely by public sector commissioners.

This led us to challenge EJAF as to whether a SIB model – with its attendant costs and complexities – might be the right way to pursue an outcomes-based approach in future. It can be argued that if commissioners remain reluctant to pay for HIV outcomes, EJAF might explicitly take the lead commissioning role, and possibly deploy a simpler payment by results model rather than a SIB. This might entail paying the providers directly through a mixture of up-front payment (to help providers with set up and ease their cashflow) and outcome payments (to incentivise detection of undiagnosed HIV) without the need for social investment and a complex operating and governance structure. Ultimately this type of model might be cheaper to develop, quicker to implement, and easier to replicate than a full-blown SIB approach, while potentially offering equal levels of impact and effectiveness.

However EJAF argue strongly that the SIB model was critical to persuading LB Lambeth to make a financial commitment, and that it has been proved time and again in their work that ownership by local commissioners – by way of financial commitment – makes an enormous difference to buy-in to the project and to the likelihood of that work continuing after EJAF has retreated. They strongly believe that with LB Lambeth acting as commissioners, offering a modest contribution from their public health budget, has enabled them to bring along senior people within the Lambeth, Southwark and Lewisham community in a way that direct funding by EJAF of an outcome-based contract (effectively a form of PbR) would not, and to reinforce relationships between LB Lambeth and providers in a way that EJAF directly commissioning would have not enabled. They also believe that engagement of Lambeth as an outcome payer is likely to be critical to the rollout of learning from this project – although Lambeth themselves argue that local public health budgets are too constrained to offer a sustainable funding model in the longer term – if HIV/AIDS outcomes are to be funded at scale, it will in their view need to be via NHS England.

They also believe that it would have been a significant challenge for EJAF itself to provide upfront funds to all providers, even at the relatively modest levels that this project has entailed. It would therefore be difficult to repeat the outcomes-based model without investor cash, especially if EJAF had to provide more initial funding to ease provider cashflow in the future.

Ultimately this is a hypothetical debate at this stage, but it will be interesting to explore in the second and third reviews whether, and to what extent, EJAF is proved right that the active engagement of Lambeth and other commissioners, and the success of this model – if its impact is supported by outcomes data – does lead to better learning and greater sustainment in the medium term.

Box 1: Areas for future investigation in Visit 2

- Do levels of engagement and testing prove to be significantly higher than achieved on projects which have not deployed an outcomes-based structure, such as the Leeds pilot project which EJAF itself funded?
- Are there any further changes to the funding structure of the SIB and/or its contracts or outcome payments? If so how do these changes compare or contrast with common features of other SIBs that we have previously evaluated?
- Has there been different performance between GP Federations that pass on outcome payments to the practice achieving the outcome, and those sharing payments with all practices?
- What further lessons does the EJAF SIB offer in terms of recruiting, embedding and funding SIB design capacity and expertise into commissioning bodies when developing an outcomes-focussed partnership?
- What lessons does the EJAF SIB offer in terms of options for recruiting and funding the performance management role in an outcomes-focussed partnership?
- Does the success of this project (if so proved) influence local and other commissioners to increase funding for HIV testing – either on an outcomes-basis, like this project, or on a conventional basis but with other learning from this project? If so, what was the influencing tipping point?
- Will providers continue to achieve the levels of outcome achievement that are needed both to make the project viable for them and to provide a basis for sustainment in the longer term?
- Do the VCSEs continue to view this project as business as usual for them, and not substantially different to a fee-for-service contract apart from the fact that payment is linked to outcomes?
- Have EJAF got the balance between the SPV's 'upfront payments' to providers (requiring at-risk investment) and straightforward PbR payments to providers right, to get the desired behaviour changes? What is an optimal balance to create a useful incentive – without putting providers in a difficult financial position or leaving them too exposed to external shocks (like COVID) – and how can future SIB designers gauge that balance?
- Does the unfolding SIB journey confirm EJAF's case that a SIB mechanism is the most elegant way of achieving the behaviours it is looking for – or is the suggested PbR plus fee-for-service model potentially a more efficient design alternative? How do possible alternative arrangements compare in terms of cashflow modelling for EJAF?
- How reliant was this SIB on the CBO funding – and if EJAF conclude they want to do more ZERO HIV SIBs – will this be feasible post-CBO?

1. Introduction

The Commissioning Better Outcomes (CBO) fund is a SIB programme funded by The National Lottery Community Fund (The Fund), which aimed to support the development of more SIBs in England as part of the Fund's work to explore innovative ways of improving the pursuit of social outcomes. The National Lottery Community Fund has commissioned Ecorys and ATQ Consultants to evaluate the programme.

1.1 The CBO programme

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

The CBO programme has **four outcomes**:

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

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

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

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

SIBs are a form of outcomes-based commissioning³ (OBC). While there is no universal definition of SIBs, the Government Outcomes Lab⁴ (GO Lab, which is a centre for academic research and practice for outcomes-based contracting and social impact bonds) posit that a 'core SIB' is comprised of four components⁵.

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

While having these components distinguishes a SIB from other types of commissioning, including fee for service⁶ and traditional Payment by Results (PbR) contracts⁷, SIBs differ greatly in their structure and there is variation in the extent to which these four components are included in the contract. This difference underlines the stakeholder dynamics and the extent to which performance is monitored in the SIB. For the purpose of this report, when we talk about the 'SIB' and the 'SIB effect', we are considering how these different elements have been included, namely, the payment on outcomes contract, capital from social investors, and approach to performance management, and the extent to which each component is directly related to, or acting as a catalyst for, the observations we are making about the project.

1.3 The in-depth review reports

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

This report is the first in-depth review of the Zero HIV SIB. Its focus is on stakeholder experiences and learning from the design and development of the SIB up to the point at which it was launched, and the immediate challenges in the period after launch.

The interviews with stakeholders whose views are reflected in this report were conducted between September and December 2019.

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

4 See: <https://golab.bsg.ox.ac.uk/knowledge/glossary/>

5 Carter, E., FitzGerald, C., Dixon, R., Economy, C., Hameed, T., and Airoidi, M. (2018) Building the tools for public services to secure better outcomes: Collaboration, Prevention, Innovation, Government Outcomes Lab, University of Oxford, Blavatnik School of Government.

6 Fee for service is where payment is based on service levels or outputs delivered, rather than outcomes

7 The practice of paying providers for delivering public services based wholly or partly on the results that are achieved. Accessed at: https://golab.bsg.ox.ac.uk/knowledge/glossary/#chapter_3_glossary-n-s__6b0a343c-76d2-4ed5-9d3c-aa767a36eab9_payment-by-results-pbr

1.4 Report structure

This report is structured as follows:

- **Section 2** provides an overview of how the SIB works, describes its structure and development process, and highlights areas which make this SIB interesting and/or different to other SIBs.
- **Section 3** describes the roles and experiences of key stakeholders to date, including the successes and challenges they have encountered, and lessons learned;
- **Section 4** draws conclusions from this review and highlights areas to explore in the next review.

2. How the SIB works

2.1 The SIB model

2.1.1 Overview and underlying logic model

The Zero HIV SIB was largely conceived and driven by EJAF. EJAF is the largest non-government funder of support to the prevention and treatment of HIV and AIDS in the UK, and one of the largest independent AIDS charities in the world. It has to date provided grants worth £164m to 1,943 projects. Further details of EJAF's pivotal role in initiating, developing and now managing and funding the SIB are provided in subsequent sections below.

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

We would summarise the high-level logic behind the SIB as follows. Subsequent sections expand on and explain the logic in detail:

- Advances in the efficacy of Anti-retroviral drugs (ARVs) mean that there is the potential to eradicate transmission of HIV and AIDS in the UK. There are estimated to be 6,700 people unaware of their HIV status in England (Public Health England 2019), of whom 1,000 are estimated to live within Lambeth, Southwark and Lewisham (LSL Sexual and Reproductive Health Strategy 2019-24). Zero transmission of HIV by 2030 is the stated objective of HM Government Health Secretary and Public Health England.

- This is a realistic objective because those who receive treatment can now live a long and healthy life, and equally importantly will reduce to almost zero their risk of transmitting the infection to others. This will have major health and wider social benefits to those living with HIV, and financial benefits to the health system. These benefits provide a strong business case for the SIB, although it is arguable that a similarly strong business case could be made for improving detection and treatment rates through other mechanisms.
- Achievement of this objective is however undermined by shortcomings in the way testing for HIV is funded by commissioners and managed by individual health practitioners (see later sections for why this is the case). Overall it appears that under fee-for-service style contracting too little testing is being done, and what testing is done is often of those who are less likely to be at risk of infection.
- As its name implies, the Zero HIV SIB aims to further the first objective of HIV eradication of transmission by addressing these challenges around HIV testing through:
 - ▶ focusing providers' effort onto those who are less likely to engage with health services, and increasing understanding of how to better engage with people in these hard to reach groups. It aims to do this by paying expressly and only for real life-changing outcomes i.e. by detecting those with HIV and keeping them in treatment, rather than simply funding HIV testing activities which may or may not pick up people at high risk of HIV infection;

- ▶ intentionally funding both testing and associated support services, to ensure that people are offered testing and encouraged to take it up wherever they enter the health system and across secondary and primary care, as well as in the community; and
 - ▶ targeting testing and associated support on the geographical areas where rates of infection and under-detection of HIV are highest, and therefore where this approach can have the greatest impact.
- A SIB is a good way to achieve these aims because i) it enables the shift to outcomes on the part of providers and ii) the shift of getting providers to work together to maximise outcomes, promotes a joined-up approach to service provision that is otherwise lacking.

2.1.2 The business case and rationale for the SIB – Zero HIV and its benefits

Anti-retroviral therapy (ART) for those with HIV is now so effective that HIV has been redefined from an acute to chronic illness, and there is a very high likelihood that those receiving ART will be able to live a long and healthy life. There are thus huge benefits to individuals if they can be diagnosed and start to receive treatment. But NHS England estimates that between **10% and 15% of those living with HIV are unaware of their status.**

The benefits of treatment are much greater if people with HIV are diagnosed early; a late diagnosis is defined as one where the patient's CD4 count (of the white blood cells that are damaged by HIV) has dropped below 350 (or reaches this point within three months of diagnosis). A late diagnosis means that the virus has already started to damage the immune system, and poses the greatest threat to the health of those with HIV. NHS England data show that 43% of those diagnosed in 2018 were diagnosed late, with late diagnosis being much higher among certain groups (e.g. 65% among black African men).

It is extremely important to note that the benefits of getting people with HIV into effective treatment, and keeping them there, are also much greater than those that accrue directly to the person with HIV, because **effective treatment reduces the risk that the infected person can pass on the virus to almost zero.**

These health benefits have concomitant financial benefits for the health system through avoidance of the costs of treatment both for those whose HIV goes undetected, and those who may be infected later through onward transmission. Research prior to the development of the SIB showed that:

- The lifetime costs of treatment for one person with HIV are estimated to be around £360,000. Thus every new onward infection by a person who tests positive for HIV that can be prevented will avoid this cost being incurred. In addition, there are likely to be additional savings due to those with HIV being diagnosed and treated more quickly and ultimately avoiding developing AIDS;
- According to estimates produced by the National Institute for Health and Care Excellence (NICE) in 2014, if 3,500 cases of onward transmission could be prevented over five years, the savings to the NHS in treatment costs alone would be £18m per year.

In developing the SIB, EJAF undertook further work to develop a clear 'savings case' for the SIB. This was based on assumptions about the likely costs of treatment for HIV and the likelihood of transmission of the virus by the two groups who are most at risk of HIV infection, men who sleep with men (MSM) and men of Black African Heritage (BAH). These two groups account for 85% of all new infections in Greater London, and are disproportionately represented among diagnoses to a huge extent relative to their share of the overall population.

The savings case calculated that detection and treatment of each new infection would lead to savings to the health system of at least £12,000, and potentially as much as £62,000 per onward infection prevented, depending on the assumptions made. The comparison between the two calculations is shown

in Figure 2.1 below. It should be noted that the more cautious assumption of gross savings of £15m was used to justify the SIB, and that this figure is itself an underestimate of financial benefits since it is based on savings from prevention of onward transmission alone; it ignores the benefits to the system of the person who has HIV being diagnosed and/or being diagnosed more quickly, and thus avoiding the costs of acute treatment as they develop full-blown AIDS and associated conditions, and potentially require high levels of social care.

It could also be argued that the financial benefits to the health system will be in avoided costs rather than

actual savings to current costs which can be cashed, since they are based on preventing additional infections in the future. The effect will therefore be to reduce future demand, and release capacity that can be used to meet other demands, rather than reduce demand in absolute terms and achieve an actual reduction in spending. It does however seem irrefutable that these are real and tangible financial benefits, calculated on conservative assumptions.

EJAF stakeholders told us that the financial benefits were important in making the case for the SIB to other actors, notably commissioners. We discuss this further in section 3 of this report.

Figure 2.1 – Summary of SIB financial case (Source EJAF)

Conservative workings	Alternative workings
<div style="border: 1px solid #00897b; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">£179,000</div> <p>Lifetime cost of treating one person, if patented ARVs are replaced by generics.</p>	<div style="border: 1px solid #004a87; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">£360,800</div> <p>Today, the estimated mean lifetime cost of treating a single person is £360,800.</p>
X	X
<div style="border: 1px solid #00897b; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">0.027773</div> <p>The NICE Costing Model assumes an onwards transmission rate of 0.027773 per year per positive patient.</p>	<div style="border: 1px solid #004a87; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">0.027773</div>
X	X
<div style="border: 1px solid #00897b; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">2.46</div> <p>Then we apply an assumption around the number of partners the patient has in a year. Research estimates MSM cohort have c.9.89 partners per annum, compared to 2.46 for BAH. We applied the lower value of the two groups.</p>	<div style="border: 1px solid #004a87; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">6.18</div> <p>Assuming a mid-point between 9.89 and 2.46.</p>
=	=
<div style="border: 1px solid #00897b; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">£12,230</div> <p>Total savings per each new diagnosis to the health system</p>	<div style="border: 1px solid #004a87; border-radius: 10px; padding: 5px; display: inline-block; margin-bottom: 10px;">£61,739</div> <p>Total savings per each new diagnosis to the health system</p>
Project Gross Savings: £15m	Project Gross Savings: £77m

2.1.3 Drivers of an outcomes-based approach

Both the outcomes sought through the SIB and the services which it funds have been shaped by substantial research and development work by EJAF to identify the shortcomings in the current HIV testing arrangements and the reasons for them, and to test alternatives. Some of this work pre-dated the development of the SIB and was undertaken as part of a wider review of EJAF's strategy in the UK and how it could make best use of its funding. This work comprised:

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

Ethnographic research

The ethnographic research was commissioned by EJAF from McKinsey with support from NHS England. It focused on LSL because these were known to be the areas with the highest prevalence of HIV, principally because of the number of people from the two highest risk groups (MSM and BAH) who live there. At the time at which the research was undertaken the prevalence of diagnosed HIV per 1,000 people aged 15-59 was 16.22 in Lambeth, 11.88 in Southwark and 7.84 in Lewisham, compared to an average rate across England of 2.27.

As mentioned above it is already a PHE objective that HIV be eradicated by 2030, and the benefits of early diagnosis are such that NICE recommend HIV testing of everyone undergoing blood tests in Emergency Departments where local prevalence exceeds 2 per 1,000. However EJAF's research showed that current testing rates were negligible by comparison (as low as 3%).

Box 2: Reasons for low rates of HIV testing

The ethnographic research commissioned by EJAF and undertaken by McKinsey found that there was a reluctance among health practitioners to offer testing for a number of reasons including:

- a perception that the process of offering a test, and associated counselling and engagement of the patient, was too complicated and time-consuming – especially for hard pressed GPs in primary care settings, though there are similar issues in hospitals;
- poor awareness of the high prevalence of HIV in the area, and therefore of the importance of testing;
- a view that offering testing was inappropriate and ‘too heavy’, especially if unrelated to the reason for the visit and perceived as targeting specific demographic groups; and
- staff feeling underqualified to address the issues and to have what can be difficult conversations.

EJAF’s ethnographic research also included extensive research with the key at-risk groups, MSM and BAH, to gain insights into the barriers to them accepting testing and how these might be overcome in the design of the service.

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

It is arguable that these barriers could be addressed through support to overcome them, without the need for an outcomes-based approach. However the pilots which EJAF also funded, described further below, indicated that addressing cultural concerns and HIV awareness among staff would not on its own be enough to effect major change.

This is not least because a further barrier to widespread testing, especially in the acute hospital sector, is the way that NHS funding works. When we interviewed one of the acute providers (see section 3) they explained that their HIV specialist consultant understood very well the health and financial benefits of testing people

and getting them quickly into treatment, not least in reducing or avoiding much higher costs to the acute system if HIV went undetected. However the relevant clinical commissioning group (CCG) would not fund testing because they saw HIV prevention as a public health issue that should be funded by local public health commissioners (i.e. the London Boroughs). In addition the primary beneficiary of reduced HIV care costs is NHS England, who are responsible for 'specialist commissioning' including HIV/AIDS treatment, but are not responsible for funding HIV testing in any healthcare setting - see box explaining in simple terms how NHS funding of HIV/AIDS prevention and treatment works.

How funding for HIV testing and care works (simplified)

NHS England has responsibility for 'specialist commissioning'. They are not responsible for HIV testing but are responsible for paying for everything else once someone tests positive.

The relevant CCG is responsible for some testing, including hospital testing and - along with NHSE - for primary care via GPs (although in some parts of the country public health have funded discrete primary care HIV testing programmes).

LA Public Health is responsible for HIV testing in sexual health clinics and for community testing (although the latter is sometimes shared with CCGs).

This mismatch of the funder of the prevention and of the organisation which benefits from the savings created, sometimes known as the 'wrong pocket' problem, is an issue that many SIBs aim to address, especially in the health sector. In this case it appears that EJAF sought to engage all the potential commissioners in the course of developing the SIB, but only LB Lambeth were prepared to make a contribution despite them having arguably the least to gain financially.

Pilot projects

In designing the SIB, EJAF also drew on two pilot projects that they had commissioned and funded in both secondary and primary care settings:

- A pilot of opt-out testing at Kings College Hospital. This trialled 'opt-out' testing where an HIV test was routinely carried out on any patient who required blood tests when attending A&E unless they refused consent. It showed that an opt-out policy would increase testing rates and successfully identify patients carrying the virus, including some groups (for example older patients) who would not normally be considered high risk;
- A pilot of screening for HIV, alongside Hepatitis B and C, when a patient first registered with a GP in Leeds. This was co-funded by EJAF and PHE and had more mixed results, with some practices achieving testing rates of more than 60% but others having very low rates of testing. This indicated that simply funding for testing was not enough – there needed to be a combination of greater incentives to GPs to offer testing, and support to changing behaviour and practice through e.g. peer influence, training to lessen awkwardness in offering testing, and reducing the stigma associated with testing. As already explained the SIB aims to address all these issues.

When EJAF undertook the pilots in 2016, it was exploring whether they could introduce something systemic that could bend the curve in London where HIV diagnoses had plateaued. The SIB offered the chance to try something new and highly responsive and to bring new money to the effort at a time when funding within hospitals and primary care was severely compromised. EJAF believes it has achieved on both these measures.

2.1.4 The Zero HIV SIB services and outcomes

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

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

The services

Unlike many SIBs, the Zero HIV SIB does not fund a single defined intervention delivered by one or more providers. Instead it funds both the HIV tests themselves and a range of supporting services delivered by a range of providers who have been contracted to ensure that people potentially living with HIV are engaged and tested however they enter the health system. Thus within the target LSL boroughs:

- **two acute providers (hospital trusts)** are incentivised to detect HIV among those who present at hospital, usually when they attend Accident and Emergency (A&E);
- **two Primary Care Partnerships** are incentivised to ensure testing by GPs; and
- **two VCSE providers** are incentivised to reach out to people at risk of HIV/AIDS within the community and encourage them to be tested.

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

- ensuring tests are offered and that people are encouraged to be tested, while allowing them to opt out if they wish;
- reviewing test results and liaising with patients, and offering them support to enter and stay in care if needed; and
- engaging with practitioners, increasing their awareness of HIV prevalence and risk and technical understanding of HIV, and thus enabling and encouraging them to offer testing.

In all cases providers are incentivised by the outcome payments both to identify those not known to have HIV and those previously diagnosed who have since fallen out of the system (technically known as “lost to follow up”).

Just as there is no single intervention there is also no numerically-defined cohort; instead, there is an expectation, underpinned by the target outcomes which each provider is expected to achieve, that nearly all those at risk within the three boroughs who come into contact with the health system, or are engaged within the community, will be offered testing and encouraged to take it up.

Figure 2.2 – Provider settings and roles (Source EJAF)

Setting	Hospitals	Primary care	Community
Approach	Maximise opportunities to test when people access health services		Target those at high risk and less likely to engage with health services
Provider	Acute services	GPs (or federations); Pharmacies	VCSE organisations
Venues	<ul style="list-style-type: none"> A&E Surgical departments Other wards 	<ul style="list-style-type: none"> GPs Pharmacies 	<ul style="list-style-type: none"> Churches Barber shops Public events
Strategies and opportunities	<ul style="list-style-type: none"> Add HIV testing as standard test when blood sample is taken Opt-out consent. 	<ul style="list-style-type: none"> Routine testing at GP registration; New testing technology; Support GPs to detect symptoms and ‘think HIV’ Bundle HIV test with other health screenings. 	<ul style="list-style-type: none"> Work with faith leaders to raise awareness and encourage HIV testing; Use peer support; Provide incentives to test; Use existing social services (e.g. housing) to promote health screenings including HIV.

Box 3: Outcome payments

All providers are paid for the achievement of two outcomes. These are:

- Each new case of HIV infection identified and linked into HIV care; and
- Each 'lost to follow-up' patient re-engaged into HIV care.

Under the contracts each provider receives an initial lump sum payment which covers a defined number of outcomes – effectively a 'minimum order' for outcomes. These upfront payments are not recoverable if the agreed number of initial outcomes is not achieved. Once the number of outcomes set out in this initial lump sum payment (equivalent to about 65% of total payments) is exceeded, each provider is paid per outcome achieved. To qualify for a Lost to Follow-up re-engagement payment the patient must have had no care visit for more than twelve months, be deemed to have stopped treatment based on the date of their last dispensed ARVs, or been recently released from prison or an institution and had no regular HIV care provider.

We have been informed that the contracted outcome payments vary by provider and they have not been disclosed to us because of their commercial sensitivity. However, we understand that the payments are substantial, and amount to several thousand pounds per new case: effectively a small payment of around £80 for each test has been converted by the SIB into a much larger payment for each new case identified or re-engagement made.

2.1.5 Rationale for a SIB approach

According to EJAF's own literature, there are a number of benefits to this project being a SIB. An internal EJAF factsheet on the SIB describes it as a 'win win' model, where, to quote directly from the factsheet:

- Private⁸ investors receive a 'blended' financial and social return
- Risk to the public purse is limited, as co-commissioners only pay for success; and
- Providers are enabled to deliver free from cashflow concerns.

In addition, the same document states that the Social Impact Bond model comes with inherent benefits:

- **An inbuilt focus on outcomes**

The nature of the Social Impact Bond agreements ensures that the project is intrinsically outcomes-oriented with first-class performance management.

- **An integrated model of HIV care**

A place-based, collaborative model brings together a new unit of local commissioners, clinicians, providers and patients to co-design and monitor services.

- **An adaptive and agile model**

The combination of private funding and expert minds affords the flexibility to innovate and adapt delivery in real time.

These are familiar arguments for the SIB model from other SIBs that we have studied as part of the CBO evaluation. In particular, the argument for SIBs being a 'win win win' model was advanced by stakeholders during the first Update Report⁹ that we produced in 2017; and our most recent Update Report¹⁰, and other in-depth reviews, have highlighted the value of SIBs in focusing all parties on the achievement of outcomes. In addition both our own and others' research¹¹ has highlighted the value of SIBs in encouraging integration and collaboration between parties, and enabling flexible delivery because the services and interventions to be used are not prescribed.

In our view the arguments advanced above justify the outcomes-based approach adopted for this project, but not all are necessarily arguments for the use of a SIB as such. Furthermore, both the structure and funding model of the SIB, and the way it contracts with providers, suggest that some of these benefits are either not as clear cut as they first appear, or could arguably have been achieved in other ways. Please see section 3 and 4 for further development of these arguments.

8 Though it should be noted that some of the investors in this SIB are VSCEs and therefore not strictly private investors

9 Downloadable at https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-Update-Report_Full-Report.pdf?mtime=20190215124522&focal=none

10 Downloadable at https://www.tnlcommunityfund.org.uk/media/CBO-2nd-Update-Report_FINAL_FINAL.pdf?mtime=20191018112839&focal=none

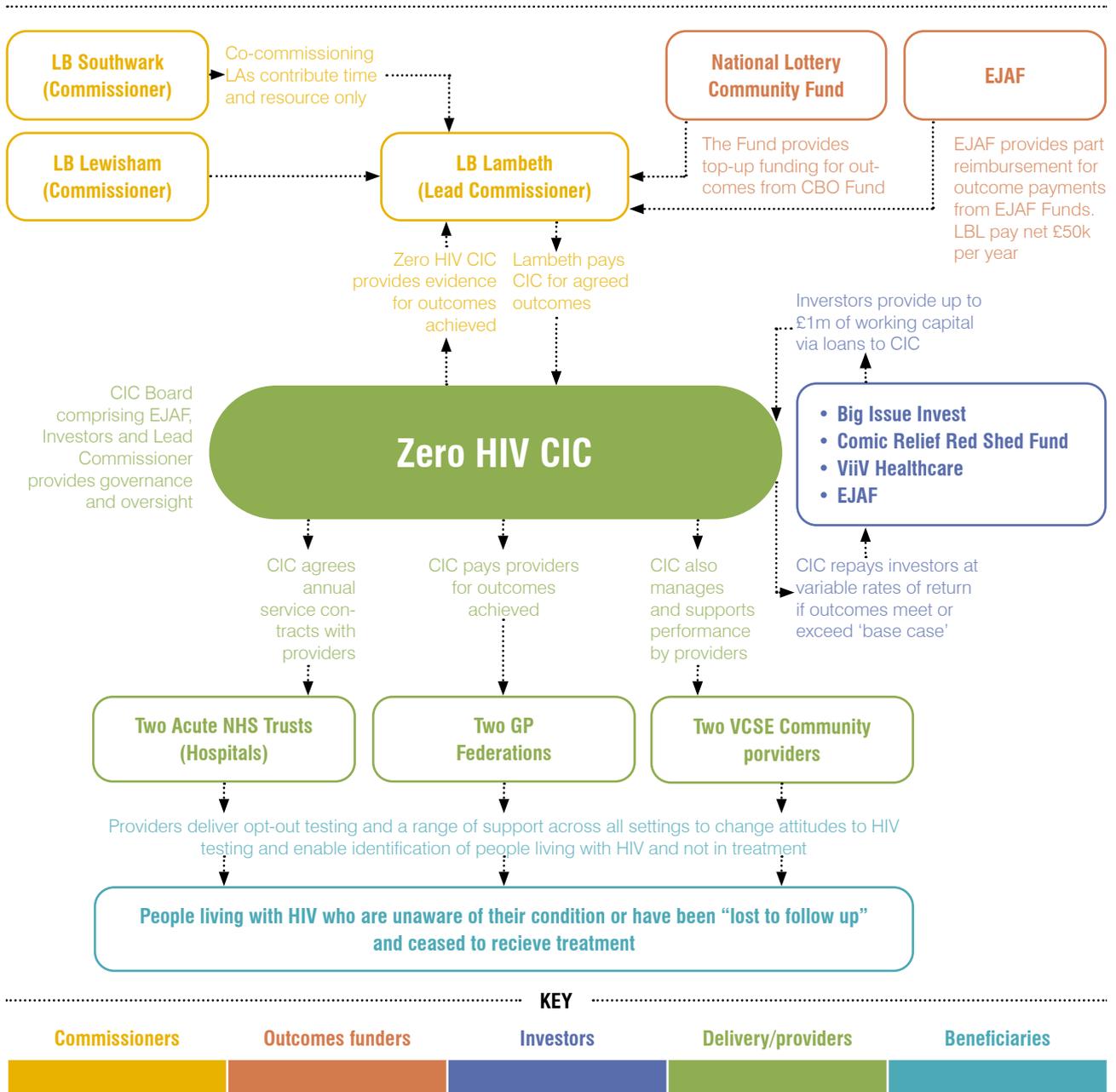
11 See for example <https://golab.bsg.ox.ac.uk/our-projects/about-evidence-report-2018/>

2.2 SIB contracting and governance structure

2.2.1 Overview and key features

The nature of the Zero HIV SIB and the number of parties involved mean that it has a complex structure, as shown in Figure 2.3.

Figure 2.3 – SIB operating and governance structure



This structure has a number of interesting features, including the following:

- The main contracting party and delivery body is a Community Interest Company, Zero HIV CIC, whose Board includes representatives from EJAF and the other investors in the SIB, and LBL as the lead commissioner. Service providers do not sit on the CIC Board. The CIC selected and contracts with the service providers, and manages their performance. Performance management is supported by a performance manager within EJAF, and underpinned by a data recording and reporting system that is used by all providers, developed in Microsoft Power BI.
- The SIB has a relatively complex and interesting investment structure. There are four investors, including EJAF itself, Big Issue Invest (BII), Comic Relief and ViiV Healthcare. Investors therefore include one established social investor (BII), two charities that are relatively new to investing and usually provide grants rather than repayable finance (EJAF and Comic Relief) and one private sector provider. It should also be noted that BII has invested from its balance sheet, rather than through its specialist SIB investment fund; it is thus investing its own capital rather than capital it manages on behalf of other investors.
- A further feature is that the investment is 'tiered', with each investor receiving a different return and being paid out sequentially according to the total number of outcomes achieved. Importantly, EJAF is paid out last and is therefore effectively acting as a 'first-loss' investor, substantially de-risking the deal for other investors. This was always EJAF's intention, and means that it was able to market the SIB to other investors on the basis that they would accept relatively low returns (see section 2.2.2 below for details) Investors are providing a total of £1m in capital between them.

- The expectation of low financial returns helps to explain why BII invested from balance sheet, since doing so gives them greater freedom to invest with a focus on capital preservation and social impact rather than on return to investors – in other words they can give greater weight to social returns and are not bound by their own and others' rules on minimum financial returns – as they would be if they had invested from one of their funds, such as the Outcomes Investment Fund.
- As implied by the stated benefit of the SIB for providers outlined above, the main purpose of the external investment is to provide initial cashflow for the providers, enabling them to fund set-up costs and cover initial outcome payments. However, our discussions with providers suggest that they will not, as is also the case in some other SIBs, continue to receive upfront funding beyond an initial period. Each provider has been provided with a lump sum payment for the initial months of the contract but thereafter will be paid by outcome payments. Providers are thus exposed to a degree of financial risk if outcomes do not materialise.

A further important feature is that ostensibly the outcomes are paid for by LB Lambeth acting as 'lead' commissioner on behalf of all three LSL LAs, and holding the contract with the CIC. In practice, however, a high proportion of payments are eventually being covered by EJAF itself, alongside The National Lottery Community Fund under the CBO Fund. When the SIB was originally conceived, it was hoped that both the LA PH commissioners, and the three CCGs, would be outcomes payers alongside the CBO Fund (which is contributing 23% to outcome payments) under a structure that would have been similar to the majority of SIBs. However we understand that although there were constructive discussions with all the local commissioners, they did not agree to contribute. It was, however, agreed that all three Boroughs would contribute time and resource to the management of the commissioning process in their respective areas and, that LB Lambeth would, as lead commissioner, make the outcome payments to the CIC in the first instance; EJAF would then reimburse LB Lambeth for all but the first £50,000 of its contribution each year.

There is a single contract for the outcome payments between LB Lambeth and the CIC, and a single contract agreement between EJAF and Lambeth for the reimbursement.

This means that EJAF is acting as both an outcomes-payer and an investor, which is highly unusual and possibly unique in UK SIBs. It clearly makes the project attractive to both the LAs (because they are not paying for a substantial uplift in local HIV testing) and the CCGs (because all the outcome payments are being met by other funders). It does however raise questions about whether, with the benefit of hindsight, there is sufficient additional benefit from the SIB mechanism to make it worthwhile. EJAF is however strongly of the view that the project could not have been launched, and would have less potential for sustainment, if it had not been constructed as a SIB and funded through social investment. We explore these arguments for and against a SIB approach further in section 4.

In addition, the structure of individual contracts is interesting. The project as a whole was intended to run for a minimum of two years with options to extend this as necessary for up to a total of six years. However the overall project is now expected to last for three years, with a possible extension to allow for recent disruption due to the effect of the Covid 19 epidemic. Within this structure, contracts with individual providers last for only one year, so that they can be reviewed and adjusted as needed as the overall contract progresses.

Finally we would note that the development of a common data collection and reporting system for this project, based around the Microsoft Power BI platform, is itself a significant feature. Comparing this project to others it is in our view no small feat both to develop such a common platform and, even more importantly, persuade all providers and other stakeholders to adopt it – where necessary adapting their own processes and systems to suit. Stakeholders to whom we spoke were full of praise for this system and its ease of use and ability to display data dynamically and in real time, which may well have been a principal reason why it was readily adopted in the first place.

2.2.2 Investment structure

As mentioned, the SIB has a tiered investment structure which is unusual for SIBs in the UK, although similar approaches have been used for international impact bond funds. The amounts invested by each party (as loans to the Zero HIV CIC) and the interest that they will receive if the project achieves the level of outcomes expected are shown in Table 2.1. Investors are not paid out until the end of the project, and in the order shown (i.e. ViiV first, EJAF last). It should be noted that returns are capped at the rates shown and therefore will not exceed these even if outcomes exceed those set out in the 'base case' – i.e. the level of outcome performance estimated as likely to occur based on reasonable assumptions about the performance of providers and the behaviour of service recipients. If outcomes are lower than expected (i.e. than the base case), investors will get less back and could conceivably lose all their money (although given that investors are paid out in turn, this would seem more likely to happen to Comic Relief and EJAF than to ViiV and BII). If outcomes are higher than the base case, returns are capped and will not increase.

Table 2.1: Investment structure

Investor	Amount invested (£)	Capped interest
ViiV	£300,000	0%
Big Issue Invest	£200,000	2.75%
Comic Relief	£400,000	4%
Elton John Aids Foundation	£100,000	0%
Total/Average	£1,000,000	2.20%

3. Stakeholder experiences and views

This section describes stakeholders' experiences of the SIB and its development process. It summarises what they see as the key benefits and disadvantages of the process, and lessons that have been learnt to date.

3.1 Stakeholder roles and experiences

In carrying out this review we interviewed a number of key stakeholders that represent all the main parties to the SIB, including:

- The EJAF Chief Executive, Head of Projects and day to day Performance Manager for this SIB;
- The lead commissioner (LB Lambeth) which represents all three of the LSL Boroughs on the Zero HIV CIC Board;
- Three of the six providers, representing each of the main settings in which the services are delivered - i.e. a Hospital Trust, a GP Foundation and a community-based VCSE;
- All the investors except ViiV, whose representative had recently left the company and not yet been replaced; and
- The National Lottery Community Fund as administrators and payers of the CBO grants to EJAF.

The roles and views of these key stakeholders are summarised below

3.1.1 EJAF

In our experience EJAF occupies a unique position in this SIB compared to all others in the UK, because of the number of roles it has taken: as already outlined in section 2 of this report it was or is initiator and main developer of the SIB, an investor, its performance manager and an important funder of the outcome payments. There are many SIBs which have been driven by a provider, and several where one organisation has acted as developer, performance manager and investor. However we are not aware of any other SIB where a VCSE organisation has also been a funder of co-payments. This in part reflects the fact that EJAF is of course primarily a funder, usually via grants, but also an apparent change in the original vision for the SIB. It was always the intention that EJAF would be a lead investor in the SIB, as explained in section 2, but it stepped in to become an outcomes payer when it became apparent that the SIB might not proceed because of the reluctance of local commissioners – especially the CCGs – to commit to funding outcome payments.

From our discussions, it appears that there were three key reasons why EJAF developed this project and went down the SIB route (Box 4).

Box 4: Why EJAF chose to use a SIB

1

To explore the usefulness of social investment as one of the ways in which they could support and enable projects

At senior level, EJAF had been interested in social investment for some time before this project was developed, but had not found an obvious way in which they could use external capital to add value. This project was in part driven by the opportunity to test social finance on a real project, since it met the key criteria for a SIB-type approach: specifically the ability to set clear outcomes and metrics; and having a clear business and financial case based on savings/avoided costs to commissioners and outcomes funders. EJAF were clear that the savings case was important to successful commissioner engagement (or more accurately engagement of the CCGs as outcomes funders) and that the SIB would have been unlikely to gain their commitment without the savings case. However, as noted, EJAF have had to step in to provide co-funding of outcome payments, which means that even this compelling degree of savings case was not sufficient to persuade CCGs to fully fund the project.

2

To build on their existing strategic research and pilot studies to make a real difference to the offering and take-up of HIV diagnosis and treatment

It is clear that the key factor here is the shift from payment for HIV testing activity to payment for HIV detection outcomes. Both EJAF's own research and PHE research and guidance had already established the value of blanket testing; the trick was to ensure that health professionals were sufficiently motivated to offer that testing, and overcome their reluctance, for a number of reasons, to have difficult conversations with those most at risk.

3

To test the effectiveness of an outcomes-based approach across all major health pathways

Again, there was evidence for the effectiveness of increased testing in both acute and primary settings (both from independent research and EJAF's own pilots) and for successful projects that aimed to target high risk groups in the community. The opportunity of this project is to prove the effectiveness of high levels of testing across all pathways, which is critical because those who are not aware that they carry the HIV virus may present in any setting and for a wide number of reasons.

The other key point made by EJAF was the importance to the success of the SIB of it being driven by a committed lead within the organisation. Although EJAF invested in its own research, and used some of its development funding from the CBO Fund to pay for a savings case to be developed by Social Finance, the bulk of its development work was undertaken internally, by a specialist SIB Portfolio Manager. This appears to have been a highly effective approach without which it seems unlikely that the SIB could have been successfully concluded.

3.1.2 Local authority commissioners

We spoke only to LB Lambeth about their commissioning role because Lambeth acts as lead commissioner on behalf of all three local public health commissioners, although all three LAs are active in supporting delivery. The manager we interviewed in Lambeth is an experienced public health commissioner who has long understood the benefits of early HIV detection and therefore increased HIV testing, having previously had a London-wide role in relation to HIV prevention when Public Health was an NHS function prior to 2013. In this role they had a long-established relationship with EJAF, and in their current role in Lambeth had been discussing with EJAF how testing levels could be boosted across LBL.

However, attacking the problem by funding testing at scale was always going to be a problem for them due to constraints on public health funding, which have worsened since it became a local authority function. Indeed our interviewee made clear that there was no realistic prospect of them ever having agreed to fund a substantial proportion of the outcome payments. From this LA commissioner's perspective, therefore, the project offered significant benefits and few downsides: they do not have to fund the full cost of the outcomes, and will see a huge increase in testing activity compared to what could realistically be achieved otherwise. To this extent the 'wrong pocket' problem discussed above works both ways: public health are expected to fund testing but do not get a financial payback, and have very limited funding; CCGs and NHSE however do get a financial benefit from early diagnosis and reduced incidence of AIDS, but are reluctant to pay for this benefit, as EJAF's experience shows.

Initially, this LA PH commissioner found it difficult to grasp how an outcomes-based approach and SIB could be made to work in the HIV context, and it took some time to 'get from concept to plan'. There was much suspicion and misunderstanding of the SIB model across stakeholders that had to be overcome, though it is interesting to note that Lambeth's willingness to embrace the SIB concept was enhanced by the fact that Lambeth was the first commissioner of the HCT Travel Training SIB; this meant that commissioning management in Lambeth had some familiarity with SIBs, which, in the view of the commissioner we interviewed, helped overcome any internal resistance there might otherwise have been.

As lead commissioner, Lambeth was directly involved in defining the outcomes that are measured and paid for through the SIB, and also in navigating the complexity of implementation across multiple parties. We discuss the challenges this caused in section 3.3 below.

3.1.3 Providers

As already explained in section 2 a key feature of this SIB is that providers are doing very different things in very different settings. This means that their viewpoints and experiences of the SIB are also quite different, as described below.

The Acute Provider

The main role of the acute providers is to engage people when they visit the hospital for the first time (usually in A&E) and ensure that 'opt-out' testing is offered alongside other blood tests. As already mentioned in section 2 we interviewed one of the two acute providers (i.e. Hospital Trusts) engaged by EJAF, and the contract manager at the Hospital Trust whom we interviewed (Lewisham and Greenwich) was already well aware of the benefits of doing such opt-out testing, and has therefore welcomed the project and the funding it offers for high levels of testing. This provider had very little previous knowledge of SIBs but have not found this a significant barrier. Their key challenge has been twofold:

- **Putting in place the operational and system arrangements to make the testing happen, and track who has been tested and when.** There have been particular challenges with systems, since there are different systems across the two hospitals that the Trust covers, and in the pathology labs where tests are conducted. A particular challenge (shared with the Primary provider – see below) is that it proved impossible to manage the opt-out testing of people in defined categories (e.g. high risk groups, or all those under a certain age) within the laboratory systems. Hospital staff therefore have to identify those to be tested by responding to appropriate alerts within the main hospital case management systems.
- **Developing a financial model to forecast outcomes and payments.** Lewisham and Greenwich NHS Trust has had upfront funding of around £60k for initial outcomes, and will then be paid per outcome thereafter. This means that they have had to model the likely flow of new HIV cases and ‘lost to follow-up’ re-engagements based on historic data, in order to be sure that outcome payments will cover the costs of tests and other support that they have to provide. The contract manager from the Hospital Trust whom we interviewed had done much of this work themselves, with support from their Finance Business Manager. They had been able to ‘get comfortable’ with the financial implications in principle but in practice, over the first few months of the project, there had been concern about new cases being lower than forecast; there had then been a spike of cases in one month which had put them back on track. This suggests that there may be challenges if there continue to be peaks and troughs in the volume of cases that generate outcomes, especially if a trough occurs for some months.

Interestingly, the pressure and incentivisation to generate outcomes had also had positive effects. The provider mentioned that they had originally set an age limit on the target audience to be tested, but had removed this and subsequently identified new cases that were much older than the original limit.

The GP Federation

The representative of the GP Federation whom we interviewed was a GP who had been recruited specifically to the part-time role, on top of their normal GP duties, of HIV Champion. Their main role is to ‘create the right structure to achieve the outcomes’ by putting in place the right systems and processes and, more importantly, raising practitioner awareness and skill levels so that they can overcome the barriers to offering testing outlined in section 2 above. As it was explained to us, the challenge was as much about changing mindsets as anything else.

The two GP federations which are providers under the SIB are in a similar position to the acute providers, in that they are paying the GPs and pathology laboratories to offer and conduct tests but are themselves paid on outcomes, following an up-front guaranteed payment for a defined number of initial outcomes.

The HIV Champion had not been involved in the initial planning of the SIB, which was done by the CEO of the GP Federation and their contract team. They had been hired when the SIB was already in place, and their role was the running of the project to achieve the outcomes specified. They explained that their role was largely focused on the individual GPs, and was largely unaffected by the ins and outs of the SIB and its financing. However they felt that the SIB outcomes provided a very clear focus for this work. They also felt very supported through the process which ensured they were held accountable for their efforts to achieve the outcomes.

The main challenge in setting things up for the GPs had been in flagging cases that needed to be tested in appropriate systems. The original plan had been to provide for automatic opt-out testing within the pathology lab systems, but this had not been possible. Instead the federation changed this to an opt-in where clinicians had to actively request the HIV test (though it remains an opt out process so far as the person tested is concerned – i.e. they will automatically be offered a test and have to refuse it). The clinician is prompted to do this through an alert system on the GP system (EMIS). This tells the GP automatically to offer a test to anyone over 18 who has not been tested in the last 12 months, which they then have to request from the laboratory. It is interesting to note that this project has provided impetus for the development of enhancements to existing systems – and the development of new ones, as explained later – that have supported the delivery of the project and reporting from it.

The greater and more on-going challenge has been engagement with GP practices and individual GPs to persuade them actually to offer the tests, and overcome their reluctance to do so. To help overcome resistance, the GP Champion initially piloted the programme in the practices that were more engaged even though there might have been lower prevalence among their patient population. After a month the programme was then rolled out to all GP practices (through their contract with the Federation). This seems to have been a sensible approach, since it built momentum that could then be used to engage and persuade the less committed practices.

We understand that there are differences in the way outcome payments received by the Federation are passed through to participating GP practices, with the Federation that we consulted passing on equal shares of payment to all practices, while the other has made payments to practices only for outcomes which they originated. It will be interesting to explore in the mid-point review whether these different incentive mechanisms have a noticeable impact on performance.

The VCSE provider

The two VCSEs who are involved in the SIB are both experienced in outreach and other community-based work to engage those with a high risk of HIV. The stakeholder whom we interviewed is the Head of HIV and Mental Health in one of these, an equality and diversity charity which specialises, among other things, in HIV outreach and prevention in London and the South East.

The VCSE providers' role is quite different to the acute/ GP providers, who are in general reactively offering tests to anyone who presents to them irrespective of condition and demographic group. The VCSEs are of necessity much more proactive, and engaging with high risk groups in the community in a wide range of settings. The provider we interviewed carries out a wide range of activities, including raising HIV awareness, offering preventative advice and free condoms, and encouraging people to have both HIV and STD tests.

At the operational level, therefore, this project was largely 'business as usual' for the provider, which is delivering very similar services through other contracts and already had the required infrastructure in place. The main challenge is that they are usually contracted on the basis of 3-5 year fee-for-service and block-testing contracts with Hospital Trusts and LAs (including some with Lambeth). They have therefore had to adapt to the increased uncertainty associated with an outcomes-based contract. Like other providers, they have received an upfront payment for an initial number of outcomes but will be paid by outcomes going forward and are therefore at some risk if outcomes do not match their forecasts. For the most part they have been able to get comfortable with this. However they did have a view that they could achieve similar results without the need for outcomes risk – for example by continuing to be paid in up-front payment tranches for defined outcome numbers. They also suggested that other outcomes could have been included – such as 'living better with HIV' – since the current outcomes do not measure success over the longer term, and there is a risk that new cases identified will fall out of the system later.

3.1.4 Investors

As already explained in section 2.3 EJAF is itself an investor in the SIB and deliberately pitched the SIB to other investors on the basis that the risk to them would be low, and that this should be reflected in target returns. Overall returns are estimated to be 2.2 % and vary by investor from 0% to 4%; the amounts invested also vary. All investment is in the form of straight loans to the Zero HIV CIC, which has used the investment to provide the initial funding to providers as described above.

Both the other investors we interviewed (Bill and Comic Relief) appear to have been strongly motivated to get involved because of the very high social impact that the project could deliver. Like many others they had low awareness prior to getting involved of the effectiveness of ART in largely eliminating onward transmission, and ultimately the potential to eradicate HIV. For Comic Relief there was an added incentive in that this was an ideal project to test their relatively new 'Red Shed' fund. Red Shed is a fund within Comic Relief that focuses on testing new and innovative ways of investing in social change, and aims to understand what the alternatives are to grants and when are they best utilised. The EJAF SIB is one of the first impact bond projects in which Red Shed has invested (along with the Educate Girls Development Impact Bond, in India) and therefore offers Comic Relief a good opportunity to test the potential of repayable finance in the right circumstances.

3.1.5 The National Lottery Community Fund

As explained in the introduction to this report the CBO programme is administered by the National Lottery Community Fund and we interviewed the current Grant Officer to get a better understanding of their involvement in the development of this SIB and the agreement that the CBO Fund should make a significant contribution to outcomes. The CBO Fund has provided both Development Grant and full co-payment Grant to this project, providing £80,600 in Development Grant in October 2015 and agreeing to a final award of grant of £1.653m (23% of total payments) in November 2017.

This project had broad support from the CBO Fund from the early stages since it clearly met the key criteria for the Fund, and in large part has met the broader objectives of the Fund (see section 4 for a fuller assessment of this).

The Development Grant of £80.6k was used mainly to fund internal resource, as mentioned earlier, with a relatively small proportion of the grant being used to fund external support. Compared to other Development Grants the award was in the middle of the range, and certainly lower than many projects, which have received grant at or close to the maximum of £150,000. The Grant Officer whom we interviewed was not familiar with the background to the Development Grant Award but other stakeholders to whom we spoke (notably investors) thought that the award had been instrumental in enabling the project, and it would not have been possible to work through the many complex issues inherent in the project without the additional support that the grant funded.

Full grant award does not appear to have raised major issues for the Fund although we would note that:

- Final Award of grant was initially deferred by the Grant Committee subject to clarification of issues relating to the referral process and the impact of the project – especially concern that it would achieve impact over and above business as usual. It is understandable that there were concerns since the referral process requires much proactive effort by stakeholders across the health system to make it successful. Moreover high levels of testing of at-risk groups ought to be business as usual – but in simple terms the system does not work as it should, due to funding constraints and other issues. EJAF was therefore able to provide reassurance on these and other more minor points that justified the award of a relatively high grant as measured by proportion of total payments (23%);

- Although Final Award was made in November 2017 the project did not go live until a year later, in November 2018. The Fund therefore had to show a degree of patience in continuing to support the project as it put all the components in place. The Fund was aware of the risks of some delay since both providers and investors were not contractually in place when Full Award was made, and in the event it took until August 2018 to finally get investors in place and until October 2018 to get some (but not all) providers agreed.

A final point to note is that the Fund was aware of the fact that EJAF's roles as both investor and outcomes payer could lead to conflicts of interest. For this reason the Grant Agreement includes a condition that, prior to the start of delivery, EJAF would ensure complete separation of duties between those supporting or involved in EJAF's investment role and its role as an outcomes payer.

3.2 Successes

The main successes of this project to date, and the benefits of using a SIB approach, have largely already been discussed in section 2, although in our view not all the claimed benefits can necessarily be attributed to the use of a SIB mechanism as such, rather than to the adoption of an outcomes-based funding model. The main benefits of a SIB approach are summarised in Box 5 below.

Box 5: Main benefits of SIB approach

1

Created much stronger incentives for providers (especially in the primary care sector) to undertake testing with high risk groups, and overcome a range of objections, of varying validity, for not doing so. It has done this by paying for the identification of new and 'lost to follow up' HIV patients, rather than paying for testing directly, and supporting providers to achieve the necessary change in mindset and attitudes – among both health practitioners and those at risk of contracting HIV.

2

Provided the basis for comparing this outcomes-based approach with more conventional funding approaches. While there is no explicit comparison group which provides a counterfactual for this project, previous projects that have attempted to increase HIV testing levels through conventional grant and contract funding, including some funded by EJAF itself, offer the potential to more directly assess the effectiveness and impact of this SIB.

3

Partly overcame the "wrong pocket" problem, where the financial benefits of improved HIV detection fall largely to the CCGs and NHS England who fund testing and treatment by Hospital Trusts, but the costs of testing are expected to be borne by public health commissioners within local government. However this has been only partially successful, since EJAF (along with CBO) is itself picking up much of the cost of the outcomes.

4

Demonstrated that a complex SIB can be developed with the right in-house resources. While this SIB did have some limited external support from Social Finance, most of the 'hard yards' were made by EJAF itself with leadership from a dedicated in-house manager with the right experience and skills, recruited specifically from a social investment background.

5

Provided the impetus for changes to intervention systems and monitoring processes that are needed to enable large scale 'optout' testing of at-risk groups in areas of high incidence of HIV, and report promptly and accurately on progress and outcomes achieved. There have been changes made to current systems and a new reporting system has been implemented across all providers. These sorts of changes could be achieved through a conventional fee for service contract or grant structure, but our research suggests that they do not usually materialise without the added impetus that an outcomes-based structure provides. In addition such system changes are relatively hard to achieve even within an outcomes-based structure, and therefore the fact that this project has achieved them is, in our view, a genuine success.

There are two further claimed benefits of the SIB approach (as opposed to the project itself) about which we are more ambivalent. The first is that the external investment provides up-front funding for the providers which relieves them of cashflow pressure. However such funding appears to have been provided only for a limited period and there is, as noted below, a potential longer-term challenge for providers in the outcome-based payment arrangements since, over the longer term of the SIB, providers have to bear fixed costs that might not be recovered if outcomes are not achieved.

The second is that the SIB enables 'an integrated model of HIV care' through 'A place-based, collaborative model'. There is no doubt that this project has stimulated a 'whole system' approach to HIV testing across different healthcare settings and referral pathways, and that this approach is vital to the success of the project. However it is arguably not essential to deploy a SIB mechanism to make such collaboration happen: the influence and leadership of EJAF, and the experienced stakeholders with which it worked, might have been sufficient to make this happen under a different model including a conventional grant structure. However EJAF dispute this, since in their experience it has been difficult to bring on board commissioners through conventional approaches, and they believe strongly that the SIB model was critical to engaging commissioners, especially Lambeth and the other LA PH commissioners, and getting their commitment to the approach.

3.3 Challenges and disadvantages

The major challenges of the SIB to date are summarised in Box 6 below.

Box 6: Challenges and disadvantages of the SIB approach

1

Engaging multiple stakeholders. Like many other SIBs we have evaluated, and as highlighted in other research, engaging multiple stakeholders is a major challenge of SIB development and this again appears to have been the case here. According to EJAF, the engagement challenges were exacerbated by high turnover in key stakeholders, meaning that new managers had to be engaged afresh; this again is a finding from other research and evaluation. The experienced LA commissioner we consulted had a similar view, and thought that the engagement challenge had been somewhat added to by EJAF not being used to working with LAs, which have ‘a different kind of bureaucracy’ to the health sector. Senior EJAF management also mentioned ‘suspicion’ of the SIB mechanism as an inhibitor of engagement, another factor that we have encountered elsewhere.

2

Persuading commissioners to fund outcome payments. As it was conceived, it appears that this SIB was intended to have a ‘conventional’ funding structure, with outcome payments being met by LA PH and/or NHS commissioners (and the CBO Fund as co-commissioner). In practice, however, EJAF appears to have stepped in and agreed to make a substantial proportion of payments as a co-commissioner. Thus commissioners have not fully committed, despite what appears to be a strong business case (and it may be the CCGs and NHS England disagree on the merits of it). Based on our research into this and other SIBs, we think it possible that this is because the promise of future avoided costs cannot create enough financial headroom to overcome current funding difficulties. This seems counter-intuitive when the future ‘savings’ are potentially so substantial, but the pressures on the health system appear to be such that NHS commissioners are very hard to persuade to pay for ‘jam tomorrow’ unless they are convinced that the payback is extremely short term. In the case of the LAs, the issue appears to be simply one of competing priorities, since Public Health budgets are already thin and over-stretched, and, as noted elsewhere, they are not the prime beneficiaries of the financial returns from this project. Nevertheless one LA PH commissioner is contributing directly to outcome payments, while the CCGs and NHS England (who arguably have more to gain) are not; whether this persuades others to follow suit later remains to be seen.

3

Potential financial risk to providers. As noted above, providers have received upfront funding from the Zero HIV SPV to ease initial cashflow. This has been in the form of a fixed payment for an agreed initial number of outcomes, and these upfront payments are not recoverable if agreed outcomes are not achieved. Once this payment is exhausted, however, providers are paid by the outcome, and might therefore face cashflow problems if they cannot generate enough outcomes, mainly through identifying new HIV cases. All the providers seemed confident that they would be able to manage this risk, and were clearly aware of it when they agreed to the contracts, but this aspect of the SIB is nevertheless worth noting because the SIB model does not, as some do, relieve providers of all risk by funding them in advance throughout the contract period. The acute provider whom we consulted commented that, if they were doing this again 'The Trust would opt for a safer payment by results contract model that did not place the risk of non-achievement of outcomes solely on the providers'.

4

Risk of a sharp fall in activity when the project ends. The commissioner and some providers expressed concern that while the project has and will continue to generate both excitement and real impact, (at least among those directly involved in its implementation) without the funding that it has provided, there will be a demoralising return to business as usual – with limited funding available on either a conventional or outcomes basis – when the project ends. This is an issue that we will want to consider closely in the second review – i.e. as the project progresses and the results come in, we will ask 'to what extent will the SIB provide a strong evidence base that will ensure sustainability of the project and its wider adoption elsewhere?'

There have been other challenges which might also have arisen if this project had been conventionally funded, rather than through a SIB, but are still worth noting because they might have been exacerbated by the performance management, reporting and data collection requirements that a SIB tends to impose. These include:

- **Data sharing.** Stakeholders told us of major challenges in sharing data, and putting in place appropriate data sharing agreements. The commissioner we consulted described this as 'a nightmare' and it was also highlighted by providers. Again, this is not a partnership issue that is unique to SIB projects; It is a particular challenge in all collaborative projects in the health sector because of the high information governance standards which each organisation in the sector requires. However, it seems likely that the additional requirements of the SIB for tracking of individuals across settings and of the levels of accuracy required for reporting of outcomes, would have made it more important that the right data sharing arrangements are in place. EJAF and other stakeholders' efforts to overcome these challenges should be counted as a success. Part of the success of the project is that providers have used patient data generated by PHE to track people who had disengaged from HIV treatment. This data has then been verified through provider activity, and where necessary PHE records have been updated. This is important as PHE data needs to be as accurate and up-to-date as possible because it is used to determine governance policy about HIV. An important wider learning point here (noted in previous reviews under this evaluation) is that data sharing and information governance in the health sector makes this type of system-changing project inherently more difficult.
- **Having the resources in place to manage performance.** EJAF highlighted the challenge of finding and funding the right people to manage the SIB and its performance, even though outcome payments have funded dedicated performance management resource. Such performance management would arguably be needed irrespective of the project structure but becomes essential when payment is linked to outcomes.

3.4 Lessons learned

The main lessons from this SIB are ones that have emerged from other SIBs that we have evaluated previously, but a number of these lessons bear repetition. They include:

Box 7: Lessons learned

1

SIBs take a very long time to develop. This has been a theme of nearly every SIB we have researched, and this SIB was no different. Development funding was awarded by the CBO in October 2015, and EJAF had done much preparatory work before then, but the SIB contracts did not go live until November 2018, 3 ½ years later. To quote directly the Chief Executive of EJAF:

**“The biggest learning is the time.
It has taken so much longer than we thought it would”**

As in other SIBs that we have reviewed, the reasons for such long delays are not hard to adduce and arise in large part from the need to engage, enthuse and ultimately commit multiple parties, all of which takes time especially when working within the complex structures of the public sector health system and with people who are very hard-pressed for time. In this case it is also worth noting the additional challenges of putting in place the necessary systems and processes to make the project work. These challenges were successfully overcome, but appear to account in part for the one-year time lag between award of final grant in late 2017 and the project finally going live in November 2018.

2

Stakeholder engagement is difficult. Again this is by no means a new finding, but this project highlights many familiar lessons about the importance of effective stakeholder engagement and the patience and persistence sometimes needed to get them on board. These challenges can occur on any project but are made worse in the SIB context by stakeholder turnover and churn. Staff turnover tends to be greater in SIBs in part because of the length of time they take to develop, and also tends to be a greater challenge because SIBs take time to understand, and therefore explaining them afresh to new stakeholders can be especially onerous. There can also be challenges due to stakeholder suspicion of SIBs or the motives of stakeholders, which tends to be greater than in most projects which operate without external investor involvement.

3

Engagement can be facilitated by the lead organisation having previous involvement in SIBs. Conversely, engagement can be made somewhat easier if one or more stakeholders have previous understanding of and/or involvement in SIBs. Although the lead commissioner in Lambeth had not themselves encountered SIBs, the involvement of their line management in the HCT travel training SIB appears to have made it easier for the organisation to get comfortable with this project.

4

A SIB can be developed without substantial external support, and may be better for it. As already explained above (3.1.1) this SIB was developed largely internally, and shows how effective this can be with the right people in place. While neither the internal or external support would arguably have been possible without the Development Grant from the CBO, those seeking to develop projects need to think carefully about the right balance of internal support – embedded in the project and driving it throughout; and external support – which, when needed at all, is arguably best used for targeted and specialist pieces of analysis.

5

Piloting prior to a SIB can help inform its development. A number of SIBs claim to be piloting new approaches, and this SIB is to an extent a pilot of outcomes-based contracting for HIV testing and diagnosis. However, it also shows the value of initial piloting on a conventional basis – in this case of both opt-out testing in hospitals and HIV screening by default in primary care. The SIB can then build on the pilots; and make further changes which are more appropriate to leveraging the intended incentives of a SIB approach – in this case testing whether outcomes-based contracts are more effective than activity-based ones in the same policy area.

4. Conclusions

4.1 Conclusions to date

Overall, it seems clear that this is an innovative, exciting and potentially transformative project. EJAF have looked carefully at the benefits of both social investment and an outcomes-based approach and have developed a project that has many of the features that have made this sort of project successful.

In particular, and most importantly in our view, they have deployed the SIB mechanism to introduce payment for outcomes in a policy area where it has the potential to make a real difference and address the shortcomings of the 'conventional' approach to HIV prevention and testing. Notably, the focus on outcomes aims to address low levels of testing by practitioners - which had otherwise been persistent, despite clear policy guidance in favour of 100% testing in high prevalence areas. The funding mechanism also aims to address a 'wrong pocket' problem, to overcome cash-strapped public health departments' reluctance to fund testing at the requisite levels because they are not the main beneficiaries of savings from early HIV diagnosis. It will be interesting to explore whether this project has a wider impact on attitudes to HIV funding in the mid-point review, not least because the contribution ultimately made by local commissioners to this project has been limited.

The project has also had other successes including attracting new investors into SIBs, and testing the potential benefits of traditional grant funders deploying repayable finance; and demonstrating both the benefits and challenges of joining up provision across the health system. Many of these benefits have been achieved because EJAF has successfully leveraged its leading position as a provider of funding and enabler of support to the treatment and eradication of HIV/AIDS. As noted throughout this report, it has driven the project throughout, and been a positive actor across a number of roles that, in their breadth appears to be unique across SIBs and similar projects in the UK.

Despite all its efforts, and a compelling business case based on both social and financial benefits, EJAF was however unable to persuade local commissioners to make the expected contribution to outcome payments. EJAF is now paying for a substantial proportion of the outcomes, and is also effectively acting as a 'first-loss'

investor. There are thus fewer benefits to this somewhat circular involvement of EJAF in the SIB model than there would have been if (alongside CBO's funding), outcomes had been paid for entirely by public sector commissioners, who would have been persuaded to do so (as was the original intention in this case) because they would have to pay only if outcomes were achieved. Furthermore, while investors are providing up-front capital, they appear not to be doing so to a substantial degree or throughout the contract period. Unlike some SIBs, the investors do not appear to be bearing all the risk if outcomes are not achieved. Indeed a significant proportion of the risk appears to have been passed down to the providers, whose payment is in large part (save for an initial 'minimum order') dependent on the achievement of individual outcomes

This led us to challenge EJAF as to whether a SIB model – with its attendant costs and complexities – might be the right way to pursue an outcomes-based approach in future. It can be argued that if commissioners remain reluctant to pay for HIV outcomes, EJAF might explicitly take the lead commissioning role, and possibly deploy a simpler payment by results model rather than a SIB. This might entail paying the providers directly through a mixture of up-front payment (to help providers with set-up and ease their cashflow) and outcome payments (to incentivise detection of undiagnosed HIV) without the need for social investment and a complex operating and governance structure. Ultimately this type of model might be cheaper to develop, quicker to implement, and easier to replicate than a full-blown SIB approach, while potentially offering equal levels of impact and effectiveness. Arguably, if this project could be scaled up with this type of simplification of the 'wiring, EJAF stand to make huge savings of effort, and build further on the evidence base for this approach, so that over time local commissioners (or even national policy makers) are persuaded to adopt the model and fund it at scale.

However EJAF do not agree. They argue strongly that the SIB model was critical to persuading LB Lambeth to make a financial commitment, and that it has been proved time and again in their work that local commissioner ownership by way of financial

commitment makes an enormous difference to buy-in to the project and to the likelihood of that work continuing after EJAF has retreated. They strongly believe that LB Lambeth acting as commissioners, with a modest contribution from their budget, has enabled them to bring along senior people within the Lambeth, Southwark and Lewisham community in a way that direct funding by EJAF of an outcome based contract would not, and to reinforce relationships between LB Lambeth and providers in a way that EJAF directly commissioning would not have enabled. They also believe that engagement of Lambeth as an outcome payer is likely to be critical to the rollout of learning from this project.

Furthermore, they believe that it would have been a significant challenge for EJAF itself to provide upfront funds to all providers, even at the relatively modest levels that this project has entailed. It would therefore be difficult to repeat the outcomes-based model without investor cash, especially if EJAF had to provide more initial funding to ease provider cashflow in the future. This may well be true, since the alternative model we are floating here is likely to have negative cashflow implications for EJAF compared to a SIB (see Box 8).

Box 8: Funding requirements of a SIB versus a PbR/FFS

	SIB	PbR/FFS
Up front payments	Shared with other investors	Funded wholly by EJAF
Outcome payments	Shared with other commissioners and CBO	Shared only with CBO
Performance management costs	Met by investors via outcomes payments	Met wholly by EJAF

Ultimately this is a hypothetical debate at this stage, but it will be interesting to explore in the second and third reviews whether and to what extent EJAF is proved right that the success of this model – if supported by outcomes data – and the active engagement of Lambeth and other commissioners does lead to better learning and greater sustainment in the medium term.

4.2 Achievement of CBO objectives

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

- 1. Improve the skills and confidence of commissioners with regards to the development of SIBs: Not achieved to a significant extent.** This does not appear to have been a major objective of the project and neither the CCGs nor the LAs other than Lambeth are actively involved in the project; it follows that their knowledge has not been enhanced. The Lambeth public health commissioner has enhanced their knowledge and understanding which has added to existing knowledge within Lambeth (acquired through involvement in the HCT travel training SIB) but there is no evidence that their skills have been transferred to other parts of the public health commissioning organisation.
- 2. Increased early intervention and prevention is undertaken by delivery partners, including VCSE organisations, to address deep rooted social issues and help those most in need: Achieved.** The SIB is targeted both at prevention of the long-term implications of HIV going undiagnosed, and aims to achieve earlier diagnosis of HIV, thus achieving similar positive outcomes. It also has a unique dimension in preventing onward transmission of HIV, albeit as a natural by-product of the way antiretroviral therapy works. As already argued above, it might have been possible to achieve this level of intervention without a SIB but there is already some emerging evidence that the use of an outcomes-based structure and payment mechanism has significantly increased early intervention compared to conventional projects. This will be something to investigate further in the second review
- 3. More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people: Partially achieved.** The upfront finance provided to delivery partners has clearly been important in enabling them to get involved in a project where payment is linked to outcomes, but as already mentioned the upfront funding is limited; and as argued above similar objectives could possibly have been achieved without the need for external investment, although EJAF dispute this.
- 4. Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs: Partially achieved.** It seems likely that EJAF will use the learning from this project to promote similar approaches elsewhere, especially in regard to commissioning HIV detection and treatment on the basis of outcomes. The providers interviewed have also learnt from their involvement in this project about both the benefits and challenges of having payment linked to outcomes and will likely continue to do so. New investors have been attracted to the SIB and the investor we interviewed, Comic Relief, sees it as an important learning exercise for them as they explore social investment and repayable finance as alternatives to grants. It is however more questionable whether other stakeholders have benefited from learning, or will have learning to share with others, due to their semi-detachment from the development and implementation process.

4.3 Areas for future investigation

In our second review (which will need to be undertaken relatively soon given the length of the contract) we will revisit this project to explore its progress over the first 18 months or so of its delivery. During this next phase, specific areas we will wish to explore will include the following:

- Do levels of engagement and testing prove to be significantly higher than achieved on projects which have not deployed an outcomes-based structure, such as the Leeds pilot project which EJAF itself funded?
- Are there any further changes to the funding structure of the SIB and/or its contracts or outcome payments? If so how do these changes compare or contrast with common features of other SIBs that we have previously evaluated?
- Has there been different performance between GP Federations that pass on outcome payments to the practice achieving the outcome, and those sharing payments with all practices?
- What further lessons does the EJAF SIB offer in terms of recruiting, embedding and funding SIB design capacity and expertise into commissioning bodies when developing an outcomes-focussed partnership?
- What lessons does the EJAF SIB offer in terms of options for recruiting and funding the performance management role in an outcomes-focussed partnership?
- Does the success of this project (if so proved) influence local and other commissioners to increase funding for HIV testing – either on an outcomes-basis, like this project, or on a conventional basis but with other learning from this project? If so, what was the influencing tipping point?
- Will providers continue to achieve the levels of outcome achievement that are needed both to make the project viable for them and to provide a basis for sustainment in the longer term?
- Do the VCSEs continue to view this project as business as usual for them, and not substantially different to a fee-for-service contract apart from the fact that payment is linked to outcomes?
- Have EJAF got the balance between the SPV's 'upfront payments' to providers (requiring at-risk investment) and straightforward PbR payments to providers right, to get the desired behaviour changes? What is an optimal balance to create a useful incentive – without putting providers in a difficult financial position or leaving them too exposed to external shocks (like COVID) – and how can future SIB designers gauge that balance?
- Does the unfolding SIB journey confirm EJAF's case that a SIB mechanism is the most elegant way of achieving the behaviours it is looking for – or is the suggested PbR plus fee-for-service model potentially a more efficient design alternative? How do possible alternative arrangements compare in terms of cash flow modelling for EJAF?
- How reliant was this SIB on the CBO funding – and if EJAF conclude they want to do more ZERO HIV SIBs – will this be feasible post-CBO?

