Final 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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January 2025

Commissioning Better Outcomes Evaluation

COMMUNITY FUND

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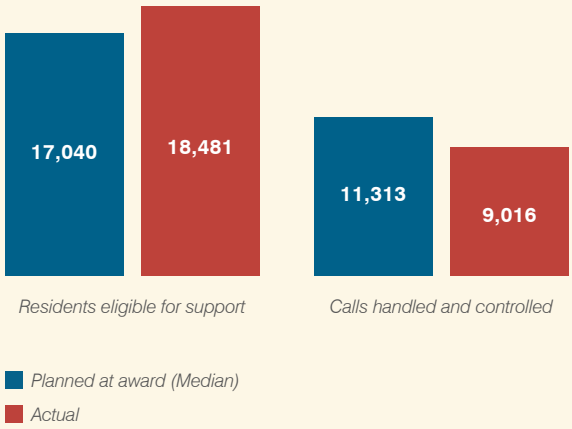
Contents

1.0 Executive Summary

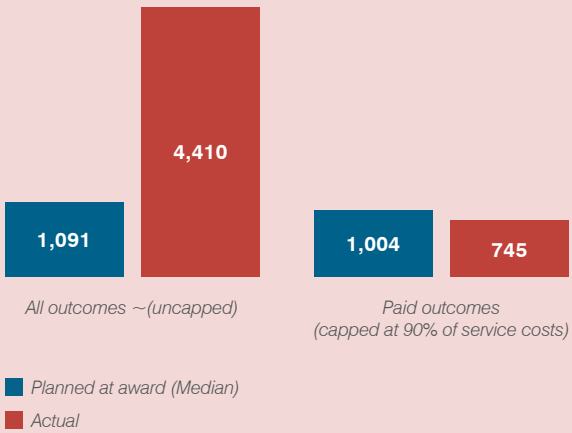
Project focus and stakeholders	
Commissioner(s):	Hammersmith and Fulham Clinical Commissioning Group (CCG) – lead commissioner Central London CCG West London CCG Hounslow CCG Brent CCG Harrow CCG Hillingdon CCG Ealing CCG (Year 1 only)
Service provider(s):	London Central and West Unscheduled Care Collaborative West London NHS Trust St. John's Hospice (Specialist training)
Intermediary or Investment Fund Manager	End of Life Care Integrator (Social Finance)
Investor(s):	Macmillan Cancer Support and Better Society Capital via Care and Wellbeing Fund
Intervention:	Telephone-based clinical advice, guidance and support to staff in older people's residential care and nursing homes
Target cohort:	Staff and residents near end of life in care homes in North West London in
Period of delivery	December 2018 – March 2022

Project achievements

Reach and engagement



Outcomes achieved



Payments and Investment	Planned[1]	Actual[2]
Outcome payments by CCGs	£2,850k	£1,698k
Outcome payments by CBO	£713k	£425k
Investment committed	£1.59m	£1.59m
Investment return	£334k	£0
Internal rate of return[3]	4.5%	0%
Money Multiple (MM)[4]	1.21	1.03

1.1 Introduction

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

1.2 NWL Telemedicine project overview

The NWL Telemedicine project provided telephone-based clinical advice, guidance and support to staff in older people's residential care and nursing homes. Its key aim was to enable patients nearing the end of life to be cared for in their homes and thus in a comfortable and familiar setting, rather than be admitted to hospital.

The project was managed and supported by the End of Life Care Integrator (EOLCI), previously known as the End of life Care Incubator, which was set up and managed by Social Finance with investment funding from the Care and Wellbeing Fund (CWF).
It was one of seven projects supported by the EOLCI to test different ways of improving end of life care for older people, all of which were structured as SIBs or Social Outcomes Contracts (SOCs).
Six of these projects were co-funded by the CBO programme, including the NWL Telemedicine project, while the other was co-funded by the Life Chances Fund (LCF). The LCF also funded a further EOLCI project focused on those living with dementia.

As its name suggests, the project was the only one supported by the EOLCI which was based on a telemedicine delivery model. The other projects supported those at the end of life in different ways but all tended to focus on face-to face-support. This service was telephone-based but with a high degree of specialist advice available. It gave callers a single point of access to a specialist nursing team in real time, with no call hand-offs: calls were answered and dealt with immediately by qualified nursing staff with expertise in end of life care. As well as offering instant access to clinical advice, the nursing team were also able to liaise with local health services and arrange face to face visits from other providers such as GPs if necessary.

The service was available to all older people's nursing and residential care homes operating in the areas covered by the CCGs involved in commissioning the service (see below). At the time the service was developed, this area included 114 homes, with a further 19 care homes covered via a separate pilot arrangement with NHS Ealing CCG.

The structure of the NWL Telemedicine project is shown in simplified form in Figure 1 below. We provide fuller details of the EOLCI and its funding structure, the projects it supported, and the NWL Telemedicine project in sections 3.1 and 3.2 of this report.

1 "Planned" means the amounts included in the CBO grant award. These are based on the "Median" scenario submitted to the CBO

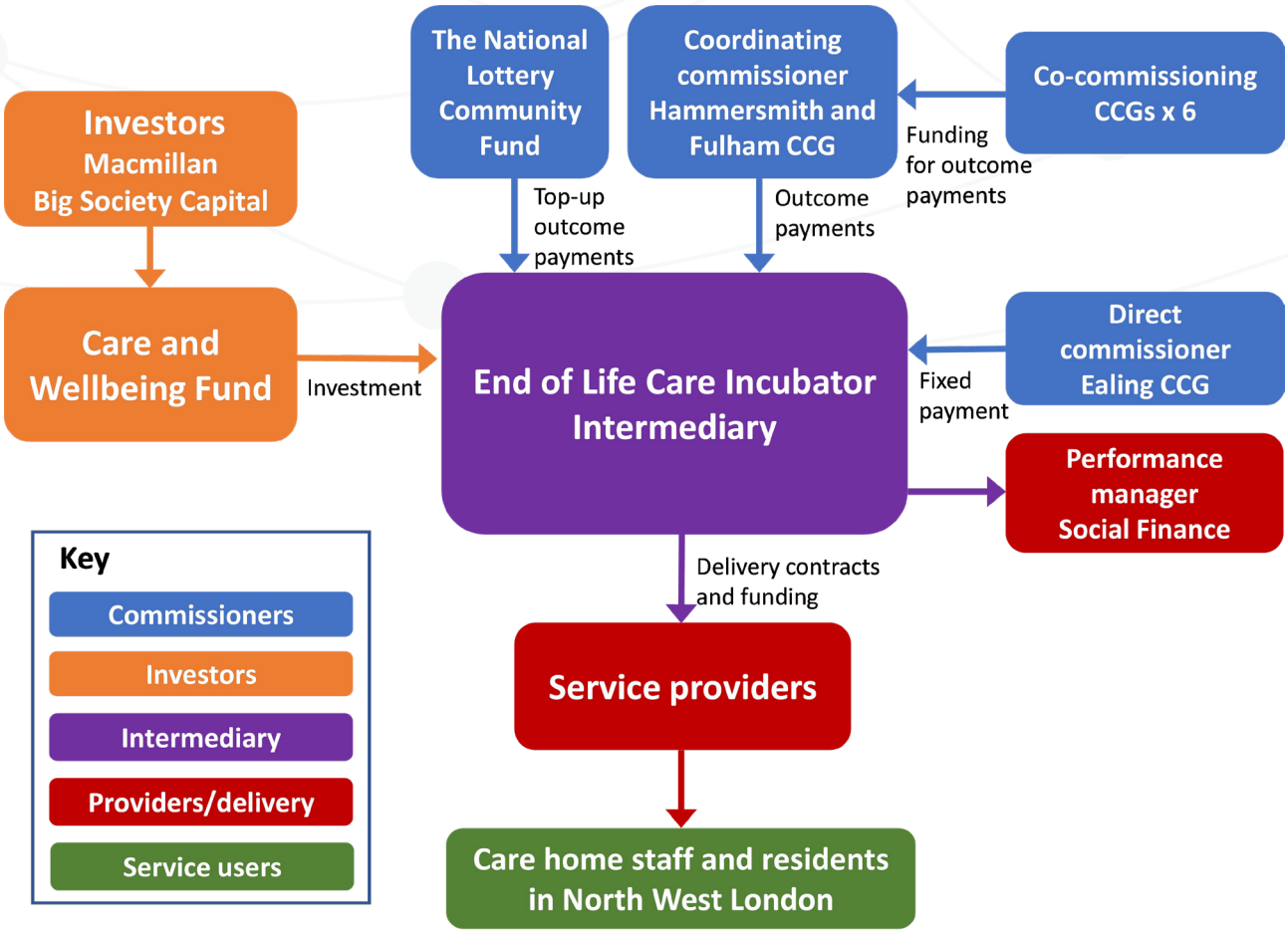
2 Actual means figures achieved at the end of the project, as reported in the CBO End of Grant report.

3 IRR is a way of converting the total returns on an investment into a percentage rate, calculated over the length of the investment and varying according to cash flow – i.e. how quickly and soon payments are made.

4 Money Multiple (MM) is a different way of measuring return on investment. It expresses the total returns as a simple multiple of the amount initially invested. The MM in this case is based on the overall SIB position, which is that investors received back only their initial capital invested, with no return, but the SIB as a whole made a small surplus of £43k. For more information on MM see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957374/A_study_into_the_challenges_and_benefits_of_the_SIB_commissioning_process._Final_Report_V2.pdf

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

Figure 1 – **NWL Telemedicine structure (simplified)**



The NWL Telemedicine project was commissioned by a partnership of seven NHS Clinical Commissioning Groups (CCGs) in the North-West London area, with Hammersmith and Fulham CCG acting as lead and coordinating commissioner. These commissioners paid for the service based on achievement of a contracted outcome, the avoidance of non-elective hospital admissions (NELs) from care homes, measured against an agreed baseline of predicted NELs if this service had not been in place. In addition an eighth CCG, NHS Ealing, contracted directly with the EOLCI for the first year of delivery on a trial basis, paying a fixed fee rather than per outcome.

The total number of outcomes for which the commissioners could pay (known as the outcomes cap) was also limited to an agreed maximum total figure and, over and above this, to 90% of the actual costs of delivering the service if lower than the agreed maximum. This outcomes cap aimed to guarantee that the commissioners would not pay more than they would if the service had not been structured as a SIB. According to EOLCI stakeholders, the cap was introduced in recognition of the extraordinary financial pressure that the NHS was under, and continues to face. The EOLCI went on to implement caps on all of the EOLC investments for the same reason, pioneering a new, 'not-for-profit' social investment model.

The National Lottery Community Fund, through the CBO programme, also agreed to support the project as a co-commissioner, covering 20% of each outcome payment (£654 of a total payment per NEL of £3,270, with local commissioners paying £2,616 per NEL).

The telemedicine service was provided by the London Central and West Unscheduled Care Collaborative (LCW) as lead provider, supported by West London NHS Trust as provider in some areas, and St John's Hospice, who provided specialist end of life/palliative care training for the service's staff.

The EOLCI, staffed and managed by Social Finance, acted as intermediary for the project and as a vehicle for managing payments from both local CCGs and the CBO. It provided funding for delivery to the providers, managed project performance and provided related data analysis and reporting. As explained above investment to finance these and other activities came from the CWF.

The project was one of a number designed and implemented by and through the EOLCI which were explicitly set up as SIBs. Specific projects were implemented over time and followed a process of feasibility work by Social Finance, and subsequent call for expression of interest in working with EOLCI, in 2015. The specific rationale for this project and its service, as explored in detail in our first review, was that Social Finance had noted that there was less evidence for the success of telemedicine for those at end of life compared to general community nursing and care. Additional reasons to explore the better application of a telemedicine approach included the fragmentation in the care home sector and its approaches to training staff, wide variation in existing support to care homes by the NHS (especially from primary care via GPs) and a view that residents in care homes generally received a poorer service than those in their own homes.

Our first review identified four key benefits of funding and delivering the project through a SIB model, including that it would:

- provide upfront funding to the commissioners 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 such as grant or Fee for Service contract, where they (rather than investors) would have had to fund the service in advance.
- link payment for the service to success rather than activity With limited access to funds, the risks to commissioners of an unproven service were exaggerated. Under the SIB commissioners were paying for achievement of outcomes rather than delivery.
- drive rigour in development, monitoring and analysis Having investors and an intermediary involved brought several benefits from their convening power to get stakeholders and partners around the table, as well as overarching governance, programme management and analytical support.
- shift stakeholder focus to preventative healthcare, and contribute to wider thinking about the use and value of preventative healthcare models.

In total the NWL Telemedicine project took around 3½ years to develop and implement from first contact with the lead commissioner and outcomes payer, in June 2015, to full mobilisation in December 2018. However it took less than two years fully to launch the service once it received in-principle approval for CBO funding in January 2017, and implementation would have been quicker had the project not encountered a number of challenges during development and implementation, These included:

- The need to bring on board more CCGs as commissioners in order to achieve critical mass and sufficient economies of scale to make the project viable. Over time this meant the project expanded to seven outcomes payers plus Ealing as a direct payer. This achieved the viability needed but the process of engaging commissioners took time and added to the complexity of managing project relationships.
- Delays in procuring the providers to deliver the service. The first procurement had to be aborted because it did not attract a credible bidder from the local area, which was considered crucial to the success of the project because of the complexity of local healthcare structures. A second procurement process was therefore needed, from which the two successful providers were successful following intervention by the lead commissioner to bring local providers together. Both of the successful providers were based in the NWL area and applied jointly having worked together previously on the delivery of a different telemedicine offer.
- Delays in agreeing contracts. According to stakeholders, there were delays in the signing of contracts which meant that the providers were asked to start delivery "at risk" and before contracts were in place.

- Challenges in recruiting staff of the right calibre: The project required highly qualified clinical staff in full-time, permanent, telemedicine-only posts, but clinical staff are generally not attracted to such roles because they lack direct patient contact.

The providers found various ways to address these challenges, including redeployment and secondment from other telemedicine services and retraining existing staff, but the implementation of these strategies further delayed mobilisation.

1.3 What has happened in practice

1.3.1 Key events

The following key events occurred between contract implementation and conclusion and had an impact on the project:

- Slower mobilisation than planned. The service originally planned to mobilise in April 2018 but due to the issues outlined above did not fully mobilise until December 2018, after a partial mobilisation in August 2018. Once the service did fully mobilise it continued to experience issues including that build-up to expected call volumes was slower than forecast, and a proportion of the calls were not appropriate for the service and did not best utilise the clinical knowledge held by the service. EOLCI thought this was in part due to limited engagement from Care Homes with the rapid turnover of staff, and implemented a renewed Communications and Engagement Strategy in the summer of 2019 to publicise the service directly to care homes, complemented by the Project Manager's attendance at care home forums to promote the service.
- Adjustment of the comparison baseline. A key challenge during development of the project was agreeing the baseline against which to compare the service's performance in reducing NELs, based on known NELs in 2016/17 and an estimate of growth (if this service had not been introduced) from that point. This challenge was exacerbated by the need to agree the baseline across multiple commissioners. During 2019 and early 2020 (prior to the impact of COVID-19 as described separately below) it became apparent that the baseline needed further adjustment due to changes in data reporting and the more accurate reporting of non-elective admissions. The effect of these changes was to agree a different and slightly lower baseline for 2019/20 and subsequent years, based on extrapolating actual NEL data for April to September 2019.
- Measuring and validating attribution. A further challenge for the project that surfaced during development, and continued during implementation, was proving attribution of outcomes (avoided NELs) to the NWL Telemedicine service. This was challenging due to the complexity of the health and social care landscape in North West London and the multiplicity of services available that aimed to reduce NELs. The EOLCI took steps to address this both by collecting data on the outcome of calls to the service, and by introducing independent assessment by medical experts of likely outcomes if the service had not been available. There was thus both quantitative and qualitative evaluation by the EOLCI and its advisors that the service was directly impacting NELs over and above any impact from other services. However this did not (and arguably could not) resolve the question of attribution entirely.
- Ending of pilot arrangement with Ealing. As explained above NHS Ealing CCG agreed to fund the service outside the SIB structure for its first year, using a conventional fee for service contracting model. At the end of this period, Ealing decided to end the arrangement and not continue funding. According to stakeholders this was largely due to the attribution issue, and uncertainty as to whether the service was adding enough impact to business as usual (which in Ealing included support to care homes from local GPs).

- **Ongoing challenges in recruiting staff of appropriate calibre.** The challenges in recruiting staff of the right calibre that delayed implementation of the service appear to have persisted throughout the early stages of the project. Stakeholders interviewed for this review reported that the recruitment and retention position considerably improved when the lead provider, LCW, recruited a new clinical lead who got to grips with the issue. This is interesting because it mirrors experience across other CBO projects that operational performance can be significantly improved by management changes, and that the main impact of the SIB model is to encourage earlier and more decisive action to make such changes.

1.3.2 Changes in response to COVID-19

The NWL Telemedicine project was less affected than some other CBO projects by the restrictions on face to face contact imposed in responded to COVID-19 because it was already a telephone-based service. It was however impacted by COVID-19 due to:

- Increased demand for the service, especially in the early months of the pandemic between March and July 2020, when remote contact became the default way for care homes to obtain support for residents.
- Conversely, and later, the NHS responding to COVID-19 by putting in place further support for care homes so that they could deal with patients' health issues without contact and increased infection risk. This led to duplication of service to care homes in NWL in some areas, while gaps remained in provision in others.
- A presumption against care home residents (and other older people) entering hospital unless due to the effects of the virus, offset by increased admissions due to the virus itself. Overall, the effect was to confound the comparison with the agreed NEL baseline although it was initially unclear what the effect would be.

In response to the impacts outlined above and to wider NHS policy on contracts during COVID-19, changes were made to the payment mechanism and to the Funding Agreement across three end of life care SIBs supported by the CBO programme (this project and those in Hillingdon and Sutton). These changes required both commissioners and EOLCI to use reasonable endeavours to support the service to adapt if it could not operate as anticipated; and for the funding arrangements automatically to move to a "payment for service" model if planned outcome metrics no longer reflected the impact of the service or could no longer be accurately modelled.

The EOLCI also drew up proposals to ask both local commissioners and the CBO programme to suspend payment on outcomes and temporarily to make payments on an activity basis, in line with wider guidance on contracts from NHS England (NHSE). While commissioners agreed to these proposals, they were never enacted.

1.3.3 Decommissioning of the Service

The NWL Telemedicine service was decommissioned in April 2022, at the end of its planned contract life. This is in contrast to some EOLCI projects, which have been sustained and subsequently funded through "business as usual" by local NHS commissioners – for example in Hillingdon. According to stakeholders, the decision not to extend this project was taken in full collaboration with commissioners and after a review of the service duplication and gaps in provision that followed changes to services during COVID-19. Data collected by this project helped inform this review, and it was a consensus decision that this service should not continue.

Whilst the service itself was de-commissioned, stakeholders observed that it enabled a joined-up approach to the provision of end of life care in care homes across NWL. This culminated in the creation of the NWL London Care Homes Quality Standard, which has contributed to a reduction in health inequalities for the population.

1.3.4 Project performance

According to end of grant data agreed with project stakeholders, the project had greater reach than originally planned, largely due to the extension of the service to additional homes over time. The plan at Median scenario was to provide the service to 17,040 residents but in practice it was available by the end of the project to 18,481 residents. It fell short of its planned number of calls handled, however, reflecting the challenges of maintaining full service capacity and ensuring care home staff were aware of and used the service. The plan at Median was to handle and resolve 11,313 calls, while the actual number handled was 9,016.

Assessment of the project's performance on its key outcome metric (NELs avoided) is complicated by the effect of the outcomes cap which limited outcomes that could be claimed and paid for to 90% of service delivery costs. Based on uncapped outcomes, the service hugely overperformed against plan at both Median scenario and High scenarios, achieving 4,410 outcomes compared to an effective plan of 1,004 outcomes at Median and 1,364 outcomes at High scenario. Given the questions around attribution noted above, we should be cautious in attributing all these outcomes to the NWL Telemedicine service, but it seems highly likely that it exceeded both its Median and High targets.

Since the service was never able to operate at full capacity, however, service costs were much lower than planned, limiting the number of outcomes that could be claimed and paid for. In practice, therefore, the service claimed for only 745 outcomes – well below Median and also below the Low scenario of 818 outcomes.

1.4 Successes, challenges and impacts of the SIB mechanism

Despite a number of implementation challenges stakeholders largely view the project to have been successful. Successes that we believe can be attributed to the SIB mechanism, and therefore part of the "SIB effect" include:

- Advance funding for a preventative intervention As highlighted in our first review, stakeholders thought that a key benefit of the social investment was that it enabled the commissioning CCGs to test whether a telemedicine service would be effective, since financial constraints would not have enabled them to pursue such an intervention from core funding. This argument is, we believe, valid even though one CCG (Ealing) chose to fund the intervention conventionally, since they did so for only one year and then withdrew.
- Driving rigour in development, monitoring and analysis As also highlighted in our first review, stakeholders thought that the presence of an intermediary and investors would drive better and more comprehensive data collection and analysis, and better management of performance. Stakeholders interviewed for this review thought that this objective had been proven, and we broadly agree. The level of data information and analysis exceeded what would be expected in a conventional contract and provided the basis not only for ongoing monitoring of the contract and its performance, but wider analysis of the patterns of service delivery across the component CCGs which fed into the review of service provision post COVID-19. While the data collection and management put in place by EOLCI did not prevent delays and arguably some missteps in the setting of the initial baseline for comparison of performance, it did enable these issues to be relatively quickly corrected.
- Providing a platform for multiple SIB projects The EOLCI vehicle has enabled and managed seven SIB projects focused on end of life care (and eight in total) and therefore made a substantial contribution to the testing of different SIB models in a single policy area. The development of such SIB "platforms" was a key outcome of the CBO, with other examples that we have reviewed in

depth including the MHEP model[6], and the HCT intensive travel training SIB[7]. A key difference between these platforms and EOLCI is that EOLCI was designed to test *different models*, while both MHEP and HCT were expressly aiming to develop a *replicable* model with many common features (and local variations) which could be rolled out successively to different commissioners.

- Enabling collaboration between multiple commissioners The NWL Telemedicine project enabled seven commissioners to engage in and collaborate across a single project, and an eighth commissioner (Ealing) to benefit from and test service delivery using a different contracting and funding model. This caused challenges for the project, but this should not detract from the success of the project in enabling successful collaboration across the NWL area, and foreshadowing the introduction of more formalised collaborative arrangements (through the Integrated Care Board and Integrated Care System) in July 2022[8]. It is a wider finding from research over several years that SIBs enable and encourage such collaboration[9], and it is also a feature of other health projects that we have reviewed under this evaluation, such as the Zero HIV Social Impact Bond[10].

The use of a SIB model also led to significant challenges, and had a number of disadvantages, including:

- Proving the impact of the intervention. An important feature and claimed benefit of SIBs is that they promote robust measurement of impact, and the project struggled to prove its impact to the satisfaction of all stakeholders. The NWL Telemedicine project did not directly measure performance against a comparison group, and we acknowledge that this would have been difficult in view of the complexity of end of life provision in NWL, and the variation in provision between individual CCG areas. It is arguable, therefore, that the project did make a reasonable attempt to measure impact robustly by measuring reductions in NELs (the key outcome) against a baseline of forecast NELs. As we note earlier, though, the project ran into challenges in establishing and agreeing (and subsequently amending) a baseline that truly represented NEL patterns under business as usual. The project also faced major challenges in establishing attribution to the NWL Telemedicine service rather than to competing services.

  We also note that if the same project had been implemented under a different contracting and funding model it would have faced similar challenges, and it is arguable that those challenges would have been less rigorously analysed and determinedly addressed. We therefore regard this as a challenge (and key learning point) rather than a disadvantage of the SIB approach per se.

- Time needed to develop and implement the SIB model. In common with all the projects we have reviewed in depth as part of this evaluation, this project took a long time to develop and implement. Multiple stakeholders identified this as a source of concern and frustration during the first review, and investor stakeholders highlighted it again during this review. Again we think it likely that a conventional project aiming to implement a similar service would also have taken a long time to design and implement, since much of the delay was caused by the understandable challenges of engaging multiple commissioners across North West London and agreeing an appropriate baseline against which to compare performance.

- Adverse impact of outcomes caps As we outline above and explain in detail in the body of this report, section 3.5.1, the amount that the CCGs could pay for outcomes was capped in two different ways: first as a total amount that they could be asked to pay; and secondly as a

6 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/MHEP-InDepth-Review-3rd-report.pdf?mtime=20231201095343&focal=none page57

7 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_Indepth_reviews_HCT_independent_travel_2nd_report.pdf?mtime=20240705112307&focal=none page 50

8 See https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like?gclid=CjwKCAiA75itBhA6EiwAkho9e60ZgWaHK6z3odpQD_dfwL8paHRpXKg78ynuguW8Cf_8Uh_C7qzcaxoC8l0QAvD_BwE

9 For example see https://golab.bsg.ox.ac.uk/knowledge-bank/resource-library/evidence-report/

10 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-3.pdf?mtime=20240409095754&focal=none

proportion of the service costs. The reasoning behind this was that it gave reassurance to commissioners worried about the additional transactional and running costs of a SIB that the cost of the service would not exceed what they would pay for a conventional contract. It did however have multiple adverse effects. Firstly, it put the project at risk of making a loss, however well managed, since service delivery costs were much lower than planned and the project could not cover its core costs from outcome payments alone. Secondly, it created a perception that the project was less successful than it was, since the project appears to have "under-performed", because it only claimed for 745 outcomes against a plan to achieve more than 1,000 – because it could only claim for outcomes up to 90% of service costs. Thirdly, it arguably reduced scrutiny of the extent to which outcomes were truly attributable to the service, since irrespective of attribution the commissioners knew they would pay only for 90% of the service cost.

Overall, based on our informed judgement (and drawing on the judgement of the stakeholders involved), **we conclude that this project was cost effective and provided good value for money**, especially for commissioners. This is primarily because the outcomes cap effectively gave the commissioners a guaranteed subsidy of 10%, and transferred both the risk that outcomes would be lower than planned, and that the service would cost more than an equivalent "conventional" service, from the commissioners to EOLCI.

In addition, and because the service achieved far more outcomes than expected, the project offered an exceptional return in cost benefit terms to the commissioners. They only had to pay for 745 outcomes, but were able to avoid costs based on 4,410 outcomes. Even if we adjust the outcomes for the likelihood that a proportion were not attributable to the NWL Telemedicine Service, non-attribution would have to have been higher than 87% for the commissioners not to be at least breaking even, which seems unlikely.

1.5 Legacy and sustainability

Even though the NWL Telemedicine project was decommissioned, it had its own legacy in the creation of the NWL London Care Homes Quality Standard. In addition EOLCI as a group of projects has one of the strongest legacies of CBO projects. We make this assessment because:

- Although this project did not sustain, other EOLCI projects have continued and been funded once the original SIB ended. Notable examples include the project in Hillingdon which ended in 2021 and has since been conventionally funded by its local commissioner, the Central and North West London NHS Foundation Trust. The EOLCI SIB In Sutton has also sustained.
- Thanks in part to the EOLCI and their involvement in the CWF, Macmillan established their own Social Investment Programme, launched in 2020 with funding of £16m; and then a specific End of Life Care Fund, launched in September 2023 with funding of £36m, to invest in end of life care across the UK. Across both these programmes Macmillan have continued to work closely with Social Finance, building on the relationship established through the EOLCI and Macmillan's investment in it (and the wider CWF) since 2015.

Through these Funds Macmillan have so far invested in four end of life projects which are effectively developments of the SIB/SOC model.[11] The End of Life Care Fund expressly aims to deploy an outcomes--based and repayable finance model under which capital will be repaid based on the achievement of defined outcomes, but with no additional return – Macmillan will thus at best expect to break even. According to Macmillan stakeholders they will fund end of life care entirely through this model in the future, and have ended conventional grant funding for such care

11 See https://www.socialfinance.org.uk/assets/documents/EOLC-Project-Crib-Sheets-August-2024.pdf

1.6 Conclusions and lessons learned

Judged as a stand-alone project, the NWL Telemedicine project had successes but also challenges. It was successful in using a SIB structure to de-risk the provision of a preventative service and to test whether there were significant benefits in a telemedicine model for end of life care. It helped more than 9,000 people and over-achieved its uncapped outcomes target (to reduce non-elective admissions) by more than 400%. It also supported the development of a specification for the better and more consistent delivery of integrated end of life services in Northwest London, as part of which commissioners and EOLCI mutually agreed that this service should not continue; and wider learning about the value of telemedicine solutions in end-of-life care, which has fed into Macmillan and Social Finance's development of further projects.

The project also faced challenges, notably in finding an acceptable and robust way of measuring its own impact. The service also spent only 60% of what it intended to spend on service delivery, with the consequence that commissioners achieved excellent value for money, but the project as a whole made a lower return than expected. Importantly, however, the stakeholders worked together to resolve the issues that they faced, and the project is therefore a good example of how SIBs can be used to test innovation and adopt a true "test and learn" approach.

Looking more broadly at the portfolio of SIB projects initiated by EOLCI and funded by the CBO, the overall assessment of success is more clear-cut. While detailed analysis of other projects is outside the scope of this review, it is clear that some of these projects have been even more successful, and some have been sustained and funded by local commissioners after the initial SIB concluded. Only one EOLCI project is viewed overall as unsuccessful, as confirmed by both Social Finance and Macmillan stakeholders during this review

The wider EOLCI portfolio has also led to what is arguably one of the most visible and positive outcomes of the CBO programme as a whole – namely the establishment of the Macmillan Social Investment Programme and End of Life Care Fund, and Macmillan's wider and long-term commitment to repayable finance as an addition to its grant activity in some areas, and as a complete replacement for grant giving in end of life care.

These developments also mean that EOLCI has made a substantial contribution to the CBO programme's overriding aim to grow the market in SIBs and other outcomes-based models. Seven projects funded by the CBO and LCF have been created; and further outcomes contracts supported by repayable finance – effectively SIBs in all but name – are being created by Macmillan and Social Finance and continue to be supported by the EOLCI infrastructure.

We would also draw the following key lessons for other projects from our in-depth review of this project:

- Measurement against a baseline is challenging. There is much debate in research circles about whether and to what extent SIBs properly and robustly measure impact, or simply count outcomes. There have been very few SIB projects in the UK which attempt high quality evaluation against a comparison group and in this context this project made an admirable attempt to find a halfway house between a "high quality" impact evaluation – using a quasi-experimental design (QED) or even a randomised control trial (RCT) – and judging all outcomes to be due to the intervention. What this project learned was that this too is very challenging, not least because it is always difficult to predict the way a baseline will change over time – in this case on an upward trajectory.
- Multiple and complex services can make attribution difficult. Many services commissioned both conventionally and through SIBs struggle to prove attribution, but the challenge appeared much greater in this case than in many projects, due to the complexity and variability of provision and the way it changed over time. This meant that even with a baseline comparator in place project stakeholders were forever questioning how much of the impact was truly applicable to this service.

- Test and learn requires collaboration What this project also demonstrates is that problems like those outlined above are bound to happen when attempting to innovate in public service provision, and are best solved by working closely and collaboratively with all stakeholders to find a solution that works for everyone, even if some compromise is required. This project appears to have adopted a collaborative approach throughout, up to and including joint agreement that the project should be decommissioned. It might seem obvious that this is the right approach, but other projects we have reviewed have found it more challenging to achieve this degree of harmonious working.

- Repayable finance offers potentially major benefits to grant givers. This project is arguably the prime example, along with others, of a CBO SIB demonstrating the role that repayable finance might play for organisations more used to conventional grant funding. In the right circumstances it offers the potential both for charities and foundations to recycle funds repeatedly, and for blended finance (where investment is only party repaid) to be used to share the cost of funding with public sector commissioners.

2.0 Introduction

This review forms part of the evaluation of the Commissioning Better Outcomes (CBO) programme and is the final review of the North-West London End of Life Care Telemedicine project (NWL Telemedicine project). This project was one of several end of life care projects designed and implemented as a Social Impact Bond (SIB). A previous review of this project, and other reports from the CBO evaluation, can be found here.

2.1 The Commissioning Better Outcomes Programme

The CBO programme is funded by The National Lottery Community Fund and has a mission to support the development of more social impact bonds (SIBs) and other outcome-based commissioning (OBC)[12] models in England. The programme launched in 2013 and closed to new applications in 2016, although it will continue to operate until 2024. It originally made up to £40m available to pay for a proportion of outcomes payments for SIBs and similar OBC models in complex policy areas. It also funded support to develop robust OBC proposals and applications to the programme. The project that is the subject of this review, the NWL Telemedicine project, was part-funded by the CBO programme.

The CBO programme has four objectives:

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

The CBO evaluation is focusing on answering three key questions:

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

12 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. There is extensive literature on government's use of outcomes-based approaches – see for example this National Audit Office report

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

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

"Impact bonds are outcome-based contracts that incorporate the use of private funding from investors to cover the upfront capital required for a provider to set up and deliver a service. The service is set out to achieve measurable outcomes established by the commissioning authority (or outcome payer) and the investor is repaid only if these outcomes are achieved. Impact bonds encompass both social impact bonds and development impact bonds."[13]

SIBs differ greatly in their structure and there is variation in the extent to which their components are included in the contract. For this report, when we talk about the "SIB" and the "SIB effect", we are considering how different elements have been included, namely, the payment on outcomes contract – or Payment by Results (PbR)[14], capital from social investors, and approach to performance management, and the extent to which each component is directly related to, or acting as a catalyst for, the observations we are making about the project.

2.3 The in-depth reviews

A key element of the CBO evaluation is our nine in-depth reviews, with the NWL Telemedicine project featuring as one of the reviews. The purpose of the in-depth reviews is to follow the longitudinal development of a sample of projects funded by the CBO programme, conducting a review of the project up to three times during the project's lifecycle. This is the final review of the NWL Telemedicine project. The first in-depth review report focused on the development and set-up of the project and can be found here. We did not conduct a second in-depth review report and this review is, therefore, the final review of the project.

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

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

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

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

For this final review, the evaluation team:

- Undertook semi-structured interviews with key project stakeholders. These were conducted between July 2023 and March 2024. There are some limitations to our research due to some key stakeholders no longer being in post or not available for interview.
- Reviewed performance data and monitoring information supplied by the project stakeholders to The National Lottery Community Fund. All analysis of project performance in this report is based on data reconciled and agreed with project stakeholders in March 2024.
- Reviewed key documents supplied by project stakeholders and The National Lottery Community Fund.
- Analysed documents and data relating to comparable projects.

2.4 Report structure

The remainder of the report is structured as follows:

- Section 3 provides an overview of how the project worked, including the SIB structure, how the project was developed, and how it compares to other CBO review projects.
- Section 4 describes major developments and changes in the project since its launch, and provides information on the performance of the project against its planned metrics.
- Section 5 discusses the successes, challenges and impacts brought about by the SIB mechanism, and assesses whether the project was value for money.
- Section 6 describes the sustainment and legacy of the project.
- Section 7 draws conclusions from this review and identifies lessons for other projects.

3.0 Project overview

The North-West London (NWL) Telemedicine project provided telephone-based clinical advice, guidance and support to staff in older people's residential care and nursing homes, and acted as a coordination hub to enable staff to provide better care for residents, particularly those in the last phase of life. The service's overarching aim was to reduce A&E attendances and non-elective inpatient admissions to hospital (NELs) by 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 was one of seven focusing on end of life care and supported by the End of Life Care Integrator[15] (EOLCI), all of which were structured as SIBs or Social Outcomes Contracts (SOCs) and funded by the CBO programme or the Life Chances Fund (LCF). The EOLCI is wholly owned by the Care and Wellbeing Fund, from which it has invested in these projects.

We describe below the overall structure, funding model and logic of the EOLCI and then, in more detail, the specific structure and rationale for the NWL Telemedicine project.

3.1 The End of Life Care Integrator

The overall structure and funding flows of the EOLCI and its relationship with the Care and Wellbeing Fund are shown in Figure 2 below.

The Care and Wellbeing Fund (CWF) was set up in 2015 to test whether social investment could be deployed to support improved health outcomes and be a tool for sustainable innovation and transformation in the health and social care sector. It has total funding of £12m and, like other specialist social investment funds[16], received half its funding from Better (formerly Big) Society Capital (BSC)[17]. The remaining £6m came from Macmillan Cancer Support, one of the largest British charities focused on providing specialist health care, information and financial support to people affected by cancer. Social Finance were instrumental in the setup of both the CWF and EOLCI and manage the CWF as "Designated Member"[18].

The CWF is not confined to investment in SIBs and SOCs and as of the date of this report had invested a total of £9.7m into 14 projects, split equally between seven end of life SIBs and SOCs and seven other investments[19]. In addition to its investment funding, the CWF has benefited from both development and top-up funding for projects from the CBO and Life Chances Fund (LCF), and development grants from Macmillan and the Health Foundation to support the exploration of investment opportunities, deal generation and fund deployment.[20]

The EOLCI sits within the CWF and was largely conceived and driven by Social Finance in their role as fund manager for the CWF to focus specifically on developing new projects to produce better outcomes for people at the end of life. The EOLCI is a social purpose, limited company which is wholly owned by the CWF. it is staffed and managed by Social Finance, as designated member of the CWF and agent director of the EOLCI.

15 The End of Life Care Integrator was formerly known as the End of Life Care Incubator. The name was changed in 2020 to reflect the focus on integrated care.

16 For example the Bridges Social Outcomes Funds – see https://bettersocietycapital.com/portfolio/bridges-social-impact-bond-fund-lp/

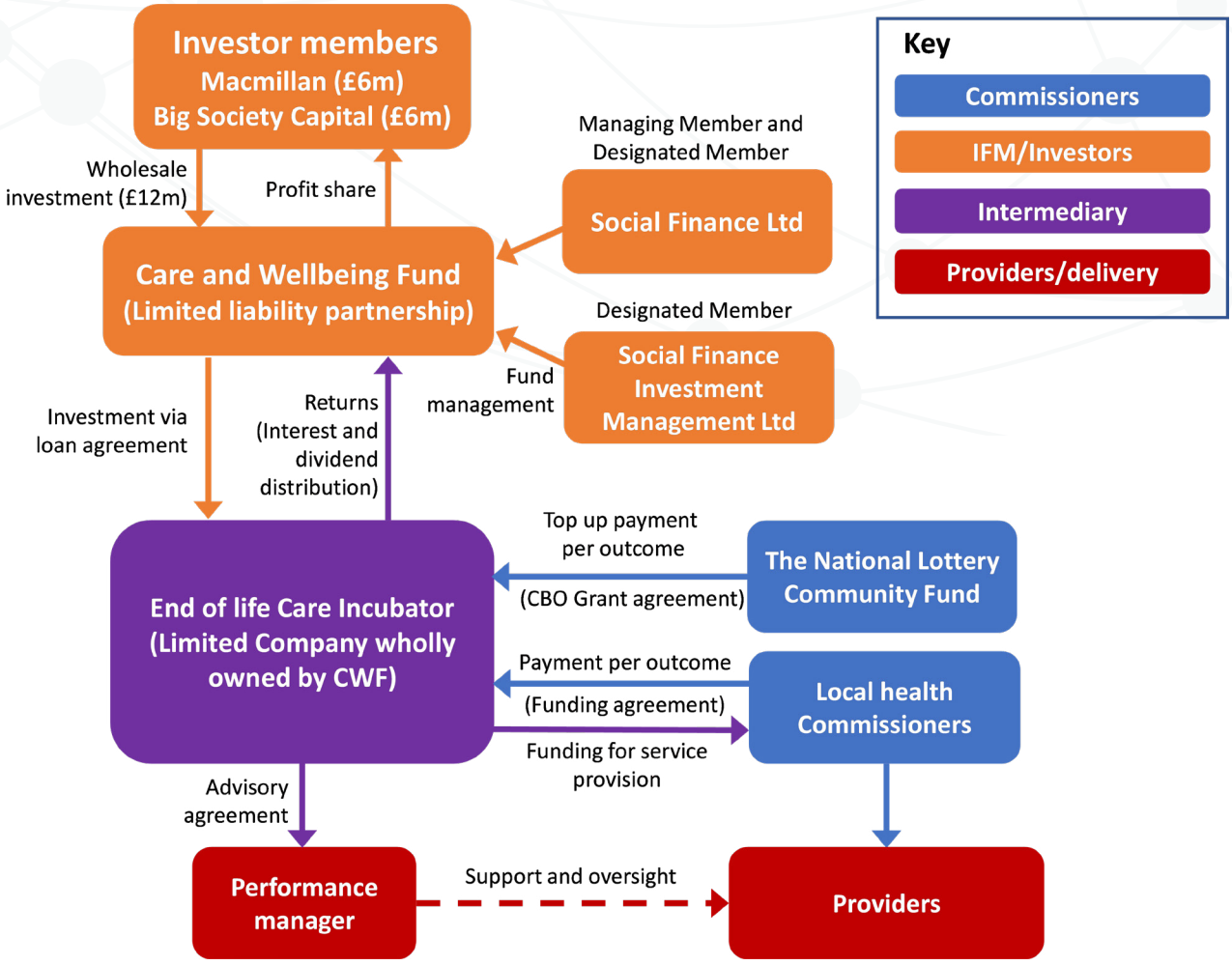
17 Better Society Capital is a financial institution, set up by but independent of government, to act as a social impact investment wholesaler and to promote the development of the social impact investment market in the UK. See https://bettersocietycapital.com/about-us/

18 CWF was, like most investment funds, established as a Limited Liability Partnership (LLP). Designated members perform certain duties in relation to the legal administration of an LLP that would, for a company, be performed by the company secretary or directors

19 One of these is the Reconnections SIB to address loneliness, which has also been reviewed in depth under this evaluation. See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/Reconnections-SIB-In-Depth-Review-Report3.pdf?mtime=20240123134728&focal=none

20 See https://www.socialfinance.org.uk/assets/documents/care_and_wellbeing_fund.pdf pages 9 and 10

Figure 2: **CWF and EOLCI legal structure and funding flows**



Seven end of life care projects have been funded and managed through EOLCI and supported by the CBO programme or LCF. In addition to the NWL Telemedicine project the CBO-supported projects are:

- Hillingdon: Your Life Line Service focused on End of Life Care coordination and a rapid response nursing hub.
- Waltham Forest: End of Life Care Transformation Programme
- Sutton Palliative Care Coordination Hub
- Somerset "Talk About" Project: A volunteer-led advance care planning service.
- Bradford REACT Service – A service with 24/7 rapid response nursing team and active identification of A&E patients at the end of life.

The end of life project managed through EOLCI and supported by the LCF is the Haringey Advance Care Planning Facilitator Service focused on better advance care planning in care homes.

In addition to these end of life care projects the Hounslow Dementia Care project has also been managed by the EOLCI and supported by the LCF. This project focuses on improving co-ordination of dementia care across the NHS, social care and voluntary sector.

The EOLCI is continuing to manage new projects which have not received CBO or LCF support and have been funded solely by Macmillan through its successor funds supporting end of life care. We discuss these projects and Macmillan's sustainment of investment in end of life care in section 6 of this report.

In summary, therefore, EOLCI was set up as a vehicle through which several projects with broadly similar objectives and outcomes could be developed and implemented in different local areas. In this it has similarities to the Mental Health and Employment Partnership (MHEP), and a similar vehicle (MHEP Ltd.) through which Social Finance has developed and implemented eight social outcomes projects with funding from Big Issue Invest.[21]

As shown in Figure 2 Social Finance had multiple roles as fund manager, intermediary and project manager across the CWF and EOLCI, reflecting the significance of their involvement in initiation and innovation at both fund and individual project level. To address any concerns about conflict of interest there was legal separation of roles between the CWF and EOLCI and both were distinct entities, with separate staffing and management. The EOLCI also had two independent directors on the Board which guaranteed its independence from day to day decision making, and ensured separation of the Board from the operational role of Social Finance.

3.2 The NWL Telemedicine project

Figure 3 overleaf shows the structure and funding flows of the NWL Telemedicine project.

The main features of the project were as follows:

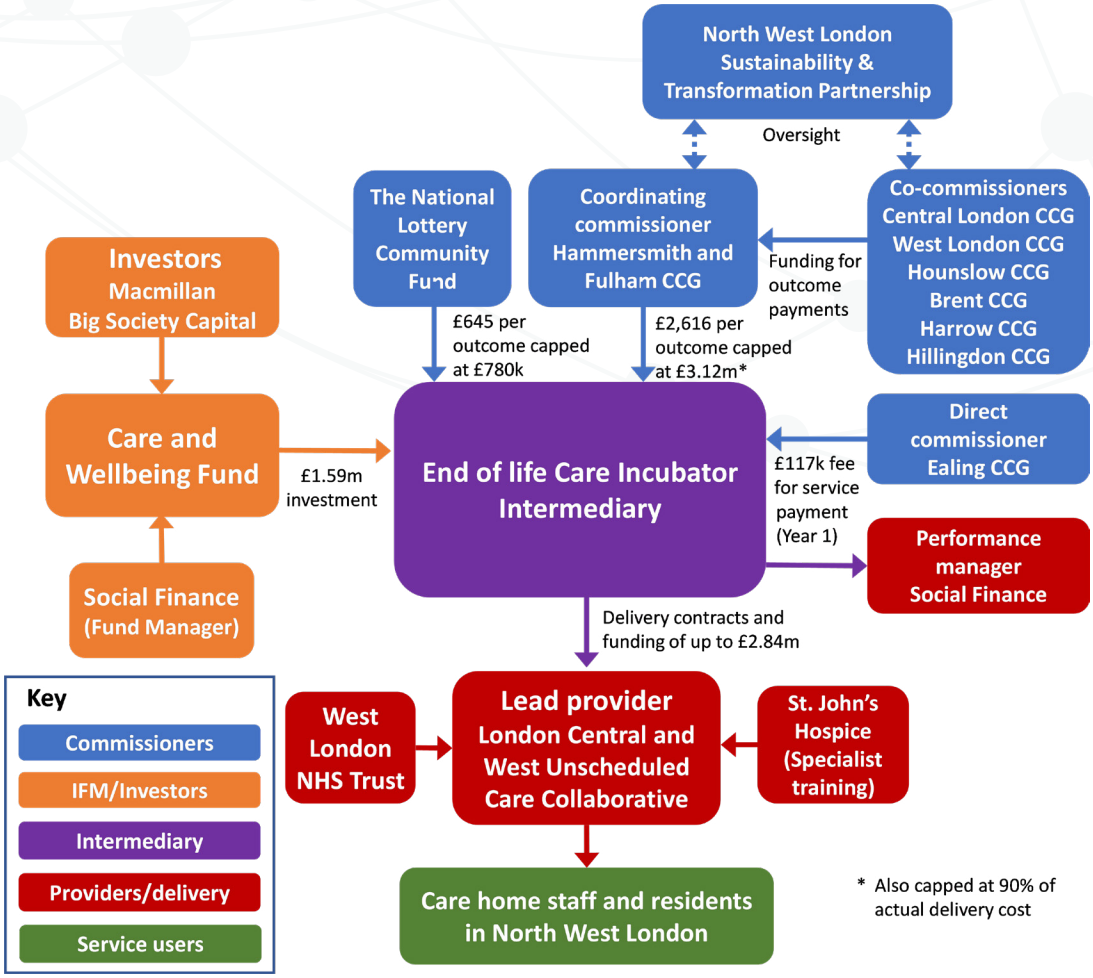
- The project was commissioned by a partnership of seven NHS Clinical Commissioning Groups (CCGs)[22] in the North-West London area, with Hammersmith and Fulham CCG acting as coordinating and lead commissioner. In addition an eighth CCG, NHS Ealing, contracted directly with the EOLCI for the first year of delivery on a trial basis, rather than working through the coordinating commissioner. NHS Ealing CCG committed funding of £111,650 which sat outside the SIB, paying for the intervention to be provided to care homes in Ealing on a fee for service (FFS) basis. According to stakeholders (including a former Ealing commissioner) Ealing were reluctant to commit to the SIB because they already had a large GP practice providing enhanced end of life support to care homes. They were therefore doubtful of the additional, demonstrable impact of the NWL Telemedicine service, but agreed to test this for at least one year.
- The National Lottery Community Fund, through the CBO programme, agreed to support the project as a co-commissioner, committing a total of £713k at Median scenario and a capped maximum of £780k at High scenario
- The CCGs reported in our first review that they were involved in all aspects of project development, and referred to the process as one of co-creation. The EOLCI and commissioners jointly agreed the service specification for the project, and the funding between them.
- The project had strategic oversight by the North-West London Sustainability and Transformation Partnership (STP), working alongside Hammersmith and Fulham as the coordinating commissioner. This was one of 44 STPs created across England in 2017, bringing together groups of CCGs and local authorities to develop integrated sustainability and transformation plans across health and social care. STPs were non-statutory but shortly after the completion of this project, on July 1st 2022, both they and CCGs were replaced under the Health and Care Act 2022 by 42 Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs).[23]

21 The first MHEP project is another of our nine-indepth reviews under this evaluation and the final report from it can be found here.

22 CCGs were clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area, including mental health services, urgent and emergency care, elective hospital services, and community care. They were established in 2012 and abolished and replaced by Integrated Care Boards in 2022 – see more details later in this section.

23 Under the July 2022 reorganisation Integrated Care Boards replaced CCGs and assumed their functions. ICBs cover a larger area than CCGs and form part of an integrated care partnership (ICP), a looser collaboration of NHS, local government, and other agencies, responsible for developing an integrated care strategy to guide local decisions and having a similar role to STPs. For further details see https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-look-like?gclid=CjwKCAiA75itBhA6EiwAkho9e60ZgWaHK6z3odpQD_dfwL8paHRpXKg78ynuguW8Cf_8Uh_C7qzcaxoC8l0QAvD_BwE

Figure 3 – **NWL Telemedicine structure**



- The providers of the telemedicine service were London Central and West Unscheduled Care Collaborative (LCW) and West London NHS Trust. LCW was the lead provider and is a social enterprise and one of London's largest providers of integrated urgent care services. Its services include the provision of 111 services for the NHS[24] and telephone booking for the GP Out of Hours Service (a system for those requiring primary care out of normal GP surgery hours). West London NHS Trust provides a full range of universal health services as well as some specialist, commissioned services. The two providers were supported by St John's Hospice, who provided specialist end of life / palliative care training for the service's staff.

- The EOLCI, staffed and managed by Social Finance, acted as intermediary for the project and as a vehicle for managing payments from both local CCGs and the CBO. It provided funding for delivery to the providers, managed project performance and provided related data analysis and reporting.

- Investment to fund service delivery by providers and the EOLCI was provided from the CWF under the investment structure outlined above, and the investors committed a total of £1.59m to this project. Social Finance acted as fund manager for this and other investments, using separate management and staff and with safeguards in place to ensure appropriate separation of duties and accountability to investors and other stakeholders.

24 111 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 intelligent software and, on referral or callback, by a range of healthcare professionals including doctors, nurses, paramedics and pharmacists.

3.3 The intervention and its rationale

3.3.1 The intervention model

The NWL Telemedicine service offer, delivered by LCW and West London NHS Trust, gave callers a single point of access to a specialist nursing team in real time. There was no call handling or call back for example, as there would be in the standard National Health Service 111 telemedicine offer[25]; calls were answered and dealt with immediately by qualified nursing staff with expertise in end of life care. As well as offering instant access to clinical advice, the nursing team were also able to liaise with local health services and arrange face to face visits from other providers such as GPs if necessary.

The service was available to all older people's nursing and residential care homes operating in the areas covered by the seven NHS CCGs involved in commissioning the service. At the time the service was developed, this area included 114 homes, and it was expected that the service would be available to 5,680 people, and engage with up to 3,771 residents per year. It therefore planned over the project's lifetime to reach a total of 17,040 residents and engage with 11,313 of them, including repeat engagement with the same residents. A further 19 care homes were covered via the separate pilot arrangement and FFS contract with NHS Ealing CCG.

This service was different from the majority of projects commissioned via EOLCI. While all the projects differ in some aspects from each other (since the role of EOLCI was explicitly to explore different models) the fundamental difference between this project and all the others is that the others involved clinicians and other staff (for example one project uses volunteers) working directly with older people in their homes. The NWL Telemedicine was the only service focused on a telephone-based offer, and the only service targeted explicitly at supporting existing staff in care homes, rather than residents directly.

3.3.2 The rationale for the intervention

The decision to choose this intervention needs to be set in the context of EOLCI's wider mission to explore options for improving end of life care. In the early days of the EOLCI's development, the team explored project ideas that could facilitate those aims; this included a feasibility study investigating different opportunities in the field, and a call for expressions of interest from CCGs interested in working with the CWF.

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).

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[26].

The EOLCI also put out a call for expressions of interest from commissioners interested in developing projects in the end of life care arena (including but not limited to telecare). This exercise attracted around 60 responses from potential commissioners. These initial expressions of interest were narrowed down first by eliminating those that did not appear viable, and then by a more detailed feasibility study process to identify

25 111 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 supported by a range of healthcare professionals including doctors, nurses, paramedics and pharmacists.

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

the projects that were most promising and should be progressed. This two stage process reduced all expressions of interest to seven potential projects..

As explored in our first review, 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. However there were also good reasons, identified by stakeholders in our first review and reinforced during this review, to explore the better application of a telemedicine approach. These included the fragmentation in the care home sector and different approaches to training staff – leading to varying levels of skills across the sector to engage with and utilise external clinical advice and support. A further issue, highlighted by stakeholders in this review, was that there was wide variation in existing support to care homes by the NHS (especially from primary care via GPs) and a view that residents in care homes in general received a poorer service than those in their own homes.

The analyses conducted in developing the SIB provided a good level of information about the types of people being admitted to hospital who could reasonably be cared for in a care home with the right support in place. This process led eventually to the initiation by EOLCI of a number of different models, the majority of which involve direct care by skilled practitioners to people in their own homes, but including the NWL Telemedicine project to address the specific issues outlined above and test where better and more equitable services could be provided, with benefits to both care home residents (and staff) and to the NHS as a whole.

3.4 The rationale for a SIB

Since the aim of the EOLCI was to find ways in which the CWF could be used to explore innovation in health care, the use of a SIB or SOC model was to some extent a given. Rather than commissioners deciding first on an intervention and then on whether a contract for outcomes and the use of social investment were useful ways of deploying it, they were from the outset asked to express interest in exploring the use of a SIB approach.

The usual and expected logic of a SIB option appraisal was thus to some extent reversed. As we observed in our first review there were existing end of life care interventions which had proved successful without using a SIB (and Ealing CCG contracted for this service outside the SIB structure). For all parties, the main driver for the SIB was that funding was readily available via the CWF (with further funding available from the CBO), and the EOLCI had identified that there were gaps in care for those at the end of life which could be addressed through a SIB, and would provide better outcomes for patients.

Our first review identified four key reasons why the SIB offer was attractive, three of which are common to many SIBs:

1. It would provide upfront funding to the commissioners. 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 such as grant or FFS contract. 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. The assumption was that savings would then be generated for the commissioning CCGs as the service facilitated a reduction in payments from the CCGs to the acute trusts made when care home residents were in hospital at end of life. There was some debate during the first review about whether the service would achieve real savings or avoided costs (see more detail in section 3.5.1 below), but, irrespective of this, the positive impact on finances was attractive to commissioners.

2. Commissioners would pay for success rather than activity. With limited access to funds, the risks to commissioners of an unproven service were exaggerated. Under the SIB commissioners were paying for achievement of outcomes rather than delivery. Interviewees highlighted that

most NHS commissioning monitors success via activity, which does not necessarily equate to financial performance or social impact.

3. **It would drive rigour in development, monitoring and analysis** Having investors and an intermediary involved 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. Commissioners could buy in such third-party support in a standard fee-for-service commissioning model, but this would be difficult to justify financially, despite the potential benefits of the telemedicine service. Furthermore, the investment was expected to drive focus on performance management, as fund managers are motivated to protect their investment and ensure intervention success.

4. **It would shift stakeholder focus to preventative healthcare**. A more technical rationale for commissioners was that the SIB would further test the case for capitation models of healthcare commissioning, mirroring the approach NHS England took when funding CCGs. Proponents of capitation models[27] argue that healthcare provided through fee for service arrangements focuses 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. Although a capitation model wasn't used in this SIB (because the risk was transferred to the intermediary and investors, not to providers) there was a view that it would contribute to wider thinking about the use of preventative models.[28]

3.5 Payment mechanism and outcome structure

3.5.1 Payment mechanism

Although the EOLCI and coordinating commissioner monitored provider performance against a range of Key Performance Indicators (KPIs) there was only one outcome against which payment was made under the payment by results mechanism within this SIB – a single payment of £3,270 for each avoided non-elective hospital admission (NEL) from care homes, measured against an agreed baseline of predicted NELs if the service did not exist. The commissioners would therefore pay only when the project reduced hospital admissions below what they estimated would have happened otherwise, based on historical data. Performance against the baseline was monitored monthly, but for outcome repayment it was calculated during an annual performance management review.

The CBO agreed to pay 20% (£654) of the total payment up to a cap of £780k at High case; payments at Median case were planned at £713k. The local commissioners therefore paid the remaining £2,616 per outcome, up to a cap on total outcome payments of £3.12m at High case (and planned service spend at Median of £2.85m).

In addition there was a further cap on the total amount that commissioners could pay, equivalent to 90% of the total service costs. This meant that in practice, and based on estimated service delivery spend at Median, there were two different outcome caps: Based on planned outcomes the cap was 1,091 but based on the planned service delivery cost the effective cap was 1,004 outcomes.

The outcome sought by the SIB was directly related to reduced hospitalisation at the end of life, and was a strong proxy measure for the desired social outcome (care home residents being able to stay in their home, rather than be in hospital). It also linked outcome payments directly to savings (or avoided costs) for the commissioners. This was a

27 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

28 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

key reason why this outcome metric was chosen as opposed to others which do not generate similar levels of saving, such as A&E admissions or ambulance call outs. Another prime factor was that NELs are inherently measurable and data is readily available from the London Ambulance Service.

Our first review identified a number of issues relating to the setting and measurement of this outcome, including:

- Challenges in agreeing an appropriate baseline: The baseline reflected NEL activity for the relevant care homes in 2016/17, with assumed growth applied each year. Historically the baseline had increased by around 6-7% annually, but a range of factors could influence the growth rate. This meant it was difficult to project baseline increases to establish whether the SIB was indeed performing as measured. The main impact of this was that it took some time to establish an agreed baseline that allowed for the right growth rate[29].
- The potential impact of the outcomes caps on SIB financial performance. As is usual, the applicant to the CBO agreed a Median, High and Low scenario for expected outcome performance, with Median scenario being equivalent to base case for expected performance. These were expressed as a total number of NELs avoided compared he baseline. Table 1 below shows the agreed scenarios based on the year one baseline of 3,944 NELs, and the total outcome payments generated at each scenario at the agreed payment of £3,270. As this Table shows, the agreed outcome cap (a total of £3.9m across local commissioners and CBO) would meet all outcome payments at the Median scenario, but would be more than half a million below uncapped payments at the High scenario (the outcomes caps would fund 1,193 outcomes, midway between Median and High scenarios). There was thus a risk that the project would achieve unfunded outcomes, as is often the case when outcomes are capped, or the service would have to cease delivery once the outcomes cap was reached to avoid a significant deficit of payments against costs.

In addition the Funding Agreement stipulated that the commissioners would not pay more than 90% of the total costs of service delivery. It was also stipulated that the CBO top up would be capped at 18% of delivery, rather than the planned 20% of outcomes, equivalent to all costs. This meant that even at Median scenario the service would be unable to cover its costs, since non-delivery costs were effectively limited to 18% of delivery costs, and the plan was always to spend 18.9% of delivery costs. The £116K fixed payment from Ealing would also have offset the losses, but without that payment a SIB loss would have been built in from the start.

Table 1: **Performance scenarios agreed with CBO programme compared to outcomes cap**

Scenario	Reduction in NELs compared to a baseline of 3,944	Total outcome payments from CCG and CBO if uncapped	Difference between uncapped payments and total outcomes cap (£3.9m)
Low	818	£2,674,860	£1,225,140
Median	1,091*	£3,567,570	£332,430
High	1,364	£4,460,280	-£560,280

* Outcomes were effectively capped at 1,004 at Median due to the clause limiting maximum payment to 90% of delivery costs

29 It appears that the SIB was initially implemented with no allowance for growth, and measurement against a flat rate of 3,944. This would have been disadvantageous to commissioners, since it would have over-estimated the impact of the service. An adjusted rate was however put in place relatively quickly and in time for comparison in future years; this rate was itself then adjusted to take account of changes in the data – see section 4.1.2 below.

- **Linking cost savings to outcome payments**. There was debate at the time of the first review about whether the service would truly release cashable savings, or allow the commissioners to avoid future costs. Some stakeholders argued that the service would generate true savings for the commissioning CCGs as the service facilitates a reduction in payments from the CCGs to the acute trusts, primarily from a reduction in the "allocation" payment for growth (or increased spend) in the negotiations over annual funding[30]. Other stakeholders argued that the service would not generate savings through reducing the number of hospital beds, but it would ensure that the right people were occupying the available beds, and free up spend and hospital space to support more people, thus avoiding unnecessary costs and improving cost effectiveness. Either way, the important point was that the proposal was financially attractive to commissioners[31].

  This is an interesting issue which has occurred elsewhere, notably in Ways to Wellness where there was a similar debate about whether the proposed SIB would truly "wash its face" and reduce costs or only avoid costs. In the end the CCGs (now ICS) in both cases accepted that the final benefits, whether as savings or avoided costs, were sufficiently attractive to engage commissioners and persuade them to make payments.

- **Attribution of the outcome to the telemedicine service**. While comparison to the baseline would provide evidence that the reduction in outcomes was additional to what would have happened without the Telemedicine service, there was also debate about where and how it could be shown that the outcomes were attributable to the intervention rather than to a varying range of other services on which care homes could draw. This continued to be an issue during implementation, and we discuss the issue and efforts to resolve it further in section 4.1.4.

- **Dependencies affecting outcome performance**. Finally, there were known to be a range of dependencies upon which the outcome target was predicated. These included the responsibilities of the commissioners and providers to ensure that the service was publicised to care homes; that care home staff were consequently aware of the service available to respond to calls; that care home staff used the service for the right issues which can be dealt with by telemedicine clinical staff; and that commissioners ensured the project had appropriate strategic support, for example through inclusion in the North-West London Last Phase of Life Strategy, and Urgent Care Strategy.

3.5.2 Investment and financial risk sharing

At launch it was expected that the investors – Big Society Capital and Macmillan, via the CWF – would provide between £1.4m and £1.8m of capital depending on outcome performance, with a plan to draw down £1.59m at the Median scenario. Based on outcome payments at Median scenario, as shown in Table 1 above, this implied an Internal Rate of Return to the CWF of between 8%-10% over the four-year lifetime of the project, or a money multiple of 2.04. The Funding Agreement allowed for the raising of more capital, if needed, through the EOLCI putting a proposal to the CWF Investment Committee.

There was also a three-month termination period in the Funding Agreement which applied to all parties.

The SIB was designed so that the risk of outcome payments falling short of delivery costs was borne largely by EOLCI as the intermediary or, through EOLCI, by investors. Providers did not bear outcomes risk directly because they were paid quarterly in advance based on actual costs incurred (and if there were vacancies or other changes to costs the payment would be reduced accordingly). Payments to providers were made by the coordinating commission and covered by capital from the EOLCI, rather than the EOLCI paying

30 A simplified guide to NHS funding structures, CCG funding responsibilities, and the way payments to CCGs from NHS England were calculated, can be found at. https://commonslibrary.parliament.uk/research-briefings/cbp-8399/. Note that this reflects the CCG funding structure in place when the SIB was developed, which is changing under the transition to ICS.

31 It was thought likely that savinsg and/or avoided costs would cover the outcome payments, and therefore there would be a net financial benefit to the commissioners. Savings from reductions in the allocation payment were estimated at around £1m, or £400k net of CBO contribution, although interviewees suggested that the avoided costs could be much higher. We analyse what has happened in practice in section 4.3.3 of this report

the providers directly as is usual in most SIBs where there is an intermediary managing payment flows.

Providers were not entirely free of performance risk, however, since payment relied on the providers meeting pre-agreed service milestones. If performance did not meet agreed standards consistently and an agreed remedial plan had not been implemented, then the coordinating commissioner could withhold or reduce payments. There was thus a small risk of providers not being able to meet all their costs because payments could be withheld, as they could be in a similar FFS contract.

3.5.3 SIB governance

There were two levels of governance for the SIB: operational and strategic. The operational structures evolved over time in the lead up to contract implementation in October 2018, when a review by all stakeholders 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 and communications teams.

Sitting above the operational group was the Joint Project Working Group, which took a strategic view and was essentially the project board. It was chaired by a director from the STP and focused on reviewing data and progress.

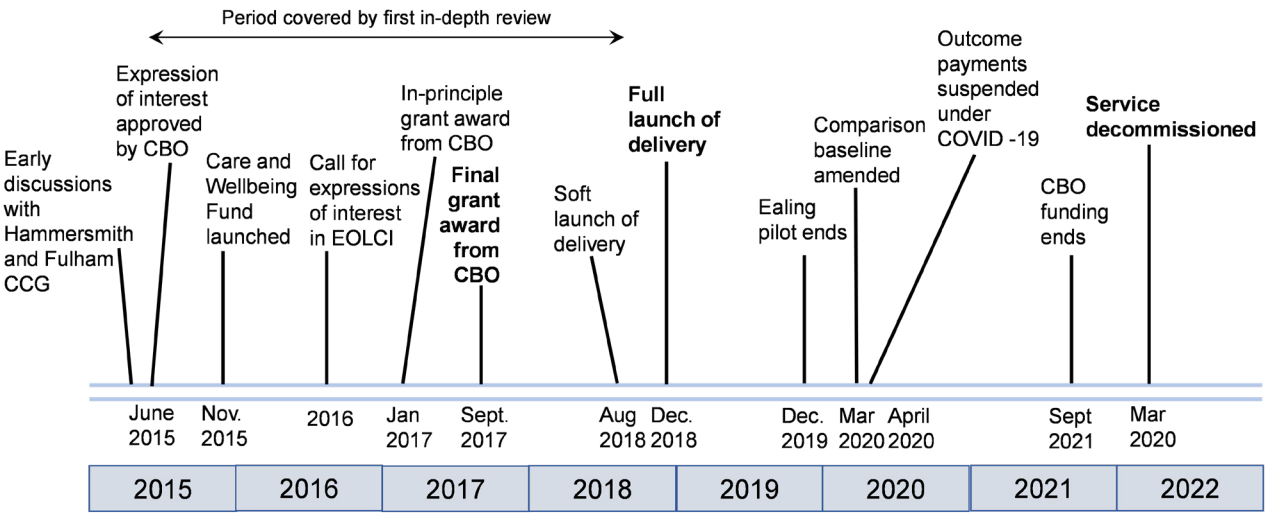
Additionally, the Memorandum of Understanding (MOU) between the stakeholders stipulated that the EOLCI, commissioners and service providers hold contract review meetings at least on a monthly basis during the first year of the SIB, with a view to reducing this to at least every three months following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

3.6 History and development

This section summarises key developments leading up to the project launch (between 2015 and 2018); Section 4 provides information on major developments during project implementation (2018 – 2022). Further information on the project design phase can be found in the first in-depth review, which focused on the development phase and stakeholders views at that stage.

Figure 4 provides a timeline summarising the major developments across the project, both before and after implementation, and is followed by a fuller description of events during the development and launch phase.

Figure 4: **NWL Telemedicine project timeline**



Key points of note during the development process were:

- The time taken to develop and launch the SIB. As is common in SIBs (and especially those exploring their application in previously untried service areas) the entire process of development took a long time – around 3½ years from first contact with the potential commissioner, Hammersmith and Fulham CCG in 2015. However the core time taken to implement the SIB once it had in principle approval from the CBO to co-funding was shorter, and consistent with and somewhat quicker than many other SIBs of similar or less complexity. Thus it took less than two years from in-principle approval in January 2017 to full launch in October 2018, and only around six months to develop commissioner engagement, secure investment commitment, develop financial metrics and put in place the management structure pre-procurement. That it took a further year to implement the project successfully was largely due to an abortive procurement process, as outlined below, and to other time consuming issues such as agreeing the baseline for outcome payments,
- Need for the project to have sufficient scale to be viable. 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 to provide the necessary economies of scale, since it was vital that there were enough care homes involved to cover the costs of the highly skilled staff operating the service. By way of illustration, there were in 2018 only five older people's care homes in Hammersmith and Fulham; across the whole of the North-West London area there were 140. This led to the broadening of the scope to include more commissioners, which provided the scale needed but caused other challenges as explored later in this report.
- Abortive procurement process. 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 (see page 15). However, this procurement was unsuccessful, due to concern that a provider from outside the geographic delivery area would struggle to provide the service effectively, and that local links were vital. As interviewees highlighted during our first review, healthcare structures in the area are complex, and it would have been resource intensive and challenging for a provider from outside the area to build the necessary links with local services.
- Second procurement round. This meant that a second procurement process was needed, by which time it had become clear that only a limited number of providers had both the access to well-qualified staff, and technological capacity and expertise needed to provide the telemedicine service. 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 were both based in the NWL area and applied jointly having worked together previously on the delivery of a different telemedicine offer.
- Delays in agreeing contracts. According to stakeholders, there were delays in the signing of contracts which meant that the providers were asked to start delivery before contracts were in place, This is unusual and required providers to start delivery "at risk" i.e. the risk (admittedly low) that the project would be aborted and expenditure incurred to that point would be hard to recoup.
- Recruiting staff of the right calibre: Staffing was a challenging aspect of project development and mobilisation and led to delays in the launch of the service. The project 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 lack direct patient contact. The providers explored various options to address these challenges, including redeploying staff from other telemedicine (though these staff had to be retrained to use a different call handling system and software); seconding staff from other local services with the support of the CCG, and developing qualifications to upskill interested staff who were qualified to the right level to meet service needs.

3.7 Comparing NWL Telemedicine with other CBO projects

The CBO evaluation team has developed a framework for analysis to compare the SIB models across the nine in-depth review projects. This draws on the SIB dimensions set out by the Government Outcomes Lab[32], adding a sixth dimension related to cashable savings. The aim is to understand how SIB funding mechanisms vary across CBO, and how they have evolved from their original conception. Figure 5 uses this framework to compare the NWL Telemedicine project with the average positioning for the CBO in-depth review projects across the six dimensions (Annex 1 describes the dimensions and the different categories that exist within each dimension. For further information on how these categories were formulated, and the rationale behind them, see the Third Update Report from this evaluation[33]).

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

The positioning of this project against the framework shows the following:

- **Payment model:** The PbR model was based 100% on payment for outcomes achieved. This is typical of the CBO projects that feature as in-depth reviews: two-thirds (six out of nine) of the projects had 100% of payments attached to outcomes. In the remaining three projects (Mental Health Employment Partnership[34], West London Zone[35] and Be the Change[36]) commissioners also paid for engagements / outputs. It is interesting to note that MHEP (which as noted earlier had a similar structure to EOLCI and was also developed by Social Finance) had a different payment structure that included payments linked to engagements.
- **Validation method:** Payments were made for all outcomes achieved, with no impact evaluation to ensure that outcomes were attributed to the intervention – indeed as already noted and explored further in section 4 attribution to the service was an issue throughout the project. Outcomes were however measured against a baseline of projected performance agreed by all stakeholders, with some effort put into getting this baseline as accurate as possible. This is a reasonably high standard of outcome measurement compared to some of the in-depth review projects, which paid for all outcomes achieved.

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

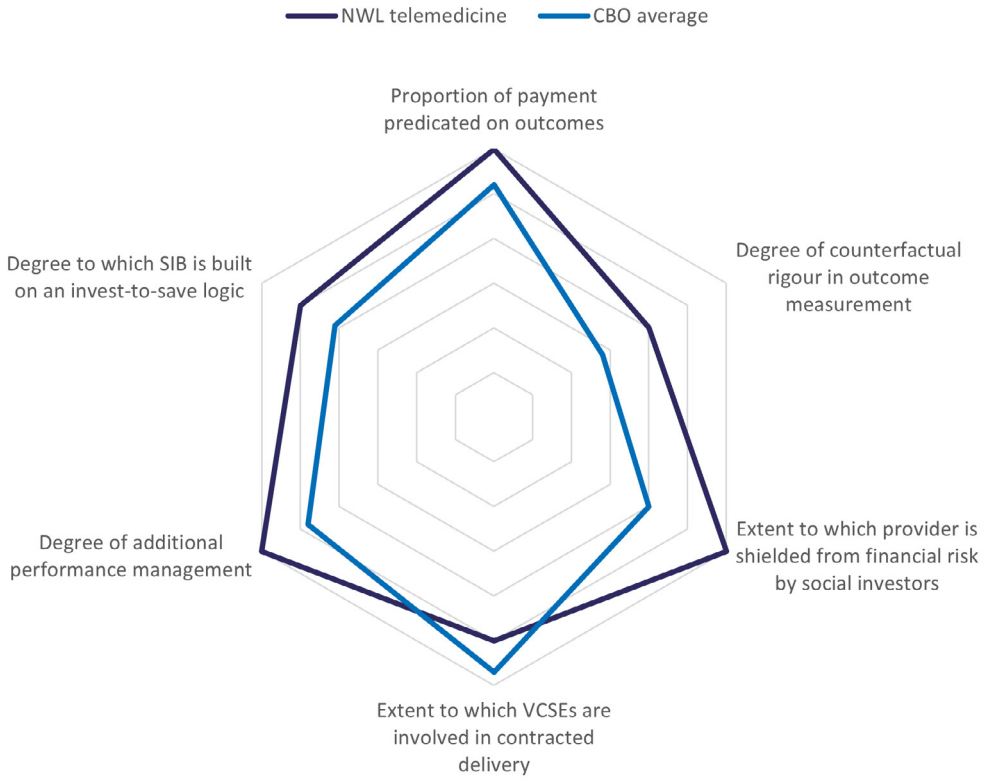
33 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-3rd-update-report.pdf?mtime=20220616134448&focal=none

34 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/MHEP-InDepth-Review-3rd-report.pdf?mtime=20231201095343&focal=none

35 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-Indepth-reviews-WLZ-collective-impact-bond-3.pdf?mtime=20230518085219&focal=none

36 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/Be_the_change_indepth_review2.pdf?mtime=20230818142242&focal=none

Figure 5 – **Comparison of NWL Telemedicine to all CBO in-depth review projects**



- Provider financial risk: The providers were shielded from nearly all financial risk and bore only the low risk – comparable to any contract – of payment being withheld if they persistently underperformed and did not agree remedial action. This is a feature of five out of nine of the in-depth review projects, with investors sharing risk with providers in the other five projects – for example through payment being expressly linked to activities or outputs such as minimal referral levels.
- VCSE service delivery: Delivery was undertaken partly by a social enterprise (LCW) and partly by a public sector body (West London NHS Trust). This is unusual, with seven of the nine in-depth review projects delivering only through one or, more frequently, a number of VCSEs. The other project where delivery is shared between VCSEs and public sector bodies is the Zero HIV SIB, and in both cases the public sector providers were NHS Trusts.
- Performance management: The SIB was designed so that EOLCI, through a dedicated team staffed by Social Finance, would provide external and additional management of performance beyond what would normally be undertaken by either a commissioner (as contract manager) or provider (as party of normal operational management). This is one of two models which are found across most CBO in-depth review projects, with the other being where performance is directly managed by the delivery organisation.
- Degree to which project is built on an "invest-to-save" logic: As explained earlier in section 3.2.2, the invest to save principle was relatively important to this project, and commissioners were attracted to the scope for financial benefits which were variously considered to be true cashable savings or avoided costs. The payment mechanism was also directly linked to an agreed cost avoided or saved by the avoidance of an NEL. There does not appear to have been an expectation, however, that the service would have to generate enough savings to justify a decision to commission based on 100% payback, as was the case in two of the nine in-depth review projects.

4.0 What has happened in practice

4.1 Major developments during implementation

This section covers major developments that occurred during the implementation of the NWL Telemedicine project.

4.1.1 Slower mobilisation than planned

At the time of our first review full mobilisation was expected in October 2018 having been delayed from an original start date of April 2018, but the service did not fully mobilise until December 2018, after a partial mobilisation in August 2018. Delivery therefore ran for 3 years and five month, compared to an original plan for a four year project (April 2018 – March 2022).

Once the service did fully launch, it continued to experience some issues which meant that build up to expected call volumes was slower than forecasted. According to stakeholders the service initially received fewer calls than expected and a proportion of the calls it did receive were not appropriate for the service because they did not indicate the need for specialist palliative care, and therefore did not fully utilise the clinical knowledge held by the service. A number of calls were focused on death administration for example.

EOLCI thought this was in part due to limited engagement from Care Homes with rapid turnover of staff, meaning that many did not know the service was available for them to use. This was a known issue when the service was in its planning phase, and our first review identified the need for consistent and regular marketing and communications to care homes, in large part because staff tended to turn over quickly.

To mitigate this, EOLCI implemented a renewed Communications and Engagement Strategy in the summer of 2019 to publicise the service directly to care homes. This was included as part of the Winter 2019/20 communications planning. It was complemented by the Project Manager's attendance at care home forums to promote the service.

There were also plans to address the under-utilisation of the service through expansion both into more care homes and into the provision of support to people in their own homes. The service was extended to cover more care homes, but plans to extend the service to those living in their own homes appear to have stalled due to the impact of COVID-19 and associated restrictions.

4.1.2 Adjustment of the comparison baseline

As already reported in section 3 it took some time to agree an appropriate rising baseline against which to compare the service's performance in reducing NELs, based on known NELs in 2016/17 and an estimate of growth from that point. According to stakeholders part of the challenge was in agreeing the baseline across multiple commissioners, although communications improved in 2019 when the CCGs put in place a revised and harmonised constitution that facilitated joined-up decision making.

During 2019 and early 2020 (prior to the impact of COVID-19 as described separately below) it became apparent that the baseline needed further adjustment due to changes in data reporting and the more accurate reporting of NELs. According to stakeholders this was because of changes in the reporting of short and longer term admissions which meant that the balance between the two was different from what had been originally forecast. According to a briefing paper prepared by the EOLCI, analysis of actual NELs between April and September showed that under the new data reporting standards the actual number of NELs was around 6% lower than it would have been under the old data standard on which the baseline was based (1,653 compared to 1,762). This led to a revision to the baseline for 2019/20 and future years as shown in Table 2 below.

Table 2: **Adjusted baseline agreed after project implementation**

Item/Service Year	17/18	18/19	19/20	20/21	21/22	21/22
Total Non-electives (old baseline)	3,789	4,220	4,704	5,250	5,864	4,887
Total Non-electives (new baseline)	N/A	N/A	4,401	4,907	5,477	4,565

Source: Social Finance briefing paper

Effectively therefore, the baseline for 2019/20 and future years was adjusted by extrapolating data for April to September 2019. The briefing paper acknowledges that this was a relatively simple way of making the adjustment which "is in keeping with the fact that this is effectively a minor administrative exercise, necessitated by a change in Data composition over which neither party [EOLCI or commissioners] had control" and "ensures that minimal resources are diverted away from other more critical activities".

It seems reasonable that this approach was adopted given the challenges that EOLCI and commissioners had faced in agreeing the original baseline, and the time and effort it consumed. Stakeholders from EOLCI emphasised during this review that the entire process was collaborative, and the change to the baseline was implemented with full agreement of all parties. According to other documents the change was signed off and included in a revised Funding Agreement in April 2020, in time for it to be used as the basis of comparison and calculation of outcome payment for the 2019/20 financial year.

4.1.3 Measuring and validating attribution

As already noted in section 3 all parties expected that it would be difficult to prove attribution to the NWL Telemedicine service due to the complexity of the health and social care landscape in North West London and the multiplicity of services available that aimed to reduce NELs. To address this and to give reassurance that the NWL Telemedicine service was genuinely impactful and reducing NELs, the EOLCI started in August 2019 to collect data on the informational outcome of calls to the service. According to successive annual reports to the CBO team this analysis indicated that only 17% of calls resulted in an ambulance dispatch or referral to secondary care, and therefore 83% of calls were successfully managed within the care home. These outcomes were also cross-referred with the primary reasons for calls and were independently reviewed by the clinical advisors on the EOLCI Advisory Board. They verified from their clinical experience that generally these types of calls would have resulted in an unnecessary NEL admission if not supported by the service. In other words, there was both quantitative and qualitative evaluation by the EOLCI and its advisors that the service was directly impacting NELs over and above any impact from other services.

Reflecting further on this issue during interviews for this review, senior EOLCI stakeholders observed that the overall impact of the service was high and at such a level that it seemed highly likely to commissioners that the NWL telemedicine service was having a significant impact, even though its scale could not be guaranteed. As one commented:

"In terms of the data, it showed such a reduction that the commissioners were actually comfortable in terms of making outcome payments back to us….Post the renegotiated baseline, that did show that the service was having enough impact to warrant this investment"

4.1.4 Ending of pilot arrangement with Ealing

As explained above NHS Ealing CCG agreed to fund the service outside the SIB structure for its first year, using a conventional fee for service contracting model. At the end of this period, Ealing decided to end the arrangement and not continue funding. According to stakeholders this was largely due to the attribution issue, and uncertainty as to whether the service was adding enough impact to business as usual – especially when, as explained in section 3, Ealing already had a large GP practice providing end of life support to care homes in its area.

4.1.5 Challenges in recruiting staff of appropriate calibre

As explained above the mobilisation of the service was slowed due to challenges in recruiting staff of the right calibre. These challenges continued after full mobilisation and appear to have persisted throughout the early stages of the project. Stakeholders interviewed for this review reported that the recruitment and retention position considerably improved when the lead provider, LCW, recruited a new clinical lead who got to grips with the issue and stabilised recruitment. This is interesting because it mirrors experience across other CBO projects that we have reviewed (including other projects intermediated and managed by Social Finance such as MHEP and Reconnections) in that SIBs are no different from other projects in being highly dependent on the quality of senior management within providers; the key effect of a SIB is likely to be that there is increased pressure to make such management changes more quickly.

4.2 Changes in response to COVID-19

4.2.1 Changes to the service

The impact of COVID-19 (and associated restrictions or, technically, Non-Pharmaceutical Interventions) on most services supported by the CBO programme was to force them to cease or reduce face-to-face work and move to a remote working model. The NWL Telemedicine service was less affected than some other services by such restrictions because it was already a telephone-based service. It was however impacted by COVID-19 and the wider healthcare system's response to it because:

- There was increased demand for the service, especially in the early months of the pandemic during what is now known as "Lockdown 1", between March and July 2020. During this period remote contact became the default way for care homes to obtain support for residents, and as is now well recognised care home residents were severely and disproportionately affected by the COVID-19 virus due to a number of factors that encouraged transmission within care homes.
- Conversely, and later, part of the response to COVID-19 by the NHS was to put in place further support for care homes so that they could deal with patients' health issues without contact and increased infection risk. According to this project's annual report to CBO in June 2022 this led to duplication of service to care homes in NWL in some areas and gaps in provision in others. This in turn led to a review workstream in NWL to map services available to care homes and identify such duplication and gaps in service. The EOLCI were part of this review and attended regular workshops with NWL clinicians and commissioners.
- There was a presumption against care home residents (and other older people) entering hospital unless due to the effects of the virus, offset by increased admissions due to the virus itself. Overall, the effect was to confound the comparison with the NEL baseline although it was initially unclear what the effect would be.

4.2.2 Changes to the SIB mechanism and impact on finances

In response to the impacts outlined above and to wider NHS policy on contracts during COVID-19, changes were made to the payment mechanism and to the Funding Agreement across three end of life care SIBs supported by the CBO programme (this project and those in Hillingdon and Sutton). For the NWL Telemedicine project the main changes with regard to local commissioning and outcome measurement were that:

- The service was categorised as an essential service by commissioners, such that if the service experienced staff shortages these would be back-filled from non-essential services, where possible, to ensure that delivery of the service could continue.
- Outcomes, if data was available, would continue to be monitored and reported; and EOLCI would continue to engage with commissioners and service providers to gather qualitative evidence regarding impact on service delivery.

To give effect to these changes the NWL commissioners agreed to enact a specific "COVID-19 clause" that was added to the Funding Agreement. This provided for both parties to use reasonable endeavours to support the service to adapt if it could not operate as anticipated, or staff needed to be redeployed to other duties; and for the funding arrangements automatically to move to a "payment for service" model if planned outcome metrics no longer reflected the impact of the service or could no longer be accurately modelled.

The EOLCI also drew up proposals to ask both local commissioners and the CBO programme to suspend payment on outcomes and temporarily to make payments on an activity basis, in line with wider guidance on contracts from NHS England (NHSE). While commissioners agreed to these proposals, they were never enacted. The EOLCI was able to continue to collect data on outcomes through the period of COVID restrictions. Payments therefore continued to be claimed and made based on outcomes. The CBO did, however, agree to a four-month extension to its grant agreement, with activity running to September 2022 (and the period for payments claims extended to the end of January 2023).

4.2.3 Decommissioning of the Service

The NWL Telemedicine service was decommissioned in April 2022, at the end of its planned contract life. This is in contrast to some EOLCI projects, which have been sustained and subsequently funded through "business as usual" by local NHS commissioners – for example in Hillingdon. According to stakeholders, the decision not to extend this project was taken in full collaboration with commissioners and after the review of service duplication and gaps in provision that followed changes to services during COVID-19. The data collected by the project was used to inform this view and develop a strategic view of how a specified base level of support could be provided to all care homes in the NWL ICS area. As one senior stakeholder explained:

"So what happened kind of post-COVID was quite rightly, there was a huge increase in people saying "we've got to get care right in care homes".....As a result there was much more of a focus on in-hours, planned care by actual people going in to care homes, rather than wanting to rely on a telemedicine model. And also there was this idea of kind of lifting the bar across North West London. I feel there was a case for investing the money in getting the basics right. Basically what had happened inadvertently was you had some who were getting a bells and whistles service with this as an addition

– which is how it should have been – versus others that really weren't getting the level of support and care from your kind of normal services and then either weren't using this or were using this when what they really needed was a GP to do a visit."

Although the service itself was de-commissioned, stakeholders observed that it enabled a joined-up approach to the provision of end of life care in care homes across NWL.

This culminated in the creation of the NWL London Care Homes Quality Standard, which has contributed to a reduction in health inequalities for the population.

4.3 Project performance

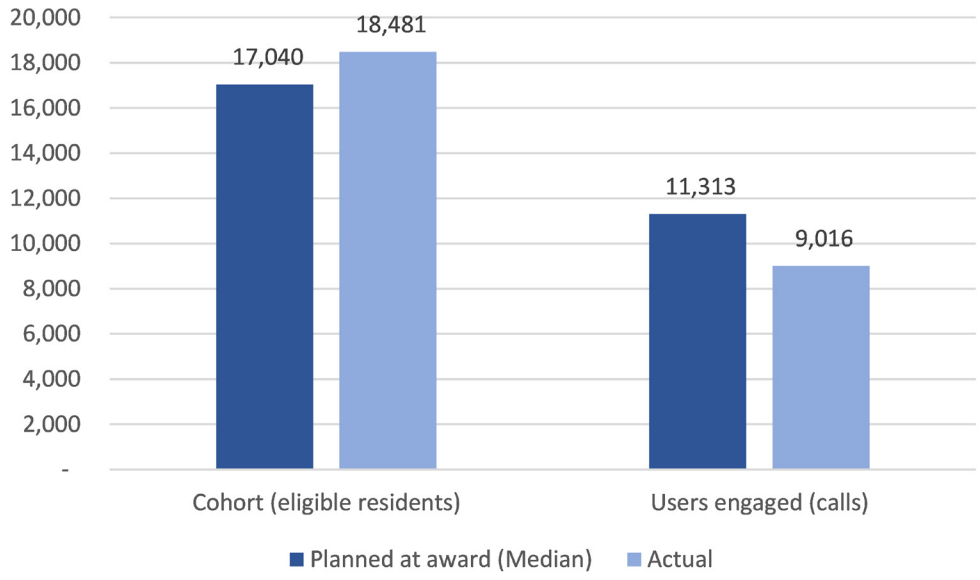
This section describes how the project performed and compares actual performance to its plans as submitted to The National Lottery Community Fund when applying for co-funding from the CBO programme. Except where stated comparison is with the Median scenario agreed with The National Lottery Community Fund and set out in the CBO grant agreement.

4.3.1 Service volume – cohort and user engagement

Figure 6 below shows how the service performed in terms of total cohort and total users, as compared to plan at Median scenario. For this project, cohort means the total number of care home residents eligible to receive the service, while user engagement means the total number of calls to which the service responded and provided advice and support.

As this shows the project had greater reach than originally planned, which reflects the extension of the service to additional homes over time. It fell short of its planned number of calls, reflecting the challenges of maintaining full service capacity and ensuring care home staff were aware of and used the service.

Figure 6 – **Service users (residents) eligible for the service and total calls (engagements)**



Source: CBO End of Grant (EOG) monitoring information as reconciled and agreed with EOLCI

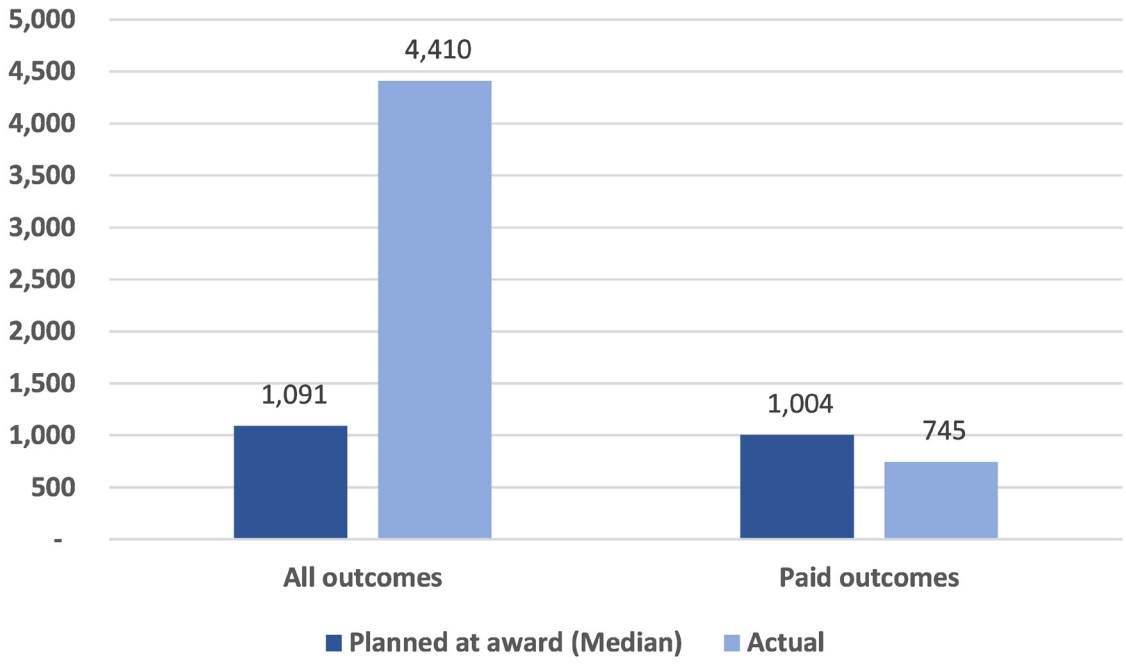
4.3.2 Outcomes achieved

Figure 7 below shows the number of outcomes achieved by the project – that is the total number of NELs avoided compared to the agreed baseline. This chart shows both the number of NELs avoided in total (ignoring the effect of the outcomes caps agreed with both local commissioners and The National Lottery Community Fund) and the number of outcomes for which EOLCI claimed payment. This shows clearly the effect of the cap on outcome payments set out in the Funding Agreement, which limited total outcome payments to 90% of the service costs until 31st March 2021, and 100% of service costs thereafter. Overall the outcome payments cap had an adverse effect on the SIB's financial position, as we explore further in section 5.2.3 below.

Based on uncapped outcomes, the service hugely overperformed against plan at Median scenario, and also against High scenario (1,364 outcomes). Since service costs were much lower than planned, however (see Figure 8) the service only claimed for 745 outcomes – well below Median and also below the Low scenario of 818 outcomes. Note that the plan at Median scenario for paid outcomes (1,004) is adjusted to allow for the cap being set at 90% of service costs as above; the project could not have achieved 1,091 outcomes unless it had been able both to charge for 100% of costs, and delivered the planned level of service.

While the service appears hugely to have over-performed, we should be cautious in attributing all outcomes to the NWL Telemedicine service since there were issues around attribution to different services as already noted above.

Figure 7 – **Outcomes achieved in total and paid for by commissioners**



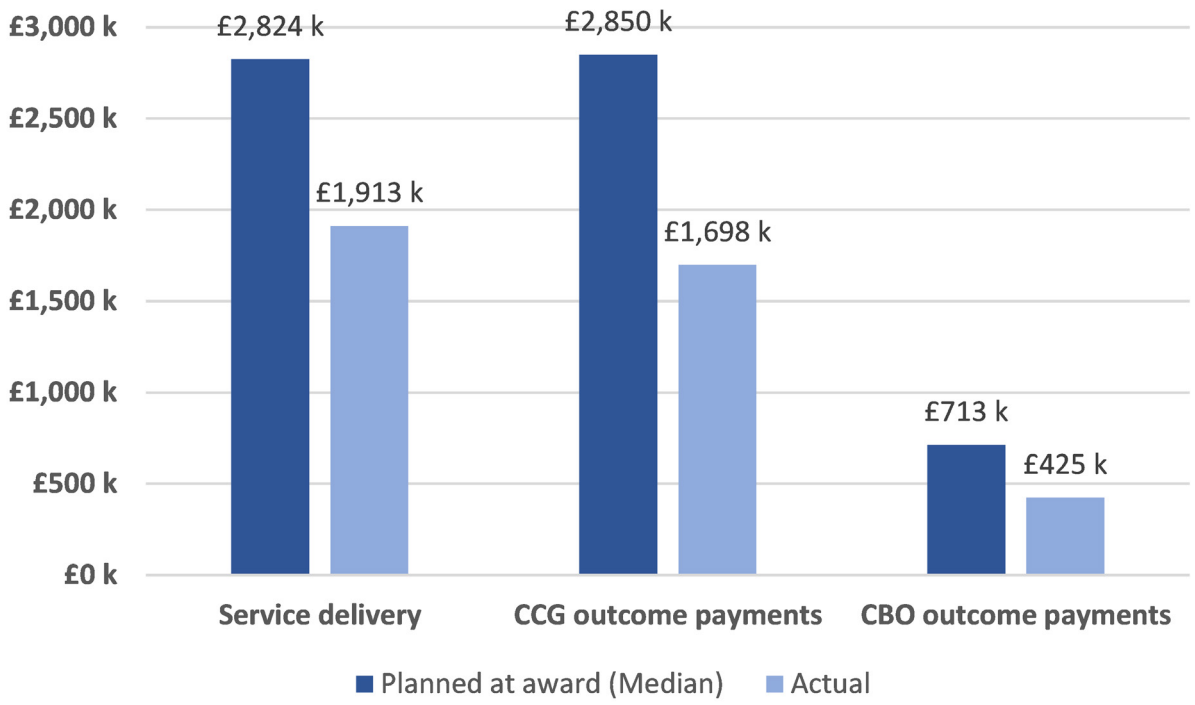
Source: CBO End of Grant (EOG) monitoring information as reconciled and agreed with EOLCI

4.3.3 Service costs, payments and savings

Figure 8 compares actual spend against plan at Median scenario for service delivery spend and outcome payments made, both by local commissioners and CBO. As this shows the service spent considerably less than planned, which in turn affected its ability to claim payments from local commissioners because it could not claim more than 90% of service costs under the Funding Agreement. This in turn had a knock on effect on total outcome payments by both CCGs and The National Lottery Community Fund as co-commissioner, both of which fell well below plan.

Please note that delivery costs shown here include support to delivery by EOLCI with a value of £252k, on top of the direct costs of delivery by service providers which totalled £1,661k. We analyse costs further and explain the inclusion of this cost in section 4.3.4 below.

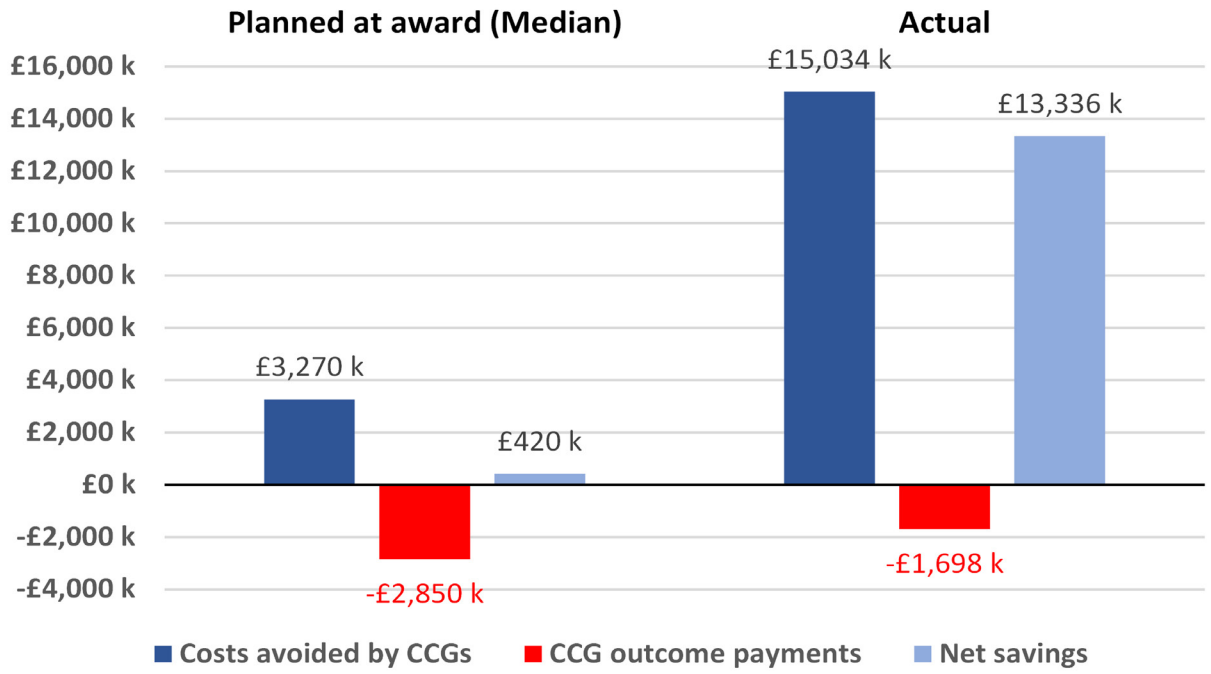
Figure 8 – **Service delivery costs and outcome payments**



Source: CBO End of Grant (EOG) monitoring information as reconciled and agreed with EOLCI

Despite outcome payments being below plan the project did significantly exceed its Median target for savings due to costs avoided by commissioners through the reduction in NELs, as shown in Figure 9. Based on EOLCI's own estimates (which have been agreed with the local commissioners but which we are unable to validate) the project achieved a net benefit to commissioners of £13.34m, equivalent to a Benefit to Cost Ratio for commissioners of 8.85 (i.e. on these estimates they received nearly £9 back for every pound spent.) In terms of overall return, including the CBO contribution, the BCR is a still very healthy 7.1.

Figure 9: **Planned and actual savings (avoided costs) to commissioners**



Source: CBO End of Grant (EOG) monitoring information as reconciled and agreed with EOLCI. Savings estimates from EOLCI and unverified by evaluators

These claimed benefits do however assume full attribution of all outcomes to the NWL Telemedicine service and as we discuss elsewhere in this report there is some doubt about full attribution given the complexity of other provision that might also have accounted for outcomes.

We should therefore treat these claimed benefits with caution, although it seems likely that savings and costs avoided due to the Telemedicine service would have exceeded plan at Median – since assuming full attribution savings are more than double plan at High scenario.

4.3.4 Overall SIB position and investment returns

Table 3 below shows the overall income and expenditure position for the project as reported to the CBO at end of grant and subsequently reconciled and agreed with the EOLCI. As this shows the project reported a small surplus of £43k (held within the EOLCI) but at the expense of a projected return to investors of £334k; investors received back their initial capital only. The surplus of £43k is equivalent to a Money Multiple of 1.03, although returns to individual projects within the EOLCI portfolio cannot easily be disaggregated.

As Table 3 shows the EOLCI estimate that they provided support to delivery (separate from performance management) with a total value of £252,195. For the purposes of assessing overall value for money in section 5.3, and to be consistent with the reporting of other CBO projects, we have treated this as a cost of the project being structured as a SIB, and therefore part of overall SIB Management costs. For the purposes of calculating service delivery costs as shown in Figure 8 above, however, we have included this cost in service delivery, The main reason for this is that EOLCI treated this support as part of total service costs for the purposes of calculating the cap on the total amount that commissioners could pay, based on 90% of total service costs. This is why total CCG outcome payments (£1,698k) are higher than direct delivery costs incurred by providers (£1,661k) despite the 90% cap.

Table 3: **Overall project income and expenditure**

Item	Median plan at award	Actual
SIB income		
CCG outcome payments	£2,850,000	£1,697,784
CBO outcome payments	£713,000	£424,446
Ealing FFS payment	N/A	£116,650
Total income	**£3,563,000**	**£2,238,880**
SIB expenditure		
Service delivery by providers	£2,824,000	£1,660,595
Total Service Delivery costs	**£2,824,000**	**£1,660,595**
Delivery Support by EOLCI	N/A	£252,195
Performance Management by EOLCI	N/A	£277,986
Total SIB management	**£395,000**	**£530,181**
Evaluation	£10,000	£0
Investment return	£334,000	£0
Other project costs	N/A	£5,109
Total costs	**£3,357,000**	**£2,195,885**
Net surplus	**£0**	**£42,995**

4.4 Stakeholder experiences

This section reports the views and experiences of stakeholders across both reviews.
Please note that we had limited access to commissioner and provider stakeholders for this final review.

4.4.1 Commissioner experience

As reported in our first review, those leading the project at Hammersmith and Fulham CCG (the coordinating commissioner) felt that the business case for the SIB was compelling. Commissioners were also driven by the SIB's ability to provide funding for a multi-year project, enabling the CCGs to overcome the restrictions of annual resource allocations from NHS England which effectively forced CCGs to run their own commissioning cycles on an annual basis, restricting the development of longer-term or new activities.

For the coordinating commissioner, involvement in the SIB was a positive experience. Interviewees described how having an alignment of purpose and collective intent between the investment fund manager / intermediary and the commissioners had been vital in terms of keeping the project on track. Although there was a view that the SIB structure had added a layer of complexity to delivery, it had also added momentum and drive, enabling the project to drive through and overcome challenges. Commissioner stakeholders also noted, however, 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.

Reflecting further for this review, the commissioner stakeholders whom we consulted thought that there had been challenges in implementation which had undermined the project, They felt that the project had not been well implemented and the approach to implementation had been "piecemeal" which meant that not all stakeholders had a positive experience. As one commented:

"It probably did get better over time, but the utilisation of it [the service] was probably significantly reduced because it just wasn't well implemented. And that is a story in the NHS because it is the implementation phase which lets us down….I loved the idea; it just wasn't properly implemented"

Stakeholders put this down to the complexity of the service and the challenges of overlapping services (as noted earlier) and to frequent changes in personnel in the project team within the NWL commissioning organisation. As another stakeholder commented:

"I think it was the project team with a number of changes in personnel… Someone started and then they went off and then another one started and they went off and actually ….there wasn't consistency because it was meant to be piloted before it was rolled out but they wanted to go big because of the delays and whatever but also I think from my point of view working across North West London it was a case of the care home providers being bombarded and it was a case of them being overwhelmed and like "what else do we have to do?" and they were getting confused….

and I think there wasn't a proper implementation plan with the other projects they were doing although it was the same team that was doing it"

Stakeholders also noted issues with stakeholder engagement – for example the GPs were engaged very late in the process, apart from the lead GP involved in developing the service specification. As noted above, steps were taken to improve internal communications within the project, some months after implementation, in part to address these issues.

Stakeholders noted that a particular issue was the overlap between the NWL Telemedicine Service and the NHS NHS*Star6 service which already provided an enhanced telephone service for care homes. This was one of three NHS111 "Star lines" launched in London in January 2017 in response to rising number of 999 calls from care homes. They provided early telephone clinical support to London Ambulance Service (NHS111star*5), Care Home (NHS111star*6), and Rapid Response (NHS111star*7) staff to improve patient care and reduce the requirement for ambulance transfer to hospital. This service was thus aiming to achieve similar outcomes to the NWL Telemedicine service and was itself subject to a review following implementation challenges in July 2019.[37]

4.4.2 Service provider experience

Across the two main providers, there was consensus that the SIB had been a time-consuming approach to financing the service, with the perceived complexity of the commissioning structures being a key factor. 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. Provider stakeholders thought that it was not always clear to whom they were accountable, given that they had a three-way Memorandum of Understanding (MOU) with the EOLCI and the coordinating commissioner which sat alongside a service agreement between the providers and coordinating commissioner. The MOU stipulated that all three parties be involved in performance review meetings, and that all three work together on resolving risks and issues.

As outlined earlier, there were also delays around contracting that led to both providers starting delivery "at risk" – that is there was a small risk that contracts would not be agreed, and it would have been challenging to recover any delivery costs incurred up to that point. Service providers were nervous about this, particularly the NHS Trust which had less flexibility than the VCSE provider to work on goodwill.

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, but conversely that the SIB had allowed for innovation in service design where standard commissioning would not, by financially "de-risking" the development of new and interesting approaches. The providers expressed the view that they would not be deterred from undertaking a SIB again, particularly since they now knew what to expect from the process and the potential challenges and benefits involved.

4.4.3 IFM/intermediary experience

As noted in our first review, Social Finance had dual roles in this SIB as both the fund manager of the Care and Wellbeing Fund, representing the interests of investors, and as part of the governance and performance management structure of the EOLCI, which holds an intermediary role in the project and has an independent board and chair.[38]

37 See https://www.transformationpartners.nhs.uk/wp-content/uploads/2020/03/NHS-111-Star-Lines-Review.pdf

38 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.

Social Finance stakeholders 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: 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.

The implementation and management support offered by the EOLCI (as the intermediary) had also 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.

Reflecting further on their experience of the project for this review, stakeholders openly acknowledged the challenges it had faced in implementation and in being part of a confusing and overlapping set of similar service provision. As already noted above, stakeholders thought that it was reasonable that the service had been decommissioned and that the best way through this was to support commissioners in developing a coherent service specification for future provision.

Stakeholders were however positive about the achievements of the project, as highlighted in the outcomes data (despite the challenges of attribution) and about the need for this sort of service and the lessons it had provided for wider provision. As one key stakeholder commented:

"This project was innovative and interesting for us because there is a huge inequality in terms of the end of life provision people get if they are in their own home compared to being in a care home but that shouldn't be the case, you should get the same level of support in a care home versus being in your own home, and so this service was providing specialist support to generalist staff, but the needs could be much the same…. I think it's quite interesting, at the time it was quite pioneering…but if you think now about the idea of virtual wards everything we were trying to do has actually come into being, and one of the things that we were very proud to do was to share a lot of learning with NHS England"

The same stakeholder observed that:

"So from an impact perspective, the primary outcome was to reduce the number of unplanned admissions from care homes. And I think whilst you can pick at the data – and of course we did – the headline was that this absolutely contributed to a reduction in unplanned admissions, and we worked really hard with our NHS partners to make sure that they felt comfortable with the attribution. So I think that because the landscape is quite complex and because there were of course lots of initiatives aimed at reducing unplanned admissions, you know, was this the sole cause? – no. However, in terms of the data it showed such a reduction that the commissioners were actually comfortable in making outcome payments back to us."

4.4.4 Investor experience

Stakeholders from the key investor, Macmillan, were also positive about the project while acknowledging that it had faced different, and sometime greater challenges compared to other EOLCI projects. They commented that:

"Where this has ended, it has done a really good job and it's like way exceeded I think the outcomes that we were aiming to achieve in reductions in none-elected admissions in length of stay so it's been a really successful project. But I think we called it the problem investment that we had…I think we predicted some of the problems they were going to have with the Telemed service from the very start. I think there was a discussion from the very start about whether it was going to be a 111 service or a specialist service, I think there were IT questions – and there was another provider which pulled out of this one at the very start. So it had a problem birth I would say to start off with."

Stakeholders noted issues similar to those mentioned by commissioners relating to getting project management support, and the challenge of recruiting and keeping staff capable of delivering the planned 24 hour service. There were also issues with setting the baseline for comparison, already noted above, which "took a long, long, long, long time to be agreed" and:

"It was a bit of an odd one from an investor's perspective, because we were holding back on money going out of the door until the baseline had been agreed"

Stakeholders observed that they had been kept fully abreast of these issues by Social Finance as IFM and intermediary. They commented that across their investments in EOLCI they had "full confidence" in Social Finance and had "really open conversations" about the challenges the project was facing. In addition:

"I felt like Social Finance were in control, it felt like a bit of a problem child, yet it was probably a star of the programme at the end and it shows the value of having a partner like Social Finance with an outcome contract and with the ability to renegotiate through the life of that contract to achieve the investment returns and the impact that we were looking to achieve…"

Stakeholders thus acknowledged that this project had been more challenging than their other EOLCI investments, which were based on direct care rather than a telemedicine approach. However this had not affected their overall view of investment in EOLCI, and their subsequent decisions (see section 6) to invest directly in end of life care. Macmillan stakeholders observed that:

"What we like as a charity is this is about focusing on outcomes and focusing on outcomes means that you are less interested in the "what it is" and more about being really clear about the outcomes you are aiming to achieve, ….And this laser-like focus on outcomes and having to shift around the service model and the service delivery…that's what really interests us as an organisation."

In addition, the challenges faced by this project have provided directly applicable learning for current investment activity – for example two of Macmillan's investments through their End of life Care Fund (see section 6) have supported telephone-based helplines alongside hands-on care.

4.4.5 CBO team experience

The CBO team had some similar experiences to other stakeholders in that there were initial frustrations around the time it took to finalise the project and hence the CBO grant award. Many of the issues that caused delay were not directly visible to the CBO team but we assume they related to the challenges highlighted by other stakeholders including recruitment, agreement of the baseline and the need to change provider at a late stage of implementation. CBO stakeholders were however aware of other issues including the challenges of attribution and the technical (IT-related) issues faced by the project.

The team was also frustrated by poor transparency and information provision in the first two years of the project and stakeholders commented that it was "hard work" to get information about this project compared to other EOLCI projects that the CBO was supporting. These issues were eventually resolved but only after considerable pressure from the CBO team. From 2022 the situation was much improved and the CBO Funding Officer was invited to attend EOLCI board meetings.

Finally the CBO team noted that the project had been very challenging to reconcile at End of Grant stage, due in part to changes of personnel within EOLCI.

5.0 Successes, challenges and impacts of the SIB mechanism

This chapter summarises the apparent benefits and disadvantages of this project being a SIB, including being supported by social investment and deploying an outcomes-based model. It also addresses overall value for money, as judged by both stakeholders and independently by us as evaluators.

5.1 Successes and challenges of the SIB mechanism

5.1.1 Advance funding for a preventative intervention

As highlighted in our first review, stakeholders thought that a key benefit of the social investment was that it enabled the commissioning CCGs to test whether a telemedicine service would be effective, since financial constraints would not have enabled them to pursue such an intervention from core funding. This argument is, we believe, valid even though one CCG (Ealing) chose to fund the intervention conventionally, since they did so for only one year and then withdrew.

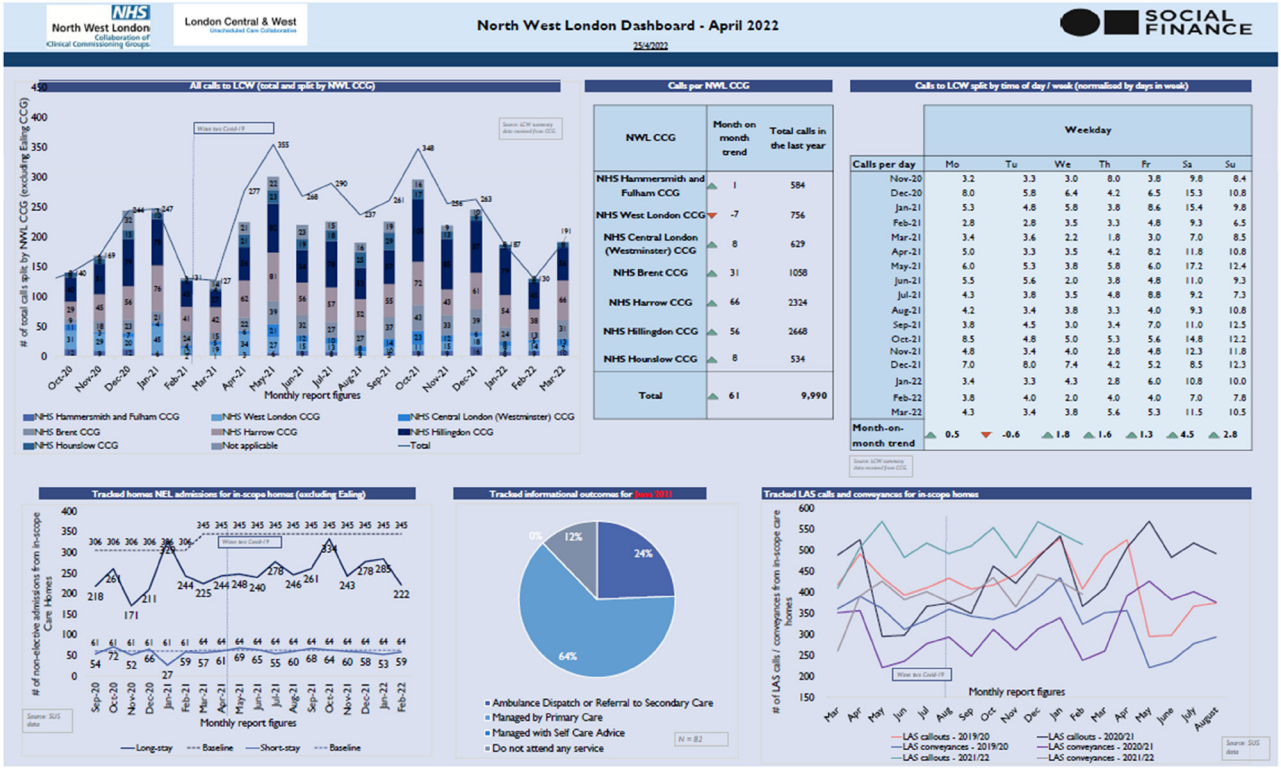
Discussion with health sector stakeholders across both this review and others (such as Ways to Wellness) indicates that upfront funding of this kind would be even more critical if the project were being initiated today than it was in the middle of the last decade; the financial pressures on the NHS, exacerbated by the impact of COVID-19, are such that it would be impossible to fund such an intervention without a cast iron business case guaranteeing almost immediate payback.

5.1.2 Driving rigour in development, monitoring and analysis

As also highlighted in our first review, stakeholders thought that the presence of an intermediary and investors would drive better and more comprehensive data collection and analysis, and better management of performance. Stakeholders interviewed for this review thought that this objective had been proven, and we broadly agree. The level of data information and analysis exceeded what would be expected in a conventional contract (see example dashboard in Figure 10 below) and provided the basis not only for ongoing monitoring of the contract and its performance, but wider analysis of the patterns of service delivery across the component CCGs. Such analysis identified inconsistencies and inequity in the patterns of provision, and provided the basis for the review of provision towards the end of the contract period. While this review concluded that this service should be decommissioned, Social Finance stakeholders thought that this was the right decision because it was more important that there was rationalisation of other provision (which had changed due to the impact of COVID-19). It was also more important that the commissioners (by then operating through a single ICB, rather than separate CCGs) "raised the bar" for end of life provision across the NWL area and agreed a base service specification. The data collected and analysed by the service appears to have made a strong contribution to this reset of provision.

A caveat is that the data collection and management put in place by EOLCI did not prevent delays and arguably some missteps in the setting of the initial baseline for comparison of performance. It did however enable these issues to be relatively quickly corrected, through a collaborative process in which stakeholders worked actively and constructively together to find an acceptable solution.

Figure 10: **example EOLCI performance dashboard**



5.1.3 Providing a platform for multiple SIB projects

Looking more widely at the EOLCI vehicle as a whole, it has so far enabled and managed seven SIB projects focused on end of life care and therefore made a substantial contribution to the testing of different SIB models in a single policy area. Since one of the objectives of policy makers (and the CBO) has been to grow the SIB/SOC sector through scaling and replication[39] we believe that this should be considered a benefit. It is only right to acknowledge it as such since we have similarly identified the ability to support more than one SIB contract as a benefit of the MHEP model[40], and the HCT intensive travel training SIB[41].

A key difference between EOLCI and both MHEP and HCT that we should note, is that EOLCI was designed to test *different* models – and that this project was testing a telemedicine model rather than face to face support, and therefore was "more different" than the other EOLCI SIBs. By contrast both MHEP and HCT were expressly aiming to develop a *replicable* model with many common features (and local variations) which could be rolled out successively to different commissioners.

5.1.4 Enabling collaboration between multiple commissioners

The NWL Telemedicine project enabled seven commissioners to engage in and collaborate across a single project, and an eighth commissioner (Ealing) to benefit from and test service delivery using a different contracting and funding model. This is a weak SIB effect because the complexity

39 See for example https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957374/A_study_into_the_challenges_and_benefits_of_the_SIB_commissioning_process._Final_Report_V2.pdf

40 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/MHEP-InDepth-Review-3rd-report.pdf?mtime=20231201095343&focal=none page57

41 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_Indepth_reviews_HCT_independent_travel_2nd_report.pdf?mtime=20240705112307&focal=none page 50

of multiple commissioner management and coordination caused challenges for the project, especially in its early stages and before more streamlined governance arrangements were implemented. It was also forced on the project since it was not viable without multiple commissioner involvement to create the necessary scale.

These issues should not however detract from the success of the project in enabling successful collaboration across the NWL area, and so reinforcing the wider role of the STP, and foreshadowing the introduction of the ICB and ICS in July 2022. It is a wider finding from research over several years that SIBs enable and encourage such collaboration[42], and it is also a feature of other projects that we have reviewed in depth, under this evaluation, in the health sector. Another example is the Zero HIV Social Impact Bond[43] which similarly foreshadowed and enabled cross-agency and cross-area collaboration, and anticipated the implementation of ICS.

5.2 Challenges and disadvantages of the SIB approach

5.2.1 Proving the impact of the intervention

An important feature of SIBs (and a key element in what is sometimes termed the initial "promise" of SIBs) is that they promote robust measurement of impact and give commissioners an accurate view of whether and to what extent the project and its intervention have achieved impact and efficacy over and above "business as usual". The NWL Telemedicine project did not directly measure performance against a comparison group to simulate the counterfactual, and therefore falls short of this degree of high quality measurement of impact.

We acknowledge, however, that it would have been challenging to identify an appropriate comparator in view of the complexity of end of life provision in NWL, and the variation in provision between individual CCG areas (and almost certainly in adjacent areas which might have offered a basis for comparison). Moreover if robust comparison had been attempted it would later have been severely confounded by the impact of the COVID-19 pandemic on health provision and demand.

In this context it is arguable that the project did make a reasonable attempt to measure impact robustly by measuring reductions in NELs (the key outcome) against a baseline of forecast NELs. As we note earlier, though, the project ran into challenges in establishing and agreeing a baseline that truly represented NEL patterns under business as usual. It took some time to establish an agreed baseline and the baseline then had to be amended to reflect changing data definitions and a realisation that the baseline did not accurately reflect underlying growth in NELs and the balance of short and long stay admissions. The project also faced major challenges in establishing attribution to the NWL Telemedicine service rather than to competing services.

We regard this as a challenge (and key learning point) rather than a disadvantage of the SIB approach per se. If the same project had been implemented under a different contracting and funding model it would have faced similar challenges, but it is arguable that those challenges would have been less rigorously analysed and determinedly addressed because there would have been less pressure to get the baseline and attribution (unless the project had invested heavily in an independent evaluation, and that evaluation had been able to solve the impact measurement issues). As it was, EOLCI and other project stakeholders appear to have done everything they could to address the issues, through amending the baseline and finding other ways, through analysis of call outcomes, to evidence attribution to this service rather than others and its efficacy in preventing ambulance call outs and admissions. We note (and explore further in section 7) that these issues are easily identified but less easily resolved.

42 For example see https://golab.bsg.ox.ac.uk/knowledge-bank/resource-library/evidence-report/

43 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-3.pdf?mtime=20240409095754&focal=none

5.2.2 Time needed to develop and implement the SIB model

In common with all the projects we have reviewed in depth as part of this evaluation, this project took a long time to develop and implement. Multiple stakeholders identified this as a source of concern and frustration during the first review, and investor stakeholders highlighted it again during this review. Both commissioner and investor stakeholders also commented on the implementation issues faced by this project – and attributed these largely to the support provided to the project within the commissioning organisations, rather than to EOLCI.

Delays in implementation also had an adverse effect on providers. In the rush to implement the project providers were asked to start delivery before contracts had bene finalised and signed – thus inviting them to deliver "at risk" and to trust that contracts would soon be put in place successfully.

Again we think it likely that a conventional project aiming to implement a similar service would also have taken a long time to design and implement, since much of the delay was caused by the understandable challenges of engaging multiple commissioners across North West London and agreeing an appropriate baseline against which to compare performance. The project also faced unexpected challenges (which might also have occurred in a conventional project) in recruiting staff of the right calibre and in having to rerun the provider recruitment process. As we noted in our first review, once the structure of the project and funding was in place it took relatively little time (around six months) to develop commissioner engagement, secure investment commitment, and develop financial metrics and the management structure pre-procurement. It is thus arguable that many of the SIB technical issues that usually consume so much rime were relatively quickly dealt with – the major challenges that lengthened the process lay elsewhere.

5.2.3 Adverse impact of outcomes caps

As we explain in section 3.5.1, the amount that the CCGs could pay for outcomes was capped in two different ways: first as a total amount that they could be asked to pay; and secondly as a proportion of the service costs. It is not unusual for there to be a cap on total outcome payments, since with constrained budgets that may fall further over the life of a project, commissioners need certainly as to the maximum amount they could be asked to pay. Other CBO projects that we have reviewed (for example the Be the Change project in Northamptonshire) have been subject to a similar outcomes cap. It means that the commissioner may benefit from outcomes that they do not pay for, as happened to an extent in Be the Change.

It is however relatively unusual for there to be a second cap tied to the cost of delivering the service, and for that cap to be set at a level below the total service cost (90% of service costs, including service support by EOLCI).

The reasoning behind this was that it gave reassurance to commissioners worried about the additional transactional and running costs of a SIB that the cost of the service would not exceed what they would pay for a conventional contract. It did however have at least two adverse effects, and arguably a third:

- It put the project at risk of making a loss, however well managed. Since the project was never able to deliver at full capacity, service delivery costs were much lower than planned and the project could not cover its core costs from outcome payments alone. The cap also limited the contribution that the project could receive from the CBO. Were it not for the separately payment made by Ealing CCG to receive the service in its first year (which was not tied to outcomes) the project would have made a loss overall.
- It created a perception that the project was less successful than it was. Judged on payments made compared to plan, the project appears to have "under-performed", because it only claimed for 745 outcomes against a plan to achieve more than 1,000, since it could only claim for outcomes up to 90% of service costs. However even allowing for the challenges of attribution, it is highly likely that the project was

well ahead of target, since the "gross" number of outcomes achieved was more than 4,000.

- Conversely, a somewhat perverse effect of the spending cap was that it arguably reduced scrutiny of the extent to which outcomes were truly attributable to the service. While as we argue above EOLCI did attempt to measure attributable outcomes accurately, there was no great incentive for commissioners to scrutinise performance closely, since they knew they would pay only for 90% of the service cost. It must be arguable that commissioners would have demanded greater outcome validation, and EOLCI would have been expected to devise a more robust measure of attribution, if the second outcomes cap had not been in place.

5.2.4 Inability of NHS commissioners to exploit the PbR model fully

An interesting reflection of stakeholders in the course of this review was that the project did not, and arguably could not have achieved one of the key benefits identified during our first review (or could not achieve it to the extent envisaged). This was that the PbR structure and linking of payment to outcomes would enable the commissioners to test the intervention at no risk. The first review observed that:

"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."

As we note above the argument that the SIB provided advance funding is valid, and we doubt that the project would have been implemented without it. The argument that commissioners pay only for outcomes and therefore have less risk than paying for a service through a grant or fee for service contract (when they pay irrespective of performance) is however not entirely valid because of NHS processes and funding structures. As one senior Social Finance stakeholder reflected, the outcomes mechanism was not as important as it has been in some other SIBs (notably in the local government sector) because the commissioners had to meet the same approval standards, and similarly commit funding, as in any other project:

"You still have to follow the rules of a standard NHS business case. We are saying yes we will take the risk but you have to plan for success – which means it needs to be in a budget line. What people don't seem to understand is that it's not free money – it's money with strings, and money with strings means that it's the same kind of rigour, the same kind of excruciating rigour to get it signed off as if it was the NHS's own money".

This is not to argue that the project did not offer value for money – indeed we think that it did, as we argue below. It is to observe that outcomes-based projects cannot easily create the benefits they claim in some sectors; and that other ways need to be found to provide a measure of value to commissioners and limit their exposure. In this case, as we note below, a critical factor was the guarantee that commissioners would not pay more than 90% of the total costs of delivery.

5.3 Value for money of the SIB mechanism

This section provides an overall assessment of whether the NWL Telemedicine project offered value for money, based on the views and experiences of stakeholders, where available, and our own independent evaluation.

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

5.3.1 Economy

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

Economy, and keeping costs to a minimum, is generally of less importance than the other VFM dimensions in SIBs and SOCs because keeping costs down can work against the overriding objective of maximising outcomes achieved. It is however still important that costs are as low as they can be while being consistent with this overriding objective.

In our view the project did take strong steps to encourage economy. Most notably, it ran an open competition for the providers of the service which required an evaluation of best value – i.e. the ability to deliver the service at the lowest price consistent with achievement of the outcomes.

There was no similar competition for the SIB management services provided by Social Finance through the EOLCI, and as in many SIBs whose initiation and development is led by an intermediary or provider such services tend to be awarded without competition – reflecting the benefits of continuity of design and development into delivery and also in effect rewarding the intermediary for developing the project at risk.

Social Finance did, however, provide strong reassurance to commissioners that they would not pay unreasonably for the costs of the SIB by guaranteeing that they would pay no more than 90% of the cost of the service. This was common practice in EOLCI SIBs (mirrored in Hillingdon, for example) and reflects a view that NHS commissioners should not be expected to pay more than they would in a conventional contract.

As already noted in section 4.3.4, this cap on costs that could be charged to commissioners worked very much in their favour, but was arguably necessary because of the relatively high SIB overheads compared to provider delivery costs. The project spent much less than planned on delivery, and more than planned on SIB management – in part because of the work needed to review performance, address issues such as the baseline adjustment, and respond to the unexpected challenges caused by COVID-19. SIB overheads (including investor returns and evaluation) were expected to be 15.6% according to Median plan, which is relatively high compared to other CBO SIBs, and at outturn were nearly a quarter of all costs (24.1%) as shown in Table 4 overleaf.

5.3.2 Efficiency

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

Efficiency, like economy, is in broad terms less important than the effectiveness dimension in assessing SIBs and SOCs. The project was however less efficient than it planned to be in two important respects. It was unable to handle and respond to as many calls as it planned at Median scenario (missing its plan by just over 20%, handling 9,016 calls compared to a plan to handle 11,313); and it experienced major challenges in recruiting staff and maintaining service delivery capacity, thus spending only 59% of Median plan on provider delivery (£1.661m compared to £2.824m).

Table 4: **NWL Telemedicine total project costs**

Type	Description	Amount	% of Total
Core costs	Delivery by providers	£1,660,595	75.6%
	EOLCI project costs	£5,109	0.2%
SIB costs	SIB Management	* £530,181	24.1%
	Evaluation	£0	0.0%
		£0	0.0%
Total		**£2,195,885**	

Source: Cost information submitted by EOLCI to The National Lottery Community Fund.

* £252K was classified as "Support to delivery" for the purposes of the outcomes cap so it could be argued that delivery accounted for 86% of spend and SIB management only 14%. However we would normally classify support to delivery by an intermediary as a SIB management cost, as shown here.

5.3.3 Effectiveness

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

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

Comparison of this project against its planned outcome targets is slightly complicated by the effect of the outcomes and service delivery cost caps, as already highlighted in section 4.3 above: without taking account of these caps, the project significantly overperformed – achieving a net reduction of 4,410 NELs compared to the amended baseline, more than four times its Median planned. Once the effect of the caps is taken into account it fell short of its effective target – though this would not matter to commissioners, only to EOLCI.

The project thus achieved very high impact from the commissioner standpoint, and led to an even greater overachievement of costs avoided compared to plan: gross avoided costs, on EOLCI's estimates, were more than 4½ times plan, and costs avoided net of provider costs (because these costs were also much lower than planned) were nearly 32 times Median plan –£13.3m compared to £420k.

5.3.4 Equity

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

In its usual meaning (as a measure of inclusive and equitable reach of all service users irrespective of personal characteristics) this project is hard to measure since data on the characteristics of ultimate service users (i.e. care home residents) is not available. There is however strong evidence that:

- The intervention was fairly targeted at all care homes – i.e. there is no evidence that some homes or areas were given preference over others. Where data showed that some homes or NWL areas were using the service more

than others, the EOLCI identified this and addressed it through engagement with CCGs and through its strategies for communicating and marketing the service to care homes.

- EOLCI went to considerable lengths to address inequalities of *existing* service provision across the NWL care homes, both before and after the implementation of this service. As explained earlier the data collected by the project helped expose such inequalities, and supported the CCGs and STP in coming to decisions on how best to address them.
- An explicit objective of the project was also to reduce inequality of provision of EOLC between people in care homes and people living in their own homes.

The project has also been very impactful at the individual service user level and providers have collected case studies to help demonstrate this – see Case studies A, B and C included below.

Case study A: **Mrs S**

Mrs S, 83, was a patient living in a care home who had an unwitnessed fall near the lift in the care home.

The carer reported that Mrs S's knee appeared slightly swollen and she was complaining of pain. The patient had advanced care planning with a Coordinate my Care (CMC) record for full escalation to hospital. The Telemedicine clinician did a comprehensive assessment and following NICE guidelines virtually conducted a multifactorial falls risk assessment with focus on mobility, transfers, pain, cognition, and postural drop in blood pressure. Based on the assessment, it was identified that Mrs S had tripped near the lift and ended up on her right knee but was able to get herself up from the floor. The telemedicine clinician reviewed Mrs S's past medical and drug history, and identified that Mrs S suffered from osteoarthritis of the knee. Mrs S was able to mobilise as normal using both her sticks and was at her baseline functionally post fall. All her observations were within normal range, and she scored 3/10 on pain scale. So advice regarding falls, pain relief and safety netting was given to both patient and carer. A follow up was booked with the patient's regular GP for next day review. When the Telemedicine clinician followed up next day Mrs S was back to her normal self and the swelling and pain had subsided.

Case study B: **Mrs T**

Mrs T, 89, was a patient living in her home in North West London who contacted the telemedicine service due to pain in her abdomen.

The Telemedicine clinician did a full assessment virtually, which found that pain was not radiating but Mrs T was reporting feeling bloated. Based on history taking and examination it was identified that Mrs T was suffering from constipation. The Telemedicine clinician reviewed Mrs T's past medical and drug history, identified that she had laxatives prescribed, and advised Mrs T to take the laxatives as prescribed. Mrs T was initially reluctant to take these due to her previous experience in hospital where she experienced loose stools after having laxatives continuously. The Telemedicine clinician provided reassurance, explained the need for and benefits of laxatives on this occasion and also gently explained the risks of not adhering to the prescribed medication, especially the risk of hospital admission. Finally, Mrs T agreed to take her laxatives. The Telemedicine clinician also educated her about fluid intake, diet and activity to help prevent constipation. The following day, a review telephone call was made to Mrs T, who reported that she had managed to open her bowels and was no longer experiencing any discomfort in her abdomen.

Case study C: **Mr A**

Mr A, 87, was a patient living in his home in North West London with his wife and daughter, who contacted the Telemedicine service on behalf of the patient.

Mr A's daughter reported that her father was suffering from loose stools and pain in his lower private parts. The patient had advanced care planning with CMC record for escalation to hospital for reversible conditions only, but the CMC record also stated that separation from his wife would cause significant distress, and he would prefer to be at home with maximum support. The Telemedicine clinician did a full assessment virtually, which revealed that the patient had had a recent admission to hospital due to gall bladder sepsis and been discharged back home two days ago. During this admission the patient was catheterised and had some medication changes.

The Telemedicine clinician was unable to get a full picture of vital signs apart from temperature which was slightly raised, but based on history and clinical examination found that the patient was passing dark cloudy urine and the catheter was draining without any bypass. On reviewing history and medication it was also found that the patient had started new medication for an irregular heartbeat whose side effects included diarrhoea. It was thus identified that the patient might be suffering with a UTI and having diarrhoea as a side effect of his new medication. The telemedicine clinician safety netted the patient and gave advice regarding UTIs and the importance of keeping hydrated to both the patient and his family, and with the consent of the patient referred him to his GP for medication review and for prescribing antibiotics if appropriate.

5.3.5 Overall cost-effectiveness

Looking at VFM as a whole, its seems unarguable that this project offered exceptional value for money to commissioners. Even though they could not be certain whether the service might have been managed at less cost by a different performance manager, and the service had lower reach than planned, the EOLCI contracted via the Funding Agreement to give the commissioners a guaranteed subsidy of 10%. The effect of this was to transfer both the outcomes risk (that outcomes would be lower than planned) and the cost risk (that the service would cost more than an equivalent service) from the commissioners to EOLCI.

In addition, and because the service achieved far more outcomes than expected, the project offered an exceptional return in cost benefit terms to the commissioners. They only had to pay for 745 outcomes, but were able to avoid costs based on 4,410 outcomes. If they had paid for all uncapped outcomes, at the agreed price per outcome of £2,616, the cost to them would have been £11.5m rather than the £1.7m they actually paid. Even if we adjust the outcomes for the likelihood that a proportion were not attributable to the Telemedicine Service, if the estimates of avoided costs are accurate, non-attribution would have to be higher than 87% for the commissioners not to be at least breaking even. This level of non-attribution seems unlikely.

Our only observation is that the effect of the caps on outcomes and costs was somewhat to undermine the impact of the PbR mechanism. Effectively the commissioner paid per outcome but only up to an agreed ceiling, and would have had similar benefits if they had been offered the same "deal" under a conventional contract. It is therefore arguable that the contract operated more like an open book relational contract than a SIB, although there were clearly other benefits from EOLCI managing the contract and providing social investment to fund the service.

6.0 Legacy and sustainability

As already noted, the NWL Telemedicine service was decommissioned in March 2022 and there was, therefore, no direct sustainment of the project as either another SIB or using a different funding and contracting structure. There was however a legacy from this project and a much stronger legacy from EOLCI and its projects as a whole, as outlined below.

6.1 Local reconfiguration of end of life care services

While this project was not recommissioned, it enabled the commissioners to test the efficacy of a telemedicine approach to end of life care and provided much data and insight that, along with other internal work, enabled the commissioners to review provision and make more strategic decisions about the future provision of end of life care. This review led to the development of a specification of future end of life services across NWL, and ultimately to the creation of the NWL London Care Homes Quality Standard.

6.2 Sustainment of other EOLCI projects

Although this project did not sustain, other EOLCI projects have continued and been funded once the original SIB ended. The most notable example to date is Hillingdon where the original project ended in 2021 and it has since been conventionally funded by its local commissioner, the Central and North West London NHS Foundation Trust. The Hillingdon service is a more conventional hands-on support service than the NWL Telemedicine project and it has achieved impressive results – accepting 2,275 referrals against a target of 1860 and enabling 93% of those referred to achieve death in their preferred place (the project's key outcome metric) and 91% to achieve death in their usual place of residence.

The EOLCI SIB In Sutton has also sustained. The project established a Palliative Care Coordination Hub and local commissioners have agreed to continue to fund the Hub, with modifications that take account of learning from the SIB. Other EOLCI projects such as Bradford are still in progress but there are reasonable expectations that these too will sustain.

Stakeholders told us in the course of this review that one of the reasons for such sustainment is that the commissioners needed to create a budget line for the SIB projects. As we note above in section 5.2.3, this worked somewhat against the NWL project because the commissioners had to go through the usual business case process and commit funding as if it were a conventionally funded and contracted project. In the longer term, however this process tends to work in projects' favour because once "in the budget" there is a greater expectation that funding will continue, despite current financial constraints.

6.3 The Macmillan Social Investment Programme and End of Life Care Fund

Arguably an even more impressive and potentially impactful legacy of the EOLCI and the involvement of Macmillan in the CWF has been the establishment by Macmillan of their own Social Investment Programme. Based in large part on experience and learning from the EOLCI and CWF, Macmillan launched this programme in 2020 with funding of £16m. Its first major project (launched in April 2022) was the Rapid Intervention for Palliative and End of Life Care (RIPEL) project, commissioned by Oxford University Hospitals Trust, where repayable funding of £6m from Macmillan was matched by a further £3m in grant funding from

Sobell House Hospice Charity. This project aims, like EOLCI SIBs funded by the CBO programme, to link repayment of capital to a reduction in non-elective unplanned hospital bed days in the last year of life against a baseline. By June 2023, more than 10,000 unplanned bed days had been avoided.

A second project was implemented in partnership with Highlands Hospice in Inverness, and is notable both for being in Scotland (where SIBs and SOCs have achieved little traction to date) and for including a telephone-based helpline alongside hands-on care.

While this report was in preparation two further projects have been implemented:

- A third project in partnership with Harrogate and District NHS was implemented to identify people who may be in their last year of life, increase their access to advance/future care planning and provide those individuals and their carers with a telephone service offering clinical help, support and advice.
- A fourth project in partnership with St Luke's Hospice, Mid & South Essex has implemented a locality-based approach to strengthen care at home for people in their last year of life by providing a high quality, responsive and flexible palliative and end of life care service.

In September 2023 the programme was extended, with the establishment of a specific End of Life Care Fund through which Macmillan intends to invest £36m in End of Life Care across the UK[44]. Across both these programmes Macmillan have continued to work closely with Social Finance, building on the relationship established through the EOLCI and Macmillan's investment in it and the wider CWF since 2015. This Fund has so far invested in two further projects to add to the end of life projects invested in by the wider Social Investment Programme as outlined above.

The End of Life Care Fund expressly aims to deploy an outcomes--based and repayable finance model under which capital will be repaid based on the achievement of defined outcomes, but with no additional return – Macmillan will thus at best expect to break even According to Macmillan stakeholders they will fund end of life care entirely through this model in the future, and have ended conventional grant funding for such care.

Macmillan stakeholders observed that there are clear benefits to an investment fund compared to conventional grant funding because the funding will be repayable and can thus be recycled and spent time and again – unlike a grant which can only be spent once, This applies even if only part of the funding is repaid – indeed there is potential for Macmillan to share the cost of end of life provision with ICBs and make the proposition doubly attractive to them. In simplified terms Macmillan can offer to fund the full cost of a project up front with the ICB repaying only a proportion of the cost, and moreover doing so only if defined outcomes are achieved.

We note that other CBO projects have demonstrated similar benefits to tradition grant funders – notably the Zero HIV SIB in which investment came from three funders more used to grant giving - the Elton John Aids Foundation, Comic Relief and ViiV Positive Action Fund[45],

The benefits to commissioners are thus similar to those delivered by this project and other EOLCI CBO projects – the opportunity to pay only for outcomes and to have upfront funding for preventative services – but with the added advantage that commissioners are guaranteed not to pay a return. In the view of some stakeholders, this is likely to make the proposition more attractive to NHS commissioners, some of whom are uneasy about the NHS being seen to pay a return to investors.

Stakeholders also told us that they have a strong pipeline of opportunities and are focusing on working at ICB level with a number of potential commissioners. They also reported that further telemedicine projects are in the pipeline, as well as projects funding hands-on care and support to those requiring end of life care.

44 See https://www.socialfinance.org.uk/insights/macmillan-end-of-life-care-fund-invitation-to-apply

45 See https://www.tnlcommunityfund.org.uk/media/insights/documents/Zero-HIV-Social-Impact-Bond-3.pdf?mtime=20240409095754&focal=none page 58

7.0 Conclusions

7.1 Overall conclusions and evaluative insight

Overall we judge this project to have been a success, both on its own terms and even more so as part of the wider portfolio of projects supported by the EOLCI.

Judged as a stand-alone project, the NWL Telemedicine project had successes but also challenges. It was successful in using a SIB structure to de-risk the provision of a preventative service and to test whether there were significant benefits in a telemedicine model for end of life care. In this respect it was different from the other EOLCI SIBs and made an important contribution to:

- The achievement of tangible outcomes for a large number of residents of care homes and others resident in their own homes. While it fell short of its plan at Median scenario for total number of calls handled it helped more than 9,000 people and over-achieved its uncapped outcomes target (to reduce non-elective admissions) by more than 400%.
- The development of a specification for the better and more consistent delivery of integrated end of life services in Northwest London, as part of which commissioners and EOLCI mutually agreed that this service should not continue.
- Wider learning about the value of telemedicine solutions in end-of-life care, which has fed into Macmillan and Social Finance's development of further projects through Macmillan's Social Investment Programme and End of Life Care Fund.

The project also faced challenges, notably in finding an acceptable and robust way of measuring its own impact. The process of agreeing an accurate baseline against which to compare the reduction in NELs was time-consuming, and the baseline had to be later amended. Moreover, given that the baseline was predicting future admissions, it could never be 100% accurate. It was also difficult to prove how much of the reduction in NELs was attributable to the project rather than other services, although it seems hard to dispute that it made enough impact to justify its costs, given the uncapped outcomes (and estimated avoided costs) it achieved.

The service also spent only 60% of what it intended to spend on service delivery, with the consequence that commissioners achieved excellent value for money, but the project as a whole made a lower return than expected.

Importantly, however, the stakeholders worked together to resolve the issues that they faced, and the project is therefore a good example of how SIBs can be used to test innovation and adopt a true "test and learn" approach.

Looking more broadly at the portfolio of SIB projects initiated by EOLCI and funded by the CBO, the overall assessment of success is more clear-cut. While detailed analysis of the other projects is outside the scope of this review, it is clear that the other projects have, on the whole, been even more successful, in that they have been sustained and funded by local commissioners after the initial SIB concluded, and have made a higher surplus despite being subject to similar guarantees about payments not exceeding service costs. Only one EOLCI project is viewed overall as unsuccessful, as confirmed by both Social Finance and Macmillan stakeholders during this review

The wider EOLCI portfolio has also led to what is arguably one of the most visible and positive outcomes of the CBO programme as a whole – namely the establishment of the Macmillan Social Investment Programme and End of Life Care Fund, and Macmillan's wider and long-term commitment to repayable finance as an addition to its grant activity in some areas, and as a complete replacement for grant giving in end of life care.

7.2 Achievement of CBO objectives

The CBO programme's overriding aim was to grow the market in SIBs and other outcomes-based models in order to enable more people, particularly those most in need, to lead fulfilling lives, in enriching places and as part of successful communities. Against this aim the NWL Telemedicine project and wider EOLCI portfolio of CBO-funded projects can be seen as a success, in that:

- Seven projects funded by the CBO and LCF have so far been created; and
- Further outcomes contracts supported by repayable finance – effectively SIBs in all but name – are being created by Macmillan and Social Finance and continue to be supported by the EOLCI infrastructure.

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

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

  Partly achieved. The direct commissioners in this SIB did not continue it, and many have now moved to other roles, making it difficult for them to apply what they may have learned from this project, Against that, new commissioners are engaging in what are effectively SIBs through the Macmillan Fund, and appear to have more confidence to do so as a result of this and the other demonstrator projects.

- Increased early intervention and prevention is undertaken by delivery partners, including voluntary, community and social enterprise (VCSE) organisations, to address deep rooted social issues and help those most in need

  Partly achieved. The NWL Telemedicine project is by definition a preventative intervention, and directly measured whether it prevented unnecessary NELs. The lead provider was a VCSE, supported by another VCSE to provide training, and while they were partnered by an NHS Trust, this appears to be an acceptable and sometimes inevitable delivery model in the health sector. This objective is only partly achieved, in our view, not because of the involvement of a public sector provider but because this objective is mainly about widening the pool of much smaller VCSEs that are able to deliver services through SIBs, and the project did not achieve this.

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

  Largely achieved. We judge this objective to be largely achieved not only because the social investment from the CWF enabled the project and its outcomes model, but because this and the other EOLCI projects led to a much greater pool of potential investment through repayable finance from Macmillan.

- Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs/OBC lessons for other projects

  Achieved. We think this and the other EOLCI project have made a substantial and demonstrable contribution to wider learning, both locally – in enabling NWL commissioners to review and reset end of life care provision – and nationally – in feeding into the ongoing work that Social Finance and Macmillan are undertaking to drive innovation and outcomes-based models in end of life care.

7.3 Lessons for other projects

We would draw the following key lessons for other projects from our in-depth review of this project:

- Measurement against a baseline is challenging. There is much debate in research circles about whether and to what extent SIBs properly and robustly measure impact, or simply count outcomes.

There have been very few SIB projects in the UK which attempt high quality evaluation against a comparison group that measures the counter-factual, and those that have done so such as Ways to Wellness have faced significant challenges[46]. In this context this project made an admirable attempt to find a halfway house between a "high quality" impact evaluation – using a quasi-experimental design (QED) or even a randomised control trial (RCT) – and judging all outcomes to be due to the intervention. What this project learned was that this too is very challenging, not least because it is always difficult to predict the way a baseline will change over time – in this case on an upward trajectory. In addition, and in common with other projects, such a baseline can be confounded by external factors – notably the impact of COVID-19 (though as others have observed, the pandemic created an external factor on a scale that virtually no one could have predicted).

- **Multiple and complex services can make attribution difficult.** Many services commissioned both conventionally and through SIBs struggle to prove attribution, but the challenge appeared much greater in this case than in many projects, due to the complexity and variability of provision and the way it changed over time. This meant that even with a baseline comparator in place project stakeholders were forever questioning how much of the impact was truly applicable to this service. It is hard to see how this could have been easily resolved, but we would tentatively suggest that in this situation three options might be considered.
  - The first is to invest in a high quality evaluation (QED or RCT) as outlined above – which with the right controls in place and implemented by an experienced evaluator, might enable more accurate assessment of the impact of the intervention, This might not work as a SIB payment mechanism, however, given the time lags and complexity involved. It would therefore need to be implemented in parallel with a simpler payment mechanism, such as the baseline comparator adopted here.
  - The second (and possibly complementary) option would be to test the service across a smaller area, where it would be easier to identify and control for other service provision. However, we acknowledge this approach could not have been adopted as part of this SIB, because it would have lacked the scale to be viable.
  - A third alternative would be to accept that full attribution is unlikely but that it is important to measure accurately the contribution to overall impact made by the Telemedicine Service. One way of doing this would have been to measure the impact using formal contribution analysis[47], allied to techniques such as process tracing to establish the effect of the service and of other factors, including alternative services such as 111star*6.
- **Test and learn requires collaboration** What this project also demonstrates is that problems like those outlined above are bound to happen when attempting to innovate in public service provision and are best solved by working closely and collaboratively with all stakeholders to find a solution that works for everyone, even if some compromise is required. This project appears to have adopted a collaborative approach throughout, up to and including joint agreement that the project should be decommissioned. It might seem obvious that this is the right approach, but other projects we have reviewed have found it more challenging to achieve this degree of harmonious working.
- **Repayable finance offers potentially major benefits to grant givers.** This project is arguably the prime example, along with others, of a CBO SIB demonstrating the role that repayable finance might play for organisations more used to conventional grant funding. In the right circumstances it offers the potential both for charities and foundations to recycle funds repeatedly, and for blended finance (where investment is only party repaid) to be used to share the cost of funding with public sector commissioners.

46 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_ways_to_wellness_second_report.pdf?mtime=20210727162600&focal=none

47 Contribution analysis was originally devised in Canada and can be used to assess the contribution made by a specific service in complex delivery systems. See for example https://www.utpjournals.press/doi/pdf/10.3138/cjpe.016.001

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

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

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