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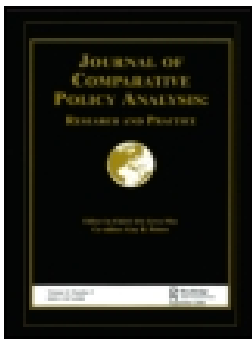
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Article



A Comparative Analysis of Social Impact Bond and Conventional Financing Approaches to Health Service Commissioning in England: The Case of Social Prescribing

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ABSTRACT *The article compares two social prescribing interventions in Northern England. One was financed through a Social Impact Bond (SIB) and the other was financed in a more conventional way. It utilises a comparative approach to understand the extent to which different methods of financing social prescribing conform to key features of the New Public Management (NPM) or New Public Governance (NPG) in their design and implementation. It finds that a SIB approach tends towards NPM during programme design and implementation and that this creates challenges for social prescribing programmes, the complexity of which appear better suited to an NPG-based relational approach.*

Keywords: social impact bonds; social prescribing; New Public Management; comparative governance; qualitative methods

1. Introduction

Promoting the health and social wellbeing of populations living in economically disadvantaged post-industrial urban areas presents significant challenges for policy makers in Western

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countries. In this article, we compare the design and implementation phases of an intervention that seeks to improve the social wellbeing and health outcomes for service users within such populations in two distinct areas of Northern England. Whilst the intervention – social prescribing – is the same in both sites – the financing mechanism is different. In one site, a Social Impact Bond (SIB) based on payment by results (PBR) is used. In the other site the intervention is financed more conventionally – through the allocation of purely public money and without a PBR component.

The comparative approach enables us to explore the following research questions:

- (a) *How does the design and implementation of a social prescribing intervention financed through a SIB compare to one that is financed through conventional commissioning processes?*
- (b) *To what extent can any contrasting features be explained by each intervention's adherence to a particular public management regime (i.e. NPM or NPG,) and what are the implications of these for the future design and implementation of social prescribing interventions, and SIBs more generally?*

These are important empirical questions with implications for understanding how the health and wellbeing of marginalised urban communities can be supported that also address an identified gap in knowledge regarding the challenges and enabling factors associated with the set-up and implementation of a SIB vis-à-vis conventional funding models. Although there are further important comparative questions about how different funding models affect programme outcomes, including whether SIBs generate better outcomes than conventional approaches, the quantitative data that would enable such a comparison are not yet available. Moreover, before quantitative outcome data can be used comparably it is first important to understand and critically reflect on the purposes for which these data are collected and the implications of this for programme implementation.

Our research questions also enable us to engage with an important theoretical debate about whether SIBs represent an extension or a diminution of the New Public Management (NPM) (Warner 2013; Fraser et al. 2018a; Le Pendeven 2019). We apply a comparative analytical framework to understand the extent to which the different approaches to financing social prescribing conform to key features of the NPM archetype or whether they are more closely aligned with the post-NPM archetype referred to as New Public Governance (NPG) (Osborne 2006, 2010). This approach enables us to ground our analysis in broader debates about the tenets of effective public management.

The SIB model has been developed over the past decade to aid the design and upfront financing of public services. SIBs purport to promote “outcomes” for service users as opposed to “outputs” by financing interventions in a way that directly connects financial reward for service providers and their investors to the achievement performance targets. SIB proponents claim that this shifts the financial risk of intervention failure from government to private investors; it enables smaller non-profit providers to access service contracts; and delivers social improvements whilst generating cashable savings for the public purse (Mulgan et al. 2011). Nonetheless, others emphasise caution regarding the SIB model, highlighting the lack of evidence about whether or not the supposed benefits of SIBs are realised in practice (Warner 2013; Cooper et al. 2016; Neyland 2018).

SIBs usually involve four different parties. Firstly, commissioners – central or local government bodies responsible for the provision of relevant public services. Secondly, service providers – who are often drawn from the non-profit sector and deliver the services to specified populations. Thirdly, external investors – who cover 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. In the UK, charitable foundations financed many of the early SIBs (Fraser et al. 2018b), but SIBs are increasingly being financed through “social investment funds”, such as the Bridges Social Impact Bond Fund seeded by Big Society Capital. The final party may be referred to as intermediaries – including investment managers, who are often involved in developing projects, securing contracts, facilitating investment and managing project delivery. It is the addition of these final two parties that sets SIBs apart from traditional PBR approaches, which are based around the commissioner–provider relationship.

SIB-financed interventions typically target costly, complex and intractable social problems. One such intervention is social prescribing, which aims to improve health and wellbeing for people with complex health conditions by enabling healthcare practitioners to refer patients to social support and activities provided by non-profit organisations in their local area (Kimberlee 2015; Dayson 2017). In practice a social prescription involves three steps: (1) a referral to a link worker (usually hosted by a local non-profit organisation) by a healthcare practitioner; (2) a conversation between the link worker and patient to identify their physical, social and emotional support needs, and social interests; (3) brokerage of a tailored programme of supported social and community activity provided by local non-profit organisations.

This article proceeds by discussing our theoretical framing, situating public service commissioning and SIBs within debates associated with public policy, management and governance. We then outline a comparative analytical framework and methodology before presenting our findings, comparing and contrasting some central components of the two social prescribing interventions and how they may conform to a particular governance archetype. Finally, we discuss the implications of our findings.

2. Theoretical Framing

Since the 1980s, the tenets of NPM asserting the superiority of private sector management techniques have permeated public services throughout the Western world. (Hood 1991; Osborne and Gaebler 1992). Although NPM is often applied in loose terms, Dunleavy et al. (2006) frame it as being based on three main principles: the *disaggregation* of public sector goals into measureable objectives for which particular actors can be held responsible; the introduction of *competition* between providers through outsourcing and contracting; and *incentivisation*, through the concentration of practices such as PBR. Despite the widespread adoption of these principles NPM has been criticised on a number of grounds, notably for its adherence to techniques imported from the private sector despite significant evidence about their inapplicability to the plural and networked nature of public services (McLaughlin et al. 2002; Salamon 2002).

More recently, a number of post-NPM models have been advocated by public policy and management scholars to highlight the impact of technological and relational developments upon public policy and service delivery (Dunleavy et al. 2006; Osborne 2006, 2010; Stoker 2006). In this article, we engage with key facets of the NPG model which

re-orientes the focus from management toward the relational aspects of governance to more accurately reflect the day-to-day realities within public services (Osborne 2006, 2010). The core premise of NPG is that a range of public and non-public organisations contribute to public sector goals, and that the relationships between these organisations can be formally governed through service contracts and administrative transactions (Salamon 2002) or be enacted in less formal spaces such as networks where institutional and personal (inter-)relationships have a central role (Rhodes 1997).

Service “commissioning” is a term used in the UK to describe a core function of public service organisations. It refers to “a cycle of assessing the needs of people in an area, designing and then securing an appropriate service” (Cabinet Office 2006) and is a key process by which public sector bodies manage their relationships with non-state providers (Rees and Mullins 2016; Milbourne and Murray 2017). Because of its association with outsourcing, competitive tendering and the separation of purchasers and providers (Bovaird et al. 2012) it has been argued that commissioning is an embodiment of the NPM (Salamon and Toepler 2015). However, others have highlighted the relational and trust-based nature of commissioning (Rees 2013) and its situation within wider models of networked governance (Rhodes 1997) and partnership (Carmel and Harlock 2008), which align more closely with NPG.

In practice, public service commissioning occurs on a continuum, with a classic NPM archetype at one extreme and a “softer” NPG archetype at the other, with various hybrid models in between, and much resting on the extent to which individual commissioners adhere to codified frameworks or apply individual discretion (Milbourne 2013). The SIB model, with its extension of PBR and introduction of external investors and intermediary actors, alongside closely monitored outcome payment targets, represents an evolution from previous commissioning approaches. It is not surprising therefore that the SIB model of commissioning, including its theoretical underpinnings, has provoked considerable debate amongst public policy, management and governance scholars (Fraser et al. 2018b).

Warner (2013) has argued that SIBs may represent an extension of several NPM logics, in particular its reliance on contracting mechanisms. In SIB-financed projects significant control over service delivery is ceded to intermediary organisations alongside an increased emphasis on performance management (Warner 2013; Cooper et al. 2016). However, there is contention concerning the extent to which SIBs conform to Dunleavy et al.’s (2006) principles of NPM (Le Pendeven 2019) and Fox and Albertson (2011, 2012) highlight SIBs’ potential to lessen some of the harsher edges of NPM as they shift the focus from process to outcomes measurement. Whilst this view is contested, it has been argued that such a shift might be seen as providing service delivery staff with greater discretion to flexibly meet client needs and better aligning the goals of all stakeholders, prompting Joy and Shields (2013) to suggest that SIBs may more closely resemble Osborne’s NPG model. SIBs, viewed through an NPG lens, may be interpreted as a variant of a public–private partnership, in that they promote long-term collaboration between public, private and non-profit actors, for example through longer contracts and contractual alliances (Teicher et al. 2006), and include anti-market elements such as the suspension of competitive procurement processes (Neyland 2018).

This collaborative rationale is prevalent in some of the most recent narratives relating to SIBs in the UK which position them as representing a shift to “neo-corporatist values” (Osborne 2006) in the commissioning of public services – suggesting that SIBs encourage

collective co-design of complex care pathways and sustained inter-organisational commitments rather than short-term competitive contracting (Fraser et al. 2018b). Thus, by promoting upfront collaboration between key actors SIBs may challenge the competitive logic which has become prevalent in the commissioning of public services as well as challenging traditional responses to policy problems by establishing of new coalitions and networks of actors. Thus, the contested, ambiguous (Fraser et al. 2018a) nature of SIB approaches to commissioning public services provides fertile ground for research building on existing comparative scholarship on the impacts of managerial reforms on NHS health policy (Bevan 2010). In the following section we outline an analytical framework to explore the research questions highlighted in the introduction.

3. Analytical Framework

This article takes as its theoretical start point Osborne's (2006, 2010) framing of the NPM and NPG as governance archetypes. In particular, we compare the extent to which the two social prescribing interventions adhere to particular archetypes. Analytically we centre on three elements of Osborne's model – (1) focus and emphasis, (2) relationship to non-public partners and the allocation of resources, and (3) governance and accountability mechanisms – as these are most relevant to public service commissioning. An overview of this framework is provided in [Figure 1](#) and explained in more detail below.

1. What is the focus and emphasis of the model?

This relates to the focus and emphasis of key actors within the public service system. Under NPM this is intra-organisational management: managing organisational resources and performance through the monitoring of inputs and outputs (i.e. efficiency) at the service level. Under the NPG archetype this is inter-organisational governance: negotiating values, meaning and relationships between multiple actors and stakeholder groupings in order to understand service processes and outcomes (i.e. effectiveness).

2. What is the relationship between the state and external stakeholders and how are resources allocated?

This relates to the role of external actors – from the private and non-profit sectors – and their relationship with public sector bodies, which is inexorably linked to resource allocation. Under NPM, external organisations are viewed as independent contractors with limited input into wider service or developmental processes. As such, resources are allocated through competitive (quasi-)market processes. Under NPG, external organisations are more engaged in service development through “preferred supplier” status and recognition of the interdependence between multiple actors within a service system. This allows for resources to be allocated based on an understanding of the networked nature of service systems, including the suspension of competitive tendering.

Figure 1. A framework for comparing SIB and non-SIB approaches to commissioning social prescribing

Regime	What is the focus and emphasis of the model?	What is relationship between the state and external orgs and how are resources allocated?	What are the governance and accountability mechanisms?
New Public Management	Intra-organisational management: managing organisational resources and performance through the monitoring service inputs and outputs	External organisations are independent contractors within a marketplace	The market and performance based contracts
New Public Governance	Inter-organisational governance: negotiating values, meaning and relationships in order to understanding service processes and outcomes	External organisations are preferred suppliers and interdependent actors	Trust, networks and relational contracts

Source: Adapted from Osborne (2006, 2010).

3. *What are the governance and accountability mechanisms?*

This focusses on the governance and accountability mechanisms and processes associated with delivery. Under NPM, services are governed through contracts, with providers held accountable for meeting performance targets. Under NPG, although services are still governed through contracts, these are more trust-based and relational and do not directly connect payment with predetermined targets, or hold providers to account over these.

4. **Methods**

This article uses a case study approach (Yin 2003) to compare two distinct social prescribing interventions in post-industrial urban settings in northern England. The comparative approach aids increased understanding around both the intervention (social prescribing) and the financing mechanism (SIB) within the context of health policy making (Dodds 2018). It draws on pooled data from three separately funded programmes of long-term research by three separate research teams. One research team has been evaluating the implementation and effectiveness of a conventionally financed social prescribing intervention since 2013. The second research team has been evaluating the implementation of the SIB-financed social prescribing intervention since 2014. Both evaluations were commissioned by local healthcare commissioners and their service providers.

Figure 2. Overview of data collected across three studies

Research Team	Conventionally financed social prescribing intervention	SIB-financed social prescribing intervention	Total
Research Team 1	2014 - 17: 39 interviews	N/A	39
Research Team 2	N/A	2015: 13 interviews 2016: 12 interviews	25
Research Team 3	2015: 15 interviews	2014: 5 interviews 2017: 14 interviews	34

The third research team was commissioned by central government to conduct a three-year evaluation (2014–2017) of the first SIB-financed projects in the UK to tackle health and social care issues. One of these projects was the SIB-financed social prescribing intervention discussed in this article. The evaluation included a comparative component, with each SIB project compared qualitatively with a project elsewhere in the country that had the same or similar interventions and target populations provided by a similar type of organisation but financed in more conventional terms. The other site was identified as part of this comparative case study approach due to intervention and demographic similarities and included in the study design as a comparative case study.

To ensure coherence and prevent duplication between the three studies the third research team liaised closely with the research teams in each site: they met and approved interview schedules, discussed relevant interviewees, and have engaged in regular meetings and data analysis workshops since 2014. In 2017 the three research teams agreed to collaborate on a more extensive comparative project by pooling data and undertaking additional joint analysis of key themes. Details on informant interviews are given in [Figure 2](#).

A total of 98 interviews were conducted across the three studies and two sites between 2014 and 2017 and relevant documents were collected and analysed. We purposively sampled informants to include public health service commissioners, non-profit providers, investment managers and investors. Most interviews were undertaken face-to-face, though a number of interviews were also carried out by telephone. Whilst interview schedules used across all interviews were not identical, there is a good degree of convergence thanks to cross-team collaboration. Interview transcripts were coded using Nvivo 10 software. Initial codes were based on themes arising directly from the interview questions. Two members from each research team analysed interview data collaboratively to ensure inter-coder reliability, closely engaging with the data and wider theoretical insights both inductively and deductively (Langley 1999) and engaging iteratively with NPM and NPG archetypes.

5. Findings

The following sections present the main findings of the study. We begin with an overview of the two interventions, their local development and comment on points of contextual significance before presenting the comparative analysis of the commissioning and implementation process in both sites.

5.1. *An Overview of the Two Social Prescribing Services*

The SIB-financed social prescribing intervention is situated in a medium-sized city – “Beardstown” – in Northern England. Like many urban areas in Northern England it remains characterised by high levels of health inequality as a legacy of earlier post-industrial economic decline. Although social prescribing-like activity had been undertaken here for the preceding 20 years, in 2011 work began to develop a large-scale social prescribing intervention financed through a SIB. This development work initially involved local health commissioners, the local non-profit umbrella body and a number of front-line non-profits with prior involvement in community-led health initiatives. Latterly it involved a wider range of actors, including SIB intermediaries, investors and grant funders. The Beardstown project was developed with two strategic aims: (1) to increase the scale and reach of previous social prescribing activity and (2) to create a culture change in the local non-profit sector which had previously delivered this activity, making them “more business-like”, in particular towards a more outcome-based performance management approach. The SIB financing model was finalised in 2014 and the service went live in 2015.

Participants in the development of the intervention put forward a number of rationales for financing this as a SIB rather than through a conventional approach. These included enabling social prescribing to achieve a greater scale than it had previously in the area, but in a way that reduced the financial risk for the public commissioner. Informants also noted there was “a political appetite to test a SIB approach” locally and explore its feasibility for future service provision. A further rationale for the SIB model was its potential to enable long-term multi-year collaboration and learning through a long-term contract between the local health service and the main social prescribing provider.

The conventionally financed social prescribing intervention was developed in parallel with the Beardstown one in a different part of Northern England labelled here as “Mooretown”. This large town is similarly characterised by high levels of health inequality and post-industrial decline. In 2011 a consortium of non-profit organisations involved in healthcare services, led by the local non-profit umbrella body, was tasked by local health commissioners to develop a new model of working between local non-profits and the NHS. This included two similar strategic aims to the Beardstown service: (1) to embed a social prescribing model at scale across the borough and (2) to ensure non-profits’ involvement in health services was better oriented to achieving priority outcomes for local health services and patients. Non-recurrent public funding was identified to resource a two-year pilot and the service was commissioned in April 2012.

Thus, the main difference between the two social prescribing interventions stemmed from the decision to finance one through a SIB and the other through a more conventional commissioning process, drawing solely on public funds.

5.2. Comparative Analysis of the Social Prescribing Commissioning Process

1. What is the focus and emphasis of the model?

Both services were commissioned to focus on outcomes for people with long-term health conditions, and both services prioritised the same two outcomes: outcome A, improvements in the personal wellbeing of social prescribing clients; and outcome B, a reduction in secondary hospital care use by clients (as a proxy for cost savings). In both sites, management of the programmes against these outcomes was supplemented by regular monitoring and reporting of activity data, such as the number and type of referrals made and the demographic characteristics of service users.

The *prima facie* emphasis was monitoring outcomes rather than inputs and outputs, and thus both cases might be viewed as embodying an NPG approach to commissioning. Despite these similarities there was considerable divergence between the two sites in terms of how this outcomes framework was implemented in practice, in particular the purpose for which outcomes data were interpreted and utilised.

In Beardstown, despite an original commitment to use data as a learning tool, the primary purpose of both outcome A and outcome B was to provide metrics for the purposes of contract management and PBR, with performance against agreed targets for both measures triggering payments for investors. This form of contract management via performance metrics aligns strongly with the NPM archetype: “[T]he data [system] ... was set up ... as a communication tool, now it’s used more as a stick rather than a carrot” (Subcontracted Provider Informant 10 Beardstown). Attempting to use performance data for both contract management and reflective learning led to tensions, as the prime provider struggled to persuade the subcontracted providers to reflect collaboratively on the implications of outcome data analysis:

I was asked to put all of [the subcontracted providers] side by side and benchmark them against each other all the time, and I ... I still have to do that to a degree with the data ... there was a stage where the providers were really pushing back, really struggling with ... just, kind of ... the fact that we weren’t trusting them to get on with it. (Prime Provider Informant 4 Beardstown)

In particular, subcontracted providers were cautious about the interpretation of their performance data for potentially punitive contract management purposes.

By contrast, in Mooretown, analysis of outcomes A and B was undertaken by an independent evaluator (one of the co-authors), and performance against these outcomes was not tied to contract management.

[T]here’s a lot of data processing that needs doing there and we haven’t got the capacity to do it, and probably not the knowledge to do that. So it’s easier to hand it over to somebody else and somebody that’s independent that can try and make sense of that. (Prime Provider 19 Mooretown)

This independent analysis of outcome data provided the basis for discussion between the prime provider and commissioners about what the service was achieving and the implications for future development of the intervention. For example, when analysis of

outcome B data provided evidence of more positive change for younger service users, this prompted discussion about whether it would be more appropriate to focus the service on younger users and how outcomes for older service users could be better understood. This use of outcome data for learning and understanding across the Mooretown programme is closely aligned to NPG approaches.

2. What is the relationship between the state and external stakeholders and how are resources allocated?

Both interventions represent a form of outsourced public service and both were a departure from previous approaches to the commissioning of health services. Unusually, both services also involved two levels of commissioning: first, the commissioning of a prime provider to manage the delivery of the service; and second, the commissioning of subcontracted providers to deliver social prescribing activities. We consider each stage in turn below.

In Beardstown, normal tendering processes were suspended to enable a Special Purpose Vehicle (SPV) to be established and become the prime provider of the social prescribing service. Although a separate organisation, the SPV retained strong links to the organisations involved in the development of the SIB, a number of which provided board members to the SPV. Similarly, the commissioning of the intervention in Mooretown built on the collaborative processes evident during the development stage. Because the service was initially commissioned as a two-year pilot utilising non-recurrent funding that was not committed to existing mainstream services this enabled commissioners to suspend normal competitive procurement processes and directly commission the local non-profit umbrella body that had led the development process.

In Mooretown, following the two-year pilot, commissioners decided to make social prescribing a recurrent mainstream service which meant that a contract to deliver the service had to be let through a competitive tendering process. As the commissioners were satisfied with the existing arrangements for delivering the service, the tender specification included a number of requirements that favoured the existing provider. These included, for example, experience of delivering social prescribing locally and a track record of working in partnership with local commissioners and non-profits within healthcare.

In Beardstown, the SPV subcontracted service providers to deliver the intervention through a competitive tender process in which potential service providers were required to respond to a conventional service specification. This was a deliberate strategy on the part of those who had developed the SIB to (a) support the objective of promoting a culture change in local non-profits in which these organisations would be more “business-like” and equipped for the challenges of delivering a SIB and (b) to gain legitimacy in the wider non-profit sector by providing opportunities to be involved in the new initiative.

By contrast, in Mooretown, subcontracted service providers were commissioned to deliver activities through a small grants programme managed by the prime provider. Local non-profits were encouraged to develop proposals for activities and services to which clients could be referred. The grant funding operated on a “test and learn” basis through which successful proposals were provided with short-term funding (6–12 months) to determine need and demand for what they are offering, with funding reviewed regularly and activities revised and developed in response to feedback from clients. The rationale for this model was

threefold: first, it secured buy-in to the idea of social prescribing from the wider non-profit sector by involving a range of providers in its implementation; second, it built the capacity of small non-profits to support social prescribing; and, third, it reduced the transaction costs for commissioners who were not equipped to manage multiple small contracts of this nature.

At a strategic level, in both sites the commissioning of the prime provider was an inherently relational process through which local commissioners sought to strengthen their involvement with a limited number of preferred non-profit providers present in existing networks. Implicitly, this was seen as necessary “reward” for their earlier contribution to the policy formulation process. It was most evident in the way that commissioners in both areas suspended normal tendering and procurement processes to ensure that key players in the development of each service were afforded an implementation role. In addition, the commissioners themselves, alongside a range of other actors, engaged in a co-production process to design both interventions.

Thus, in both cases, NPG-style processes of contracting preferred providers, acknowledged as interdependent actors, were followed, as opposed to the competitive tendering processes that are promoted by NPM. However, the two services diverged somewhat in their commissioning of social prescribing activities at an operational level. Whilst Beardstown reverted to a traditional NPM approach involving competitive tendering, Mooretown extended its NPG-based principles to facilitate the involvement of a broader range of non-profit providers in the service.

3. What are the governance and accountability mechanisms?

Both sites demonstrated multi-layered, multi-actor governance and accountability mechanisms. However the complex multi-stakeholder nature of Beardstown marked it out as considerably more complex, in governance terms, than Mooretown. This was related to the fact that there were more actors involved in the financing and overall governance of the service at a strategic level. Those financing the service included public funders – both national and local government commissioners; charitable funders; and an investment manager. The SIB model required that the investment manager received a return on the original investment based on complex calculations linked to data collected on outcomes A and B, overseen by the local NHS commissioner but with close scrutiny of the methodology from the investment manager.

Therefore commissioners and the SPV (which oversaw payments to the subcontracted non-profit providers and outcome payments to the investment manager) had multiple contractual and financial relationships at a strategic level with a variety of organisations. These included relationships between the health commissioners and the SPV pertaining to the performance of outcomes A and B, and between the SPV and the investment management company that provided upfront money to finance programme delivery. Although the contracts covered an extended period, finance was contingent on the SPV achieving performance targets, expressed in the form of output- and process-based Key Performance Indicators (KPIs) – including targets for numbers of people recruited onto the programme, the speed with which referrals are seen, and the completion of data capture exercises within particular time windows.

This second arrangement was crucial to the delivery of the intervention. Failure to meet targets in respect of the KPIs meant that one payment from the investment manager to the SPV was withheld – with implications for the parties involved:

[O]nce it was clear that the [subcontracted] providers weren't, weren't meeting their KPIs, [the investment managers] said, well, we need to look at this, and, we're not going to provide anymore [financial] draw down until we've had a good look at this and decided what this is all about. (Prime Provider Informant 1 Beardstown)

[I]t changed the relationship. There was a period when it, it felt like, you know, mummy and daddy were withholding our pocket money, and there was that mood in there, which I think was partly, you know, created some tension in me ... I thought I'm not used to being treated this way. (Prime Provider Informant 3 Beardstown)

A further layer of governance and accountability relationships existed between the SPV (prime provider) and the non-profit subcontracted providers of the intervention. These relationships at the operational level focused on monitoring output and process-based KPIs which mirrored those that the investment managers used to monitor performance of the SPV. Payment for providers was not (initially) contingent on meeting these targets, but provision was made for cancelling subcontracts in the event of failure to meet targets and, unlike the main contract, subcontracts were to be renewed (or not) after two years.

In contrast, in Mooretown, the prime provider received funds for social prescribing directly from the local NHS commissioner and passed these on as grants to local non-profit subcontracted providers for services provided with no requirement to calculate outcomes or payments to external investors. The commissioner and the prime provider collaboratively monitored progress towards outcomes A and B as well a series of output- and process-based KPIs.

Similar to Beardstown, these included the number of clients referred and engaged with but did not include data capture targets. Importantly, and in contrast to Beardstown, financial payment was not tied to performance in any way in Mooretown. Rather, data was used relationally as part of a learning and development process. Here, the second layer of governance relationships was between the prime provider and the subcontracted local non-profit providers in receipt of small grants (17 providers received grants to deliver 20 services between 2014 and 2016). Given the number of relationships at this level, and the relatively small size of the grants involved (most are less than £10,000), the accountability mechanisms were necessarily light touch. Initially, on a monthly basis providers were required to confirm the start and end date for each service user, document any reasons for their support ending, and list the nature of any onward referrals made.

Unlike in Beardstown, there was no evidence that the pressure from the KPIs was passed down to the subcontracted providers. However, as the service evolved, the accountability requirements did become more onerous, with detailed breakdowns of the amount of time spent supporting each service user requested. This was in part a response to a request from the NHS commissioner for more information about the unit cost of each activity to monitor value for money and to ensure consistency of resource allocation across the different grants. But it was also born from a view within the lead provider that grant recipients should be more accountable for the funding they received.

I've got a finance department here who are saying with all the changes in the charity regulations we've got to go in and audit what we're giving the grants out for, I've got our auditors saying you've got to do that, we've agreed with them that we will spot check, well we'll pick a couple of organisations a year, we've done that and in every case it's been problematic cos we've had to say if you're telling us you're spending this much you've got to give us evidence that you're spending it on. (Prime Provider Informant 1 Mooretown)

This additional scrutiny was met with frustration by a number of grant holders, who had to change their monitoring processes in response, and led to an argument that these additional non-delivery costs should be met through a proportionate increase in the value of the grant provided. This frustration was further compounded by the fact the grants were short term (usually less than 12 months) and did not cover the full costs of delivery. Thus, the grant funding, whilst welcomed by providers, did not support long-term planning or sustainability.

Thus, we find considerable divergence in the approach taken to governance and accountability between the two sites. In Beardstown, the contractual relationships at the strategic level filtered down to the operational level, with stakeholders at each level holding each other to account for performance against tightly specified targets. This performative use of data, and the apparently punitive consequences for failure to meet targets, suggests that the SIB model of accountability and governance is closely aligned with the principles of the NPM.

By contrast, in Mooretown, the actors took a more relational approach to accountability and governance at the strategic level that is arguably much more closely aligned with NPG principles. However, this was not replicated at the operational level, where there was an increasing focus on the relationship between service costs and service outputs, and ensuring that these costs were not "too high". Despite services being provided through grants rather than contracts, this approach was increasingly more closely aligned with the NPM (Hood 1991; Osborne 2006, 2010), suggesting that even when strategic-level accountability is primarily relational, contract management practices can be subject to NPM "creep" in the search for "greater accountability".

6. Discussion and Conclusion

We now discuss the empirical and theoretical significance of our findings in relation to our original research questions. Empirically, the comparative qualitative case study approach of this article illuminated important contextual factors that were key in both Beardstown and Mooretown to the development, implementation and governance of social prescribing. These empirical findings have been interpreted through the theoretical prism of NPM and NPG archetypes proposed by Osborne (2006, 2010). In his original development of these ideas, Osborne emphasised their characterisation as Weberian archetypes through which to analyse and discuss the practical and conceptual development and implementation of public services. Indeed, Osborne acknowledges that such models are inevitably a simplification and that elements of the regimes will often coexist with each other or overlap, with a variety of working practices operating in the shadow of a dominant hierarchy in which the tenets of one archetype are pre-eminent.

Our analysis of the commissioning of SIB and conventionally financed social prescribing services bears this out. To characterise either the Beardstown or Mooretown model as NPM or NPG in the purest sense would be to oversimplify what are highly complex series of processes, relationships and behaviours. Rather, a more appropriate point to consider is whether or not one regime appears dominant over the other in different approaches to the financing and commissioning of social prescribing, followed by the implications for the financing of similar interventions.

It is clear from our analysis that, during the commissioning phase, both sites were broadly similar and embodied an NPG-style approach. The initial development of both interventions was possible due to a number of long-term and embedded trust-based relationships between key actors in the local public and non-profit sectors and it seems unlikely that either service would have been developed in their absence. Moreover, in both sites there were dual strategic objectives of embedding social prescribing at scale and reorienting the commissioning of non-profits to focus on achieving strategic outcomes, with outputs and service processes a secondary consideration. However, from this common start point there was considerable divergence between the two sites, with the SIB financing model a seemingly crucial factor in accounting for this shift.

The implementation of the SIB-financed intervention, and the governance and accountability processes associated with this, were driven by an inherently contract based approach (Warner 2013; Cooper et al. 2016). In particular, the need to meet performance targets and a subsequent drive to hold different stakeholders at various layers to account for achieving them was a defining feature of governance relationships, leading to an erosion of the trust and relational accountability that had been a feature of the development phase (Warner 2013; Fraser et al. 2018a). By contrast, in the conventionally financed service, although governed by a contractual relationship, the absence of tightly defined performance targets enabled a number of the trust-based relational accountability mechanisms to be retained at the strategic level (Osborne 2006, 2010; Teicher et al. 2006). However, this was less evident at the operational level, where more stringent reporting requirements were implemented.

Thus, it would seem that neither site fits neatly within an NPM or NPG archetype. Whilst both services embodied many of the key features of NPG during their development, the SIB-financed intervention deviated away from this during its implementation, to the extent that it came to more closely resemble a traditional, arguably even extreme, NPM regime (Warner 2013; Fraser et al. 2018a) that displayed elements of disaggregation, competition and incentivisation (Dunleavy et al. 2006; Le Pendeven 2019). By contrast, during implementation the conventionally financed intervention retained many of the NPG principles that characterised its development.

The experience of these two social prescribing interventions, using two different financing mechanisms, enables us to reflect on the suitability of the SIB model for supporting the design and implementation of social prescribing. Given the complex and multi-layered nature of the challenges that social prescribing interventions seek to address – problems which span social and healthcare interventions, and necessarily involve networks of public and non-profit actors – a relational approach seems a necessary response. However, our data highlight the tensions created for provider organisations under the SIB model when the complexity of this work is simplified into a NPM-style performance and accountability structure and there is a move away from the

relationally focussed mechanisms that enable a project to get off the ground in the first place. Although it might be argued that this is a necessary trade-off in support of a shift to a more outcome-oriented approach by non-profits, the evidence from the conventionally financed intervention demonstrates that an outcome focus can be achieved whilst retaining a more relational approach in the longer term.

Overall, and in spite of the claims made by its advocates, we found little evidence of the SIB mechanism providing relief from the “tyranny of targets”, nor did it necessarily lead to operational freedom or flexibility for non-profit providers (Mulgan et al. 2011). In fact, we found quite the reverse, particularly when the SIB approach was compared with the conventionally financed intervention. This echoes previous studies, which found that the institutional work of establishing a SIB is in tension with, and undermines, the institutional work required to establish an effective social prescribing intervention (Fraser et al. 2018a; Lowe et al. 2018). If this is correct, it further suggests that commissioners who are interested in supporting social prescribing interventions may preferably seek to maintain the relational and trust-based aspect of their approach to development throughout the life-cycle of commissioning and delivery by focussing less on outcomes as performance targets and more on evidence as a tool for learning and development (Osborne 2006, 2010; Teicher et al. 2006). In practice this is likely to require an alternative financing model to the SIB or, at the very least, supplementing the PBR aspect of a SIB with a more nuanced and relational approach to outcome measurement and performance management.

Looking beyond our primary foci of social prescribing and SIBs, our analysis also contributes to wider theoretical debates within the study of public policy, management and governance. In particular, we highlight the comparative utility of the NPM–NPG distinction in analysing the different approaches to financing and commissioning public services evident in our two case studies. However, our analysis also leads us to suggest a number of ways in which the depiction of the NPM–NPG archetypes (Osborne 2006, 2010) could be refined to give greater conceptual clarity. Specifically, we propose that the distinction in *emphasis* between NPM and NPG should not focus on whether one is concerned with processes and outputs and the other with outcomes. Rather, a more useful distinction lies in the purpose for which outcome data is gathered (Bevan 2010). Under NPM, the principal purpose is managing performance with outcome data used for extrinsic motivation – rewarding actors based on their progress toward outcome targets. By contrast, we argue that NPG approaches use outcome data for reflection on progress towards shared goals as part of a more relational model of accountability. Applied to this case, this distinction leads to a hypothesis which explains why SIBs appear to be a less appropriate financing mechanism for social prescribing than conventional commissioning: it is not because one or the other has a greater outcome focus, it is that one uses outcome data for performance management, the other for learning,

Finally, it is necessary to reflect on the limitations of our study. We do not address the issue of outcomes or the comparative effectiveness of the respective interventions in this paper as the requisite quantitative data is not yet available. Furthermore, this is a qualitative comparison of just two case studies of a specific service intervention which limits our ability to generalise beyond Beardstown and Mooretown (and, by extension, England), and the social prescribing intervention, to conclusively assert that the differences identified were due to the financing mechanism rather than wider contextual

factors. However, given that our findings fit with the broader international evidence about SIB management practices (Fraser et al. 2018a), and are nested with a broader debate about governance archetypes, we feel that these limitations do not diminish our contribution to the emergent evidence around social prescribing, SIBs, and the wider study of public policy, management and governance.

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