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

North-West London End of Life Care Telemedicine Project

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Introduction

The Commissioning Better Outcomes (CBO) programme is funded by The National Lottery Community Fund, with a mission to support the development of more social impact bonds (SIBs) and other outcomes-based commissioning[1] 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 North-West London End of Life Care Telemedicine Project is one of these.

This report is the first in-depth review of the Telemedicine Project. 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 in 2018 with follow up in 2020. There are some limitations to our research as a result of staffing changes within key stakeholder organisations at the time of the fieldwork – where gaps in our knowledge exist, these will be further explored during our second in-depth review where possible.

SIBs are a form of outcomes-based commissioning[2] (OBC). While there is no universal definition of SIBs, the Government Outcomes Lab[3] (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 components[4]. These include:

- Payment on outcomes
- Independent and at-risk capital (social investors)
- High degree of performance management
- Strong social intent (i.e. delivery undertaken by voluntary, community and social enterprise organisations (VCSEs).

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, 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.

About the SIB model and intervention

The North-West London Telemedicine Project provides a tele-support clinical advice, guidance and coordination hub to enable staff in older people's residential care and nursing homes to better care for residents, particularly those in the last phase of life. The offer gives callers from older people's care homes a single point of access to a specialist nursing team in real time. The service's overarching aim is to reduce A&E attendances and non-elective inpatient admissions to hospital for care home residents, resulting in a better patient experience and allowing patients nearing the end

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

of life to be cared for in a familiar and comfortable setting. The project was awarded CBO funding to deliver an intervention for up to four years, between April 2018 and September 2022.

The project is supported by the End of Life Care Integrator (the EOLCI), a social purpose, limited company which is wholly owned by the Care and Wellbeing Fund. This investment fund provides the capital for the SIB and funds for performance management; capital is provided by Big Society Capital and Macmillan Cancer Support[5]. The EOLCI is staffed and managed by Social Finance, and the organisation takes a key role in this SIB, acting as investment fund managers for the Care and Wellbeing Fund and also providing implementation and project management support for the SIB. However, there are measures in place to minimise the conflict of interest in their roles, such as separate staffing and management, and independent directors sitting on the EOLCI board.

The Telemedicine Project has been commissioned by a partnership of seven NHS CCGs in the North-West London area. The Sustainability and Transformation Partnership (STP) for North-West London has taken on an oversight role, working alongside Hammersmith and Fulham NHS CCG in their role as the coordinating commissioner, representing the interests of all seven CCGs. As commissioners, the CCGs will repay the social investment, depending on the achievement of outcomes.

At the time the service was developed, its target delivery area included 114 older people's homes, and it was anticipated that the service would engage with up to 3,771 residents over the project's lifetime. The SIB aims to avoid costs and release capacity for its NHS commissioners by avoiding up to 1,364[6] emergency hospital admissions from care homes over the four-year lifetime of the project. The number of avoided admissions is calculated as the difference from a historical baseline figure of admissions from older people's care homes in the area.

The providers of the Telemedicine Service are a social enterprise - London Central and West Unscheduled Care Collaborative (LCW) - and West London NHS Trust. The two providers are supported by St Johns' Hospice, who provide specialist end of life / palliative care training for the service's staff. The providers are paid on a fee for service basis.

Successes and perceived benefits of the SIB approach

For the commissioners, the SIB mechanism was seen as crucial for the development of the telemedicine service, providing up-front, risk-free capital that would not otherwise have been available to them. Interviewees highlighted several factors which they perceived as key successes in the development of the SIB.

- Building on an evidence-based model. The delivery model for the SIB was drawn from research which highlighted gaps and needs in service provision for people at the end of life, and also from evidence arising from an existing telemedicine model addressing similar needs.
- Close relationships with commissioners. The EOLCI strove to build strong relationships with commissioners from the inception of the SIB, and ensured commissioners had the ability to input to the model to ensure it had strategic fit with other initiatives.
- Experienced providers. The two providers have an existing relationship and were already jointly delivering a project focusing on routing calls from care homes to 111, to enable faster response times, in four of the eight SIB boroughs. This project was thematically similar but structurally different as the SIB service

5 https://bigsocietycapital.com/portfolio/care-and-wellbeing-fund/

6 1,364 avoided emergency admissions is the SIB's high scenario; the provider contract assumes up to 1,057 with a break-even point of 705.

required dedicated, specialist staffing. They also have experience in delivering more generalist telemedicine services; this expertise equipped them to hit the ground running to some extent.

- Breaking short-term funding cycles. Interviewees argued that the SIB has allowed commissioners to test an intervention outside the standard NHS one-year funding cycle. This is because the SIB enables them to commit to a longer-term project – they have more certainty on their long-term funding than is usually the case because they know that the savings generated by the project can be used to pay for the outcomes. The savings are generated by a reduction in payments from the CCGs to the NHS Trusts providing acute hospital care.
- Dual package of funding and support. As interviewees unanimously flagged, the SIB model not only brings access to up-front capital, but also access to expertise and rigour in planning, development, partnership working and performance management. Interviewees felt it was beneficial that this package of support does not stop at the point that contracts are signed but extends for the full duration of the funding agreement.
- A simple payment metric. The outcome payment metric was deliberately kept simple in order to facilitate the rigorous monitoring required by a SIB, but fully reflected the overarching aim of the intervention - to improve outcomes at the end of life for those in older people's care homes, by reducing non-elective hospital admissions.
- The CBO grant. The outcomes co-funding from The National Lottery Community Fund has been important for generating buy-in and faith in the initiative from those in the NHS who are new to SIBs.

Challenges and disadvantages of the SIB approach

There were a number of challenges encountered in establishing the SIB.

- Data quality and attribution of outcomes. To an extent, the service has been re-shaped in a number of ways to meet the data needs of using a PbR mechanism. For example, while the outcomes for those living in older people's care homes were worse than those living in the community, some stakeholders believed that the focus on older people's care homes was beneficial to the SIB because those outcomes were thought to be more easily tracked for monitoring and payment trigger purposes. However, this is not without difficulty and there have been challenges related to identifying care homes as callers. It can be challenging to predict the baseline figure for non-elective admissions to hospital from the care homes; the growth in admission levels can fluctuate under the influence of external factors. Finally, attribution can also be challenging because there are multiple interventions focused on improving care in older people's care homes and reducing hospital admissions.
- Securing buy-in from stakeholders. Interviewees acknowledged that SIBs were a new concept for many involved, including finance staff within the commissioning CCGs. For those within the health sector, there was a question over the motivations of investors and intermediaries. This created inhibitions and the EOLCI had a slow start. With the lead commissioner, the EOLCI was obliged to spend time encouraging CCGs to come on board, or to observe and buy in to the concept at their own pace.
- Complexity of commissioning structures. Operating across a number of CCGs has been challenging in terms of the logistics of setting up a new service, including difficulties in getting information sharing agreements off the ground – often as a result of working through multiple governance structures for sign off - and working across different IT systems in each area. Alongside these issues, providers have also found it challenging to address the needs of the range of stakeholders involved in the SIB.

Furthermore, operational issues hindered the development of the intervention. These primarily included getting the right technology in place for call routing to the service, and recruiting highly qualified medical staff to work exclusively on the call centre side of a telemedicine project. More usually, medical staff providing telemedicine would prefer to combine this with face-to-face work with patients, and as a result it took time to get the right staff in place.

Lessons learnt

The evidence generated in this review highlighted a number of key lessons learnt.

The balance of support and funding is vital: Regardless of their role in the SIB, there was consensus amongst interviewees that the support which accompanied the SIB has been critical for a successful launch, motivating stakeholders and driving the telemedicine service forward. However, a key lesson from this project is that there is a need for a constant and consistent oversight and ownership in the commissioning organisation to keep this momentum going. The learning from this SIB very clearly demonstrates that outcomes-based commissioning needs substantial commissioner and provider capacity and continuity, including at senior levels, in addition to the input of the investment intermediary; SIB management effort cannot simply be outsourced to an intermediary.

SIBs are a dynamic process; flexibility is key to create a service which meets patient needs within the complexities of the SIB model: Flexibility on the part of all stakeholders has been important in this SIB. The project was designed to test a specific hypothesis – thus, it needed some elements of design to remain true to ascertain whether the inputs would lead to the outcomes desired. To an extent, the SIB's necessity to evidence change has shaped the model, for example requiring dedicated, ring-fenced staffing which caused delays in launching the service. This is a limitation of outcomes-based commissioning in a complex landscape such as healthcare.

Working with multiple commissioners brings opportunities but is complex: Involving a number of commissioners was vital for the SIB to be financially viable, but the approach also had good fit with strategic policy agendas in North-West London. However, the SIB's widening of the footprint of the service has had the knock-on effect of creating an operationally complex situation. In this case, having a single coordinating commissioner working closely with the EOLCI has helped.

Stakeholders need to be aware of what a SIB entails: For the majority of stakeholders involved in this SIB, there was little to no previous experience of delivering services in an outcomes-based commissioning scenario. The research for this report has highlighted issues which those new to SIBs would benefit from prior awareness of, such as ensuring providers are pricing appropriately to cover the level of senior-level input needed. A key lesson therefore is to ensure that all stakeholders are clear on the complexities of delivering a SIB and what that involves in practice.

Keeping the payment mechanism simple: Reporting against one outcome, using data that is readily available from existing datasets to form the baseline, has simplified a complex exercise for evidencing outcomes. However, even this process has not been without challenge. The project also has formalised additional KPIs, meaning providers are held to account on service quality, retaining focus on providing good patient care without further complicating the evidence base needed to trigger payments.

Conclusion

There was little doubt amongst interviewees that the SIB model has given commissioners a level of financial freedom to address an important problem. For interviewees in all stakeholder groups, there was a consistent view that the joint offer of investment and support to manage the development of the intervention has provided the only feasible opportunity to develop the telemedicine service - an intervention which addresses strategic STP priorities for efficiencies and reducing non-elective admissions while reducing health inequalities for the residents of older people's care homes. Commissioners expressed that the SIB model, and accompanying investment, meant that the constraints of the more typical single-year funding cycles in the NHS were circumvented and in an otherwise cash-strapped system, the investment allowed for the development of new-to-the-area service. A number of mechanisms facilitated this, particularly that the agreement between commissioners and the EOLCI meant that the first repayment was not made until the 18-month mark, and cashable savings arising from the intervention allowed commissioners to make the repayments via the outcomes payments at the point they were due. Finally, while telemedicine projects such as this do exist elsewhere in the country, they have only been developed with non-core funding (eg innovation funds).

While there were some successes in the development of the intervention, the interviews for this review also clearly demonstrated that commissioning this service through a SIB has led to operational challenges which would likely have been avoided in other, more traditional, commissioning models. However, the evidence does highlight that all stakeholders have been flexible where needed; stakeholders were not so wedded to the hypothesis that they would not allow adaptations where they could prevent project failure or impede value.

The role of Social Finance in this SIB is particularly interesting, as the managers of the investment fund and also the intermediary. Their involvement drove the development of the SIB in both theoretical terms (identifying a problem for the commissioner, and a potential solution) and practical terms (convening and coordinating stakeholders). As managers of the Care and Wellbeing Fund, they have ultimate responsibility for protecting the investment by identifying, developing and managing a successful project. The presence of an independent board and chair for the EOLCI as fund managers is important for maintaining separation between the two roles.

Our review shows that so far, the Telemedicine Project has partially achieved the objectives of CBO. We will explore this further in our second review, along with a number of other priority themes. These will include the balance between the achievements of the intervention against opportunity costs i.e. what aspects of this service could have been developed without a SIB? Was the complexity added by the SIB model worth it? Crucially, we will more thoroughly investigate the savings case for the SIB, and the extent to which costs avoided (as opposed to cashable savings) can be held up as value for money in the NHS commissioning environment.

Introduction

The Commissioning Better Outcomes (CBO) programme is funded by The National Lottery Community Fund, with a mission to support the development of more social impact bonds (SIBs) and other outcomes-based commissioning [7] models in England. The National Lottery Community Fund has commissioned Ecorys and ATQ Consultants to evaluate the programme.

The CBO programme

The CBO programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2024. It made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar outcomes-based contractual models (OBCs) 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, North-West London End of Life Care Telemedicine Project, is part-funded by the CBO programme.

The CBO programme has four outcomes:

- Improve the skills and confidence of commissioners with regards to the development of SIBs/OBC
- 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
- More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people
- Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs/OBC.

The CBO evaluation is focusing on answering three key questions:

- Advantages and disadvantages of commissioning a service through a SIB model; the overall added value of using a SIB model; and how this varies in different contexts;
- Challenges in developing SIBs and how these could be overcome; and
- 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.

7 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.

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

SIBs are a form of outcomes-based commissioning[8] (OBC). While there is no universal definition of SIBs, the Government Outcomes Lab[9] (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 components[10]. A core SIB comprises:

- Payment on outcomes
- Independent and at-risk capital (social investors)
- High degree of performance management
- Strong social intent (i.e. delivery undertaken by voluntary, community and social enterprise organisations (VCSEs).

While having these components distinguishes a SIB from other types of commissioning, including fee for service[11] and traditional Payment by Results (PbR) contracts[12], 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.

The in-depth review reports

A key element of the CBO evaluation is our nine in-depth reviews, and the review of the North-West London End of Life Care Telemedicine Project (here-in referred to as the Telemedicine Project) 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 Telemedicine Project. 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 progress in the period after launch.

The interviews with stakeholders whose views are reflected in this report were, for the most part, conducted in September 2018. A small number of follow-up interviews were conducted in 2020. As such, it covers a period of time prior to the COVID-19 pandemic.

8 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.

9 See: https://golab.bsg.ox.ac.uk/knowledge/glossary/

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

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

12 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

Limitations of the research

At the time of the fieldwork, there were significant staffing changes within some key stakeholder organisations. This meant researchers had limited time with some interviewees, leaving gaps in our knowledge on some pertinent issues relating to the SIB's development. Where they occur, we have highlighted these gaps throughout the report, and will explore issues further during our second in-depth review where possible.

Report structure

This report is structured as follows:

- Chapter 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.
- Chapter 3 describes the roles and experiences of key stakeholders to date, including the successes and challenges they have encountered.
- Chapter 4 draws on lessons learned to develop conclusions from this review, and highlights areas to explore in the next review.

How the SIB works

This chapter provides an overview of the SIB and how it works, including its overall logic and key drivers, the structure of the SIB operating model, how the SIB was initiated and developed, and the governance structures around the SIB.

The SIB model

The North-West London End of Life Care Telemedicine Project provides a tele-support clinical advice, guidance and coordination hub to enable staff in older people's residential care and nursing homes to provide better care for residents, particularly those in the last phase of life. The service's overarching aim is to reduce A&E attendances and non-elective inpatient admissions to hospital for care home residents, resulting in a better patient experience and allowing patients nearing the end of life to be cared for in a familiar and comfortable setting.

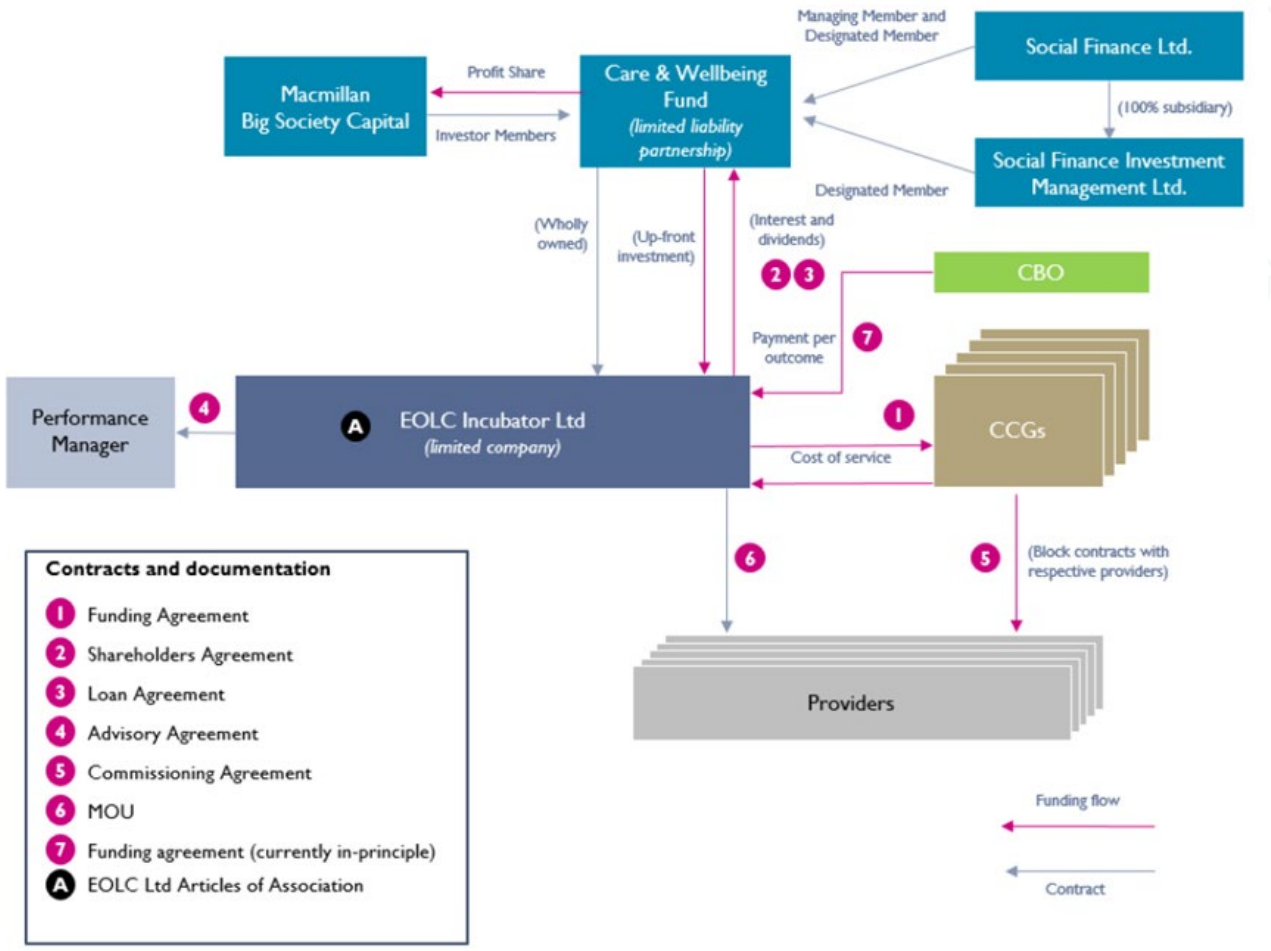
The project forms one of four projects supported by the End of Life Care Integrator (EOLCI – formerly known as the End of Life Care Incubator. The name was changed to reflect the focus on integrated care.) at the time of writing (2020)[13]. The EOLCI is a social purpose, limited company which is wholly owned by the Care and Wellbeing Fund. It has a specific aim to invest in better community-based care at the end of life. The EOLCI is staffed and managed by Social Finance, as managing member of the Care and Wellbeing Fund; this investment fund provides the capital for the SIB. The Fund makes use of £12 million of social investment from Big Society Capital and Macmillan Cancer Support. It is also supported by a development grant from the Health Foundation to help the team develop investment opportunities to create social impact.

Figure 2.1 sets out the contracting model and investment flows for the Telemedicine Project. The diagram highlights the complex nature of Social Finance's involvement in this SIB (and the other three SIBs operating under the EOLCI umbrella). For all intents and purposes, the organisation holds the role of Special Purpose Vehicle (SPV) / intermediary[14] in this SIB, whilst also representing the interests of the investors as fund managers. The interviews flagged the significance of Social Finance's involvement in conceiving the project, ensuring fidelity to the intended model and putting project management in place to keep the development and launch on track as much as possible. These roles are explored further in Chapter 3 of this report; at this juncture however, it is important to note that there is legal separation of roles between the Care and Wellbeing Fund and EOLCI and Social Finance Ltd. Both the EOLCI and the Care and Wellbeing Fund are distinct entities, with separate staffing and management. The EOLCI has two independent directors on the board which form a majority, and as such are able to outvote Social Finance. All of these measures minimise any conflict of interest between the roles.

13 The other three EOLCI SIB projects include Advance Care Planning in Haringey, Rapid Response End of Life Care Nursing in Hillingdon, and System Integration in Waltham Forest. For more information see https://www.careandwellbeingfund.co.uk/

14 A Special Purpose Vehicle (SPV) is a legal entity created to hold the contract, receive investment, and pay the service provider. An SPV is a company with limited liability that is set up to protect the stakeholders and separate the contract from the delivery organisation's other activities, reducing their risk and making it easier for investors to fund the specific contract. The intermediary in a SIB structure often raises capital and brings other stakeholders together to agree upon transactional details. They may be involved from the very start of the concept through to delivery, performance management and quality control.

Figure 2.1 **End of Life Care Integrator Legal Structure and Funding Flows**

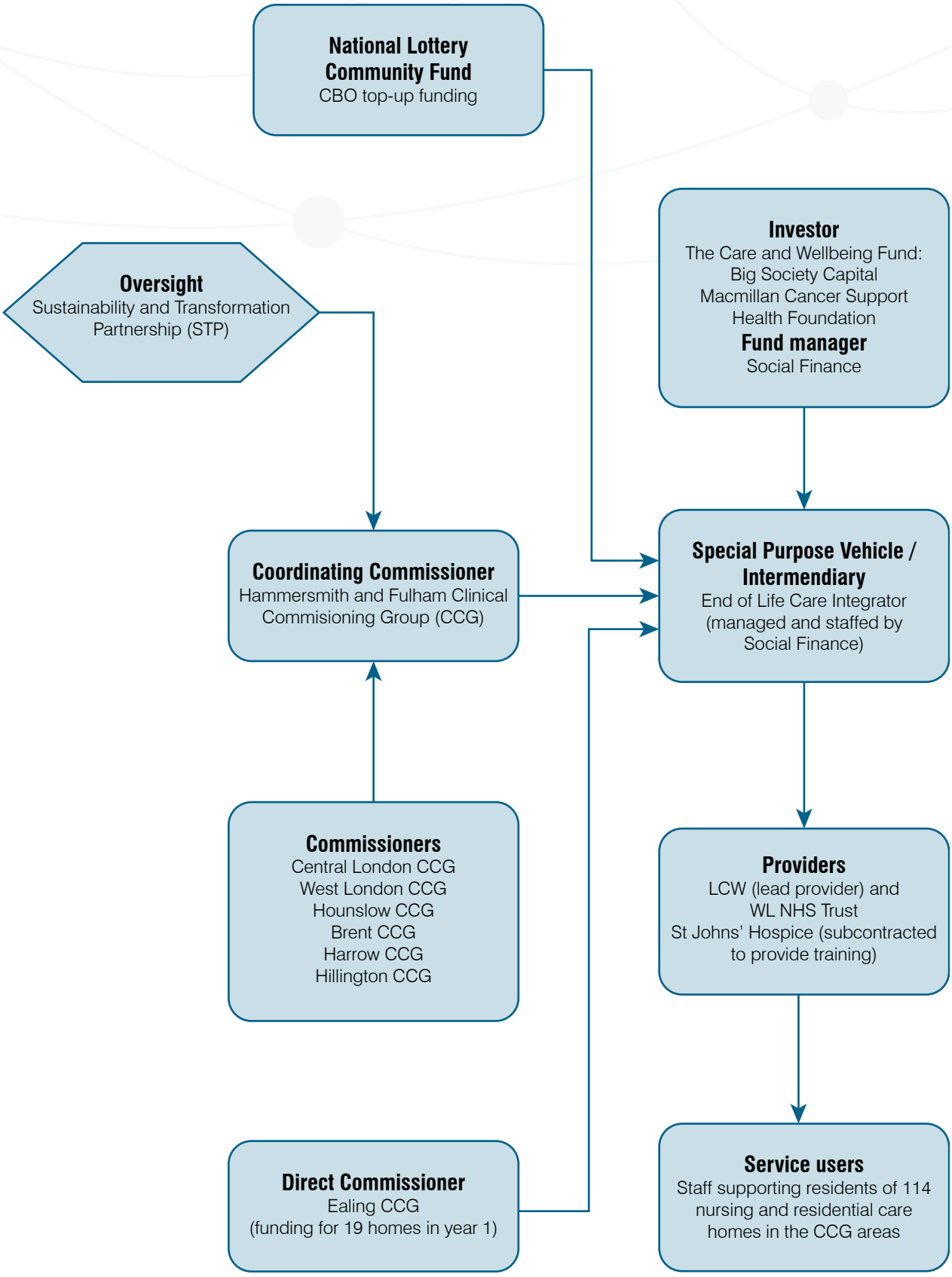


Source: Social Finance. NB: The EOLCI changed name from End of Life Care Incubator to Integrator after this chart was developed. They are the same organisation. In this chart, the term Funding Agreement refers to payments based on outcomes (e.g., between the CCGs and EOLCI).

Figure 2.2 provides information about the key stakeholders involved in the Telemedicine Project specifically.

The telemedicine project has been commissioned by a partnership of seven NHS CCGs in the North-West London area. The proposal for the project (both the intervention and the SIB) was approved by each of the CCGs' finance and performance committees and governing bodies, and the CCGs have been heavily involved in all aspects of project development; interviewees referred to the process as one of co-creation. The service specification for the project was jointly agreed by the EOLCI and the commissioners, and a funding agreement is in place between the EOLCI and the seven CCGs. NHS Ealing's role is slightly different as the eighth commissioner, having opted into the SIB on a trial basis. They contracted directly with the EOLCI for the first year of delivery, rather than working through the coordinating commissioner as the other CCGs do.

Figure 2.2: **Key parties in the Telemedicine Project**



Since the development of the SIB proposal, Sustainability and Transformation Partnerships (STPs) have been created in 44 areas across the UK, bringing CCGs and local authorities together to develop their own plans to address their local priorities for health and care. The STP for North-West London has taken on an oversight role, working alongside Hammersmith and Fulham as the coordinating commissioner.

The providers of the telemedicine service are London Central and West Unscheduled Care Collaborative (LCW) and West London NHS Trust. LCW, the lead provider, is a social enterprise and is one of London's largest providers of integrated urgent care services; this includes the provision of existing telemedicine services for the NHS including 111 and the GP Out of Hours Service (a telephone booking system for those requiring primary care out of normal GP surgery hours). They work alongside West London NHS Trust, a provider of a full range of universal health services as well as some specialist, commissioned services. The two providers are supported by St Johns' Hospice, who provide specialist end of life / palliative care training for the service's staff.

Overview of the intervention

The North-West London Telemedicine Project was awarded CBO funding to deliver an intervention for up to four years, between April 2018 and March 2022. The offer gives callers a single point of access to a specialist nursing team in real time; there is no call handling or call back for example, as there would be in the standard National Health Service 111 telemedicine offer[15]; calls are answered and dealt with by qualified nursing staff with expertise in end of life care. As well as offering instant access to clinical advice, the nursing team are also able to liaise with local health services and arrange face to face visits from other providers such as GPs if necessary. The service is provided by two organisations – one a social enterprise (LCW Unscheduled Care Collective) and the other an NHS Trust (West London NHS Trust).

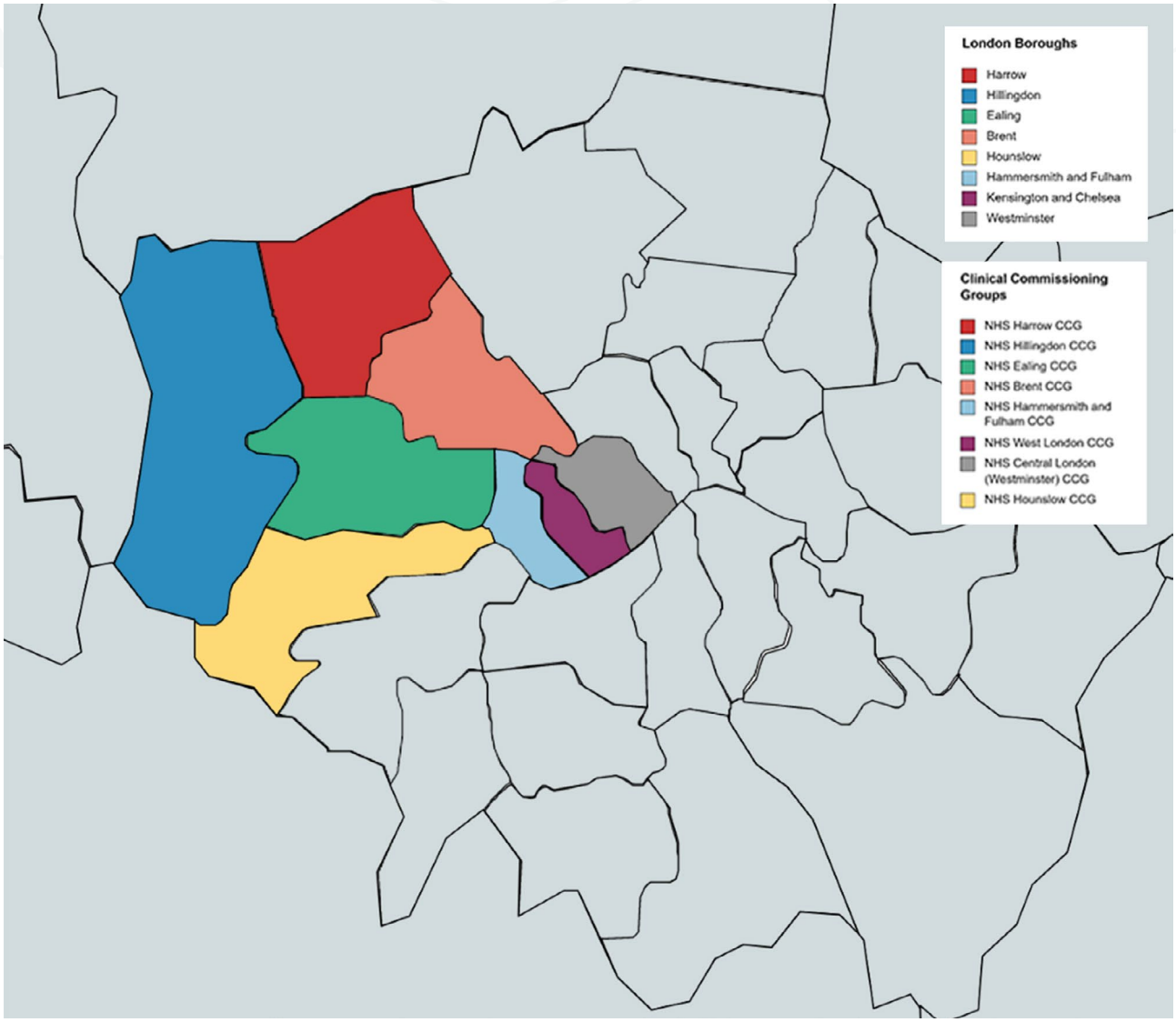
The service is available to all older people's nursing and residential care homes operating in the areas covered by the seven NHS Clinical Commissioning Groups[16] involved in commissioning the service. The CCGs cover the areas of Central London, West London, Hounslow, Brent, Harrow, Hillingdon and Hammersmith and Fulham, and the latter has the role of coordinating commissioner, acting as the lead and representative for the commissioners as a whole. Furthermore, NHS Ealing CCG also committed to fund the provision of the service into their 19 older people's care homes in year one of delivery. Each of these CCGs sits within the North-West London (NWL) Sustainability and Transformation Partnership[17] (Figure 2.3).

15 111 is a telephone service provided by the National Health Service in the UK. The service is intended to provide help to those who need medical assistance quickly, but who are not in an emergency situation which would warrant a call to 999. Calls are assessed by trained advisors who are supported by a range of healthcare professionals including doctors, nurses, paramedics and pharmacists.

16 CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. They are responsible for commissioning healthcare including mental health services, urgent and emergency care, elective hospital services, and community care.

17 STPs are areas covering all of England, where local NHS organisations and councils drew up shared proposals to improve health and care in the areas they serve. STPs were created to bring local health and care leaders together to plan around the long-term needs of local communities.

Figure 2.3 **Map of NWL CCGs and corresponding London Boroughs**



Source: https://patientsknowbest.com/CIE/

At the time the service was developed, this area included 114 homes, and it is anticipated that the service will engage with up to 3,771 residents over the project's lifetime. The SIB aims to avoid costs and release bed capacity for its NHS commissioners (as opposed to releasing cashable savings) by avoiding up to 1,410[18] emergency hospital admissions over the four-year lifetime of the project.

Initially, the service was scheduled to operate 24/7, 365 days a year (following other models providing similar services, as examined in section 2.1.2 of this report).

However, before the service fully launched the providers and the EOLCI reviewed plans against call data for other telemedicine services such as 111; this data showed little demand for support in the early hours of the morning and as such the lines were staffed between 8am and 2am. At the time of the first round of fieldwork for this in-depth review (September 2018), the project team were also preparing to pilot a video-conferencing offer as part of the service.

18 1,346 avoided emergency admissions is the SIB's high scenario; the provider contract assumes up to 1,091 with a break-even point of 818.

Rationale for the intervention

End of life and palliative care has shifted into a key position in health policy-making over the last decade, with end of life care becoming one of eight clinical pathways developed by each Strategic Health Authority in England as part of the Next Stage Review (NSR) process in 2008[19]. This review was quickly followed by the Department of Health's End of Life Care Strategy[20], which highlighted that of the 500,000 people who die each year, most wish to die at home; however, the majority die in hospital. Table 2.1 shows highlights that 45% of deaths in England in 2018/19 occurred in hospital; almost twice the number of those occurring at home, or those occurring at a care home. Research conducted by commissioners found that people in their last years of life were high-intensity users of health services; when they become acutely unwell, they tend to be moved to hospital rather than being managed and supported in the community. Indeed, commissioners highlighted that 40% of hospital bed days in the area were occupied by people in their last two years of life.

Table 2.1 – **Death registrations by place of occurrence, England, financial year 2018/2019**

All deaths	485,812
Deaths in hospital	220,449
Deaths in usual residence	216,443
– **Home**	117,232
– **Care home**	106,058
Hospice	29,080
Other communal establishment (hotel, hostel, student residence etc) or other	12,993

Source: Office for National Statistics - https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/009982rollingannualdeathregistrationsbyplaceofoccurrenceenglandfinancialyearendingmarch2019

19 Department of Health, 2008, *High Quality Care for All: NHS Next Stage Review* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf

20 Department of Health, 2008, *End of Life Care Strategy*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf

The way people die has also changed. Death rates are projected to rise significantly over the next decade[21], and it is becoming increasingly common that deaths arise from prolonged illness rather than more sudden or immediate causes. These factors all impact on the way health and care services are delivered, and the ability to provide effective care at the end of life will have a material impact on system performance in the coming decade[22].

The EOLC Telemedicine Project was largely conceived and driven by Social Finance in their role as fund manager for the Care and Wellbeing Fund. The End of Life Care Integrator (EOLCI) sits within the Care and Wellbeing Fund to focus specifically on developing new projects to produce better outcomes for people at the end of life. In the early days of the EOLCI's development, the team explored project ideas that could facilitate those aims; this process included a feasibility study investigating different opportunities in the field, and a call for expressions of interest from CCGs interested in working with the Care and Wellbeing Fund.

The feasibility study identified a number of models which provided an evidence base for the hypothesis that community services can deliver better experiences for people at the end of life (and their families), and prevent costly and unnecessary hospital care. For example, the EOLCI team was particularly interested in the Marie Curie Delivering Choice Programme; an approach based on Marie Curie's Rapid Response nursing model which is fully staffed by end of life care specialists (rather than generalist nurses). Much like the Telemedicine Project, this service puts a coordination hub in the centre, though it is focused specifically on supporting patients in the last 4-6 weeks of life. The Department of Health and Social Care commissioned an assessment of the allocative efficiency of the Marie Curie model, while a number of other evaluations had proven the success of the approach in reducing the number of cancer patients dying in hospital or experiencing emergency admissions to hospital in the last weeks of life.

The EOLCI also explored the Immedicare model, a telehealth intervention developed and delivered by the Airedale NHS Foundation Trust with funding from the NHS Yorkshire and Humber Regional Innovation Fund. This intervention is staffed by a nursing team offering support to care home staff as well as people in their own homes who are registered with the service. The service has also been formally evaluated as successfully reducing non-elective admissions for care home residents[23]. However, Social Finance noted that across the board there was less evidence for the success of telemedicine compared to general community nursing and care such as that provided in the Marie Curie model; in Social Finance's view this is due to a number of reasons, which includes that the care home sector is fragmented and homes take different approaches to training staff – as such, there are varying levels of skills across the sector to engage with and utilise clinical advice and support.

The analyses conducted in developing the SIB provided a good level of information about the types of people being conveyed to hospital who could reasonably be cared for in a care home with the right support in place. In the EOLCI's view, the data suggested that a telemedicine service to provide that support was likely to be of considerable value.

Following the exploration of the issue via the feasibility study, the EOLCI put out a call for expressions of interest for commissioners interested in developing projects in the end of life care arena. A number of potential commissioners responded, primarily because the Telemedicine Project aligned with their own strategic aims as well as those set nationally. While there is an obvious human impact from a lack of choices over care at the end of life, the interviews for this report found that there are also significant implications for the health sector. The successful commissioners of this SIB pointed out that local end of life care services need to reorganise to meet the changing needs of the target group.

21 Nuffield Trust, October 2016, *Understanding patient flow in hospitals* https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/patient_flow.pdf

22 Ibid.

23 Hex, N and Wright, D, 2016, *Economic Evaluation of the Gold Line: Health Foundation Shared Purpose project*

While there is a need for reorganisation of end of life care services at an operational level, there is also a strong alignment between the telemedicine project and the NHS Quality, Innovation, Productivity and Prevention (QIPP) programme, which has been developed to reduce costs and waste in the NHS whilst retaining focus on quality of care. There are a number of national workstreams relating to the programme, including one focusing on commissioning in end of life care. This workstream aims to reduce emergency attendances and bed days, the use of inappropriate or unwanted treatment and the number of complaints. Under the QIPP programme, CCGs are required to produce plans and trajectories for savings, and interviewees across the research flagged the extent to which this project could support QIPP activity. This is supported by a report from a working group set up as part of the 'Shaping a Healthier Future' initiative in North-West London, which estimated that by focusing support on the frail elderly in care homes, approximately £14m could be saved or allocated to other hospital bed usages by reducing the number of inappropriate admissions referred from older people's care homes. Finally, the plan for the North-West London STP sets out that by 2020/21, residents of supported accommodation will only go into hospital electively; the telemedicine service clearly aligns with that aim.

Finally, interviewees expressed that this project could be a potential enabler for the future; for example, a video conferencing offer could be viable for the ambulance service, allowing them to access support to make better decisions for patient care. This intervention provided a testbed for a responsive telemedicine service.

Rationale for commissioning the intervention through a SIB

Arguably, the fact that existing end of life care interventions have proved successful without using a SIB suggests that such offers can be provided through standard fee for service contracting models. However, access to capital to develop new services is a key consideration; in the Immedicare model delivered by the Airedale NHS Trust, start-up capital was provided by a local NHS innovation fund rather than core CCG budgets. Overall, in North-West London there were four main drivers for delivering the telemedicine project through a SIB:

- **Provision of upfront investment to the commissioner**

At the time of the SIB's instigation, the North-West London CCGs were in financial recovery and had no funds available to launch such a service via a standard commissioning route. The SIB provided the funds required to invest in the development of the project (as a model that was new to the area) and get it off the ground. Savings are generated for the commissioning CCGs as the service facilitates a reduction in payments from the CCGs to the acute trusts. This primarily comes from a reduction in the 'allocation' (payment) for growth (or increased spend) in the negotiations over annual funding[24].

24 More information about NHS funding structures, CCG funding responsibilities, and the way payments to CCGs from NHS England are calculated, can be found here: Fair Shares: A Guide to NHS Allocations, NHS England and NHS Improvement, 2020, https://www.england.nhs.uk/wp-content/uploads/2020/02/nhs-allocations-infographics-feb-2020.pdf or at https://commonslibrary.parliament.uk/research-briefings/cbp-8399/

Paying for success rather than activity

Because the commissioners had limited access to funds, the risk associated with sponsoring an unproven service was exaggerated further; the funds helped alleviate the risk but also meant that the commissioners were paying for achievement of outcomes rather than just delivery. Interviewees highlighted that often, NHS commissioning monitors success via activity, though this does not necessarily equate to financial performance or social impact.

Rigour in development, monitoring and analysis

Having an investor and intermediary brought several benefits in relation to convening power to get stakeholders and partners around the table, as well as overarching governance, programme management and analytical support. It could be argued that commissioners could buy in such third-party support in a standard fee for service commissioning model, but as public sector commissioners are generally working with limited budget and resource, this would be difficult to justify, despite the benefits evidenced in the process of developing the telemedicine service. Furthermore, the investment drives the focus on performance management, as fund managers are motivated to protect their investment and ensure intervention success.

Shift stakeholder focus to preventative healthcare

Commissioner interviewees believed there was a strong case for moving to capitation models of healthcare commissioning, mirroring the approach NHS England takes when funding CCGs. Although a capitation model wasn't used in this SIB, the model could support a move to capitation funding between CCGs and NHS Trusts in the future. SIBs are designed to protect providers from financial risk, which could prove important in a capitation payment structure; in a pure capitation model, providers would take on responsibility for the delivery of care to a defined population for a set fee, regardless of the cohort's health levels (NHS England weight their allocations to CCGs to take some of these factors into account however). Proponents of capitation models[25] argue that healthcare provided through fee for service (or indeed, payment by results) arrangements focus on volumes (number of patients engaged or supported) rather than value. On the other hand, the set payment-per-head of a defined cohort in capitation encourages focus on preventative work, which gives a greater financial reward in the long run than the treatment of the ill. However, capitation models also shift financial risk from healthcare commissioners to providers, who have very limited control over a population's actual medical needs, but only the care they provide[26].

It is worth noting however that for all parties, the main driver for the SIB was that the investment was readily available via the Care and Wellbeing Fund, and the EOLCI, in their remit as fund manager, had identified that there were gaps in care for those at the end of life which they believed could be addressed through SIB delivery. Whilst the commissioners were not explicitly looking to address their own issues in end of life care with a SIB, they were attracted to the model as an opportunity to provide better outcomes for patients while avoiding costs in the acute health sector.

25 Such as Miller, H.D., *From Volume To Value: Better Ways To Pay For Health Care*, Journal of Health Affairs, vol 28, no 5, Sept / Oct 2009 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.5.1418

26 Porter, M.E and Kaplan, R.S., *How to Pay for Health Care*, Harvard Business Review, July-August 2016 https://hbr.org/2016/07/how-to-pay-for-health-care

SIB governance structure and financial model

Governance

There are two levels of governance for the SIB: operational and strategic. At the time of conducting the initial fieldwork for this review (September 2018), the governance structures had been something of a work in progress; while all involved recognised the importance of good governance, there was consensus that the process had been somewhat inefficient for some time due to staffing changes within the commissioner and STP, and a resulting lack of ownership of the project. Work between the stakeholders to review this led to a revised and more streamlined process, eradicating multiple meetings per week involving different parties to a roster of weekly operational group meetings involving project management-level staff, communications teams and so on.

Sitting above the operational group is the Joint Project Working Group, which takes a strategic view and is essentially the project board. The group is chaired by a director from the STP and focuses on reviewing data and progress. Interviewees believed that getting the working group in place, with a fixed chair, had encouraged activity and general progress in the right direction for the SIB.

Additionally, the MOU between the stakeholders sets out that the EOLCI, commissioners and service providers would hold contract review meetings at least on a monthly basis during the first year of the SIB, with a view to reducing this to at least every three months following mobilisation.

Financial model

Payment flows

Table 2.2 sets out the key financial metrics for the Telemedicine Project. It shows that over the lifetime of the project, the investors – Big Society Capital and Macmillan, under the umbrella of the Care and Wellbeing Fund - will provide £1.6m of capital[27] to cover the cost of the service's Hub (referred to as the core funding for the initiative). This capital is paid to the coordinating commissioner quarterly in advance, and the coordinating commissioner is responsible for disseminating payment to the service providers on a quarterly basis, again in advance. These payments are based on service costs per month; if there are vacancies or other changes to costs the payment would be reduced accordingly. This provider payment is made quarterly in advance on a fee-for-service basis and as such is not dependent on the achievement of outcomes, so risk is transferred, in-principle, to the investor from the provider, as is the usual case in SIBs.

However, it does rely on the provider meeting pre-agreed service milestones, and also the full defrayment of preceding payments. In theory, this means that the providers are very likely to receive full payment for their services, though there are also a number of key performance indicators in place (described in full in Annex 1 of this report). Should performance not meet these standards consistently and there not be an agreed remedial plan implemented, then the coordinating commissioner could withhold or reduce payments accordingly. Conversely, should more investment be needed, the intermediary would develop a proposal to present to the investment committee. Finally, there is a three-month termination period in the Funding Agreement which applies to all parties.

27 This figure represents the amount of investment in a median scenario; the full range is £1.4m to £1.8m.

Table 2.2 **Key financial metrics for the NWL Telemedicine Project**

Total operating cost	Up to £2.98m
Total costs including operating costs, management costs and investor return	Up to £3.9m
Return payable to investors	£334,000*
Contract Financing	
– **Social investment**	£1.59m*
– **NHS Ealing funding**	£116,650**
– **Commissioner outcome payment**	£2,616 per outcome (avoided non-elective hospital admissions from care homes) (capped at a total of £3.12m)
– **CBO top up**	£654 per outcome (20% of total outcomes payment, capped at £780,000)
– **Implementation support**	Provided pro-bono

* Based on a median scenario

** Year one only – future funding subject to review at the end of the first year of delivery

Outcome mechanism

As noted, although the EOLCI and the coordinating commissioner monitor provider performance against a range of KPIs, in this SIB, commissioners and The National Lottery Community Fund pay against one trigger outcome only; £3,270 per each avoided non-elective hospital admission from care homes below a pre-agreed baseline of 2,944. This baseline is based on the Non-Elective Hospital Admission activity for those care homes in 2016/17, with assumed growth applied each year. In other words, the commissioners only pay when the project reduces hospital admissions below what they estimate would have happened otherwise, based on historical data. Historically the baseline has increased around 6-7% annually however, and there are a range of factors which can influence this. This means it is difficult to project figures for baseline increases in order to establish whether the SIB is indeed performing as measured. Of the £3,270 outcome payment, the commissioners pay £2,616 and CBO pays a further 20% (£654). This is further detailed in Table 2.2 below. Up to 1364 patients are expected to achieve this outcome, with 1,091 achieving it to reach the expected contract median scenario.

Both commissioner and CBO contributions are capped below the high scenario, supporting up to 1,193 outcomes, so neither will pay for every person achieving high scenario should this be achieved, and in this eventuality the SIB itself will bear the additional cost of the remaining 177 patients' outcomes.

Table 2.3 **Primary metrics for outcome payments**

Expected non-elective hospital admissions from care homes based on historical baseline	2,944	Corresponding outcome payments for commissioners & CBO (i.e. no. of outcomes * outcome payment of £3,270)
If no. of non-elective hospital admissions is higher than 2,944:		£0
Point at which commissioners start paying outcomes payments	Non-elective admissions from care homes fall below 2,944 by:-	
Expected number of outcomes achieved		
– **Low scenario**	818	£2,675,000
– **Median scenario**	1,091	£3,563,000
– **High scenario**	1,364	£3,900,000
Point at which commissioners start paying outcomes	1,364	n/a

At the outset of the SIB, it was anticipated that the intervention could achieve a reduction of 8-10% from the baseline (that is, up to a total of 1,410 avoided non-elective admissions, with a contract expectation of 1,091 being achieved), based on what similar programmes had been able to achieve in other areas. Performance against the baseline is monitored monthly, but for outcome repayment it is calculated during an annual performance management review. Reviewing performance annually for the outcomes payments aims to ensure there is enough data to accurately measure it, although there are a number of challenges related to measurement which are explored in section 3.3 of this report.

There is a range of dependencies upon which the outcome target is predicated. Not least of these are the responsibilities of the commissioners and providers to ensure that the service is publicised to care homes in the area to facilitate uptake at an adequate level. This is particularly important given that the service is designed to be responsive, so staff cannot be deployed to other tasks as they would then not be available to respond to calls. It is also vital that awareness raising is ongoing; not only to ensure an appropriate volume of calls, but also to ensure that calls are made appropriately, with care home staff using the service for issues which can be dealt with by telemedicine clinical staff.

Commissioners also have a responsibility to ensure the project is given appropriate strategic support, for example through inclusion in the North-West London Last Phase of Life Strategy, and the Urgent Care Strategy.

Finally, and as will be discussed further at section 3.3, the quality of the data for the measurement of outcomes is vital. Conveyance and hospital admission data is readily available to the EOLCI analysts. To further aid the monitoring process, a list of postcodes associated with the care homes within the North-West London has been generated. This is used to identify Non-Elective Hospital Admissions from the correct cohort of care homes.

Cost savings linked to outcome payments

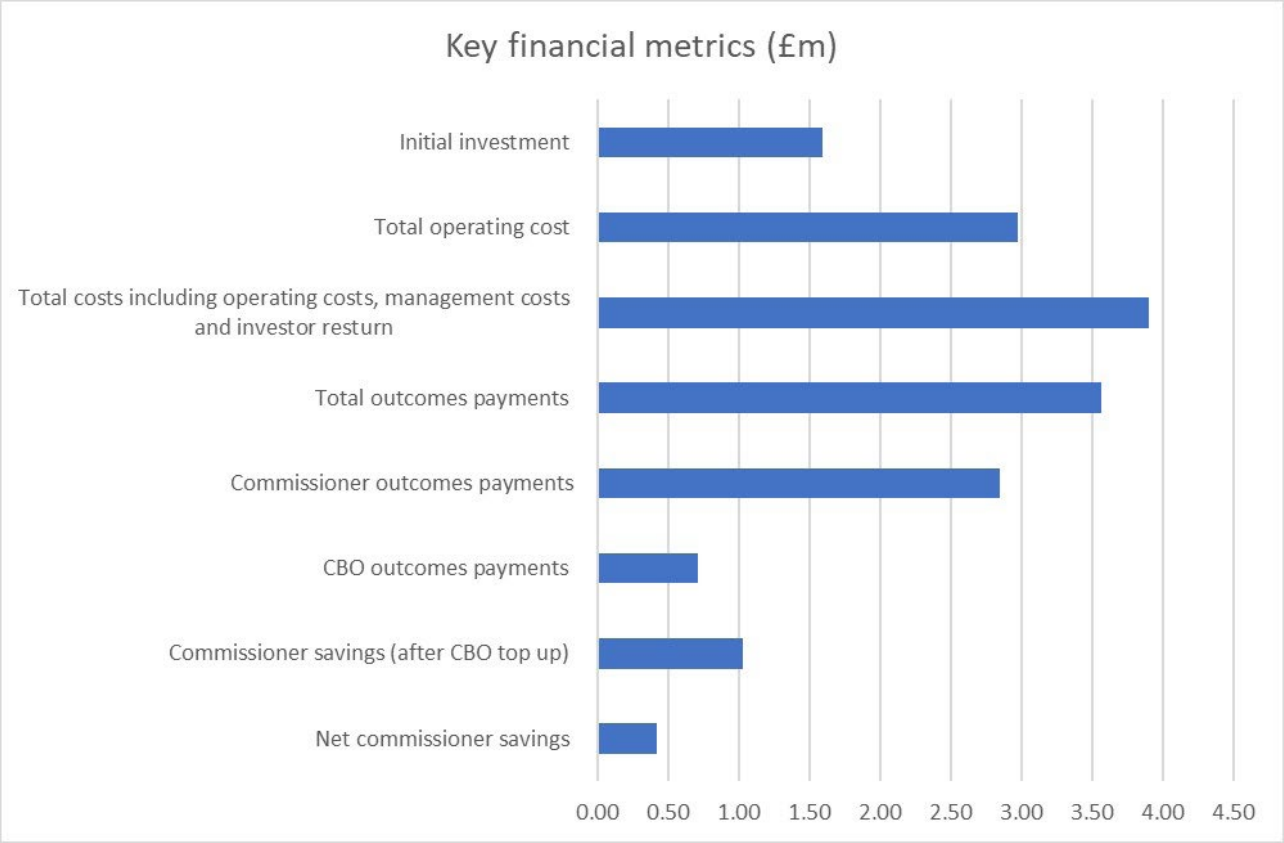
The outcome sought by this SIB is directly related to reduced hospitalisation at the end of life, linking outcome payments to savings for the commissioners. The service has allowed the commissioning CCGs to reduce the growth allocations paid annually to acute trusts, and as such they have been able to create *cashable savings*, releasing cash to repay investors and reallocate spend from hospitals to community services.

The flow of savings between budget lines at the commissioning CCGs will be explored in more detail during our second in depth review. A representative from the Care and Wellbeing Fund noted that some commissioners have argued that if a service does not close hospital beds, then it is not generating savings. However, proponents of this project argue that the service contributes to ensuring that the right people utilise the beds that are available, thus reducing backlog and waiting times. This means the telemedicine service frees up spend and hospital space and allows the commissioner to use this hospital space to support more people; as well as the savings generated in the reduction in growth allowances, the project therefore also *avoids unnecessary costs* and *improves cost effectiveness*. As a result, the proposal was attractive to commissioners.

It is likely that the avoided costs will cover the outcome payments; local data shows that the cost of an admission ranges from £2,500 - £4,000, and commissioner outcome payments (£2,616) are at the lower end of that bracket[28]. Figure 2.4 provides a comparative illustration of EOLCI's initial investment against the total outcomes payments (which includes £780k from the CBO Fund) and commissioner savings. On the basis of the data used to compile this, cashable savings for the commissioners should total £1.033m, although interviewees suggest that the actual avoided costs could be much higher.

28 Variances in savings are expected, driven by bed days and re-admission rates. However, the SIB stakeholders reached a figure of £3,000 as a conservative level of saving across the CCGs, and so expect savings to exceed this on average.

Figure 2.4 **Comparison of key financial metrics: initial investment, costs, payments and savings (median scenario)**



There were a number of motivating factors for the choice of outcome measure, as described by interviewees for this research. Firstly, non-elective admissions are inherently measurable and data is readily available from the London Ambulance Service; this was a prime factor in the choice of the outcome. Interviewees also reflected that the measure is the only way to test the project's hypothesis that telemedicine would reduce avoidable admissions and stays in hospital. However, this outcome is one of a number of measures which could have been selected for tracking, such as A&E admissions and ambulance call outs. The costs incurred by these activities alone are far lower than a non-elective admission, however. Given the SIB was intended to generate cashable savings rather than releasing bed capacity, it would have needed to operate at a vast scale for alternative outcome indicators to generate the cost reductions necessary across the CCGs to ensure operating costs would not outweigh the benefits.

Other payments: Investor return and implementation support

As outlined in Table 2.2, the commissioners are liable for the repayment of the investment at a rate dependent on outcomes; this will be up to £3.27m from the commissioners (not including CBO) at the high scenario, with the contract expectation being £3.12m at the median scenario. The target Internal Rate of Return (IRR)[29] to the Care & Wellbeing Fund is 8%-10% over the four-year lifetime of the project, or a money multiple of 2.04. CBO outcomes payments are capped at 20% of the contract expectation (thus, £780,000). This means CBO will not pay for outcomes achieved above the 1,057 avoided non-elective admissions which are expected at a median scenario – should the high scenario be achieved and the provider overperforms, then the additional 353 outcomes would be paid for fully by the commissioner. In the median scenario that is anticipated by the contract, and taking into account the CBO top-up, the commissioner will not pay any more than the equivalent of the core funding provided by the investors. In other words, in a median scenario the CCGs will only pay for what the service would have cost to commission without the associated costs of the SIB.

Alongside the investors' core funding, NHS Ealing CCG committed to provide funding of £111,650 to support provision of the telemedicine service into their 19 older people's care homes in year one, with an intention to review their involvement at the end of the first year. This funding sat outside the SIB itself, paying for the intervention to be provided to homes in Ealing on a fee for service basis.

Development process

Although interviewees expressed that the SIB development process had taken around two years, it is important to note that the telemedicine project was based on earlier work connected to the development of two SIB-funded interventions in 2014 and 2015 (although neither of these proceeded). Because the preparation undertaken for these models underpinned the telemedicine project development, CBO allowed the EOLCI to submit a full application in 2016, despite not having received development funding from CBO in the earlier stages. During the research process for this in-depth review, interviewees also highlighted that conversations started between Hammersmith and Fulham CCG and Social Finance in 2015. Taking these factors into account, the lead-in time for this SIB is around four years.

However, a long lead in time is not unusual for SIBs, both within and outwith the EOLCI. Furthermore, as Table 2.3 shows, the telemedicine project received an in-principle grant award in January 2017; from there, it took around six months to develop commissioner engagement, secure investment commitment, develop financial metrics and the management structure pre-procurement – a relatively fast turnaround compared to other SIBs. It may be that the learning from earlier model development informed and thus speeded up this process.

29 Internal Rate of Return (IRR) is a common metric for fund managers. This takes into account that money (capital i.e. brought back in) now is worth more than money in the future (because it can be redeployed). IRR is used by investors to compare investments which might have different lengths, amounts, and patterns of repayment. This can be confusing, but it is helpful to remember that with IRR, just as with annual rate of return, the timing of repayment is an important consideration. The most effective way to really understand how an IRR is calculated, and the different factors that will affect it, is through a financial model that uses the actual figures for a given investment deal. More information can be found at: https://golab.bsg.ox.ac.uk/the-basics/social-impact-investing/ and https://www.investopedia.com/terms/i/irr.asp

Table 2.4 **Key milestones in the telemedicine project's development**

Date	Activity
2015	Care and Wellbeing Fund established
2015	Initial conversations between Hammersmith and Fulham CCG and Social Finance
2016	Call for expressions of interest from CCGs released by EOLCI
January 2017	In-principle grant award made by CBO
September 2017	Final grant offer made by CBO
September 2017	Investment signed off by the Care and Wellbeing Fund investment committee
June / July 2018	Six-week review period led by EOLCI
August 2018	Soft launch of delivery
September 2018	Development of pilot for video conferencing offer
October 2018	Full service delivery underway

As the table highlights, in 2016 the EOLCI undertook an early exploration of interest for their first wave of activity; the process sought to find CCGs interested in working with the Incubator and to identify what needs those CCGs aimed to address. This exercise attracted around 60 responses from potential commissioners; a triage exercise reduced this number down to seven potential commissioners. The EOLCI undertook a feasibility study for each one in order to select which projects to progress.

The telemedicine project was conceived through talks between Hammersmith and Fulham CCG and the EOLCI. As plans progressed, it became clear

that more CCGs would need to be involved in the SIB to provide economic viability for the project; there was a minimum threshold for the project where costs need to be defrayed effectively to make the SIB viable, in terms of economies of scale. It was vital that there were enough care homes involved to provide an adequate level of engagement (and thus, the resultant avoided costs) in order to cover the costs of the highly-skilled staff operating the service. By way of illustration, there are only five older people's care homes in Hammersmith and Fulham; across the whole of the North-West London STP area there are 140. It would not be economically viable to provide the service needed to achieve appropriate outcomes (and generate commensurate avoided costs) across a smaller number of homes. However, the wider partnership of commissioners has led to a number of challenges which will be explored later in this report.

The contracting process for providers was a key factor in the long lead-in time for the service. The first round of procurement aimed to contract with the provider for the Immedicare service already referenced in this report. However, this procurement was unsuccessful; interviewees flagged that it became clear that a provider from outside the geographic delivery area would struggle to provide the service effectively, and that local links were vital. This was primarily to ensure that the service would be able to deploy local services efficiently in the case that a patient needed care beyond what the telemedicine project could offer. As interviewees highlighted, healthcare structures in the area are complex, and for a provider from outside the area to build the necessary links with local services would be resource intensive and challenging. This made the financial plan untenable.

As commissioner representatives flagged, during the procurement process it became clear that there was a limited number of providers who would be well positioned to provide the telemedicine service, in terms both of access to well-qualified staff and technological capacity and expertise. When the second procurement round opened, the lead commissioner suggested bringing all local providers together to explore the offer and potential joint ways of working. The two successful providers, who are both based in the area, applied jointly having worked together previously on the delivery of a different telemedicine offer.

The procurement process proved to be a key challenge for the SIB, to the extent that the Care and Wellbeing Fund investment committee challenged the benefits of pursuing the project given the complexity, delays and the number of moving parts which were proving difficult to pull together. However, the EOLCI saw merit in continuing and played a significant role in moving the project forward at this point.

Indeed, according to interviewees across all roles this tenacity has carried the project forward when it has met difficulties. This was the case to the extent that the EOLCI seconded a member of staff to the STP on a part-time basis in the run up to the launch, project managing the process and ensuring that all parties remained on track. The EOLCI also conducted a detailed review over a six-week period before the launch which focused on reassessing the model and approach following the development period, in order to ensure that the processes put in place were fit for purpose and would meet the aims of the project.

A final priority in the development of the service was marketing the offer to potential service users – the older people's care homes themselves as well as other stakeholders such as GPs. In the early stages, this was led by the commissioners of the SIB, who are also the commissioners of the care homes. Visits were initially targeted at those older people's care homes with the highest number of conveyances to hospital according to the data, but difficulties arose when the launch of the service was delayed due to difficulties recruiting staff; keeping momentum going in marketing is challenging in such circumstances. However, evidence from the Marie Curie Rapid Response service highlighted that communicating the offer was vital, and for the telemedicine project this continues to be the case. Analysts at the EOLCI regularly review the data on marketing visits to care homes and cross reference this with data on project performance to look for correlations and review whether engagement is working. A key challenge in this respect is the high level of staff turnover in the care homes themselves; it is difficult for the EOLCI and commissioners to know whether knowledge of the service is disseminated amongst staff so usage is maintained after those involved in marketing visits move on. The second visit for this in-depth review process will explore the impacts of marketing and care home staff turnover on performance in more detail.

Stakeholder experiences and views

This chapter of the in-depth review report examines the SIB from the perspective of each of the different stakeholder groups, and also draws out the key successes, challenges and lessons learned.

Stakeholder roles and experiences

Commissioners

There was little understanding or experience of SIBs within the finance teams of the commissioning CCGs, but those leading the project at Hammersmith and Fulham CCG (the coordinating commissioner) felt that the SIB was a compelling business case to take forward, as already described.

Importantly, commissioners were also driven by the SIB's ability to provide funding for a multi-year project. CCGs are provided with annual resource allocations from NHS England to cover the costs of providing health services for the population they cover; the funding formula is reviewed each year[30]. This means CCGs' own commissioning cycles run on an annual basis, restricting the development of longer-term (or indeed, new) activities. By providing up front and 'at risk' investment, the SIB model enables commissioners to test new models of care. The first repayment is made after 18 months, allowing time for the service to embed and demonstrate impact outside of the 12-monthly budgeting process.

For commissioners, this shift to being able to commission a service over a number of years under the SIB has been valuable in allowing them to attempt to align their services with policy developments such as the NHS Long Term Plan, which seeks to improve care quality and outcomes in the next ten years[31]. Having confirmed funding in place for the intervention lets the CCG commissioners take a longer-term, preventative view for care provision locally, particularly as the delayed outcome payments allow time for the development of evidence of efficacy.

For the coordinating commissioner, involvement in the SIB has been a positive experience. Interviewees described how having an alignment of purpose and collective intent between the investment fund managers / intermediary and the commissioner has been vital in terms of keeping the project on track. Although there was a view that the SIB structure does add a layer of complexity to delivery, it also adds momentum and drive, maintaining forward trajectories through focused project management on the part of the intermediary when challenges have arisen. However, even with the focused support from the intermediary, the coordinating commissioner noted that as the partnership of commissioners grew, the process of managing it became much more complex. In response, the coordinating commissioner built a small, focused team with a dedicated programme manager to facilitate the administration of the programme from their side.

30 For more information on NHS England's approach to calculating CCG funding, see https://commonslibrary.parliament.uk/research-briefings/cbp-8399/

31 https://www.longtermplan.nhs.uk/online-version/

The STP

The STP holds strategic oversight of the project as part of their role to coordinate services and develop system-wide priorities for the North-West London area. STPs were developed alongside the NHS Long Term Plan and were developed between 2015 and 2017 – around the same time that the telemedicine project was developed. The primary intention of the development of STPs was to create local, integrated care systems. Indeed, the NHS Long Term Plan sets out that all STPs must have fully integrated care systems in place by 2021; in North-West London this will see the eight CCGs merge to become one body.

For the STP, a key challenge has been the long gestation of the project. The shift in the NHS landscape was significant in the time between project conception and launch, with the agenda of the integrated care pathway gaining increasing importance. In the STP's view, this pushes against the SIB structure for the telemedicine project, which ideally needs to be a standalone service sitting outside other healthcare systems in order to attribute outcomes to its own intervention. However, in the case of the telemedicine service, this challenge has been avoided by negotiating that all reductions in non-elective admissions from older people's care homes will be attributed to the project, as it sits within the integrated care pathway.

> "If you follow a particular resident, there are so many interfaces… it's a process of identifying need, knowing where to go with it and making that onward referral and so on; it's a pathway through lots of parts of the service. We need to commission the interfaces rather than the steps in the process so it's more joined up." (STP representative)

However, as stated above, there is good fit between the offer and the STP Plan, which sets out that by 2020/21, residents of supported accommodation will only go into hospital electively. There was motivation within the STP to keep the profile of the SIB and the intervention high, and work alongside the right stakeholders to raise awareness and interest and identify aspects of the model that are transferrable.

As with the commissioning CCGs, there was little experience of SIBs within the STP prior to this projects' inception, and the move away from more typical models of NHS funding was perceived as being challenging.

> "It was like a dark art when I first came into it. What is it? Who's paying for it?" (STP representative)

This was exacerbated by a number of changes in personnel within the STP, meaning ownership and understanding of the project fluctuated. However, the support from EOLCI moved the project on considerably. The STP also funded some time from an EOLCI staff member to be embedded in the STP for a short period before the service launched, in order to speed up the launch of the intervention. In the eyes of interviewees from the STP, having that member of staff in place has brokered relationships between the various parties involved in the SIB and dissipated challenges that could exist between them in the development of a complex project.

Social Finance: Investment fund manager and intermediary

As the managers of the Care and Wellbeing Fund, the fund which owns the EOLCI (the intermediary for the SIB), Social Finance hold a relatively unusual position in this SIB in comparison to others. As fund manager, Social Finance represents the interests of the investors, while the EOLCI holds an intermediary role in the project and has an independent board and chair.[32] There is an MOU in place between the organisation and the intervention providers.

Across the board, interviewees saw the two-pronged approach of the provision of investment alongside implementation and management support as being essential to get the SIB off the ground. In the EOLCI's view, their experience in this field was beneficial as they could provide reassurance to other stakeholders around the table, who were mostly new to SIBs, and in some cases nervous about the approach.

In this SIB, the implementation and management support offered by the EOLCI (as the intermediary) had been vital to maintaining momentum and ensuring the project launched. Interviewees saw it as logical that this support would come from an organisation with an interest in safeguarding the social investment. There is an argument that management support could be procured elsewhere by commissioners in say, a Fee for Service standard contracting arrangement, diminishing the argument for SIB arrangements. However, EOLCI argued that they were best placed to do it because they were close to the investment or funding, and they argued this was critical; two earlier SIBs developed by the Integrator involved external consultants to facilitate the relationships and management, but neither of these SIBs progressed to launch. Equally, it is unlikely that the CCGs could have commissioned a similar package of development support and performance management without the 'carrot' of the up-front investment; given their own financial difficulties, this expense would have been very difficult to justify.

Although this SIB has taken around four years from inception to launch, Social Finance was not concerned about the lead-in time; this was a large project and acted as a proof of concept for SIBs in health. EOLCI report that subsequent SIBs have had a shorter lead-in time. Interviewees expressed that having an intermediary organisation in place is beneficial in the long run, but acknowledged that the level of rigour arising from intermediary intervention can also negatively impact on the lead-in time, particularly in terms of scrutiny of evidence bases and different aspects of project development pre-mobilisation.

"That process is always longer than we had first anticipated." (Investment fund manager representative)

While interviewees agreed that there had been challenges in the development phase, they saw this as useful learning, both for this project and others in the future.

"It's all a test and learn process… We need to boil down for the reason the challenges occur to either surmount them or avoid them next time." (Investment fund manager representative)

32 Although Social Finance runs the EOLCI, it is structured as an intermediary body that is independent of Social Finance and where the majority of board members are external to Social Finance.

Providers

Across the two main providers, there was consensus that the SIB had been a time-consuming approach to financing the service, and the perceived complexity of the commissioning structures was a key factor within this. The providers felt that the number of stakeholders involved added to the lead-in time for developing the service and for having approaches agreed; with eight commissioners, the STP and Social Finance involved, there were always numerous views to consider. Crucially, interviewees felt it was not always clear who they ultimately answered to, given the providers have a three-way MOU with the EOLCI and the coordinating commissioner which sits alongside a service agreement between the providers and coordinating commissioner. The MOU stipulates that all three parties are involved in performance review meetings, and that all three work together on resolving risks and issues.

There were also delays around contracting and this led to both providers starting delivery at-risk; service providers were nervous about this, particularly for the provider who is an NHS Trust and has less flexibility than the VCSE provider to work on good-will.

The consensus was that the development of the SIB had taken much more director-level time across the providers than an equivalent fee-for-service contract would have done due to the scrutiny applied by the intermediary during the development phase (see section 3.3 for more discussion of this issue). However, providers also stated that the support and expertise accompanying the funding model had been very helpful in terms of providing insight and steer (despite being time-consuming), and views on the relationships between providers, the intermediary and commissioners were generally positive. Providers also felt that the SIB had allowed for innovation in delivery where standard commissioning would not, by financially "de-risking" the development of new and interesting approaches.

Interviewees representing the providers expressed that they would not be deterred from undertaking a SIB again, particularly now they know what to expect from the process and the potential challenges and benefits involved.

Successes

Interviewees highlighted a number of factors which they perceived as key successes in the development of the SIB.

Building on an evidence-based model: The delivery model for the SIB was drawn from research which highlighted gaps and needs in service provision for those at the end of life and also from evidence reviewing an existing telemedicine model (The Immedicare Model) addressing such needs. The Immedicare Model had been fully evaluated, and being able to draw on evidence on what works has been vital to the development of a model that fits with local pathways, despite a lack of local data to support the business case. One interviewee from the EOLCI referred to an organisational desire to "invest to solve", and building on existing, tried and tested approaches fits that ethos.

Close relationships with commissioners: The EOLCI strove to build strong relationships with commissioners from the inception of the SIB, and ensured commissioners had the ability to input to the model to ensure it had strategic fit with other initiatives. Although the EOLCI set out the strategy and vision for the SIB, interviewees from the Care and Wellbeing Fund managers referred to the development process as "collaborative co-creation". This approach was also described as an attempt to "galvanise" the stakeholders involved in the process to apply appropriate rigour to delivery and monitoring.

Experienced providers: The two providers have an existing relationship and were already jointly delivering a project with a similar theme in four of the eight SIB Boroughs. They also have experience in delivering more generalist telemedicine services such as 111; this expertise equipped them to hit the ground running to some extent.

Although the two providers were initially acting jointly, restructuring to have LCW as the lead provider has streamlined communication between commissioners, EOLCI and the providers as there is now a single point of contact with the providers.

There was also evidence of how the SIB mechanism, and the elements within the SIB, have brought additional benefits for the various parties involved.

Breaking short-term funding cycles: The SIB has allowed the commissioners to test an intervention on a risk-free basis outside the standard NHS one-year funding cycle. This is made possible by the SIB providing access to up-front funding and capital and allowing commissioners to only pay for outcomes achieved – on a delayed basis - using funds which have been freed up by reduced costs for the CCGs in their payments to the acute sector. Breaking this cycle is particularly important when developing a new intervention with a new audience; the upfront capital plus development support and set-up time is accounted and allowed for. This also means that commissioners can better align their services to the NHS Long Term Plan. As one interviewee noted, the commissioners would not have been able to put the service in place without the SIB because of their own financial constraints. The approach also opens doors to more imaginative ways of using public money in the health economy.

"Working with EOLCI has shown us that there are lots of other [funding] models. How we conceive of money in the NHS is old school. NWL is £2bn health economy – we just need to be more imaginative about how that money is used. SIBs are one way of highlighting the more imaginative ways we can use public money." (Commissioner representative)

This also supports the attainment of one of the core outcomes of the CBO Fund – to up-skill commissioners in SIBs. Although key parties (commissioners and the STP) have seen core staffing changes, the embedded support from the EOLCI has supported buy in from those parties. The second wave of research for this in-depth review will explore further the extent to which newer staff have had their capacity built in relation to SIBs.

Dual package of funding and support: As interviewees unanimously flagged, the SIB model not only brings access to up-front and risk-free capital, but also access to expertise and rigour in planning, development, partnership working and performance management, all of which contribute to managing the money mechanism associated with the SIB. Interviewees highlighted that it is beneficial that this package of support does not stop at the point that contracts are signed but extends for the full duration of the funding agreement.

Commissioners interviewed expressed that

"The programme would never have got off the ground without Social Finance – they offered an enormous amount of support and were instrumental in being able to carry on rather than scrapping the whole idea when we met problems. The collective intent to make it happen was vital."

Other interviewees described their approach to problem solving as helpful challenge. One particular example of this problem-solving approach was the role the EOLCI played in keeping the project on track when the first round of provider procurement failed. Commissioner representatives highlighted that a huge amount of due diligence and preparation had been done but that did not prevent an unsuccessful process; the commissioner felt that it was likely they would have walked away from the project at that point without steer and guidance from the EOLCI.

"They gave us a mature and considered response that meant we were able to do something that will be a much better answer. It was a turning point in the programme." (Commissioner representative)

From Social Finance's perspective, the provision of support alongside the funding is a vital aspect of this SIB model, not least because as investors they carry the risk of testing an intervention that is new to the locality, in terms of offering a specialist, responsive service with a specific target group (as opposed to say, 111's approach which includes call handling; only 50% of callers to 111 receive a clinical assessment). Engagement with the support is important to safeguard the investment (which ultimately, has been made with funds in part from a charitable source).

A simple payment metric: The outcome payment metric was deliberately kept simple in order to facilitate the rigorous monitoring required by a SIB. Interviewees recognised that the simplicity of having a single outcome to measure could mean that the quality of the patient experience is overlooked; however, the development of broader KPIs seeks to keep delivery on track and ensure the service provides good quality care.

"The outcome measure is almost a proxy for developing a better system in the community – anticipatory and timely intervention to avoid crisis." (Investment Fund Manager representative)

However, the interviews at baseline stage did not clarify to what extent a Theory of Change or other logic modelling had been conducted during the development to underpin this assertion.

The CBO grant: The outcomes co-funding from The National Lottery Community Fund has been important for generating buy-in and faith in the initiative from those in the NHS who are new to SIBs. The grant has allowed for a cap on repayments from the commissioners (90% of service costs for the first 18 months, then 100% thereafter). This essentially means they only repay what the service would have cost to deliver without the SIB, with the additional development and monitoring costs covered by the grant[33].

This has mitigated risk for the commissioners, but interviewees also believed it has also mitigated any perception that the EOLCI are

"taking money out of the system"

or even attempting to privatise services – a common perception when external organisations become involved in delivering services on behalf of the NHS. The National Lottery Community Fund's involvement as a charitable organisation has, on the surface, legitimised the approach.

33 Thus, the SIB is liable for funding any outcomes above the cap; this is covered in the delivery costs in the high and median scenarios and would represent a loss of £0.56m of capital in a low scenario. It should also be noted that the CBO grant cannot fund any return to the investor, so these costs would need to be covered by the commissioner. However, CBO would offset this by supporting the costs of delivery.

Challenges and disadvantages

This report has highlighted that getting the telemedicine service up and running took time; the SIB was four years in the development phase. There were a number of challenges which contributed to the time required to establish the service, and these are explored below, giving consideration to the disadvantages of the SIB. Where relevant, approaches to overcoming these challenges are highlighted, while Section 3.4 provides an overview of the 'lessons learned'.

Data quality and attribution of outcomes: The performance management and monitoring required to evidence success, and thus trigger outcomes payments, has provided challenges for the project. The service is provided to older people's care homes to address poorer outcomes for residents compared to those living at home. However, identifying older people's care homes in the data as callers to the telemedicine service has been problematic. Although a system has been developed which highlights care homes by flagging their postcodes in the caller data, it is possible for this to be skewed if there is another House of Multiple Occupation (HMO) such as a hostel in the same postcode.

A further challenge (both operationally and strategically) has been that the SIB model requires the service to be ring-fenced or separated from other areas of healthcare provision, for example by having dedicated staff who work only for this service. As an interviewee from the STP noted,

"staff are badged to do one job, to do x thing, to deliver y outcomes."

This ensures that outcomes can be attributed to the telemedicine service rather than any other healthcare interface, thus allowing the SIB to

"pinpoint forensically the attribution of investment to a particular outcome" (Commissioner representative).

This was problematic when setting up the service, and as noted, caused delays in launching. There are also challenges around attribution where patients are passed to other parts of the urgent care pathway should the telemedicine service be unable to meet their needs.

As one interviewee questioned, if another service prevents an admission to hospital, can that outcome be rightfully attributed to the telemedicine service? However, it could be argued that this is evidence of the integrated care pathway successfully working, and a valid outcome claim if the initial call to the telemedicine service ultimately prevented an admission or call to the ambulance service.

Sitting over and above the issue of attribution is the difficulty in establishing the baseline figure for non-elective admissions to hospital from the care homes in order to understand project performance. As referenced earlier in this report, the number of admissions can vary year to year depending on external factors, and as such it is difficult to project the growth in the baseline for a given year in order to know the service is working.

A number of measures have been put in place to address these challenges where possible. The project's operational group members regularly review data collection processes and interviewees highlighted that there is an ongoing process of data validation. For example, all calls to the service are reviewed to assess whether the clinical need the patient presented with would likely have resulted in a conveyance to hospital and / or an admission in the absence of the telemedicine support.

For the efforts made to improve data quality, one interviewee felt that the system is

"not perfect, but good enough to demonstrate change in healthcare",

while another argued that the checks and balances put in place provide some triangulation to the data which

"gives some comfort".

However, there was also consensus that it is

"hard to count things that haven't happened."

Securing buy-in from stakeholders: Interviewees acknowledged that SIBs were a new concept for many involved, including finance staff within the commissioning CCGs. For those within the health sector, there was a question over the motivations of investors' and intermediaries' approach; interviewees felt that organic growth was important in terms of encouraging CCGs to come on board and buy in to the concept at their own pace. One interviewee noted that it had been important to keep the language consistent throughout the early stages, and that this had helped stakeholders understand the direction of travel.

"It felt like a campaign at the time – going round with posters and slides to sell the vision, firstly to CCG colleagues locally and in neighbours – trying to address some of the reticence and show why this was a good model." (Commissioner representative)

Although commissioners were brought on board, staffing changes within the lead commissioner meant that the programme lost its initial champion. Equally, the introduction of the STP – making them responsible but not accountable for the project – muddied waters and saw the project become enmeshed in other STP activities to some extent. The context for the project, and the initial vision for it, was partially lost during this process. This is perhaps an inherent challenge of setting up SIBs – which as we have seen typically have a long lead-in time – in an ever-evolving, complex policy arena such as healthcare.

Complexity of commissioning structures: Operating across eight CCGs has been challenging in terms of the logistics of setting up a new service. This has particularly included difficulties in getting information sharing agreements off the ground and working across different IT systems in each area. Alongside these difficulties, providers have also found it challenging to address the needs of the range of stakeholders involved in the SIB; with eight commissioners, the STP, the EOLCI, two providers and ultimately the investors in the Care and Wellbeing Fund, there are often competing views to address and needs to fulfil. Interviewees felt the embedding of EOLCI staff in the project has helped to unify the approach across the interested parties, and gave the project more focused oversight, particularly in light of restructure within the CCG.

"From the provider perspective, it blurs the boundaries of who is the commissioner. There is a conflation of roles because everyone is just mucking in and that's confusing for providers, especially if there's a different view between the investors and the CCG." (Intermediary representative)

For providers, this level of scrutiny has led to the project feeling "micro-managed", and has required a much higher level of senior input than a project of this financial value would usually require. This of course leads to questions about the sustainability of the approach and the extent to which providers can afford to be involved in SIB delivery if they require a disproportionate level of input from their most expensive members of staff. However, providers felt that some of this was due to them being new to SIBs and this complicated commissioning approach; if working under similar structures again, they felt they would be better equipped to plan for this way of working.

Recruitment of staff: Staffing has been a particularly challenging aspect of the project development for a number of reasons. The EOLCI required highly qualified clinical staff in full-time, permanent, telemedicine-only posts; this would align the service with that provided by Marie Curie's Rapid Response and Delivering Choice interventions, on which the telemedicine project's approach is based, as well as ensuring high quality provision. However, clinical staff are generally not attracted to such roles as they are lacking direct patient contact. In other services, telemedicine posts would likely be filled by agency staff who work shifts alongside roles in patient-facing services, but this approach was not aligned with the model developed for the Telemedicine Project. Where possible, the providers have tried to pull staff from other telemedicine services to get the service off the ground, though there have been additional complications relating to training needs as other services use a different call handling system and software.

The providers have also explored options such as seconding staff from other local services with the support of the CCG, and developing qualifications to upskill interested staff who are currently not qualified to the right level to meet service needs.

These complications led to delays in the launch of the service, and although they appear to be operational in nature and driven by the project model, they are driven by the SIB to some extent, in terms of ensuring the approach offered something different to existing services.

"We were saying, 'This has to be different, and it's not going to be any different if we don't think about the skills that are required to support them [the care homes].'" [Investment Fund Manager Representative]

Representatives from the Care and Wellbeing Fund noted that as well as maintaining fidelity to the proposed model, putting the right staff in place would also have an impact on the financial envelope, and putting say, GPs in place to respond to calls (which had been one proposed solution when recruitment of nurses was flagging), would increase costs as well as preventing observation of a nurse-led model such as the ones the intervention was based on.

Getting the right technology in place: Ensuring the call routing is working appropriately has been a logistical challenge which led to delays in getting the service fully operational. Following the launch in August 2018, it was clear that not all calls were getting through to the Hub. Stakeholders were not able to advertise and raise awareness of the service until these issues were resolved. Interviewees viewed this process as test and learn; once these issues are explored and resolved then scope is opened up to roll out the service to other areas, both geographically and thematically.

Conclusions

The first round of research for our review of the North-West London End of Life Care Telemedicine SIB highlighted a number of interesting themes. The project addresses a human need as well as a strategic one, and should allow for the re-allocation of around £1m of NHS funding due to savings in allowance payments from the commissioning CCGs to NHS Trusts, and significantly more in terms of costs avoided.

Particularly interesting features of the project include:

- Close adherence to a core SIB model according to the GO Lab definition with all four of their key components featured in the SIB design. Across the SIBs that feature as in-depth reviews it is one of the closest to the original concept of a SIB. Where it mostly differs is that delivery is undertaken by a public sector body (West London NHS Trust) and VCSEs (London Central and West Unscheduled Care Collective (LCW, a social enterprise), with St John's Hospice (a charity) taking on a small, subcontractor role). SIBs were originally conceptualised as being a delivery model to support the role of VCSEs in delivery of Payment-by-Results-type contracts. In this case, the providers involved were identified as the most capable, experienced providers with local knowledge. Their involvement was essential for the SIB, regardless of their organisation type. In terms of performance measurement, the SIB deviates somewhat from the GO Lab definition by using a historical comparison approach rather than a current comparison group.
- Encouraging the National Health Service (NHS) to explore new commissioning models and new models of intervention; these would otherwise be unavailable in standard NHS funding arrangements due to a lack of available capital for establishing new ways of working on a fee for service basis, as well as being tied to annual funding cycles that do not necessarily support longer-term pieces of work. This SIB supported this shift by providing capital with no risk to the commissioners, and delayed repayments and cost savings both help to break the funding cycle. Although this model is based on existing models such as the Immedicare telemedicine service and the Marie Curie Rapid Response model, there are no existing examples of a similar service being commissioned without upfront capital. For example, the Immedicare service was developed using an NHS Innovation Fund grant. The upfront funding provided by the End of Life Care Integrator and the CBO top up mean that while the commissioners still pay for outcomes, they do so on a delayed basis, and so the flow of cash and savings is shifted which allowed the project to proceed.
- The multiple roles held by Social Finance as the managers of the investment fund and also the intermediary. Their involvement drove the development of the SIB in both theoretical terms (identifying a problem for the commissioner, and a potential solution) and practical terms (convening and coordinating stakeholders). As managers of the Care and Wellbeing Fund, they have ultimate responsibility for protecting the investment by identifying, developing and managing a successful project.

Given the financial circumstances of the commissioners, this is particularly critical. Moreover, the interviews for this review evidenced that this intervention would not be taking place without the SIB financing structure, with commissioners otherwise unable to access the capital to invest in testing and establishing a service which is new to the area.

As we have highlighted in this report there were two factors which influenced Social Finance's involvement in this management role; firstly, historic learning on their part where externally commissioned performance and project management resulted in two unsuccessful SIB development projects, and secondly, a desire to protect the investment from the Care and Wellbeing Fund. Interviewees saw it as logical that the support required to develop and launch the SIB would come from an organisation with an interest in safeguarding the social investment.

In this context, it is important to note that other research conducted for the CBO evaluation, and that done by others exploring SIBs outside the CBO programme, has flagged that the 'win' scenarios commonly associated with SIBs do not always come to fruition. In these cases, there is a balancing act between the competing priorities held by different stakeholders. Where trade-offs between priorities have been required, such as those flagged in our evaluation of the Youth Engagement Fund[34], the value of an independent chair as intermediary has been valuable to broker the route forward. In this SIB , the intermediary has a dual role of supporting the SIB's implementation but also needing to protect the investment, albeit with an independent chair and board in place. In future visits to the SIB for the in-depth review, we will explore this further.

The research also highlighted a number of lessons learnt across the range of stakeholders.

The balance of support and funding is vital: Across all interviewees, regardless of their role in the SIB, there was consensus that the support which accompanied the SIB has been critical for its successful launch; the external commitment and drive from Social Finance in both their roles in the SIB have ensured the project got off the ground. A key lesson from this project is that there is a need for a constant and consistent oversight and ownership in the commissioning organisation. In this case, there has been significant restructure in the strategic landscape (following the establishment of the STP) and within the coordinating commissioner which has affected the efficacy of the project management.

The EOLCI embedded resource in the STP in the run up to the launch of the service in order to maintain momentum, and this created an alignment of purpose and focus between stakeholders which could easily have been lost without careful management.

The SIB approach to contracting was new to both the commissioners and the providers, and the guidance that accompanied the process was valued by both. The balance of support and funding was seen as vital by all parties, and capacity and expertise was needed for developing the contractual relationships, MOUs, standards, targets and analytical approach.

The learning from this SIB very clearly demonstrates that outcomes-based commissioning needs capacity and continuity.

SIBs are a dynamic process and flexibility is key to create a service which meets patient needs within the complexities of the SIB model: Flexibility on the part of all stakeholders has been important in this SIB. On one hand, the project was designed to test a specific hypothesis – thus, it needed some elements of design to remain true to ascertain whether a responsive, clinically-led telemedicine service could reduce non-elective admissions to hospital. To an extent, the SIB's necessity to evidence change has shaped the model – for example through requiring dedicated staffing and other aspects of delivery - this is a potential limitation of outcomes-based commissioning in a complex landscape such as healthcare.

Data generated in early delivery have highlighted the strengths and weaknesses of certain elements of the model (such as the lack of demand for a 24-hour service). During the development phase it has proved to be vital that stakeholders were not so wedded to the intervention model that it failed to progress, or progressed in a way that does not offer value either fiscally or operationally. Providers felt it important that commissioners and the EOLCI trust their judgement, which arises from experience in delivering telemedicine (albeit in other formats with different audiences). At the same time, the EOLCI revisited the model and hypothesis during the SIB

34 Ronicle, J and Smith, K, 2020, Youth Engagement Fund Evaluation: Final Report https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886650/YEF_Evaluation_Report_.pdf

development process to establish whether initial plans still held true, as well as identifying which elements of the model could be flexed. The development of this project has been an iterative process and the stakeholders have all had to be equipped to work in a responsive manner to accommodate that; indeed, when revisiting the model and hypothesis the interviewees from the EOLCI expressed that they were prepared to halt the project should it have proved the most appropriate path forward.

Working with multiple commissioners brings opportunities but is complex: This intervention needed to operate at scale for two reasons. Firstly, it needed to fit local strategic approaches, particularly in terms of the integration agenda which sees all eight commissioners encapsulated within the North-West London STP. Secondly, it needed to deliver across multiple CCGs to make the intervention approach financially viable and properly test the hypothesis on which it is predicated. Because it is a responsive service, the staffing costs are high; this has meant that the project needed a wider footprint to facilitate the number of calls needed to justify the costs of delivery. However, this wider footprint has had the knock-on effect of creating an operationally complex situation in which eight commissioners and the STP must be coordinated. In this case, having a single coordinating commissioner working closely with the EOLCI has helped; certainly, this model shows that having a unified focus and aligned message is important in ensuring clarity for stakeholders. It is important to note however that in an ever-changing NHS landscape, this issue may be less prevalent in future, as local-level CCGs are absorbed into larger Integrated Care Systems under the NHS Long Term Plan. Finally, this level of complexity has posed challenges for providers, and has required significant senior level input as well as intensive support from the EOLCI to maintain momentum.

Stakeholders need to be aware of what a SIB entails: For the majority of stakeholders involved in this SIB, there was little to no previous experience of delivering services in an outcomes-based commissioning scenario. Indeed, this SIB was the first to launch world-wide in this policy area, meaning that all stakeholders – including Social Finance – are breaking new ground with this intervention in this geographical area.

The research for this report has highlighted issues which those new to SIBs would benefit from prior awareness of. Primarily, this related to ensuring that providers are pricing their service appropriately; in this example, providers felt that there was not enough funding in place for contingency and change, and they were unprepared for the amount of senior project management time that would be required to deliver the SIB (particularly in terms of liaison with commissioners and the EOLCI while developing the intervention). A key lesson thus is to ensure that all stakeholders are clear on the complexities of delivering a SIB and what that involves in practice; providers and commissioners alike felt unprepared for the realities of a SIB.

However, the main aim of the CBO Fund was to facilitate new SIB projects in new policy areas, and to some extent some uncertainty should be expected in such circumstances.

Keeping the payment mechanism simple: Reporting against one outcome, using data that is readily available from existing datasets to form the baseline, has simplified what is already a complex exercise for evidencing outcomes. However, even this process has not been without challenge, and the EOLCI has put a number of steps in place to address the inherent challenge that comes with measuring something that has not happened. EOLCI analysts review calls made to the service and cross reference them with clinical data on whether those circumstances would likely have otherwise resulted in a conveyance; this additional layer of scrutiny has been important to provide reassurance that the service is achieving what it intends to and resolve some of the issues around attribution of outcomes in an integrated care pathway. Furthermore, having KPIs which are formalised through the MOU and service agreement means that providers are held to account on service quality, and also retains focus on providing good patient care without further complicating the evidence base.

Achievement of CBO objectives

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

Improve the skills and confidence of commissioners with regards to the development of SIBs: Partially achieved. There is little question that this project has opened up SIBs to a new audience in the health sector; as noted, none of the commissioners had previous experience of SIBs. The appetite to try the approach was high amongst the CCGs, and those key participants have taken responsibility for "selling" the approach more widely to their colleagues. Our second visit will explore to what extent this has been a success, particularly as more SIBs have since launched under the remit of the EOLCI , across London and the wider UK, and to what extent the learning around SIBs has been retained and expanded in the context of staff turnover in the STP.

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: Partially achieved. There is little question that this intervention has been designed to address a genuine human need; that is, to support those at the end of life to remain in their care homes rather than be conveyed to hospital. This is important because those residing in care homes have worse outcomes at the end of life than those who live in their own homes. However, far more older people live in their own homes, and the EOLCI is exploring approaches to broaden the scope of the service to those in their own homes; this is a factor that will be explored in more detail in our second in-depth review report.

More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people: Partially achieved. There are two VCSE providers involved in the delivery of this intervention, although one is acting on a subcontractor basis and has a relatively minor role in the programme. The other VCSE, one of the two main providers, is a large social enterprise; although it is a VCSE organisation it has significant capacity already and this project forms only a small proportion of its delivery portfolio. That said, this is the first time the organisation has delivered under a SIB model and there has been significant learning around that organisationally.

Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs: Achieved. As noted, this SIB is breaking ground by launching in a policy area which is new to outcomes-based commissioning world-wide. As such, all those involved, in all roles, have developed their understanding of what the key challenges and barriers are to delivering SIBs in a complex landscape such as health. All parties interviewed for this research believed that outcomes-based commissioning has the potential to be a useful tool in the health landscape and can see the benefits of using NHS money in more imaginative ways to develop new services.

Areas for future investigation

There was little doubt amongst interviewees that the SIB model has given commissioners a level of financial freedom to address an important problem at a human level, as well as STP priorities for efficiencies and reducing non-elective admissions. However, it has also been a constraint in terms of fitting the service in the wider care system. In our research for the second in-depth review report, we will explore the balance between the achievements of the intervention alongside the opportunity costs; what aspects of this service could have been developed without a SIB? Was the complexity added by the SIB model worth it?

Interviews for this report indicated that the service was not addressing the needs of the broader range of people at the end of life because it focused only on providing a service to those residing in older people's care homes. The next wave of research will explore the service roll-out to those in their own home.

We will also further explore the issues around the complexity of communications associated with a multi-layered structure involving commissioners, the STP, providers, the EOLCI and the Care and Wellbeing Fund. Key questions around accountability and oversight, and protection for providers in case of performance issues will be raised to ascertain the extent to which roles can be navigated without provoking conflict.

Finally, and crucially, the next visit will more thoroughly investigate the savings case for the SIB, and the extent to which cashable and costs avoided savings, the price of the outcomes and of the delivery and SIB management costs, can be held up as value for money in the NHS commissioning environment.

Annex 1: Service Provider KPIs

		Description	Numerator	Denominator	Frequency	Target Threshold
1.1	**Mobilisa-tion**	Proportion of care homes with initial meeting/ assessment completed in line with agreed mobilisation plan	Number of care homes with initial meeting/ assessment completed in month	Number of care homes due initial meeting/ assessment in month per agreed mobilisation plan	Monthly	90%
1.2		Proportion of care homes agreeing to participate and incorporate service into escalation process	Number of care homes agreeing to participate and incorporate service into escalation process in month	Number of care homes with initial meeting/ assessment completed in month	Monthly	95%
1.3		Care home mobilisation in line with agreed profile	Number of care homes mobilised in month	Target number of care homes due to be mobilised in month per agreed mobilisation plan	Monthly	85%
2.1	**Operations**	Communications plan activities in line with agreed communications plan	Number of activities completed in month	Number of planned activities in month	Monthly	90%
2.2		Monthly proactive engagement with care homes in line with agreed engagement plan (including proactive engagement of low utilising homes, annual impact reporting to care home staff)	Number of care homes which have been contacted (telephone/ face-to-face) in month	Number of care homes to be contacted in month per agreed engagement plan	Monthly	90%

		Description	Numerator	Denominator	Frequency	Target Threshold
2.3		Ongoing care home staff training in line with agreed training plan (initial, ongoing and refresher training around how and when to use the service)	Number of care homes which have received training in month	Number of care homes to be trained in month per agreed training plan	Monthly	90%
2.4		Calls answered within agreed maximum response time	Number of calls answered directly within agreed maximum response time	Total number of calls to hub	Monthly	90%
2.5		Proportion of calls for which time to clinician response is within maximum agreed clinical response time	Number of calls with time to clinician response within maximum agreed clinical response time	Total number of calls to hub	Monthly	95%
2.6		Number of overall calls to hub in line with target profile	Number of calls to hub in month	Target number of calls to hub in month	Monthly	80%
2.7		Proportion of care homes which have made at least one call within the last month	Number of care homes which have made at least one call within the last month	Number of care homes within the last month	Monthly	80%

		Description	Numerator	Denominator	Frequency	Target Threshold
3.1	**Quality**	Clinical audit of sample of case notes (covering a set of agreed topics including reasons for calling, nature and quality of advice and signposting, outcomes of calls, and accurate recording of information via post-event message)			Quarterly	
4.1	**Outcomes**	Non-elective activity (including split by care home)	Number of non-elective admissions for residents of participating care homes		Monthly (3-month lag)	15% reduction against 2016/17 baseline

Source: Funding Agreement between EOLCI, the Coordinating Commissioner and Service Providers. The KPIs as set out in this table were subject to final agreement, and as such may have since varied.

Annex 2: Organisations consulted for this report

2018:

Hammersmith and Fulham CCG

North West London STP

End of Life Care Integrator

Care and Wellbeing Fund

London Central and West Unscheduled Care Collaborative

West London NHS Trust

2020:

End of Life Care Integrator

Care and Wellbeing Fund

Commissioning Better Outcomes Evaluation

COMMUNITY FUND

ATQ Consultants

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