

To SIB or not to SIB? A comparative analysis of the commissioning processes of two proposed health focused Social Impact Bond financed interventions in England

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Policy bullet points

- Very little is known about the local decision-making processes related to the initiation or not of Social Impact Bond (SIB) financed interventions - but we know that many proposed SIB financed interventions are not initiated.
- This study explores these decision-making processes and compares a SIB financed intervention that was initiated with one that was not initiated.
- The study increases empirical understanding of these phenomena and highlights the theoretical utility of a decentred governance approach to explain why it can be difficult to initiate SIB financed interventions in an English healthcare context .

To SIB or not to SIB?

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Abstract

We explore the development of two proposed Social Impact Bond (SIB) financed interventions in health care in the English National Health Service (NHS). This is important because very little is known about the processes involved in the localised development of these nascent financing mechanisms. We apply a ‘decentred’ approach to network governance to the case studies – one in which a SIB financed intervention was initiated and another in which it was not. We find that moving from the prevailing competitive quasi-market NHS commissioning traditions to new forms of integrated commissioning may require a more collaborative approach to service procurement than has typically been the case in the recent past in English healthcare. This may pose dilemmas for the relevant networks.

Introduction

Social Impact Bonds (SIBs) are a new mechanism for the commissioning, upfront financing and delivery of public services drawing on some non-government funds and using outcomes-based contracts. The UK is a global leader in the development and implementation of SIBs. Several central government departments in England have fostered SIB development – for example, the Ministry of Justice enabled the world’s first SIB at Peterborough Prison (Disley et al, 2015) and the Department of Work and Pensions has established several pilot SIB projects focusing on Youth Engagement, Training and Employment (DWP, 2014). In 2013, nine varied projects received central government ‘seed funding’ via the Department of Health to explore the potential for SIB application to health and social care in the English NHS. This funding allowed projects, often led by service providers at the invitation of commissioners, to obtain support from intermediary organisations - new actors with specialist knowledge in SIB development offering advisory services and liaison between investors, commissioners and service providers - for the local design and negotiation of potential SIBs.

As part of a broader evaluation (*The Authors, 2018*), we followed the progress of these nine proposed projects from 2014-17. Five of the proposed projects were initiated as SIB financed interventions whilst four were not. In this paper we qualitatively explore two of these projects in detail – one which was initiated as a SIB and one which was not - in order to illuminate the reasons why SIB financed interventions may or may not be initiated. This is important because there is little knowledge of the reasons why proposed SIB projects are, or are not initiated. Furthermore, this is not an issue confined to these health and social care projects. We know, for example, that of the 62 areas that received grants to develop SIBs as part of the Commissioning for Better Outcomes Fund in the UK launched in 2014, 37 of those decided

against launching a SIB financed intervention. (Ecorys and PIRU, 2017). Additionally, many proposed SIB projects receive public subsidies and other forms of quasi-public funding in the UK, to help with their establishment, so understanding why some do not proceed may help inform future decisions of grant-makers. Moreover, many of the SIBs which are initiated suffer long delays in set up and implementation (Tan et al, 2015). These delays are often due to the complexities involved in establishing new contractual agreements, performance metrics, and distributing risk and accountability across often new networks of organisations and individuals (Disley *et al*, 2015; Social Finance, 2011; Rudd et al, 2013; McKay, 2013; Pauly and Swanson, 2013; DWP, 2014; Tan *et al*, 2015). Therefore, reflections on why SIBs may not be initiated, or run into delays may be of practical use to interested parties and policy makers. Beyond these empirical concerns, there are also important theoretical questions posed by SIBs for public policy and management studies linked to how SIBs may impact upon notions of governance (Fox & Albertson, 2011; Warner, 2013; Joy & Shields, 2013; McHugh et al, 2013; Fraser et al, 2016). In the following section, we firstly describe what a SIB is, then briefly discuss the recent research literature into SIBs and introduce our analytical approach.

Social Impact Bonds: What they are and what we know

SIBs usually involve four different parties. Firstly, commissioners – these are normally central or local government bodies responsible for ensuring relevant public services are made available to target populations. Secondly, service providers – who are often drawn from the charity sector and will deliver the interventions commissioned. Thirdly, we find external investors who provide (all or some of) the upfront costs of service provision, in exchange for a commitment by commissioners to re-pay their initial investment plus a return if pre-defined

target outcomes are achieved. The final party may be referred to as specialist intermediaries (GO Lab, 2017), involved in developing the project, securing the relevant contracts amongst the respective parties, facilitating investment and managing the delivery of the project.

There is a limited but growing empirical literature that focuses on aspects of SIB implementation. This consists mainly of reports commissioned by governments and consultancies – seeking to highlight the practical policy lessons to be learned from SIB projects (Disley *et al*, 2015; Social Finance, 2011; Rudd *et al*, 2013; Tan *et al*, 2015; DWP, 2014; *The Authors*, 2018). These reports are almost exclusively qualitative and highlight many of the practical challenges involved in initiating SIBs such as high transaction costs, complexity in contractual negotiations and the need to avoid adverse behaviours, such as ‘cream-skimming’ (i.e. focusing on those members of the client group that are most likely to generate outcomes with minimal effort) or ‘parking’ (i.e. putting aside difficult cases that are unlikely to generate outcomes payments). A further subset of work focuses more intently on how and why actors might decide *not* to pursue a SIB mainly due to a misalignment of actor interests (McKay, 2013; Pauly and Swanson, 2013; Giacomantonio, 2017). Whilst useful, such studies frequently fail to engage with potentially relevant theoretical public policy and management literature and theories of governance as well as with empirical data.

Away from a specific focus on work exploring why SIB financed interventions may not be initiated, a recent literature review on SIBs in general in high-income settings identified three emergent narratives. Firstly, a public sector reform narrative located within wider New Public Management (NPM) theory (Ferlie *et al*, 1996). Secondly, a private financial sector reform narrative concerned with promoting Social Entrepreneurship. Thirdly, a cautionary narrative sceptical of SIBs, and other public and financial sector developments such as NPM and

Social Entrepreneurship. This review found that much of the work available on SIBs consists of commentaries in the ‘grey’ literature, often produced by interested parties pursuing reform agendas that focus on the proposed benefits of SIBs, accompanied by a smaller, more critical, predominantly academic, literature (Fraser et al, 2016).

Proponents of SIBs frequently draw on the public sector reform and private financial sector reform narratives to argue that SIBs provide ‘win-win’ solutions to ingrained public policy problems through improved provider performance and better outcomes for specific population groups, by transferring both the risk of failure and the need to provide up-front finance for service delivery away from public commissioners to private investors (Cohen, 2011). Further recent work has emphasised how SIBs can encourage better contract management between government and providers (Government Performance Lab, 2017). Conversely, critics of SIBs argue that claims of their effectiveness remain unfounded, that SIBs may prove costlier than traditional financing methods for public commissioners and that they may ultimately fail to transfer risk from the public to the private sector (McHugh *et al*, 2013; Warner, 2013;).

A number of these more critical academic authors draw on theories derived from the wider governance and management literature. Warner (2013) argues that SIBs may be seen to represent an extension of certain logics of the NPM – underlined by a reliance on contracting mechanisms through which significant control over service delivery is ceded by the public authority to intermediary organisations who implement an increased performance management regime (Warner, 2013). In contrast, Fox and Albertson (2011) highlight SIBs’ potential to lessen some of the harsher edges of NPM as they are intended to shift the focus

from *process* measurement to *outcomes* measurement. Joy and Shields (2013) suggest that, rather than the NPM, SIBs may be more accurately seen as a manifestation of what Osborne (2006) terms the post-NPM, New Public Governance (NPG) paradigm which emphasises a move in public management towards re-integration of public service commissioning and provision, requiring closer collaboration between commissioners and providers across public, private and not for profit sectors, and a diminution in the reliance on NPM style competitive contracting.

SIBs may also be seen as a variant of a Public-Private Partnership (PPP) – the virtues of which are contested. Warner (2013) highlights that, in the American experience, inducements seen as essential to attracting private investors to PPPs, such as confidentiality agreements and guaranteed market share ultimately serve to ‘undermine the market competition basis on which efficiency claims are made’ (Warner, 2013; p308). Whilst Warner suggests that SIBs as a form of PPP may have the potential to avoid some of the worst problems identified with infrastructure PPPs in the US, overall, she advocates a cautionary approach to the uptake of SIBs. Proponents of PPPs suggest that they promote long-term collaborations between public and private players that are ‘working arrangements based on a mutual commitment (over and above that implied in any contract) between a public sector organisation with any organisation outside of [the] public sector’ (Bovaird, 2004; p199 – quoted in Teicher et al, 2006 p87). In this way ‘PPP overcome the problems associated with agency and transaction cost theories (with their focus on legal contract specifications) by moving to relational contracts based on trust and shared understanding of the wider goals required of the service’ (Teicher et al, 2006; p87). From this perspective, SIBs can be seen as part of a wider shift to ‘neo-corporatist values’ (Osborne, 2006) in the commissioning and delivery of public services in that they are likely to require collaborative co-design of complex care pathways

and sustained commitments from key actors (providers, commissioners, intermediaries and investors). Such a perspective suggests that SIBs represent movement towards trust-based regimes of governance – aligning more closely in theoretical terms to the NPG (Joy & Shield, 2013; Osborne, 2006) and implicitly challenging the competitive logic of the quasi-market in English health care commissioning, and the NPM's focus on contracting and performance management regimes, highlighted by Warner (2013).

Thus, there are interesting questions emerging about whether SIBs challenge or reinforce existing governance logics for actors, institutions and networks involved in experimenting with this new commissioning tool. These questions relate to logics of competition and collaboration. Developing a SIB at the local level frequently involves the cultivation of new relationships between actors and the establishment of new networks for service delivery in response to existing and emerging policy problems (Government Performance Lab, 2017). This in turn may strain (or conversely, it may strengthen) existing relationships and network governance

Beyond SIB specific work there is an extensive literature on network governance and its implications for public management (Newman, 2001; Dunleavy et al, 2006; Stoker, 2006; Osborne, 2006). Newman (2001) in particular has highlighted how governance consists of multiple and conflicting strands, simultaneous upwards and downwards flows of power and disparate forms of power/knowledge. These flow within and across organisations as they negotiate interdependent relationships (p38). We explore how network governance is actively created by local actors in two specific sites in this paper.

To do this, we are influenced by a ‘decentred’ theory of network governance (Bevir & Rhodes, 2007; Bevir & Richards, 2009). This approach encourages an exploration of how ‘new patterns of rule, including institutions and policies, are created, sustained, and modified by individuals. It encourages recognition that the actions of these individuals are not fixed by institutional norms or a logic of modernisation, but arise from the beliefs individuals adopt against the background of traditions and in response to dilemmas’ (Bevir & Rhodes, 2007; p6). Thus it is through ‘ideas’ that individuals and groups make sense of the world around them. ‘Situated agents’ act on ideas and may elevate ideas into new ‘beliefs’ over time. ‘Practices’ are what Bevir’s approach (Geddes, 2014) refers to as the sets of actions pursued by actors – these are influenced by their beliefs. Within organisations and across networks, these practices come to be viewed as ‘traditions’ – or the accepted ways of doing things. In this way ‘traditions are the ideational background within which agents find themselves’ (Geddes, 2014; p5). It is from these traditions that agents select their broad beliefs concerning the appropriateness of certain actions. In turn, these beliefs may change when having to confront ‘dilemmas’. A dilemma can be posed by an idea which - if it stands in contradiction to another established belief, practice, or tradition - poses a problem for individuals or groups. Such dilemmas can only be resolved by either accommodating or discarding the new idea (Bevir & Rhodes, 2007; Geddes, 2014). This is the first paper to explicitly draw on a decentred approach to the study of Social Impact Bonds and encourages a contextually-focused ‘bottom-up’ approach.

A key role of the SIB mechanism may be to challenge the *status quo ante* (Cohen, 2011;). In this sense the policy may represent a ‘disruptive innovation’ in that it may challenge existing actors (commissioners, providers, and other interested parties) to rethink their existing practices (i.e. ways to manage, or govern specific policy problems or perceived social,

clinical and operation failures) through the introduction of new ideas. In our two selected cases we explore in detail if, how, when, and why the local networks of actors encountered dilemmas associated with the process of developing, commissioning and initiating the respective SIB financed interventions, how these interacted with their existing traditions, beliefs and their situated agency. We discuss *how* traditions and networks of actors interact to lead to the initiation or not, of the proposed services.

Methods

Research Design & data collection

We draw on comparative case study methods (Yin, 2013; Eisenhardt, 1989) to explore the perceptions and narratives offered by key actors of the processes involved in developing local services through a SIB mechanism across the two selected case study sites. Qualitative case studies are an appropriate method for exploring issues related to policy implementation (Pope and Mays, 1995), exploring ‘how’ and ‘why’ questions about phenomena through detailed contextualised accounts of cases (Yin, 2013). We undertook qualitative documentary analysis of relevant policy documents (both local and national) and conducted interviews with relevant actors *before and after* the decisions were made to initiate the respective services through a SIB (or not).

We conducted 29 interviews overall (10 in Site A and 19 in Site B over 2014-17). We purposively sampled informants to include commissioner, intermediary, provider, legal and management consultancy viewpoints. Most interviews lasted an hour. We used an interview schedule that asked informants about their professional background, work history, an

overview of their understanding of the proposed intervention and their understanding of the SIB financing mechanism. We discussed prospective opportunities and challenges faced in SIB development whilst allowing informants the space to express their own narratives (Fontana and Frey, 2000). In both sites, informants were asked to reflect on the extent to which they could promote or inhibit the update of a SIB in their local area. In keeping with the decentred approach, informants were asked to explore whether the proposed SIBs identified current problems, challenged established ways of delivering solutions to problems and offered new ways of delivering services.

Data analysis

Interview transcripts were coded using NVivo 10 (QSR International, 2009). Initial codes were based on themes arising directly from the interview questions including: *measurement, complexity, competition, risk, trust, and collaboration*. We developed case study reports for each site. Three members of the research team analysed data collaboratively to ensure inter-coder reliability and interrogated the data repeatedly in order to understand the reasons for the decision not to contract public services through a SIB mechanism at each site. Through this process we developed secondary codes related to the ‘situated agency’ of the actors, the existing ‘traditions’ they identified and the ‘dilemmas’ they acknowledged around their work to initiate a SIB (Bevir & Rhodes, 2007; Bevir & Richards, 2009) closely engaging with the data and wider theoretical insights both inductively and deductively (Langley, 1999).

Findings

The findings section is divided into three parts. First we introduce the two case study sites and highlight the local policy failures that the proposed SIB financed interventions aimed to

remedy. We then present the narratives or stories that emerged from each case study in turn to explain why each proposed project was initiated or not.

Problems, failures, dilemmas.

In both sites, the local actors identified two distinct existing local policy problems, or failures which prompted the local interest in developing a SIB financed intervention. The first of these may be labelled a *service failure*. The service failures identified in each site respectively highlighted historic local deficiencies in social, clinical and operational terms. Secondly, actors identified a *finance failure* –highlighting an inability to finance solutions to the respective service failures at speed or scale (see table 1):

Insert Table 1 about here

The focus in Site A was End of Life Care services. Local healthcare commissioners there had reviewed the local End of Life Care provision and identified high levels of fragmentation in its existing form and recommended redesign. Various clinical and operational problems were identified that had negative impacts on patients – for example, unplanned hospital admissions in the final weeks of life, and higher levels of death in hospital - as opposed to death at home or in hospice care, which is often preferred by terminal patients and their families. It was also the case that poorly coordinated End of Life Care led to higher overall costs for the local healthcare economy than might have been expected from a better coordinated service.

Concurrent to, yet separate from these local discussions about the End of Life Care problems in Site A, other national English NHS and charitable sector providers were in discussions about developing a SIB financed intervention to be applied to healthcare. Rather fortuitously, these organisations chose to focus on End of Life Care. A commissioner in Site A learned of

these developments and this led to a successful application for ‘seed funding’ to support collaborative work towards an End of Life Care focused SIB in Site A with support from the aforementioned SIB intermediary organisation and the national NHS bodies and charitable sector provider.

Site B’s SIB proposal was focused on better self-management of long-term conditions through Social Prescribing Services (i.e. non-medical interventions in the local community to foster sustained healthy behaviours). Social Prescribing has a long and well established history in Site B. For over twenty years, local actors, drawn from medical, academic and voluntary backgrounds, had been experimenting with Social Prescribing interventions to try and encourage local people with long-term health conditions to improve their social wellbeing and clinical conditions. It was hoped that by increasing access to Social Prescribing Services local healthcare services would benefit through reduced emergency and unplanned hospital admissions. This would not only have clinical and operational benefits, but would also deliver hypothetical cost savings to the local healthcare economy. A local umbrella charity with a long interest in Social Prescribing learned about the potential of SIB financing through an intermediary organisation and entered into discussions with local healthcare commissioners and investment managers (based in a different city) to explore the potential of SIB financing to develop these ideas – again, aided by ‘seed funding’ from national government. In both Sites A and B, this initial ‘seed funding’ was shared amongst the respective local and national organisations and was used to fund exploratory project development.

Both sites identified different local service failures, which had negative social, clinical and operational impacts on their local populations and on health services as a whole. These failures were attributed to poor integration of existing services, inadequate overall planning and deficient communication between different service silos in the local NHS infrastructure. Given this, the SIB mechanism is attractive as it not only provides access to supplementary up-front finance, but also encourages early and consistent integrated discussions amongst a new network of actors including (existing and new NHS, third sector and potentially private) provider organisations, local healthcare commissioners, relevant national actors, SIB intermediary organisations, investment managers and lawyers. However, NHS commissioning has since the early 1990s been structured through established ‘traditions’ of quasi-marketised managed competition. (Ferlie et al, 1996). These firmly established rules, or norms have come to discourage integrative multi-actor service redesign at the local level as such interactions may presage perceived and actual conflicts of interest when services are put out to competitive tender. As we will show, the inherent shift within SIB development processes towards greater collaboration in the design and commissioning of solutions to entrenched social problems led to local ‘dilemmas’ for actors in both Sites A and B by challenging their ‘traditional’ beliefs about the guiding principles behind their commissioning practices (Bevir & Rhodes, 2007) . In the next sections, we highlight the ways in which network governance is locally created, negotiated and reproduced through the narratives of the different situated agents involved in these proposed SIB financed interventions as we present the ‘stories’ that developed in each of the chosen sites and explore these ‘dilemmas’ further.

Site A: network narratives of conflict and caution

The networks of actors in Sites A and B had many similarities as well as significant differences. The network in Site A was newer, had a wider selection of actors from more diverse institutional backgrounds and organisations and was less established than that in Site B. End of Life Care had been on the agenda of local actors in Site A for a shorter time than Social Prescribing had been under discussion by the local network in Site B. Nonetheless, actors at Site A reflected upon positive, promising early interactions between the different organisations during the initial period of local SIB development. The overall narrative that emerges around these early interactions is a positive one. In 2013, healthcare commissioners, local NHS hospitals, a large national cancer and palliative care focused charity, a firm of public sector legal specialists, an intermediary organisation and representatives from national NHS support organisations started work to review the service design of End of Life Care in Site A. Over the course of a year, these actors developed a network and worked collaboratively to engage other interested parties – including existing private and charitable local hospice provider organisations delivering End of Life Care services and the wider public, through a series of local events.

A dedicated project team sat at the heart of the network to lead on the proposed SIB development work. The project team reviewed the relevant literature and developed potential care models and funding arrangements for a new End of Life Care service in Site A. They selected a model that was used for the original pre-qualification questionnaire to be issued in accordance with NHS commissioning standard procedures. However, before this questionnaire was issued, there was a fundamental breakdown in the constitution and functioning of this recently established network. Having collaboratively designed the service model to be put out to tender, three partners, integral to this well-functioning network: the SIB intermediary, a large charity and a local NHS partner organisation, informed the

commissioners that they intended to collectively bid for the contract to deliver the service in Site A. This came as a shock to the commissioners who had not anticipated this scenario:

'[A member of the charity organisation] said "Well you know we'll bid for this when it comes up", and I said "But you can't, you know there's a huge conflict of interest here", and I said... "[E]ssentially you've developed this model with us, you've got all the insider information, the highs, the lows, the data, the lot".'

Commissioner, Site A

This turn of events damaged relationships within the network. The SIB intermediary organisation and the respective NHS and charitable provider organisations chose to 'step away' from their collaborative work with the commissioner - thus splintering the network of actors working on the project:

'So we formed ourselves into one of the potential provider [groups], so we then had to move away from the preparation of the process. Of course, that's absolutely classically right from a procurement point of view, but of course what it did is it then left [others in the network] to do their own thing... I'm sure that reduced its chance of success in that people would be involved in driving and working together as a team, that thing is then broken up, they're starting again.'

Provider, Site A

A further problem was linked to incumbent local providers' concerns about losing existing contracts should the new service be commissioned along SIB lines. This was because the SIB project encouraged a larger provider with greater resources, not previously active in the region to bid for local services. This perception of greater and potentially unfair competition facing existing providers through the new involvement of a much bigger, national provider added to the strains on actors within the network:

'[Existing providers] thought they would lose some business and were very anxious and were breathing down the necks of the [commissioners] at every stage'

Provider, Site A

All actors involved in Site A referred to deep 'difficulties' within the relationships between agents and organisations, particularly as they related to reconciling perceptions of fairness, propriety and balancing the goals of competition and collaboration in the processes of service design and the eventual commissioning process in this network. These relationship difficulties posed significant problems for the governance of the SIB development process. Existing local providers felt threatened by the new external actors who they perceived to be too close to the commissioning actors. The commissioners in turn felt that the actions of the actors who were 'stepping away' were problematic. Whilst 'stepping away' might be seen as the right thing to do in terms of commissioning processes – it did little to assuage the existing providers of their concerns around perceived conflicts of interest given the detailed knowledge these actors had due to their involvement in the design of the proposed service model.

The degree of collaboration required to design this SIB financed intervention posed a dilemma (Bevir & Rhodes, 2007) for actors in the network in relation to how to commission the intervention in a competitive, and 'fair' way – i.e. one without the perception of conflicts of interest identified above. In response to this dilemma some actors within the network used their situated agency to emphasise probity, distance and rigidity of legal process in terms of the process towards the commissioning of the service in the following stages whilst other actors complained about impossibility of delivering a 'fair' commissioning process. As a whole, the network remained very keen to demonstrate that a robust competitive tendering

process for the new End of Life Care service would take place, and that all parties would maintain the appropriate detachment from each other. Actors within the network sought to resolve the dilemma posed by the SIB requirement for collaborative service design by emphasising traditional strategies of cross-organisational distancing and signalling an ongoing belief in the fairness of an established managed competitive approach to service commissioning.

Ultimately, this strategy floundered. Just two returns met the pre-qualification questionnaire criteria (hardly the flourishing competition hoped for by many in the network). Furthermore, between the pre-qualification questionnaire being issued and the invitation to tender, a review of the original metrics drawn up on the service model was commissioned. This review by the commissioners found that the metric linked to the number of unplanned admissions to hospital in the last month of life had been incorrectly calculated in the original work, and therefore the activity in year one of the proposed contract should be measured instead, and subsequent metrics for years two and three be based on year one data. For the two potential bidders, this then caused confusion about firstly, risk exposure; and secondly, the ability to make a return on any investment given the likely tighter margins. The commissioners had instigated a closed bid process which precluded detailed negotiations with bidders around their respective bids. A bid led by one group was abandoned due to this confusion. A second group went ahead with a bid – however, it was deemed non-compliant by the commissioners. In light of not receiving a single compliant bid, the commissioners discontinued further work on the SIB. They cancelled the original procurement processes for the respective elements of the End of Life Care, and commenced a new open procurement process to provide similar services but not financed through a SIB.

Site B: network narratives of promise and possibilities

The network of actors involved in the proposed SIB financed intervention in Site B had a longer history in their respective area than that in Site A. In Site B, the network included a committed assemblage of advocates for Social Prescribing led by a group of senior doctors who were perceived as being professionally and academically credible. These individuals had good local links with primary and secondary care organisations, some held healthcare commissioning and provider roles and they had very well defined links with local voluntary care organisations. These actors instigated the work on the SIB application. This network of Social Prescribing enthusiasts had spent over two decades working to demonstrate the clinical, social, operational and financial effectiveness of Social Prescribing. They were skilled at forging relationships with regional and national policy makers and funding councils to generate the finance to further the Social Prescribing agenda. The attractions of the SIB model for these local actors were three-fold: first, it would allow them to scale up Social Prescribing in their city to a greater number of patients; second, it would generate long term funding for the service over a proposed time period of 5-7 years (as opposed to the shorter, annually funded grants for previous, smaller scale projects); and thirdly, the SIB model also offered an exciting research opportunity to further the cause of Social Prescribing because it encourages counterfactual measurement to demonstrate attribution to generate outcomes-related payments.

Nevertheless, similar dilemmas (Bevir & Rhodes, 2007) around conflicts of interest in the commissioning processes of a SIB financed intervention highlighted in Site A emerged here too. In contrast to Site A, where stories of tension between network actors and local

governance procedures that emphasised rigidity and a commitment to competitive tendering prevailed, in Site B, the narratives emanating from network actors highlighted collaboration, innovation, risk taking and enduring commitment to flexibility in order to overcome these dilemmas. A sense of a joint commitment to the project comes through from interviews with actors within the network. The dominant discursive sentiment is one of *possibility* and *determination*.

As mentioned, in Site B, the informant interviews touched on similar ‘conflicts of interest’ noted in Site A. For example, as with Site A, numerous actors reported that there were concerns about how commissioning a SIB, and the requisite early and ongoing provider-commissioner collaborations therein, ran counter to the traditions of competitive commissioning values. However, the stories developed by actors in Site B recounted a local determination to *suspend* the usual commissioning arrangements, and commission the service as an *exception* to standard rules. For instance, informants talked of how the ‘standard’ NHS contracting processes had to be sidestepped to commission and initiate this programme. This clearly contrasts with the narratives in Site A which emphasised procedural adherence, and relational breakdowns and a lack of trust amongst network partners. The narratives related to these issues in Site B emphasised ‘possibilities’ and flexibility:

‘[N]ormally the contract is the contract, and the contract is, is not flexible but the idea of a contract’s not to be flexible. You know, it is to create that black and white, whereas with, with [this SIB programme], you know, there’s a lot of grey’

Commissioner, Site B

In contrast to Site A – where narratives focused on contractual rigidity and a desire to follow ‘classically right’ processes in relation to public sector procurement traditions to avoid

perceptions of conflicts of interest, in Site B we find narratives that emphasise suspension of usual commissioning rules or regulations – contractual ‘greyness’ or doing things ‘back to front’ – guided by the desires of community and voluntary voices using their situated agency to persuade other actors of the value of the proposed project and a desire to generate the finance from social investors:

‘We would never [normally] procure a service the way that we have done this [time], with actually someone coming to us [as commissioners] and... [Saying] “this is something we want to do, this is the way of getting funding, if we go this route we’ll find the social investors for you”. So they came to us with a package, and [a senior commissioner] was enlightened enough to say, “let’s go for this, let’s work with them and try and see if this’ll work” ... I’ve always said [this Social Prescribing Service] was not procured in the normal route, it was back to front, it was ground up from the, the community itself saying this is what we want, and the voluntary sector organisations organised themselves and came to us.’

Commissioner, Site B

Whilst this commissioner highlighted unease about commissioning the service in this way, and spoke of legal concerns (which were reviewed with senior NHS commissioning regulatory bodies before proceeding) – the network ultimately overcame this unease collectively. An important difference between the two sites is the local development of a ‘prime-contractor’ model, effectively co-commissioning the service between the commissioners and the voluntary group in Site B. This was led by locally established and credible figures who already had the trust of key network partners. Additionally, no existing providers were set to lose out as the proposed SIB financed service was *additive* (in its absence there was no existing major SPS provision). Furthermore, there was little threat of

large external providers bidding for local contracts (as no such providers exist in Social Prescribing – in contrast to End of Life Care) – so unlike in Site A, local providers in Site B were less inclined to feel threatened by the proposed SIB financed intervention. These contextual distinctions are important and we will return to these in the discussion section.

Discussion

We explored, in two different sites in detail, how, when and why dilemmas (Bevir & Rhodes, 2007) linked to efforts to design and commission healthcare services through a SIB financing mechanism either became unsurmountable or were overcome. We did this through an interpretation of the interactions of networks of actors within their specific historical and local contexts. This work builds on broader network governance approaches (Newman, 2001; Osborne, 2006) to explore the specificities of inter-organisational relationships in localised contexts.

We used a ‘decentred’ approach to network governance (Bevir & Rhodes, 2007; Bevir & Richards, 2009) to explore whether, and if so, how, and to what extent, specific local traditions were challenged by new ideas or beliefs linked to these two respective SIB-financed interventions. In each site, actors identified two distinct service and finance failures. One service failure related to End of Life Care, the other a lack of Social Prescribing. SIB financing was attractive in both cases as it offered a way to respond to these failures at pace and at scale. However, the SIB mechanism required a focus on early and ongoing integrated multi-actor service re-design that posed dilemmas for the governance of the networks of actors in both sites. Existing beliefs around ‘fairness’, competition and collaboration, coalesced within network narratives around the response to the dilemmas articulated in these sites as ‘conflicts of interest’ in commissioning processes.

Actors within networks locally negotiate new ideas and dilemmas within existing traditions and belief systems. Governance is locally reproduced through the narratives of these situated agents (Bevir & Rhodes, 2007). Different narratives were developed by actors in each site – we interpreted these narratives to develop overall stories from each site around the process of the proposed interventions. The comparative purchase is rendered through the local differences – these in turn are linked to local historical and contextual issues.

The approach taken in Site A was conservative, reflecting the prior ‘traditions’, and sought to minimise the perceptions of any conflict of interest within a ‘difficult’ local network of actors. A governance approach was developed that emphasised ‘fairness’ and a reliance upon rigid norms of provider competition above all else. Here, a desire to do what was ‘classically right’ on the part of the network actors emerged as the overriding story from the collected informant narratives. The dilemma faced by the network, was in how to reconcile the collaborative nature of SIB service redesign processes and the knowledge disparities this generates between different organisations, with the competitive service tendering traditions that most actors felt guaranteed a ‘fair’ process. The ultimate outcome was consistent with the beliefs and traditions of the historical context as reproduced by actors – in this case, a reverence for the traditions of competitive tendering. The result of the tendering process in Site A was that no compliant bids were received - therefore the service could not be commissioned. What mattered most here was that the *process was deemed to be fair* and consistent with the prevailing traditional beliefs of the actors in the network.

In Site B informant narratives identified an equally prevalent, traditional belief in competitive tendering, however, these beliefs were challenged by a desire derived through the network of actors to govern in a more collaborative and less firmly rule bound manner. Local actors' beliefs were sufficiently altered by the promise of delivering Social Prescribing at scale through a SIB so as to accommodate a shift from the traditions of competitive commissioning of health services to a practice with greater flexibility. The dilemma posed by some of the *anticompetitive* collaborative implications of SIB commissioning was ultimately overcome. The narratives around the significant breakdown in network relations discussed by actors at Site A contrasted with narrative reproductions of a deeply committed network at Site B built on longer-term, trusting relationships amongst actors – this is evocative of the PPP principles identified by Teicher et al (2006). The story that emerged at Site B was one that emphasised *taking a chance and getting things done*. In this sense, Site B overcame the dilemma of how the inherent collaborative neo-corporatist (Osborne, 2006) elements of SIB commissioning makes traditional NPM style (Ferlie et al, 1996) NHS competitive tendering problematic.

There are a number of historical and contextual factors that are significant in explaining the divergences found in these sites. First, is a factor that Bevir & Rhodes (2001) refer to as the 'continuation of the activity of governing.' In Site A, End of Life Care services are essential and not optional, therefore the relationships between actors within the network must remain functional at all times because if not, then extremely vulnerable patients may suffer. Hence the significance of the narrative of existing providers, fearful for their futures, 'breathing down the necks' of commissioners. This was not an issue at Site B, where Social Prescribing Services were deemed optional as opposed to essential, with clear implication for the relational dynamics between different network actors. This may have implications beyond these cases – SIB financed interventions may be more likely to be initiated where they avoid

the continuation of the activity of governing – i.e. they may be better suited to establishing additive, non-essential services as opposed to replacing existing essential ones.

Secondly, in Site B, efforts were made to ensure that local provider organisations would share in the delivery of the new services if and when they were commissioned – this contrasted with Site A, where there was great fear that existing actors may lose out to a large national charity that had not previously operated in the local area. This finding might suggest that SIBs are more likely to be initiated where they work with existing local providers rather than threatening them – once more highlighting neo-corporatist values (Osborne, 2006).

Thirdly, the professional and academic legitimacy of local policy champions and the historical legacy of prior reform efforts are significant. In Site B, there were over 20 years of consistent efforts from powerful actors consistently striving for the delivery of Social Prescribing at scale. The initiation of the SIB in this area reflects the strongly established relationships and mutual trust within the local network. In contrast, at Site A, less established actors without local roots lacked such professional legitimacy and had not demonstrated the same local effort to convince other local actors of the utility of the SIB financing mechanism to deliver the End of Life Care reforms. This finding highlights the importance of localised professional and jurisdictional power, as well as the significance of time in developing trust amongst agents within networks.

In terms of the broader implications of this research, with respect to the theoretical debate around the governance implications of SIBs, our contribution is to highlight the potential for a decentred approach to take a ‘bottom up’ view of how networks negotiate the competing

logics of national policy initiatives. In an English healthcare context, SIBs encourage the construction of an early and enduring new network of actors to explore local policy issues collaboratively - explicitly aiming to develop new ideas and challenge existing practices. Such efforts at SIB development highlight tensions between the logics of competition and collaboration in the traditions, or governance of local commissioning. SIB development encourages pre-contractual collaboration between actors, signalling a form of re-integration of commissioning and provision of services in the shape of informal local PPPs (Osborne, 2006; Dunleavy *et al*, 2006; Joy & Shields, 2013; Bovaird, 2004).

Finally, this paper empirically highlights the ongoing tensions between different health and social policy initiatives pursued by governments in the UK since the early 1990s and more generalizable challenges of commissioning services, especially in low competition contexts. Efforts to integrate health and social care services in England occur within a contested milieu in which local actors must accommodate the competitive logics of the 1990s quasi-market reforms (Ferlie *et al*, 1996) and the Health and Social Care Act 2012 initiatives, alongside emergent collaborative logics emphasised by SIBs and outcomes based commissioning approaches (Joy & Shield, 2013). Local networks of actors have to negotiate these 'sedimented' governance logics (Jones, 2017) to deliver what is desired by national government, what the law allows (as they interpret it) and what they wish to do locally for their populations. 'Decentring' governance helps explain how local actors achieve this.

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Table 1: Local Policy Failures

Site	Local policy failures that led to SIB proposal
A	<ul style="list-style-type: none"> • Service failure: Poor End of Life Care arrangements overall with lack of coordination at specific points, resulting in overburdening of services, poor quality patient outcomes and increased local service costs • Finance failure: Lack of local finance to remedy these failings rapidly
B	<ul style="list-style-type: none"> • Service failure: Large co-morbid population poorly catered for, resulting in overburdening of services, poor quality patient outcomes and increased local service costs • Finance Failure: Lack of local finance to scale up promising local pilot work over the past two decades