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

Mental Health and Employment Partnership (MHEP)

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Commissioning Better Outcomes Evaluation

COMMUNITY FUND

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Contents

Foreword

By Samantha Magne, Knowledge and Learning Manager at The National Lottery Community Fund

You are about to read the probing, summing-up of a key story in the Commissioning Better Outcomes (CBO) Journey. It will give you an in-depth look at a key Social Impact Bond (SIB) within CBO's community of initiatives commissioned by local public services.

A SIB is the art of using social investment to combine de-risking commissioners through Payment by Results (PbR), with the de-risking and sustaining of contracted delivery providers through the provision of capital. The MHEP (Mental Health and Employment Partnership) story reveals some highs and lows of applying the SIB concept – and explains how far its commissioners, providers and investors got, in their own unique context, in making, managing, and demonstrating the difference their intervention aimed to achieve. The story concludes by revealing their journey's legacy. It explains its importance for the broader 'so what?' and 'what next?' picture of outcomes-based approaches to commissioning.

This stuff matters because everyone involved cares about the quest to make pursuit of outcomes the heart of what they do. We all set out with big ambitions; the prize was SIBs would help public and social organisations overcome administrative and financial constraints blocking early action on entrenched social needs. To make that happen, ideas about how bringing public, social and private sectors' interests to the table were required, to get money flowing where it was needed.

You will see it is not easy to pull off and maintain the robustness of SIBs' driving-logics. And whilst our top-up offer has been a significant draw to the quest, ranging from sometimes leveraging much larger co-funding for innovation, to encouraging more attention on performance for existing work, such incentive can also work to distort the picture of demand for PbR and capital. There are important lessons to take home, whether you are interested in this social policy area or the evolution of outcomes-oriented approaches to commissioning. As SIBs morph into new outcome mechanisms, be alert to the strengths and weaknesses of their logic.

This SIB's story illustrates just one of several ways CBO SIBs attempted to configure their approaches to managing money, relationships and learning for achieving and being accountable for better outcomes. We suggest you pick out successes and cautionary tales at two levels - the intervention's delivery and the SIB mechanism's configuration - noticing where these intertwine.

There are rich pickings in the report. CBO, as a catalytic co-commissioner paying for results, has taken away key reflections including:

Policy Takeaways:	Intervention Approach	SIB Structure & Effect
Highlights	Individual Placement Support (IPS) is an evidence-based model supported by 22 randomised controlled trials. If providers work in the right conditions, fidelity to IPS can help people overcome barriers around mental health to access employment as part of recovery. When MHEP1 providers received sufficient referrals, they found employment opportunities for most of their clients.	The first set of MHEP's suite of projects (MHEP1) was treated by its instigators as a test-and-learn exercise to hone a SIB structure which DWP (Department for Work and Pension) could emulate in future. This led to the lowlights below, but Social Finance (SF) refined their understanding of how to translate the IPS evidence base into scenario modelling, to later persuade new stakeholders to introduce the IPS service in 8 new areas
Lowlights	IPS is a service model that explicitly depends heavily on well-functioning collaboration between co-located multi-disciplinary teams, and on stability of high-quality client relationships with experienced staff. Both are known risk factors, yet the commissioners and MHEP were reactive in addressing the related risk and impact of restructures in the services' host Community Mental Health Teams (CMHS). The weak relationship with CMHS impacted on referrals, on the SIB's functioning, and on provider's staff recruitment and retention. This lack of pro-activity was disappointing given CCGs (Clinical Commissioning Groups) were involved in the commissioning partnerships in all 3 MHEP1 areas and, development funding had been invested in MHEP's set-up research and business planning.	It may be that Social Finance intended the SIB to help providers adjust to PbR and use it to increase impact. Yet they did not structure it to pay providers originally for results: providers were to be funded predominantly on payment from local commissioners for *inputs* (engagements generated by referrals), over which providers had limited control. Engagement payments were set to be paid en bloc and in advance. From 2015/16, most financial risk in MHEP was thus, unusually, carried by commissioners. From 2017 there was an evolution of the payment structures, and this differed across the three boroughs. These changes addressed some concerns about managing emerging referral and performance difficulties and internal cashflow arrangements of the SIB from the perspective of MHEP, but did not ease cashflow difficulties for providers as much as intended and left them still exposed to issues of low referral rates. CBO did not have full sight of all the funding structures and cashflow within them, making it hard to extract clear learning points. Providers flagged that this experience indicates that in so far as SIBs are designed to leave community providers exposed to PbR, this should be no more than 25% of the cashflow to them.

Policy Takeaways:	Intervention Approach	SIB Structure & Effect
Questions	The National Lottery Community Fund's interest in employment support has been significant. We have explored this in setting up the Building Better Opportunities grant programme, as well as in CBO. Both produced significant volumes of performance data, despite one being an in-advance actual costs payment model, and the other driven by PbR. IPS reminds us that success hangs on the quality of relationships between service users and their staff; but can this be counted? If parties are concerned about measuring what creates the conditions for success, would it be more apt to test government inputs to employability services, to check if they meet criteria for empowering quality relational working conditions?	We have learned that PbR co-commissioning programmes, such as CBO, may have an unintended effect of attracting local commissioners to join PbR schemes perhaps driven more by the promise of extra funds than strong interest in PbR design (or in using SIBs' capital logic to service its funds-flow management). This is especially so when finance intermediaries offer SIBs as packages that come with this co-funding and a promise of reducing commissioner management burden. A key question we posed for the MHEP evaluation was whether MHEP would continue without co-commissioning. Once CBO's successor programme (the Life Chances Fund) ends, MHEP's journey may too, as NHSE (NHS England) is rolling out IPS under a national scheme. Social Finance has benefitted from the opportunity of setting up MHEP, to gain experience of IPS and win the contract to supervise the NHSE new IPS Grow roll-out – which will not be using PbR. Questions now more generally are whether DWP, albeit with its continuing interest in PbR, has recognised PbR does not serve all employment policy challenges well and, noted this report's advice from charities to limit PbR to no more than 25% of a contract's total costs (which is largely accounted for by SIB and prime overheads).

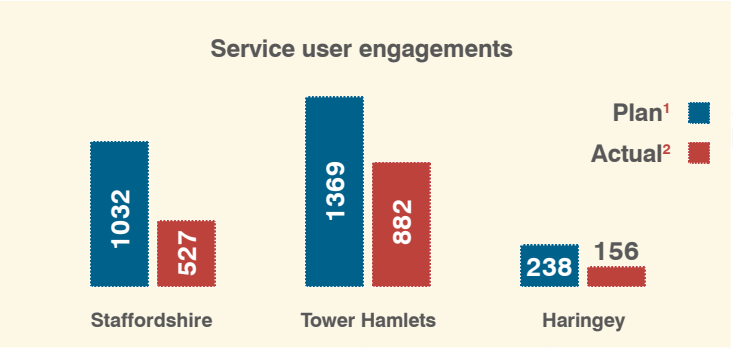
We recommend you look out too for the evaluation's in-depth reviews of eight other CBO SIB journeys and, the final programme-level report. It will combine important insights about the realities, politics and economics of deciding how to commission for better outcomes and point to 'where next.'

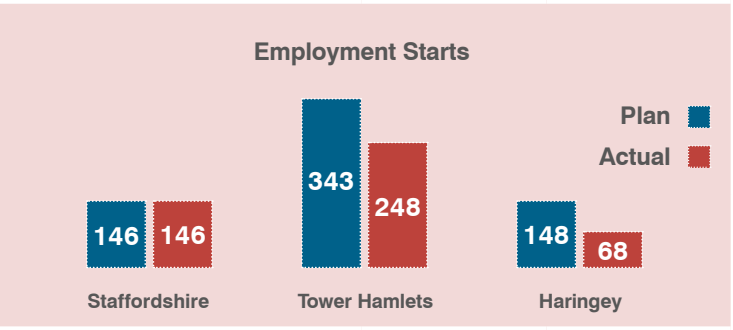
We are sharing these reports on the Government Outcomes Lab (GO Lab) website – sign up there for updates!

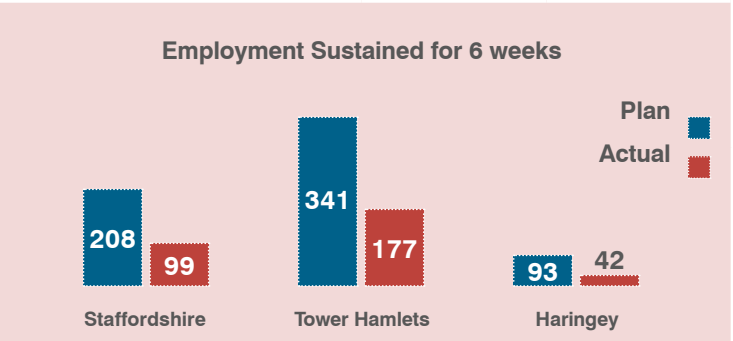
1.0 Executive Summary

Project focus and stakeholders	
Commissioner(s):	Staffordshire County Council and CCG Tower Hamlets CCG London Borough of Haringey and Haringey CCG
Service provider(s):	Making Space (Staffordshire), Working Well Trust (Tower Hamlets) Twining Enterprise (Haringey).
Intermediary or Investment Fund Manager	Social Finance
Investor(s):	Big Issue Invest via its Social Enterprise Investment Fund
Intervention:	Individual Placement and Support
Target cohort:	People with severe mental health conditions engaged with community mental health teams
Period of delivery	January 2016 – March 2020

Project achievements







Payments and Investment	Plan	Actual
Outcome payments	£2,785k	£2,014k[3]
Investment committed	£400k	£400k
Investment return[4]	£112k	£118k
Internal Rate of Return[5]	8%	8%
Money Multiple[6]	1.28	1.29

1.1 Introduction

The Commissioning Better Outcomes (CBO) Fund is a social impact bond (SIB) programme, funded by The National Lottery Community Fund, which aims to support the development of more SIBs and other outcomes-based commissioning[7] (OBC) models in England. The National Lottery Community Fund has commissioned Ecorys and ATQ Consultants to evaluate the programme. A key element of the CBO evaluation is nine in-depth reviews, and this review of the first project commissioned through the Mental Health and Employment Partnership (MHEP 1) is one of these. It is the final review of this project and aims to draw overall conclusions about the success of MHEP 1, its value for money, and the lessons that we think can be learned from it for other projects.

1.2 MHEP overview

MHEP is a vehicle through which local commissioners – Local Authorities (LAs) and/or Clinical Commissioning Groups (CCGs) – can contract for the delivery of specialist employment support for people with mental health needs. This review is of the first MHEP project (known as MHEP 1) and comprises three separate contracts with commissioners in Staffordshire, Tower Hamlets, and Haringey, MHEP has so far enabled the implementation of eight projects[8], four of which cover multiple commissioners, including MHEP 1.

MHEP provides a platform for the commissioning and delivery of Individual Placement and Support (IPS). IPS is an evidence-based, high fidelity intervention that aims to help people living with severe mental health conditions to find and sustain employment. IPS is designed to be integrated into local mental health services via Community Mental Health Teams (CMHTs). This enables the service users to be supported holistically, with IPS employment specialists working as part of the clinical team to support service users living with mental illnesses. The IPS employment advisor is involved in case discussions and offers a personalised / bespoke employment support service to the patient built around their wishes and needs. Once a placement has been made, support is provided to both the new employer and the employee to ensure sustainment.

MHEP as a platform for multiple SIB-type contracts to deliver IPS was conceived and designed by Social Finance (SF). Each MHEP project follows a broadly similar structure although there are differences in the detail, such as the number of commissioners and the way providers of IPS are contracted. We provide further details of MHEP projects and their structure in section 3.1 of this report.

1 Planned' means the amounts included in the CBO grant award. These are based on the 'Median' scenario contained in the CBO application form (sometimes also referred to as the 'base case') i.e. the level of achievement that was thought likely to be achieved.

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

3 Includes additional performance and fee for service payments by commissioners totalling £417,500

4 As explained in the body of the report it is challenging to identify the returns made specifically on investment in MHEP 1 separate from those made across MHEP 1 and 2. Returns on MHEP 1 alone were much lower and probably negative.

5 IRR is essentially a way of converting the total returns on an investment (for example profits made by a business, or in this case total outcome payments) into a percentage rate, calculated over the length of the investment and varying according to cash flow – i.e. how quickly and soon payments are made. IRR calculations are complicated, but in simple terms the earlier you get the money back the higher the IRR, because IRR takes account of the 'cost of money'. For more information see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957374/A_study_into_the_challenges_and_benefits_of_the_SIB_commissioning_process._Final_Report_V2.pdf

6 Money Multiple (MM) is another way of measuring returns. It is simpler than IRR and expresses the total returns as a simple multiple of the amount initially invested. Unlike IRR, MoM does not vary according to when payments are received For more information on both IRR and MM see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/957374/A_study_into_the_challenges_and_benefits_of_the_SIB_commissioning_process._Final_Report_V2.pdf

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

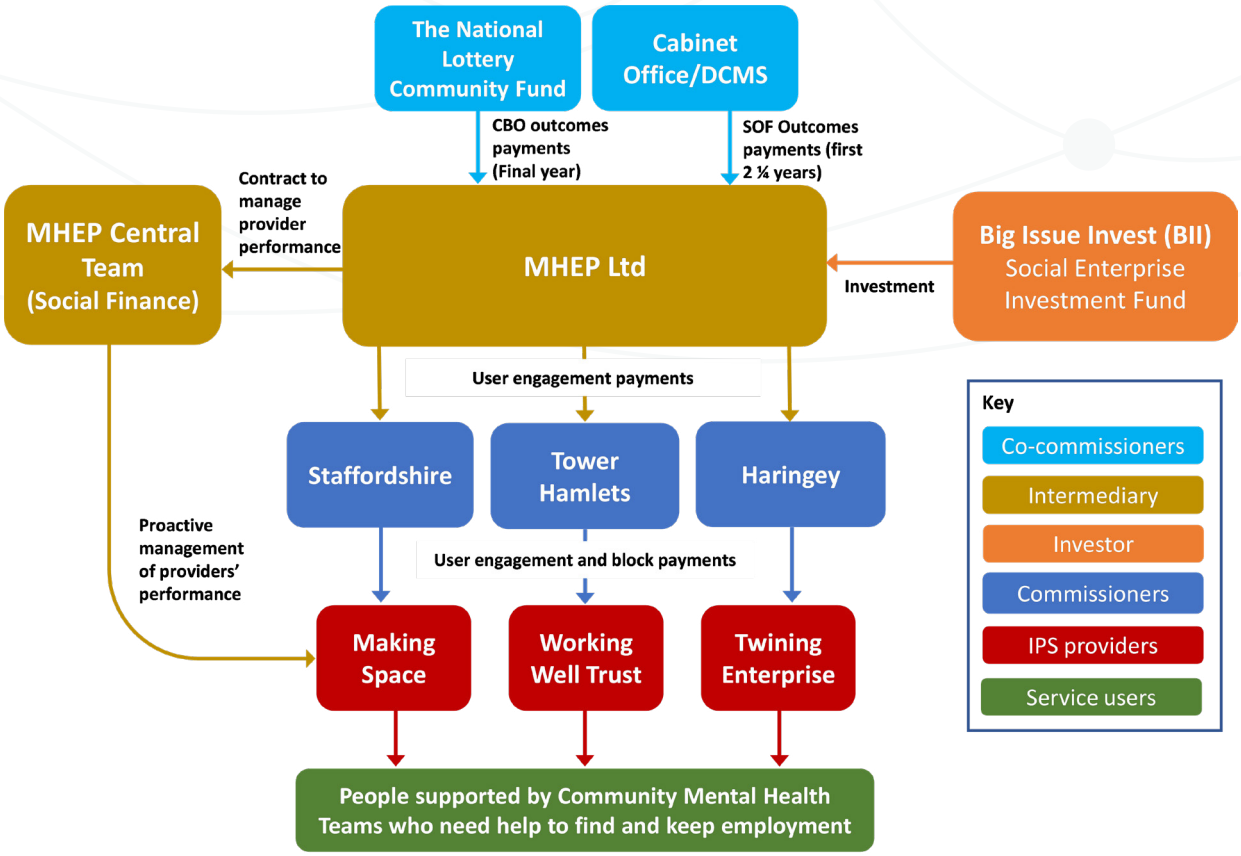
8 This includes one project (West London Alliance Addictions) which funds Individual Placement and Support for those misusing substances rather than with mental health issues. See section 3.1 for more details.

Since MHEP 1 was the first project to deliver the MHEP model, its development involved both the establishment of the MHEP platform and the detailed implementation of contractual arrangements for MHEP 1. In summary the development and implementation process (described in detail in section 3.4) was as follows:

- SF developed the MHEP model following discussion with the Department for Work and Pensions (DWP) about the potential to use SIB-type contracts to fund employability support for those with health conditions or disabilities, including those with mental health conditions.
- This led SF to apply for a development grant of £148,000 from the CBO programme in early 2014, and use part of it to research potential interventions, leading to a clear view that IPS was the most appropriate intervention with a strong evidence base. The development grant was also used to develop outcome metrics, engage providers, commissioners, national policymakers, and social investors, build a detailed financial model, raise capital and design and launch the MHEP vehicle.
- Following discussions with both local commissioners and potential co-commissioners (both the Social Outcomes Fund or SOF and the CBO) SF conceived the MHEP vehicle as a way of enabling bodies to commission and fund IPS services more easily.
- SF applied for co-commissioner funding from SOF and/or CBO (under a common application process for both funds) in early 2015 and received in-principle approval for SOF funding of up to £987k for the first project.
- Following further discussion and resolution of various issues, MHEP Ltd was established as a vehicle with investment from BII, and the commissioners involved in MHEP 1 made firm commitments to it. Subsequently IPS providers were procured in each area (using slightly different processes) with all contracts under MHEP 1 being live by April 2016.

The eventual structure of MHEP 1 is shown in simplified form in the Figure below, and in more detail in section 3.1 of this report. Section 3.5 also provides more details of individual contracts in each area.

Outline MHEP 1 structure (Simplified – see full structure in Section 3)



In overview:

- MHEP Ltd provided overall governance and a vehicle through which various sources of investment and funding could flow through to providers. MHEP Ltd is owned by BII, via a £40,000 equity investment.
- BII also made a loan of £360,000 to MHEP Ltd. to provide start-up and working capital for the first two contracts, MHEP 1 (as detailed below) and MHEP 2, which covered three LA/CCG areas in North London: Camden, Enfield and Barnet.
- SF engaged three commissioners in MHEP 1, as either combinations of LA and CCG or CCG alone. These were in Staffordshire, Haringey and Tower Hamlets.
- These three commissioners, working in partnership with MHEP Ltd, each procured a different provider to deliver the IPS intervention. These were Making Space (in Staffordshire), Working Well Trust (in Tower Hamlets) and Twining Enterprise (in Haringey).
- MHEP Ltd appointed SF to provide contract and performance management support, via the MHEP Central Team, once contracts were in place..
- The payment structure was complicated but under the original arrangements the plan was that local commissioners would pay providers £700 per user engagement), while the SOF and CBO paid MHEP Ltd. £90 per user engagement and agreed amounts for employment outcomes (six weeks of job retention and six months of job sustainment).
- MHEP also provided working capital to providers (to cover start-up and other costs). The intention was that this would be through a further payment of £300 per user engagement, although in practice arrangements varied for each commissioner. The £300 payment only applied in Haringey, with other areas requesting a different model, including upfront block payments covering a defined number of engagements. These payments were funded from the loan capital provided to MHEP Ltd by BII.

1.3 What has happened in practice

As described in our second review of MHEP 1[9], all three contracts faced challenges which led to changes in both operational and contractual arrangements. Since that review, there were further changes in the third year of each contract when they transitioned from being co-funded by SOF to being co-funded by CBO. The changes made were complex and varied for each contract, and we describe them in detail in section 4.1 of this report. In summary:

- Each contract did not achieve the levels of performance expected, especially in terms of referrals and successful user engagements. This caused financial and delivery challenges for providers, and each provider, with support from the MHEP central team, implemented operational changes.
- Each contract was also renegotiated and reset, with new performance targets and changes to payment arrangements between MHEP and the providers.
- These changes enabled the contracts in both Tower Hamlets and Haringey to continue through to their end dates, and led subsequently to a contract extension in Haringey and further contracts in Tower Hamlets.
- The contract with Staffordshire could not be recovered and in October 2018 it was terminated six months early, with existing staff being transferred to an NHS in-house provider, Step On, that was already delivering IPS in North Staffordshire.

The reasons contracts under-performed and had to be reset vary between each site, with some common features. Across all the sites the targets set for each provider for user engagements appear to have been optimistic, and were described by commissioner stakeholders as 'unrealistic'. Providers thus came quickly under financial pressure because their payments were linked to user engagement volumes. There were also challenges, compounded by the PbR mechanism and financial pressure on providers, to maintain adequate staffing levels.

Other challenges included the need to improve operational management (in Staffordshire, where a new service manager was appointed in 2017) and challenges in maintaining fidelity with the IPS intervention protocols. A particular issue, key to the efficacy of IPS, was that the IPS was not fully integrated into local CMHTs, especially in Staffordshire and Tower Hamlets.

According to most stakeholders the MHEP Central Team played a valuable role in responding to these challenges, and supported all the sites in various ways to stabilise and improve performance. MHEP also made changes to each contract's payment mechanism, introducing a payment for job starts (rather than retention for six weeks) and increasing the amount of block payment made to each provider to help with their cash flow.

This combination of operational support and contract renegotiation enabled the contracts in Tower Hamlets and Haringey to continue, helped by support from the respective commissioners. The main reason why Staffordshire could not be turned round appears to have been a lower level of engagement from the commissioner, due in part to the departure of key commissioning staff, and the availability of another provider through whom IPS provision could be continued relatively easily.

The challenges faced by all three contracts are reflected in performance compared to plan. Performance in terms of both total cohort referred to the intervention and total users engaged was well below plan at Median scenario and was, at outturn, below the Low scenario. User engagement, the key driver of payments to providers, was between 51% and 66% of plan, and 59% overall. This shortfall in engagement fed through directly into similar shortfalls against employment targets, although performance against the 'job start' outcome, introduced on contract renegotiation, was somewhat better. Against this target, Making Space achieved 100% of its target of 146 starts in Staffordshire, and Working Well achieved 72% of a target of 243 in Tower Hamlets.

9 See https://www.tnlcommunityfund.org.uk/media/Indepth-Reviews_MHEP_Visit-2_FINAL.pdf?mtime=20190819133237&focal=none pages 10-15

1.4 Successes, challenges and impacts of the SIB mechanism

Across all three reviews of MHEP 1 we identify the following successes of the project that can be attributed to the 'SIB effect':

- ***The ability to create and promote a replicable model***. MHEP was created as a vehicle that would enable multiple commissioners to purchase IPS through an outcomes-based model with local contract flexibility. This objective has been realised, with seven core MHEP projects in place or completed and a further related project – Addictions – covering eight commissioners on its own. We think it unlikely that such a model could have been constructed and implemented without the use of a central delivery vehicle and the deployment of social investment, and therefore right to view its creation and rollout as a clear SIB effect and benefit of the SIB mechanism.

- ***Strong and additional performance management***. Most commissioner and provider stakeholders told us that they valued the role played by the MHEP Central Team in providing external and additional performance management of contracts, and support to providers when they faced challenges. We should caveat that Staffordshire stakeholders had a more mixed view of the value of the team, and it appears that some of the problems faced by these contracts were more structural than operational – and thus could not entirely be solved by performance management however effective it might have been, Furthermore the value of the team needs to be considered in light of its costs (more than £300,000 and over 17% of total costs).

- ***Enabling a wider outcomes-focused culture among providers*** Both Working Well and Twining said that they had benefited from the additional discipline and scrutiny of delivering an outcomes-based contract. This had improved their culture and ability to deliver future contract on an outcomes basis, with the clear caveat, in both cases, that they would not want more than 25% of payment to be linked to results.

The project also faced challenges either due to or made greater because it was a SIB. These included:

- ***Optimistic modelling and forecasting of engagements and outcomes.*** A substantial factor in all three contracts falling quickly behind targets was that the original performance targets proved in practice to be unrealistic. In our view this must at least in part be due to 'optimism bias' (a recognised phenomenon in feasibility study and option appraisal) in the business case forecasts, although commissioners agreed these targets and in Staffordshire the targets were entirely set by the commissioner based on previous reported performance for a similar service.. Providers also exhibited optimism bias when they bid to deliver targets that rapidly proved unachievable, and in one case bid to deliver at a lower price than the proposed outcomes tariff.

- ***Inappropriate balance of risk between providers and MHEP*** The initial design of MHEP – which envisaged providers receiving funding only from user engagements, albeit in part converted to an upfront block payment – appears to have been flawed and to have passed an inappropriate amount of financial risk to providers. Once block payments were expended, providers appear rapidly to have fallen into deficit, so compounding the issues they were already having in mobilising challenging contracts and retaining management and staff. The plan to fund providers solely on outputs then had to be abandoned, and block payments both reintroduced and increased. SF stakeholders argue that subsequent MHEP contracts have learned lessons from MHEP 1, and reduced the risk to providers. We accept this, but MHEP 1 was not explicitly set up as a test and learn project, so the stress for providers and disappointment for commissioners must be seen as a weakness of MHEP 1.

- ***Complex operating and commissioning structures.*** While MHEP was explicitly designed for replicability, the MHEP model appears to have very complex structures and commissioning and payment mechanisms that are hard to

understand even by the standards of SIBs, which are necessarily complex. While much of this is due to a high degree of variation at local and individual contract level, to accommodate local commissioner preferences, the core design of the SIB is itself complicated in such matters as the way payment is made to providers. We also note that other SIBs that we have reviewed which were designed for replicability – such as the Positive Families Partnership[10], and HCT Travel Training[11], were arguably able to replicate contracts with less complexity, and more standardisation, in part because their core structure was deliberately kept as simple as possible.

Overall we find it hard to conclude that MHEP 1 on its own represented good value for money, although as we argue below it provided huge learning that SF and others were able to apply in subsequent, more successful MHEP projects. Commissioners were attracted to it by the opportunity to test bringing together national and local funding to fund employment services, given that there are both local and national benefits from the outcome. It also provided the opportunity to maintain and expand existing services which were under cost pressure, or in Haringey's case develop IPS services for the first time. However, the outcomes achieved fell well short of what they were led to expect, and they had to put considerable effort into maintaining services or, in Staffordshire's case, rescuing the service by absorbing it into another contract. While both the other commissioners, and all providers valued the support provided by the MHEP Central Team, this support added considerably to costs and it is hard to see how these costs can be justified in terms of additional impact for local commissioners or service users (though stakeholders argue that total SIB costs, at 23%, are comparable with, or lower than the share of costs accounted for by prime contractors on national employment programmes). In addition, the payment structure and the complex way funding was channelled to providers appears to have made it more difficult for them to deliver effectively.

1.5 Legacy and sustainability

MHEP scores well in terms of both local legacy and national sustainment, since:

- MHEP as a model has now been replicated across a further seven projects, including Addictions, though each one has had to be adapted to local conditions, limiting the easy replicability and scalability of the MHEP model.
- Two of these projects are extensions or new projects initiated by commissioners of MHEP 1, Haringey (extended into MHEP 3) and Tower Hamlets (commissioner of both MHEP 6 and 7).
- Although Staffordshire did not conclude the MHEP contract it has continued to commission and fund the IPS intervention. In addition, the County Council has since commissioned other outcomes contracts.

A wider legacy of MHEP is in the influence it has had on the wider adoption and funding of IPS as an intervention by NHS England (NHSE), through the initiative known as 'IPS Grow'. The evidence provided for the value of IPS by early MHEP projects did not directly influence NHSE to adopt IPS and roll it out more widely; since it had already made its own judgement on the efficacy of IPS by the time MHEP 1 was implemented. According to both NHSE and SF stakeholders, however, lessons learned from MHEP were influential in the development of the rollout and SF and the MHEP team were consulted during the development of NHSE's plans. In addition, SF has been actively involved in the implementation of IPS since 2019, following selection through open competition.

10 See https://www.tnlcommunityfund.org.uk/media/insights/documents/CBO-Positive-Families-Partnership.pdf

11 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_Indepth_reviews_HCT_independent_travel.pdf?mtime=20190320122439&focal=none

1.6 Conclusions

Overall, it is difficult to evaluate MHEP 1 and the extent to which it benefited from being a SIB, for two reasons.

- First, some of the benefits of MHEP 1 to commissioners and providers were not strictly benefits of the SIB mechanism. Commissioners were attracted by the benefits of additional funding (from SOF and CBO) as well as by the opportunity to test the effectiveness of combining national and local funding to deliver targeted employment support . Providers saw benefit in in learning to deliver IPS through outcomes contracts, but also in improving their operational capacity and capability to deliver IPS irrespective of funding mechanism.
- Second, some of the benefits of the MHEP model appear to have come through more strongly in subsequent MHEP contracts, which stakeholders observe were able to learn from the missteps made on MHEP 1, and adopt a better payment structure with a better balance of risk, especially for providers. Since a total of eight contracts delivering IPS have now been implemented through the MHEP platform, it is hard to argue that MHEP as a whole has not been successful.

However this overall positivity about the MHEP model cannot entirely excuse the shortcomings of MHEP 1, even though it achieved good outcomes for service users, and both Haringey and Tower Hamlets chose to commission further IPS services through the MHEP platform.. In particular:

- The levels of performance achieved by MHEP 1 fell far short of what local commissioners were promised, and therefore the impact of the project on local communities and individuals was relatively disappointing. There was also a vicious circle of performance shortfall leading to lower-than-expected engagement payments and thus to an inability to recruit sufficient high calibre staff – damaging performance further.
- Providers similarly faced challenges when they were unable to achieve the user engagement targets set. They were well supported to address the challenges they faced by the MHEP Central Team, but might not have needed so much support if the targets they were set had not been so challenging, and apparently incorrectly calibrated.

In our view the root causes of these issues can be traced back to the initial design and development of MHEP, and especially to the fact that the original business case assumptions around achievable levels of user engagement and employment outcome were either incorrectly calibrated or were not stress-tested sufficiently before MHEP 1 launched. Partly as a result it achieved only 59% of planned levels of user engagement and 60% of planned employment outcomes overall.

From the point of view of testing IPS in a UK context this was understandable, since the previous studies provided relatively little data on likely outcome performance,. Moreover some of the targets were the choice of local commissioners, notably in Staffordshire, and were set by reference to previous claimed performance – by the same provider – which in practice turned out to be unreliable. MHEP stakeholders reasonably argue, therefore, that MHEP 1 provided learning which has been fundamental both to successor MHEP contracts – especially those supported by the LCF – and to shaping wider market expectations of IPS performance.

The issue with this is that MHEP 1 was not set up explicitly as a test and learn project, or promoted to potential commissioners on that basis. This meant that there was inevitably some disappointment when performance was well below expectations. It also meant that that the MHEP model, which provided working capital to providers based on user engagements, did not insulate the VCSE providers sufficiently from financial risk. This led to a downward spiral of additional pressure, increasing staff turnover and the creation of further undershooting of performance targets.

In this context the efforts made by the MHEP Central Team to resolve the issues were admirable, but they beg two important questions

- First, while SIBs are good at resolving operational and performance issues, due to well-resourced performance management teams and the alignment of interests between commissioners, providers and investors, ***are they sometimes resolving problems that they have themselves partly created?*** – in this case through a complicated funding and payment structure which had to be largely unwound later.

- Secondly, ***is the additional cost and effort involved in such performance scrutiny justified by the impact achieved*** – when compared to either a conventional contract or simpler outcomes-based structure.

Finally, MHEP as a replication model appears to show some of the benefits and disadvantages of such models that we have seen elsewhere:

- On the upside, such models make it easier for commissioners to engage at minimum risk and cost to them, compared to contracts that they lead and design themselves from the 'bottom up'.

- On the downside, commissioners may not fully consider the value for money of such a model, compared to alternative ways of contracting for the same intervention, especially when the model comes with almost guaranteed co-funding attached.

In light of these issues a further question is whether commissioners could have achieved the benefits of MHEP in different and more direct ways. Most obviously, commissioners could themselves have applied to CBO for development grant and to SOF and/or CBO for top-up funding, either for a simple PbR model or for their own 'commissioner-led' SIB. They could then have contracted directly with providers, using a similar mix of block and outcome payments but in a much simpler structure. Equally providers could have sought working capital direct from BII or another social investor. This might not have suited all commissioners because it would have inevitably have required more time and effort than joining MHEP, or providers because of the financial risk. Arguably, however, the risk would have been no greater, and the contracts and payment arrangements much simpler, than those they had through engagement in MHEP 1. There would however have been costs to the commissioners and providers in such arrangements, for example in arranging their own contract management which would diminish some of the benefits.

In terms of lessons for other projects, we would highlight the following:

- ***Aim to avoid 'optimism bias in developing a business case for a SIB.*** This not only has a direct financial impact when over-optimistic targets are missed, but also imposes a further burden as adjustments are made to contracts and operations to mitigate that impact and re-calibrate the modelling. We have seen such optimism bias across a number of the SIBs that we have reviewed, and it appears to reflect both a natural tendency for providers to 'aim high'; and a specific tendency for SIB designers (including commissioners) to stretch assumptions in order to make the financial and social case more compelling. While in this and other cases stakeholders argue that performance cannot be accurately predicted when a business case is prepared, this is an argument for building in further allowance for possible optimism bias, not less. Equally, we accept that optimism bias is not confined to SIBs – and national employment programmes have consistently over-estimated performance – and that in SIBs there is at least direct accountability for correcting any overestimation of performance

- ***Assess the true value of pro-active support from a performance management team.*** Such performance management has become a feature of many SIBs and it clearly has benefit in protecting the interests of investors and fund managers. We believe it is important for commissioners in particular to carefully consider the true value for money of such support, since in provider or intermediary-led SIBs such as MHEP it is sometimes presented to them as part of the package, making it harder for them to evaluate its cost. However they need to take account of the costs that they would otherwise incur themselves – in contract management and themselves taking responsibility for performance and (when co-funding is involved) in validating and reporting outcomes and claiming payments.

- ***Ensure all parties understand fully the balance of risk sharing between investors, intermediaries, and service providers*** The MHEP 1 SIB transferred a significant proportion of risk to providers by linking most payment to challenging targets for engagement with the IPS intervention. This is similar to many of the SIBs we have reviewed, which sometimes link provider revenue to an aspect of performance, usually outputs such as the generation of referrals or successful engagement, This is not in itself a bad thing, since it incentivises provider performance, but it can be an issue if providers suppose that, like some SIBs, they are free of financial risk and it is being borne wholly by the investors and/or their intermediary. It is therefore important that providers and other parties understand and accept the way that risk is going to be shared with them, and are willing and able to bear that risk.

- ***The importance of effective implementation of a proven intervention.*** Some of the challenges faced by the three MHEP 1 contracts were down to the way the contracts were implemented by providers and commissioners, including poor adherence to defined fidelity protocols for IPS, inability to maintain staffing levels, and the need to have in place effective operational management. While similar challenges would probably have arisen in a conventional contract or in-house service, they arguably matter more in a SIB contract because poor implementation will have a direct and immediate effect on revenue. They also matter if the project is testing the benefits of a SIB model, because it becomes harder to disentangle the effect of the SIB mechanism from the effects of the intervention and how it has been implemented.

2.0 Introduction

This review forms part of the evaluation of the Commissioning Better Outcomes (CBO) programme and is the final review of the first project undertaken by Mental Health and Employment Partnership (MHEP 1). Previous reviews of this project, and other reports from the CBO evaluation, can be found here.

2.1 The Commissioning Better Outcomes (CBO) programme

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

It should be noted that the project reviewed here actually comprises three contracts awarded under what is collectively known as 'MHEP 1' – please see further details below and in section 3.

The aim of the CBO programme is to grow the SIB market and other forms of OBC. It has four objectives:

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

The CBO evaluation is focusing on answering three key questions:

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

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

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

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

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

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

2.3 The in-depth reviews

A key element of the CBO evaluation is our nine in-depth reviews, with MHEP 1 featuring as one of the reviews. The purpose of the in-depth reviews is to follow the longitudinal development of a sample of projects funded by the CBO programme, conducting a review of the project up to three times during the project's lifecycle. This is the final review of the project known as MHEP 1. The first in-depth review[15] report focused on the development and set-up of the contracts that comprise MHEP 1. The second in-depth review[16] report focused on implementation of the project mid-way through its respective contracts.

We have used the GO Lab / Brookings definition of what constitutes a single SIB project: Each impact bond project that begins work under a new outcomes contract, with a new target cohort, a distinct geography, and/or with a later start date is counted separately. MHEP 1 therefore comprises three separate projects and three separate contracts (two with extensions) as explained in detail in section 3 below. However, we refer to **'families'** of projects when they have very similar characteristics (such as the same service provider, same special purpose vehicle (SPV) and/or very similar outcome payment structures). MHEP as a whole is, therefore, a family of projects, outlined in more detail in section 3.

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

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

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

15 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/comissioning_better_outcomes_in_depth_review_190320_122442.pdf?mtime=20190320122441&focal=none

16 See https://www.tnlcommunityfund.org.uk/media/Indepth-Reviews_MHEP_Visit-2_FINAL.pdf?mtime=20190819133237&focal=none

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

The second in-depth review of MHEP 1 also identified areas to investigate further in the final review: We summarise these as follows:

- ***How have the contracts performed relative to expectations?*** Were the initial financial drawdown allocations from CBO and SOF fully utilised, and how closely did outcomes payments match predictions made at the outset? Have the three sites performed differently and if so how and why?
- ***What has been the value of MHEP as a model spanning multiple sites?*** What lessons can be learnt from the different challenges faced by each commissioner and their providers, and position of each site when the MHEP model was introduced? How well did operational knowledge transfer between projects and how did the MHEP vehicle support these processes?
- ***What has been the role and value of the contract management team?*** To what extent has the MHEP contract management team helped both commissioners and providers develop their own capacity to manage outcomes-based contracts, or has it created dependency on that team? Has the cost of management of the SIB provided good value for money and added value compared to alternative approaches to performance management?
- ***How successful has MHEP been as a replicable vehicle for both future contracts and for the roll out of the Individualised Placement and Support (IPS) intervention?*** To what degree can MHEP be considered a SIB, or should it more usefully be thought of as a service-enabling or scaling vehicle? What has been the extent of further commissioner engagement and roll-out of IPS contracts, and what other lessons have been taken on board in this expansion?

For this final review, the evaluation team:

- undertook semi-structured interviews with representatives from nearly all the main parties to the project, including:
  - two of the three lead commissioners of the contracts (London Borough of Haringey and Staffordshire County Council);
  - the three providers of the intervention (Making Space, Working Well Trust, and Twining Enterprise);
  - the organisations who provided commissioning support for the project, namely the CBO team and the Department for Digital Culture, Media, and Sport (DCMS) who assumed responsibility from the Cabinet Office for the Social Outcomes Fund (SOF);
  - Social Finance (SF) in its role as both initiator and designer of the MHEP model, and as the provider of contract management of MHEP 1; and
  - Big Issue Invest (BII) as the lead investor in MHEP and owner of MHEP Ltd.
- reviewed performance data and monitoring information supplied by the project stakeholders to The National Lottery Community Fund; and
- reviewed key documents supplied by project stakeholders.

We also interviewed NHS England (NHSE) in light of the wider implementation, with NHS funding, of the intervention delivered through MHEP contracts, namely Individual Personalised Support.

2.4 Report structure

The remainder of the report is structured as follows:

- Section 3 provides an overview of how the MHEP model works, and describes in more detail how MHEP 1 worked, including the SIB mechanism.
- Section 4 describes major developments and changes in the three contracts since the launch of MHEP 1, including their performance against planned metrics, and stakeholder experiences.
- Section 5 discusses the successes, challenges and impacts brought about by the project, including an assessment of the Value for Money of the SIB mechanism.
- Section 6 describes the sustainment and legacy of the project.
- Section 7 draws conclusions from this review and highlights lessons for other projects.

3.0 MHEP overview

This section describes both MHEP as a model that has been used to manage and implement a number of separate projects, and (in more detail) the set up and structure of MHEP 1.

In overview:

- MHEP is a vehicle through which local commissioners – Local Authorities (LAs) and/or Clinical Commissioning Groups (CCGs)[17] – can contract for the delivery of a specialist intervention known as Individual Placement and Support (IPS);
- MHEP has so far enabled the implementation of eight projects, four of which cover multiple commissioners, including MHEP 1. Both MHEP as a whole and individual projects are technically SIBs because they involve payments to MHEP and individual providers based on the outcomes achieved, and both MHEP as a whole and individual projects are supported by social investment (from BII).
- MHEP 1 was the first project set up under the MHEP umbrella and comprises three separate projects with commissioners in Staffordshire, Tower Hamlets, and Haringey.
- Each contract has its own provider and although the projects are part of the MHEP model there are differences of structure and other features (e.g. outcome payments) between each contract.
- The payment structure was complicated but essentially and under the original arrangements local commissioners paid providers £700 per user engagement, while the SOF and CBO paid MHEP Ltd. £90 per user engagement and agreed amounts for employment outcomes (six weeks of job retention and six months of job sustainment).
- MHEP also provided working capital to providers (to cover start-up and other costs), The intention was that this would be through a further payment of £300 per user engagement, although in practice arrangements varied for each commissioner. The £300 payment only applied in Haringey, with other areas requesting a different model, including upfront. block payments covering a defined number of engagements. These payments were funded from loan capital provided to MHEP Ltd by BII.

3.1 Overview of the MHEP model

The overall financing and organisational structure of MHEP (which applies across all MHEP projects) is shown in Figure 1 below. MHEP 1 was the first project to be initiated within this structure. The development of MHEP as a model and of MHEP 1 as a project are thus intertwined, with MHEP 1 being both the first implementation of the model and to an extent a testbed for subsequent contracts. We provide a much more detailed description of MHEP 1 and its structure in section 3.2. below, and describe the process through which MHEP 1 was developed in section 3.4.

MHEP was conceived and designed by SF but was established as a limited company with investment from BII, and MHEP Ltd. was and still is majority owned by BII. SF has a subsidiary interest in MHEP which confers some voting rights and a seat on its Board.

BII's initial investment in MHEP comprised £40k of equity investment to purchase shares in MHEP, and a further £360k as a loan to MHEP Ltd. repayable at an agreed 8% compound rate of interest. BII invested in MHEP from its second Social Enterprise Investment Fund (SEIF II), which supported a range

17 In July 2022, CCGs were dissolved, and their duties taken on by the new integrated care systems (ICSs), with CCGs ceasing to exist as statutory organisations However CCGs were the commissioning organisations throughout the lifecycle of the MHEP 1 project and we have continued to refer to them as CCGs throughout this report.

of social enterprises to achieve social impact and was not dedicated to SIBs or similar contracts.

The total investment of £400k was intended to provide enough capital to enable the implementation of both MHEP 1 and a second project (MHEP 2) each covering three contracts with three different commissioners. While this review focuses largely on MHEP 1, the financing structure means that this review also considers some aspects of MHEP 2, notably arrangements for the repayment of capital to BII.

The MHEP model and structure has since been used to implement a further seven projects, with BII injecting further tranches of capital (all as loans) on a number of occasions. While these projects are outside the scope of this review (and are supported by the Life Chances Fund or LCF, rather than by the SOF and CBO) we show in Figure 2 below the projects supported through MHEP to date. These include one project (West London Alliance Addictions) which is funded and managed through MHEP but uses a different IPS intervention aimed at those with drug and alcohol issues rather than mental health challenges.

Note also that the six subsequent projects were funded by BII from a different source: BII invested in MHEP 1 and 2 as noted above from its second Social Enterprise Investment Fund (SEIF 2). It has invested in all other MHEP projects from its Outcomes Investment Fund (OIF) a specialist fund set up by BII specifically to invest in social outcomes contracts (SOCs) such as SIBs.

Figure 1 – **Overview of MHEP model (all projects)**

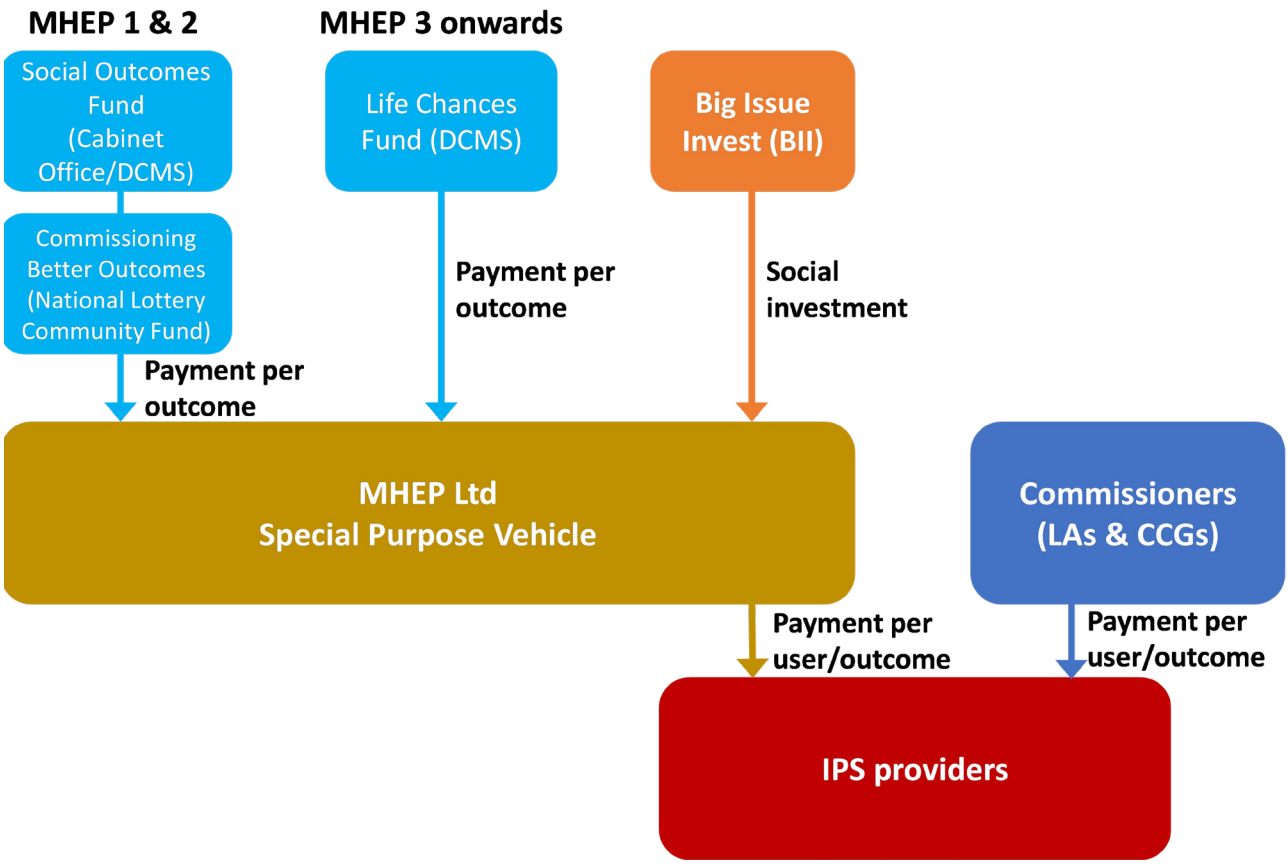
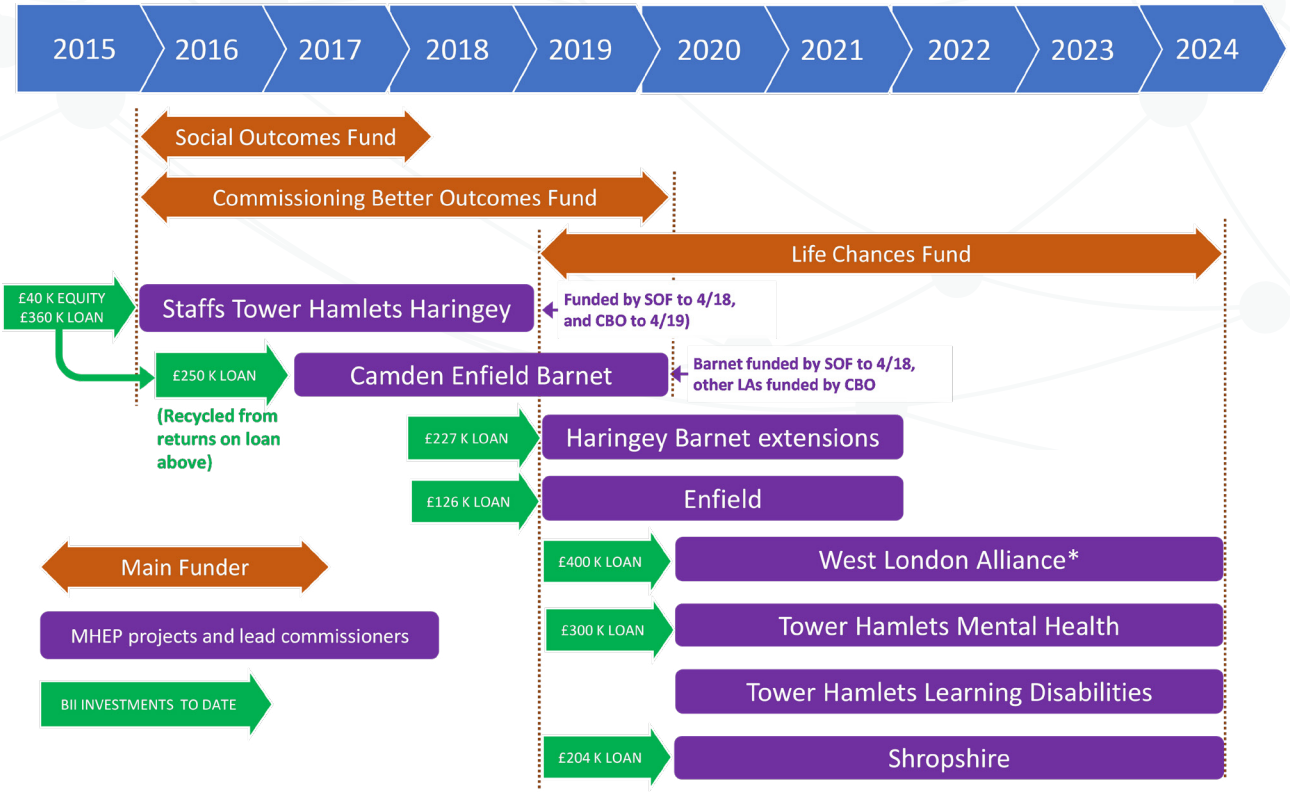


Figure 2: **MHEP projects to date**



* The West London Alliance (WLA) project deploys the IPS intervention to address a different cohort with drug and alcohol issues but the capital from BII has been injected via MHEP Ltd according to MHEP published accounts

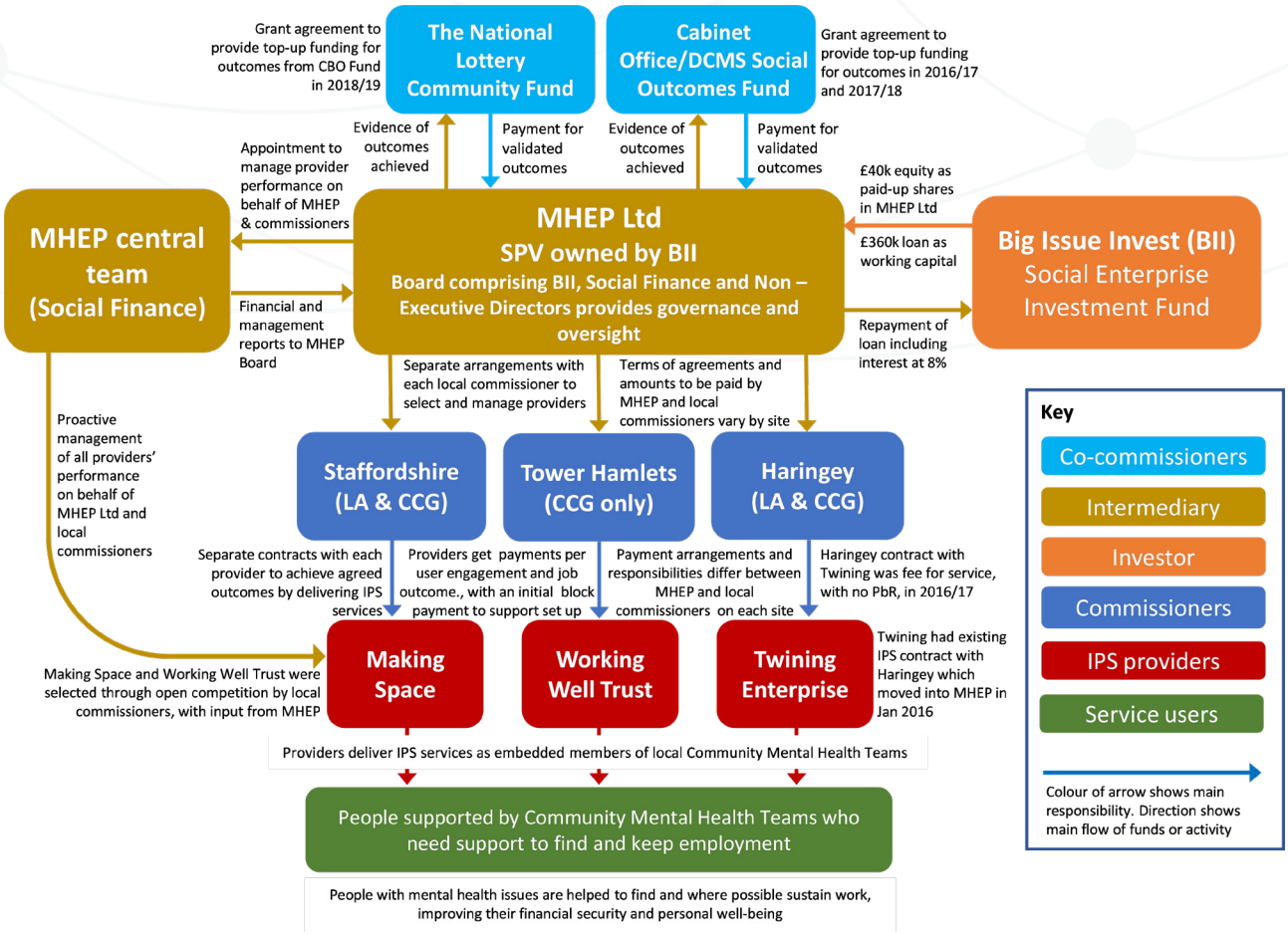
3.2 Set up of MHEP 1 and key stakeholders

The structure of MHEP 1 is complex, both because of the number of parties involved and because the contractual arrangements varied by commissioner and by provider for each contract. Figure 3 shows the key parties, their relationships, and the flow of funding between them. We provide further details of individual contracts in section 3.5 of this report, and describe how they changed over the course of each contract in section 4.

In overview (with further details of arrangements in section 3.4 below) the key stakeholders and their roles were as follows:

- MHEP Ltd provided overall governance and a vehicle through which various sources of investment and funding could flow through to providers. As mentioned above MHEP Ltd was and remains owned by BII, who invested £40,000 in equity in the vehicle on its establishment.
- SF developed the MHEP model and subsequently engaged potential commissioners that were interested in using an outcomes-based model to procure providers of the IPS intervention. SF also provided contract and performance management support once contracts were in place. They were appointed to this role by MHEP Ltd and worked under delivery agreements with each commissioner.

Figure 3: **MHEP 1 structure and operational flows**



- SF engaged three commissioners in MHEP 1, which were either combinations of LA and CCG or CCG alone. These were:
  - Staffordshire County Council and Staffordshire CCG (collectively referred to in this report as Staffordshire). Staffordshire County Council was the lead commissioner and contracting party;
  - the London Borough of Haringey and Haringey CCG (collectively referred to in this report as Haringey). Again, the local authority (London Borough of Haringey) was the lead commissioner and contracting party; and
  - Tower Hamlets CCG (referred to as Tower Hamlets).
- These three commissioners, working in partnership with MHEP Ltd, procured one different provider each to deliver the IPS intervention. The procurement arrangements were different for each contract and are described further in section 3.4 and 3.5 below. These three providers were Making Space (in Staffordshire), Working Well Trust (in Tower Hamlets) and Twining Enterprise (in Haringey). Each provider had different payment arrangements and we describe the payment structure in more detail in section 3.5.
- BII provided social investment of £400k to MHEP Ltd. (£40k as equity and £360k as loan) as described above.
- Finally MHEP received part funding of outcomes payments from the SOF and CBO. Both SOF and CBO agreed to fund MHEP 1 from the outset, although on different timetables, with SOF funding MHEP 1 for the first two and a quarter years, and CBO funding the project in its third year.

CBO also funded and a fourth-year extension in Tower Hamlets. Initially SOF agreed to pay up to £986,959 over up to three years to April 2018, with CBO agreeing to pay up to £336,111 for 18-19.

Later extensions to Haringey and Tower Hamlets were funded separately, with SOF (£48k) and CBO (£80K) funding a year each in Haringey and CBO (£88K) covering the extra year in Tower Hamlets,

3.3 The intervention model

The Individual Placement and Support (IPS) intervention[18] is an employment support service. designed to be integrated within local Community Mental Health Teams (CMHTs) for people who experience severe mental health conditions. It is an evidence-based programme that aims to help people find and retain employment.

IPS is also an intervention which requires a high degree of implementation 'fidelity' – i.e. the degree to which an intervention is delivered as intended to ensure successful translation of evidence-based interventions into practice[19]. Successful implementation of IPS requires fidelity to a number of factors including caseload per person delivering it, boundaries of the work done by the employment advisor etc: the UK IPS Fidelity Framework specifies 25 criteria against which fidelity should be assessed[20].

An important aspect of IPS fidelity and one considered key to its success by practitioners, is its integration into and co-location with local mental health services via CMHTs. Co-location enables IPS employment specialists to work as part of the clinical team to support service users who may have experienced mental illnesses including psychosis, bipolar disorder, major depression, or a personality disorder. Members of the clinical team can ask for advice and guidance about a service user who is accessing employment support, which means the person is supported holistically.

The IPS employment advisor is involved in case discussions and offers a personalised / bespoke employment support service to the patient built around their wishes and needs. Once a placement has been made, support is provided to both the new employer and the employee to ensure sustainment, help with any adaptations, and build up mutual confidence between all parties.

As outlined further in section 3.4 below, there is a substantial evidence base for the effectiveness of IPS which was a key reason for its selection during the MHEP development process.

3.4 History and development

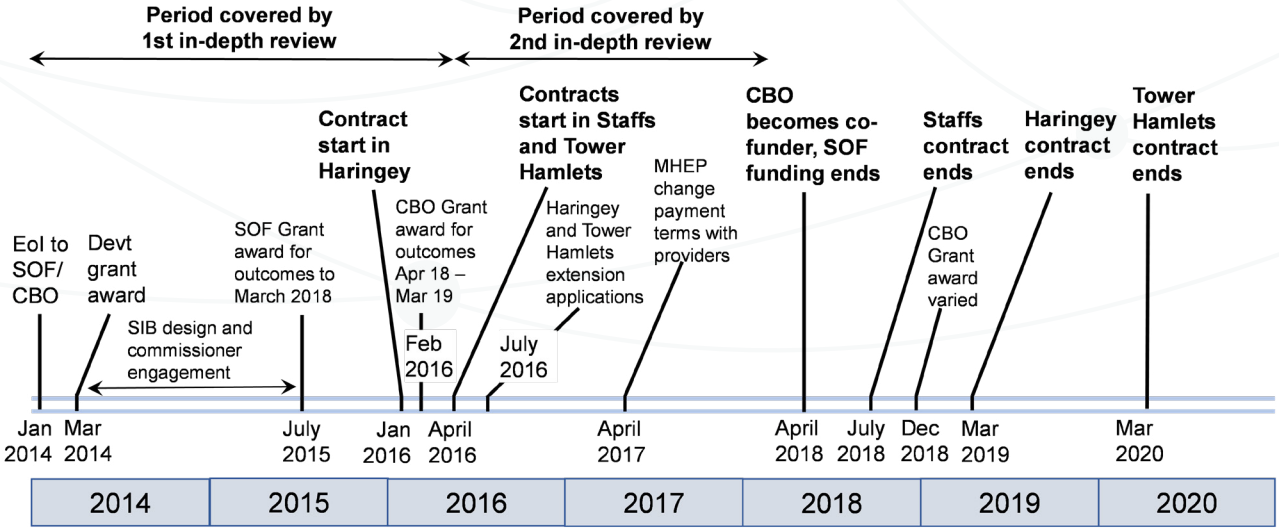
This section describes the process of development of MHEP as a vehicle and of specific contracts with each local commissioner and provider. It first provides an overview of key milestones and activities across the development of MHEP (and MHEP 1 as its first manifestation) as a whole. It then provides further details of the initial contracting arrangements in each local area. The key milestones over that period are described below and Figure 4. provides a timeline of key events. As this shows the majority of the development work was done between mid - 2014 and April 2016, when all three contracts that comprise MHEP 1 were fully implemented..

18 This description of IPS is a summary of information from the NHS England website, which provides further information at https://www.england.nhs.uk/mental-health/case-studies/severe-mental-illness-smi-case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/

19 See for example https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3409469/ for an evaluation of fidelity

20 See for example this IPS assessment framework from the Centre for Mental Health Training https://www.centreformentalhealth.org.uk/sites/default/files/fidelity_review_form_uk_-_updated_dec_2018.pdf

Figure 4 – **Timeline of key events**



3.4.1 Development timetable and key milestones

3.4.1.1 Quarters 1 and 2, 2014.

During mid-2014, SF was in discussion with various parts of central and local government about potential new areas where the application of social investment and SIB-type contracts might be appropriate. One of these was with the Department for Work and Pensions (DWP) which was interested in potential interventions for those furthest from the employment market and 'hardest to help', in particular those with physical and mental health conditions.

A particular issue was that the Work Programme[21] (which used a payment by results approach to support people into work) had shown only a marginal improvement in outcomes for people with mental health conditions. In effect, there was a perceived 'gap' in service provision for this cohort.

This thinking led to a development grant application to the CBO programme by SF in January 2014, and the award of a grant of £148,400 in March 2014, broken down into key activities as shown in table 1 below. . With the benefit of this grant, SF researched the feasibility of using social investment to support a specialised mental health employment intervention, and provided a range of other support to the development and launch over an eighteen month period' According to SF stakeholders this support included engagement with providers, commissioners, national policymakers, and social investors, a cost-benefit analysis, including developing a bottom-up tax and benefits model; designing and launching the MHEP vehicle; and raising capital from investors.

21 The Work Programme was a payment-by-results programme launched by the then Coalition Government's throughout Great Britain in June 2011. It was delivered by a range of private, public, and voluntary sector organisations supporting people who are at risk of becoming long-term unemployed to find work. It replaced previous Labour government programmes such as the New Deals, Employment Zones, and Flexible New Deal.

Table 1: **Breakdown of Development Grant to SF**

Activity	Funding agreed
Metrics	£37,300
Investor / Commissioner Engagement	£21,800
Legal Advice / Support	£27,400
Research	£61,900
Total	**£148,400**

In researching possible interventions, SF found that only one, IPS, had a significant body of evidence as to its effectiveness in supporting patients with mental health conditions into sustained employment. SF found that there were (at that point) 22 randomised control trials whose results showed approximately twice the success rate for IPS when compared to other programmes/interventions or to no intervention. According to one senior SF stakeholder

"We did a very detailed review of the academic evidence base for IPS, including engaging with the US pioneers of the model, the UK pioneer (Rachel Perkins), the academic that led the European IPS trial (Tom Burns), and the Centre for Mental Health. We also engaged extensively with all the leading IPS providers at the time – including CNWL, Southdown, and Dudley & Walsall."

3.4.1.2 Quarters 3 - 4, 2014

Based on this evidence, SF approached both central Government and the NHS to find commissioning interest. DWP was the logical commissioner given its interest (both policy and financial) in people with mental health needs entering and keeping work. In late 2014, however, DWP was not in a position to commission or fund an IPS service centrally and it and other government departments were not eligible for support from either SOF or CBO, so the focus for seeking commissioners fell on local health and government organisations. NHS England was supportive and helped promote the proposition to local CCG commissioners, Mental Health Trusts (MHTs) and other health bodies. SF was also able to engage with LA commissioners given the scope for joint commissioning and funding across LAs and CCGs.

There was also interest from the Cabinet Office in supporting the proposition via the SOF since it was one of the key objectives of SOF to provide funding on behalf of central government departments that benefited from outcomes achieved by SIBs and outcomes contracts but were unwilling or unable to fund those outcomes directly – as DWP was in this case. According to SF stakeholders MHEP was expressly designed from the outset to test the potential to combine national and local funding on employment programmes for people with additional barriers. Their central hypothesis was that national programmes (with £billions of funding) were not achieving good outcomes for those with additional barriers, and local programmes were sub-scale because most of the benefit is national. There were very few (if any)

examples of programmes being co-funded nationally and locally, so MHEP was viewed as an important opportunity to test the extent to which central and local funding could be successfully combined.

There was also interest in seeing IPS proven in the UK context which, if successful, might provide the basis for much wider commissioning in the future.

Despite high levels of initial interest from different health and local government commissioners, there were frustrating challenges in gaining the level of solid commitment that would allow the project to apply to SOF/CBO Fund for a contribution towards the outcomes payments, and test the viability of a central/local co-funded approach. In response to this challenge, SF conceived the MHEP vehicle as a way of enabling local commissioners and SOF (and potentially CBO) to jointly commission IPS services and achieve this joined-up approach.

3.4.1.3 Quarter 1 2015

In early 2015 SF submitted a full application for co-commissioner funding from SOF and/or CBO, since at the time of the application the two funds were managed through a common application process, with each successful application funded according to best fit with the respective programme objectives. For both MHEP 1 and 2, CBO and SOF jointly funded the applications at up to 50% of the total outcomes funding.

For MHEP 1, reflecting its objectives above of providing substitute funding for other government departments and enabling interventions with promise to be rolled out at greater scale, SOF approved in principle co-commissioner funding of up to £986,959 in March 2015. This positive commitment by SOF proved to be key in helping reach agreement with local commissioners over the next two quarters.

In line with the joint funding approach the CBO team (which managed the application process to both SOF and CBO) was also considering a CBO contribution to MHEP. However, the March 2015 CBO panel (comprising a mix of internal and external appointees[22] that decided on awards) deferred its decision pending:

- SF securing commitment from the local commissioning partners with whom it was in discussions; and
- resolution of issues surrounding the MHEP structure. Essentially CBO was concerned about potential conflicts of interest if SF was both owner of the MHEP vehicle (and therefore managing delivery) and designing new contracts with local commissioners.

3.4.1.4 Quarters 2 and 3 2015

With SOF having given both in-principle approval to support MHEP, and final approval in July 2015, there were three major developments in the second and third quarters of 2015:

1. SF was able to secure commitment to MHEP from Staffordshire and Tower Hamlets as local commissioners and conclude Memorandum of Understanding (MoU) agreements with them. We provide further details of the background to these decisions in section 3.4.2 below.
2. SF engaged with social investors and between July and October 2015 secured £400k of capital investment in MHEP from BII. The purpose of this investment was primarily to fund MHEP's contribution to engagement payments for providers, and working capital for MHEP until outcome payments were generated. We explain the basis of payment and balance of risk between investor, MHEP and providers in sections 3.5 and 3.6 below.

22 All applications for CBO funding were considered by a panel comprising two members of the England Committee of The National Community Lottery Fund (then the Big Lottery Fund), two investors, two providers and two commissioners. One of the England Committee members chaired the panel and had the casting vote on tied decisions.

BII found the MHEP investment proposition was unusual in the amount of research and development work that had been undertaken before and through the SOF/CBO application process, thanks to the development grant award. Partly because of the work already done, the decision process for BII was a relatively short four-month period from end to end. Although there were other social investors reviewing the MHEP opportunity at the same time, BII found the proposal attractive and was in a position to make a rapid investment committee decision.

3. The third major development was resolution of the CBO team's concerns about the structure and ownership of MHEP. This appears have been resolved by BII taking ownership of the MHEP vehicle, rather than SF, through the injection of £40,000 of equity.

In light of these developments CBO gave approval in principle to a grant award covering Staffordshire and Tower Hamlets of up to £336,111 in outcome payments in October 2015. It then gave final approval to the same contribution in January 2016, subject to the award being payable only for outcomes achieved after the SOF-funded period, i.e. after April 2018[23].

3.4.1.5 Late 2015 – Early 2016

In the final quarter of 2015 Staffordshire and Tower Hamlets began the procurement of IPS providers through open competition. This was a joint process between local commissioners and MHEP under the co-commissioning agreements and MoUs put in place with each commissioning authority. MHEP's role included supporting commissioners with the Invitation to Tender (ITT), specification of the IPS service, outcome definitions and outcome payment structures. MHEP also had representation on respective selection panels, given that its viability would depend on the ability of respective providers to achieve outcomes and thereby generate outcome payments.

At this point SF also concluded agreement with Haringey, which was in a different position because it had recently procured an IPS service, through open competition, with in-house funding. The process was therefore one of moving this contract under the MHEP umbrella from January 2016.

The result of these processes was that a contract was in place in Haringey from January 2016 (based on novation of the existing arrangements) and new contracts with providers in Staffordshire and Tower Hamlets went live in April 2016. We provide further details of these initial contracts immediately below.

3.4.2 Commissioner and provider engagement process

This section gives a brief synopsis of the process by which each local commissioner decided to commit to MHEP, how providers were appointed, and the structure and basis of agreement in each area at contract commencement. Further detail of the development process for each commissioner is in our first review. In addition, we provide details of payment arrangements and funding flows in sections 3.5 and 3.6 below.

3.4.2.1 Staffordshire County Council

Staffordshire already had a contract in place for the delivery of IPS in the county when it first engaged with SF about the possibility of commissioning via MHEP in 2015. This contract was let in 2010 after a review of mental health employment support services provision, following which Staffordshire decided to specify IPS and commissioned the service provider Making Space on a block contract for five years. This contract had been a success and Staffordshire was looking at options for re-letting it during 2015.

23 This proviso meant that the original contract with Haringey was not funded by CBO, since on the original timetable the Haringey project was expected to have closed by April 2018.

The Council was also interested in the potential for using social investment and this confluence of interests led to engagement with SF and the eventual agreement to work with MHEP. Staffordshire already understood the IPS delivery model and so how it got funded was the decision point. Stakeholders admitted at the time that the contribution from SOF and CBO was an important deciding factor because it would fund more provision than other contracting arrangements, and enable them to explore the potential for combining national funding (akin to DWP programmes, but funded via SOF) and local funding to grow IPS.

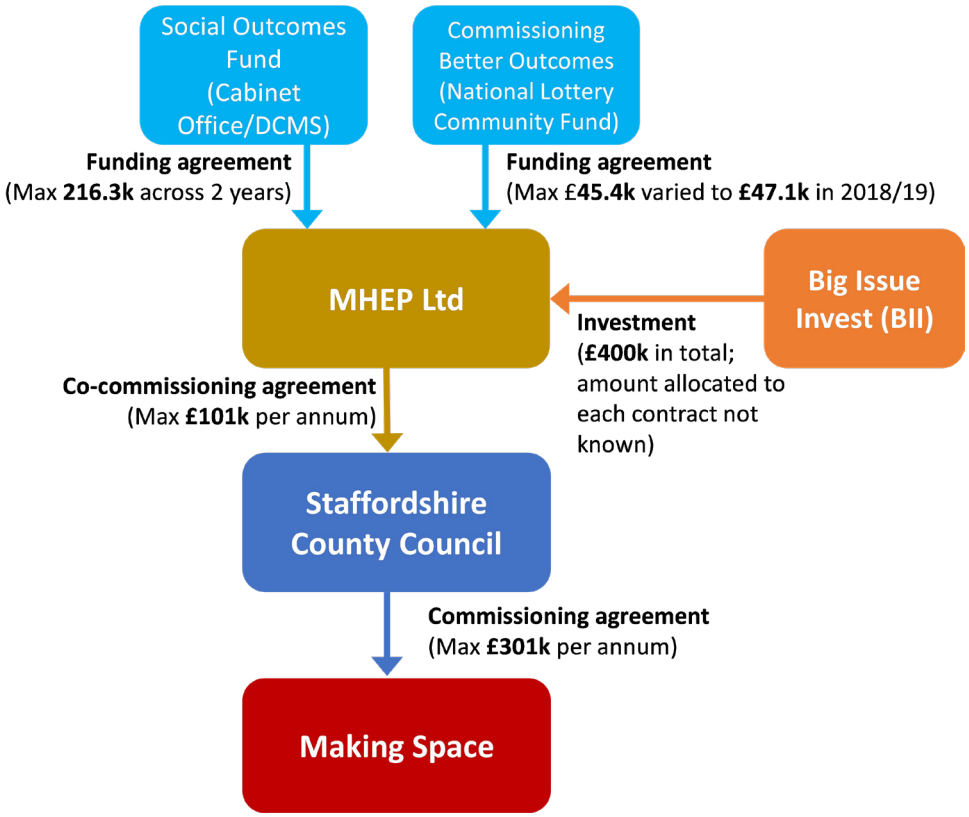
Following the joint procurement process with MHEP described above Staffordshire again contracted with Making Space for three years with an option to extend for a year. The contract started in April 2016.

Figure 5 below shows the structure and anticipated financial flows for Staffordshire at contract start but note that the allocation of SOF and CBO funding to individual contracts was provisional, and based on anticipated referrals. The allocations made by both SOF and CBO were made en bloc to MHEP 1 without reference to specific contracts, and in CBO's case were set at a maximum of 12% of outcome payments as a whole, with SOF paying 38%. There was a funding agreement between Staffordshire and MHEP that defined who paid for which outcomes. Making Space had a single contract with Staffordshire which paid the provider in the first instance and then invoiced MHEP for its proportion of the payments.

Both Staffordshire and MHEP made block payments to providers – paid in advance but contingent on user engagements being achieved – to give providers working capital until engagements started to flow. Staffordshire paid £65.6k as an upfront block payment in 2916/17, and MHEP paid £28.2k. The equivalent payments in 2017/18 were planned to be £65.6k and £27.9k

There was also a Co-Commissioning Protocol between MHEP and Staffordshire that covered the contract management tasks that MHEP delivered as part of its services. As we explain further in section 3.7 and section 4, the MHEP contract management team (referred to in this report as the MHEP Central Team) played an important role in managing performance and seeking to address performance issues during contract delivery.

Figure 5: **Staffordshire contract structure**



3.4.2.2 Tower Hamlets

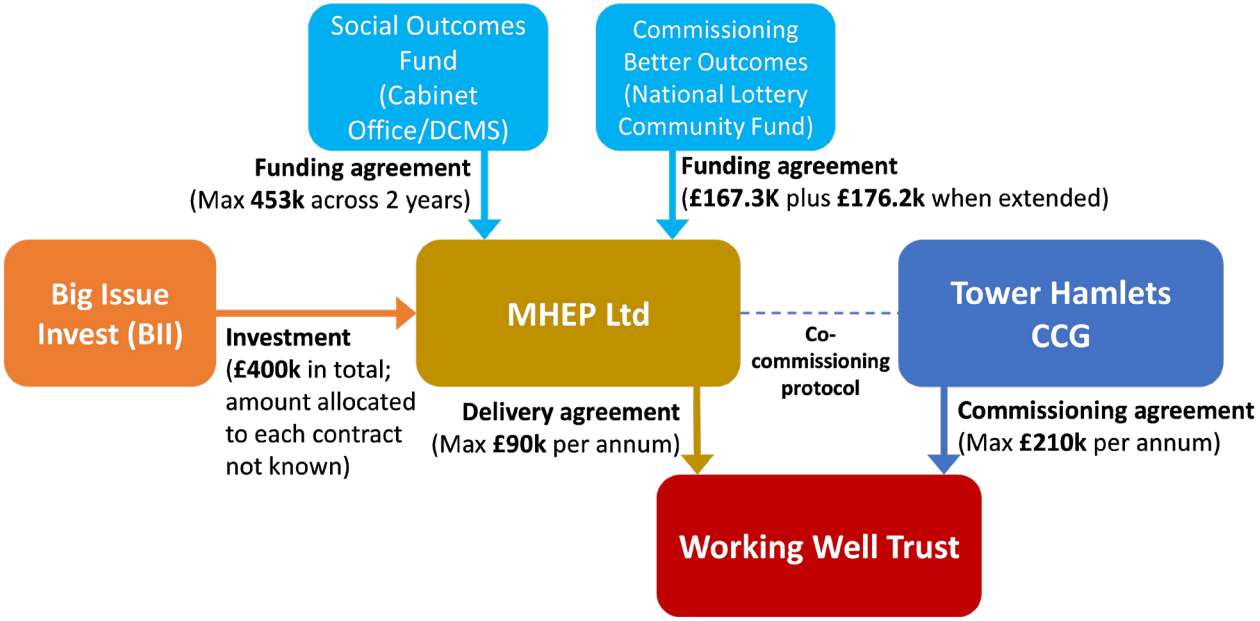
Tower Hamlets was in a similar position to Staffordshire in having an existing contract in place and due to be relet (in April 2016) for employment support to people with mental health issues. It was therefore able to engage with SF with a view to moving to MHEP at that point. In Tower Hamlets' case, the intervention funded through the previous contract was not IPS although it did use a similar embedded worker model, so the precedent for working within the local CMHT was already established.

Having agreed to become part of MHEP 1, Tower Hamlets went through a competitive procurement process and let a three-year contract for IPS services starting on 1 April 2016 with Working Well Trust (Working Well) as its chosen provider.

The structure and financial flows for the Tower Hamlets' contract on commencement are shown in Figure 6 below. Contractual and Invoicing arrangements were different to Staffordshire, with both MHEP and Tower Hamlets paying providers directly for outcomes. There was an MoU between Tower Hamlets and MHEP and technically the provider had two contracts – one each with MHEP and Tower Hamlets. In practice the service specification was identical so from the provider perspective it was effectively working to a single contract.

Both Tower Hamlets and MHEP made block payments to providers – paid in advance but contingent on user engagements being achieved – to give providers working capital until engagements started to flow. Tower Hamlets paid £110.2k as an upfront block payment in 2916/17, and MHEP paid £47.1k. The equivalent payments in 2017/18 were planned to be £110.5k and £47.7k.

Figure 6: **Tower Hamlets contract structure**



3.4.2.3 Haringey

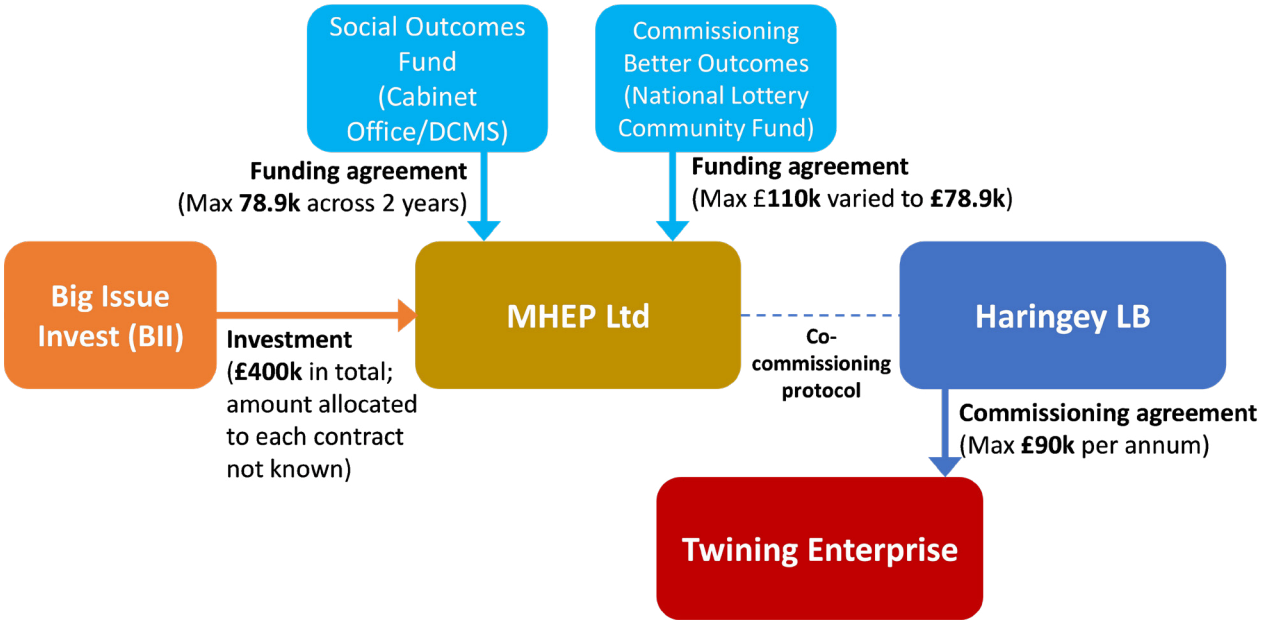
Haringey was in a different position to the other commissioners because it had a relatively new contract for delivery of IPS in place. This followed a review at the start of 2015 of its commissioned mental health services through which Haringey identified the benefits of IPS, including its embedded personnel delivery model and strong evidence base. With funding of £180k over two years from its own Public Health and Adult Social Care budgets, supplemented by other funding, Haringey tendered delivery of IPS and appointed Twining Enterprise (Twining) to deliver IPS from July 2015.

In August 2015, SF approached Haringey to find out more about the IPS service that had been commissioned. This discussion led to Haringey entering formal negotiations to join the MHEP programme, which would provide an additional £90k of funding; i.e. a further year's equivalent budget. The project was originally due to go live at the start of October 2015 but Haringey and MHEP only reached agreement in October 2015, and then completed contract discussions by January 2016, so the project actually started delivery then.

The Haringey contract was originally for one year only, but Haringey subsequently applied (in July 2016) for a two-year extension which was granted in early 2017. This extended the contract until March 2019.

At this point and under a co-commissioning agreement between Haringey and MHEP, Twining was formally engaged by MHEP as a provider of the IPS service. MHEP was also engaged to provide contract and performance management of Twining jointly with Haringey. The overall contract structure is shown in Figure 7 below. Note that the CBO contribution shown here was applied for prior to the closure of CBO to new applications in July 2016, but only agreed in March 2017, and was not part of the original £336,111 agreed for the other two contracts.

Figure 7: **Haringey contract structure**[24]



3.5 Payment mechanism and outcome structure

3.5.1 Payment mechanism

The payment structure of MHEP is complicated. Mapping who paid what for each outcome is challenging, and is made less transparent by the fact that there was some variation between the three contracts. In addition and as we explain in section 4 below, all the contracts changed substantially after contract commencement.

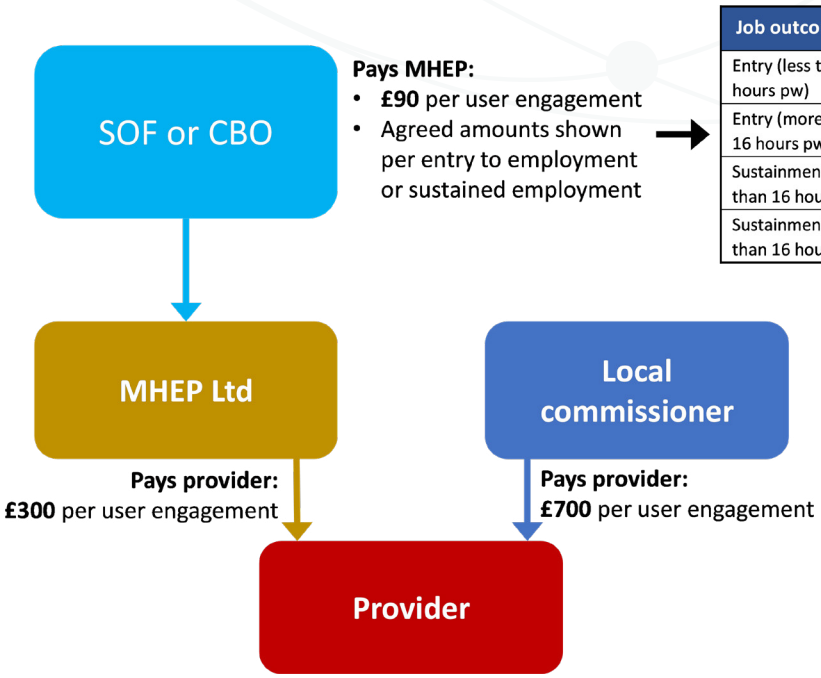
When contracts first started, the payment structure was intended to be relatively straightforward and consistent, and is illustrated in Figure 8 below. As this shows the plan was that:

- Each local commissioner would pay £700 per successful use engagement;

24 Please note that in practice the maximum contribution from the SOF and CBO was capped at £89,999 because the local commissioner contribution (£90,000) had to be more than 50% of total funding

- The SOF (in the first two years) and CBO (in year 3) would pay MHEP a co-commissioner contribution of £90 per user engagement, and specfied payments (see Figure 8) for entry to and sustainment of employment.
- MHEP would also pay £300 per successful user engagement; but this was not a commissioner payment in the usual way we understand such payments within outcomes contracts. It was an innovative and somewhat unusual way of providing delivery funding and working capital to providers, and was funded from the social investment BII had provided. We discuss this further in section 3.6 below.

Figure 8: **Payment structure and flows**



Job outcome	Trigger	Payment
Entry (less than 16 hours pw)	Sustained for. 6 weeks	£700
Entry (more than 16 hours pw)	Sustained for. 6 weeks	£1,350
Sustainment (less than 16 hours pw)	Sustained for. 6 months	£1,400
Sustainment (more than 16 hours pw)	Sustained for 6 months	£1.650

There is a worked example of how MHEP proposed that this payment structure would work in Tower Hamlets in its application to SOF/CBO, which is shown in Box 1 below.

Under this payment structure, local commissioners were thus paying only for user engagement (an output rather than an outcome) and the majority of true outcome payments (by both number and value) were always intended to be paid by the central funds – SOF and CBO[25]. According to stakeholders the rationale for this was that:

- While it made sense for local commissioners to contribute because they were benefiting from the improved health and social outcomes for service users, the majority of the benefit of MHEP (both social and especially financial) accrued to DWP rather than local commissioners. It was thus logical for SOF to fund it, since as outlined above SOF had specific objectives to act as a proxy 'outcomes payer' where there were wider savings to government[26], and also to support potentially replicable SIB models.
- The combined user engagement payment (from local commissioners and MHEP capital) would help providers get used to working within a payment by results model, with MHEP and the local commissioners paying for relatively low risk engagements and investors taking the risk on employment outcomes.

25 This was only possible because CBO and SOF treated engagement payments as outcomes and were funding less than 50% of the combined engagement and outcome payments. This was on the proviso that they were paid retrospectively on achievement of the engagement or outcome concerned.

26 See for example https://www.gov.uk/government/news/report-shows-uk-leading-the-way-in-social-investment which explains that "The Social Outcomes Fund helps tackle the problem of costs for an intervention borne by one part of government reaping benefits across other government agencies, which has previously inhibited the use of SIBs

Box 1: **Worked example of MHEP payment structure(from MHEP CBO/SOF application)**

MHEP and Tower Hamlets CCG co-commission an IPS service in Tower Hamlets. At the end of the quarter April - June 2018, the service reports 40 users successfully engaged in the service, 10 job entry outcomes (6 at <16 hours per week, 4 at >16 hours per week), and 3 job sustainment outcomes , 2 of which are >16 hours per week.

MHEP will pay the provider £12,000 (£300 x 40 users) and Tower Hamlets CCG will pay the provider £28,000 (£700 x 40 users). MHEP will fund its payments to the provider from a pool of social investment.

Total payment from MHEP and CCG to provider for the quarter = £40,000

We propose that the CBO fund will pay MHEP according to the tariff described above:

40 users successfully engaged x £90 per user = £3,600

6 job entry outcomes (<16 hours/week) x £700 per outcome = £4,200

4 job entry outcomes (>16 hours/week) x £1,350 per outcome = £5,400

1 job sustainment outcome (<16 hours/week) x £1,400 per outcome = £1,400

2 job sustainment outcomes (>16 hours/week) x £1,650 per outcome = £3,300

3.5.2 Investment and financial risk sharing

The MHEP contribution to outcome payments for user engagement (£300 per user) was not an outcomes payment in the way the term is conventionally applied to social outcomes contracts (SOCs) and SIBs. It was essentially the means by which MHEP could provide working capital finance to the providers. This was on the assumption that, provided they could generate early referrals and convert them to enough engagements, the providers would have enough cash to fund their operations. We note that:

- This was an unusual and innovative way of providing funding to providers. While all SIBs and SOCs are different, the more usual model would be for the contract holder (In this case MHEP Ltd) to receive all the outcome payments (including from local commissioners) and then fully fund providers to cover their costs. In some cases the contract holder will link payment to outputs[27] but it is unusual for such payments to be made alongside those from commissioners, as if MHEP were a co-commissioner rather than an investor;
- According to MHEP stakeholders, the original intention was that across all contracts MHEP would fund providers solely through variable user engagement payments. However, MHEP used its capital to provide an upfront 'block' payment to support the providers in Staffordshire and Tower Hamlets in meeting their start-up costs. Haringey also had a different structure because the CCG had already agreed to fund the existing contract (starting in July 2015) to the tune of £90,000 per year. In year one, therefore, this payment was provided up front and as a block to the provider, with variable payments only applying above this amount.
- These block payments were effectively an advance payment 'on account' in anticipation of future user engagements, funded jointly by local commissioners and MHEP. They thus assumed each provider would achieve a specified minimum number of engagements and would only receive variable payments for user engagements over and above this base level. The block payments were not repayable by providers if the base threshold was not reached.
- MHEP stakeholders admit that the model evolved quickly, and that a number of different payment mechanisms were tried. Here and elsewhere, therefore, stakeholders were trying out different payment and investment arrangements in

27 See for example Ways to Wellness, where the contract holder (Ways to Wellness) paid providers for referrals achieved https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_ways_to_wellness_second_report.pdf?mtime=20210727162600&focal=none

order to achieve an optimum balance of risk. As we explore in section 4, further changes were made after contract commencement in an effort to find the right balance.

What is clear is that, at the outset, there was a sharing of risk between MHEP and the providers, as is often the case in SIBs and SOCs:

- MHEP was bearing the risk that enough people would engage with the intervention and ultimately find work. Without this the outcome payments for job entry and job sustainment from SOF and CBO would not materialise.
- Providers were bearing the risk that they would be able to engage sufficient users, since, even with non-repayable block payments in place, they would need to generate further variable payments to cover their costs.

A further point is that BII was investing in MHEP Ltd and the £400k capital initially invested was used to finance both MHEP 1 and the subsequent MHEP 2 contract. When the MHEP 2 opportunity arose in 2016/17 MHEP sought permission from BII to reuse existing capital to finance it, and allocated £250k loan capital to MHEP2 when it started in 2017/18. Also in 2016 BII, in agreement with MHEP, re-invested £40K loan capital in the MHEP 1 extension of the project in Haringey (for draw down from the start of FY 2017/18) and £100K in the extension of the Tower Hamlets contract (for drawdown from the start of FY 2019/20).

3.5.3 Performance management and governance

As outlined above MHEP Ltd provides overall governance of MHEP projects, including several that are still delivering services and outcomes. It appears to provide relatively little oversight of individual projects with the majority of day-to-day operational management being the responsibility of the MHEP Central Team.

The board of MHEP Ltd reflects the fact that it is almost wholly-owned by BII (with SF having only a small minority stake, and no other shareholders). The Board had/ has an independent Chair, some further non-executive Directors and members from both BII and SF.

Day to day operational management was the responsibility of providers, but they were supported and scrutinised by the MHEP Central Team, which comprised SF staff and was answerable to the MHEP Board and to local commissioners. The precise arrangements under which the central team operated for MHEP 1 varied according to terms agreed with each local commissioner, but its primary role was to ensure that each project performed in line with expectations, and to act if performance did not meet such expectations. As we explore in section 4, it was active in the early years of each project when performance did fall short of expectations in various ways.

3.5.4 Comparing MHEP with other CBO projects

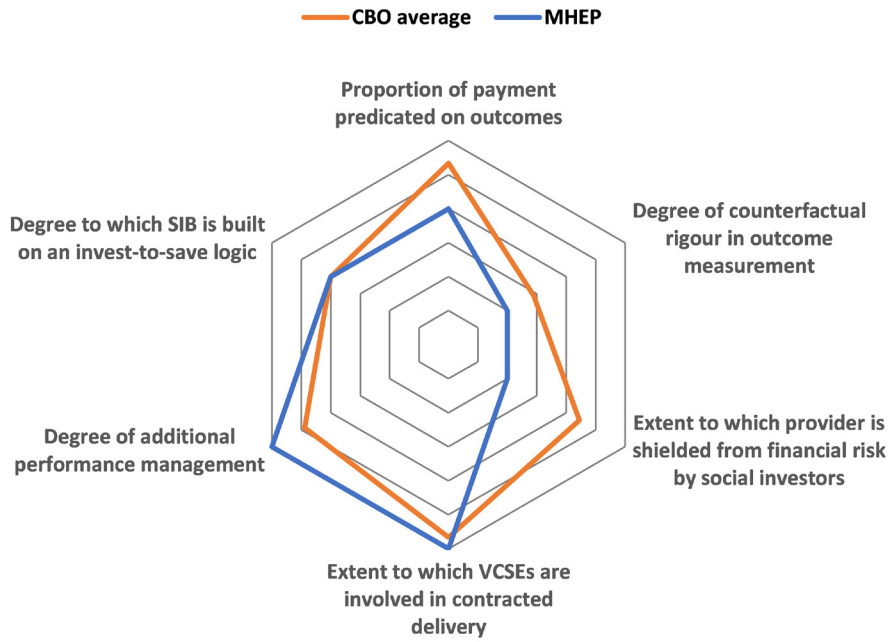
The CBO evaluation team has developed a framework for analysis to compare the SIB models across the nine in-depth review projects. This draws on the SIB dimensions set out by the Government Outcomes Lab[28], adding a sixth dimension related to cashable savings. The aim here is to understand how SIB funding mechanisms vary across CBO, and how they have evolved from their original conception. Figure 9 uses this framework to compare MHEP 1 with the average positioning for the CBO in-depth review projects (Annex 1 describes the dimensions and the different categories that exist within it).

It is important to stress that these are not value judgements – there is no 'optimum' SIB design, but rather different designs to suit different contexts. For further information on how these categories were formulated, and the rationale behind them, see the most recent Update Report[29] on this evaluation.

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

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

Figure 9: **SIB dimensions in MHEP and other CBO in-depth reviews**



The positioning of MHEP against each dimension within the framework shows the following:

- **Proportion of payment linked to outcomes:** The PbR model was, as conceived, based only partly on payment for outcomes achieved. This is typical of one third of the CBO projects that feature as in-depth reviews: two thirds (six out of nine) of the projects have 100% of payments attached only to outcomes. In this and two other projects (West London Zone and Be the Change) commissioners also pay for service user engagements (and in MHEP 1 a proportion of user engagement payments were converted at contract commencement to a non-repayable block payment, as outlined above).
- **Validation method:** Payments were made for all outcomes and outputs achieved. There was no impact evaluation to ensure that outcomes were attributed to the intervention, and no allowance for 'deadweight' (i.e. outcomes that might be achieved and not attributable to the intervention). This is typical of SIB models in CBO, and only one of the nine in-depth review projects features measurement against a defined comparison group. In this case, MHEP stated in their application to SOF/CBO that the establishment of a comparison group of other service users within each Mental Health Team would be explored 'subject to funding and feasibility' but this appears to have been ruled out on cost grounds. MHEP also explored the establishment of a comparison group as part of its local evaluation (undertaken by BIT)[30] but again appears to have ruled it out on cost grounds. In both its original application and as part of our consultations for this review, MHEP stakeholders argued that deadweight was likely to be very low, since employment rates for those with mental health conditions, and those finding work without intensive support, are low. In addition, MHEP stakeholders argue that previous randomised control trials of the IPS intervention showed impact that is more than double that achieved by control groups.
- **Provider financial risk:** The three providers of the MHEP 1 contracts were not entirely protected from financial risk, and shared that risk with MHEP Ltd and, through MHEP, with BII as the investor. This is a feature of four of the nine in-depth reviews, with the other five constructed so that the provider was entirely protected from financial risk. In the latter group of IDRs this risk was borne by the intermediary or other

30 Gadenne, Violet et al: (2020): Individual Placement Support: A Social Impact Bond model Evaluation report. Available at: https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/Social-Impact-Bond-individual-placement-support.pdf?mtime=20200713125657&focal=none

body managing the project on behalf of investors. The way in which risk is shared varies from project to project and, in the MHEP case, the hard risk was largely that the providers would be unable to achieve enough user engagements. The sharing of risk in this way was a deliberate attempt to 'acclimatise' the providers to working in a PbR context. It was also made known to and accepted by the providers at the point when they bid to deliver each contract

- **VCSE service delivery:** A single VCSE organisation was responsible for all delivery in each of the three contract areas that comprise MHEP 1. This is typical of the in-depth reviews in that all nine involve delivery by one or more VCSEs; although several of the other projects reviewed have more than one provider for each contract, and some comprise a mix of VCSE and public sector providers, especially those delivering in the health sector.
- **Performance management:** MHEP 1 (and MHEP as a whole) was designed so that there would be strong external contract and performance management by a defined team which sat outside the day-to-day delivery structure. This is a model found in five of the nine in-depth review projects, although the nature of the performance management team and its degree of separation from other parties to the contract varies. Two of the other four projects or families of projects were designed so that performance would be managed internally by the provider, while in the final two families/projects there was a mix of external and internal performance management.
- **Degree to which project is built on an 'invest-to-save' logic:** MHEP was expected to generate savings, both to DWP, in reduced benefit payments to those with mental health conditions who find and sustain work, and to local commissioners, primarily through engagement in IPS leading to improved mental health outcomes that are closely associated with reduced in-patient treatment episodes (though the latter are more likely to be avoided costs than savings). We do not, however, view it as a project which was primarily driven by an invest to save logic, where savings were expected to fund all or a high proportion of the outcome payments. We think this because local commissioners do not appear to have been motivated by the promise of savings to engage with MHEP, and in two of the three sites the commissioners already had conventional IPS contracts in place – and were thus already benefitting financially from service users finding work and improving their mental health. Similarly, while there arguably should have been an invest to save logic for DWP, the Department had chosen not to be an outcomes payer despite the clear financial benefits to it.

4.0 What has happened in practice

In this section, we describe in more detail the developments in each of the three MHEP 1 contracts since their launch. It is structured as follows:

- Section 4.1 describes what happened in each contract area, and the contractual and operational changes that were made as a result;
- Section 4.2 describes how MHEP 1 performed overall and by contract according to CBO data; and
- Section 4.3 explores in more detail the different views of the SIB mechanism and of specific events expressed by key stakeholders, where not already included in earlier sections.

4.1 Contractual and operational changes

4.1.1 Overview

As already described in our second review of MHEP 1[31], all three contracts faced challenges which led to changes in both operational and contractual arrangements. In addition, and since our second review, there were further changes in the third year of each contract when they transitioned from being co-funded by SOF to being co-funded by CBO. In summary:

- Each contract did not achieve the levels of performance expected, especially in terms of referrals and successful user engagements. This meant that each provider, with support from the MHEP central team, implemented operational changes; and
- Each contract was renegotiated and reset, with new performance targets and changes to payment arrangements between MHEP and the providers, as part of the response to these challenges.

The evidence suggests that these changes were largely successful in both Tower Hamlets and Haringey, since these two contracts were turned round sufficiently to continue through to their end dates, and led subsequently to a contract extension in Haringey and further contracts in Tower Hamlets. The contract with Staffordshire could not be recovered, due in large part to major staffing issues, and in October 2018 it was terminated approximately six months early.

We describe in more detail what happened in each contract area below. We also provide a view on the main reason for performance issues in each contract, why the response to those issues differed, and how successful the changes were.

4.1.2 Staffordshire

4.1.2.1 Key events

Staffordshire ran an open procurement process, in collaboration with MHEP, and contracted with Making Space for a three-year IPS service, with an option to extend for a further year, starting on 1 April 2016.

Despite having previous experience of delivering IPS in Staffordshire, Making Space experienced challenges in mobilisation of this contract from the outset. This appears to have been because the Making Space teams on the ground were not as well equipped as everyone thought to step up to delivering IPS on an outcomes basis, and therefore to be subject to more rigorous scrutiny of performance.

By mid-2017, this led to a 'robust' set of conversations between Staffordshire County Council, MHEP and

31 See https://www.tnlcommunityfund.org.uk/media/Indepth-Reviews_MHEP_Visit-2_FINAL.pdf?mtime=20190819133237&focal=none pages 10-15

Making Space over the need to strengthen the management team, and to the appointment of a new manager in the third quarter of 2017. This manager completely changed the staffing, re-established basic process management, re-branded the service and effectively re-launched it. We note that a common factor across several of the CBO projects that we have reviewed in depth has been the introduction of experienced operational management either in addition to existing management or to replace them.

In parallel, the contract terms were re-negotiated and MHEP changed the way it made payments to Making Space to enable it to meet expectations (from both Staffordshire and MHEP) for it to recruit more experienced staff at a higher cost level. These changes included:

- Increasing the amount of funding provided in an upfront block. The original MHEP contract allowed for £60,000 of block funding and £240,000 linked to user engagements per annum. These proportions were changed to £75,000/£225,000 and then later to £82,500/£217,500 to adjust the funding balance and increase the block payment from MHEP, thus easing cashflow and enabling Making Space to implement a new, higher cost staffing model.
- MHEP starting to pay Making Space per user entering employment. This 'job start;' outcome was initiated by Working Well in relation to the Tower Hamlets contract (see below) and was adopted by MHEP across all three contracts, It meant that providers were paid for job starts (irrespective of duration) and thus further eased provider cashflow.

These changes to the contracts between MHEP and providers did not affect arrangements between MHEP and SOF, which continued to make co-payments under the arrangements described in section 3.5. In addition ,local commissioners continued to make a mixture of engagement and block payments as described in section 3.4. When CBO took over co-funding responsibility from SOF some changes to the co-commissioning contracts were made, the main effect of which was to introduce payment to providers based solely on outcomes, with no block payments by commissioners. Under these changes, made to reflect restrictions on the CBO programme's governance[32], local commissioners made payments for job starts (applying a similar metric to that introduced between MHEP and providers as described above) with job retention outcomes being paid by CBO, as they had been previously by SOF.

Once the new staffing structure was in place and the service had effectively been relaunched, stakeholders reported improvements in performance by the first quarter of 2018, despite the team continuing to be under strength (with only five out of seven staff in post). In April 2018, however, two of the five in-post team members resigned which meant a difficult challenge of hiring for four roles for only the final year of the contract. In effect, despite best efforts, Making Space continually found itself trying to deliver its contract targets without enough staff.

At this point, Staffordshire indicated that it would probably end the contract early. The main reasons for coming to this conclusion were that:

- there had been relevant staff changes in Staffordshire's commissioning team – this is discussed further below;
- the contract had been consistently under-performing from the outset;
- the SIB contract arrangements were complex, and any further re-negotiation would have eaten further into the limited remaining contract timetable; and
- NHS England Wave 1 transformation funding, under its IPS Grow initiative, was becoming available to Staffordshire CCGs to fund an increase in provision of IPS services without the need for this contract.

Although MHEP submitted a position paper and it was then agreed Making Space would try to fill the vacant

32 The reasons for these changes are technically complex but in simplified terms there was a risk that if block payments by commissioners had continued, they would have constituted more than 50% of total payments made which would have breached CBO terms on the proportion of payment linked to outcomes, and that CBO could not fund more than 50% of all payments. Note also that these changes were agreed in January 2019 and were applied retrospectively with effect from 1st April 2018.

roles, the decision to terminate at the end of October 2018 was later confirmed. The initial Staffordshire commissioning lead was by then the commissioner at the Stafford and Surrounds CCG which had an in-house IPS provider, Step On, serving some parts of North Staffordshire. The availability of NHS England funding along with the existence of this other in-house provider facilitated the change of provider, and Step On took over the provision of IPS services county wide on 1st November 2018. The remaining Making Space team were transferred under TUPE[33] Regulations to the new provider, and the client data was also passed over under the formal agreement. Staffordshire County Council and NHS England funding was combined from April 2019 onwards, so the overall contract for IPS services was larger than the previous MHEP contract

4.1.2.2 Analysis

The evidence suggests that several factors combined to lead to the early termination of the contract with Making Space in Staffordshire.

First, the performance targets set for the provider turned out to be far above what was achievable. These initial performance expectations were not set by MHEP or based on research into the effectiveness of IPS, but were set by the commissioner based on previous performance under the existing, conventional contract, as reported by Making Space.

This issue was compounded by Making Space's confidence as the incumbent IPS provider in South Staffordshire, which led it to bid at a discount against the user engagement tariff proposed, since it thought it could keep staffing levels up and deliver IPS profitably at lower payment levels than the MHEP targets required.

Instead, the change to the MHEP model with both challenging performance targets and increased scrutiny of validated employment outcomes, appears to have exposed delivery and uncovered some issues in Making Space's reporting, suggesting that previous performance was not at the level supposed. It also appears that staff started to object to being measured on successful user engagements and began to leave, but it was unable to offer competitive salaries, and the loss of staff cycle became a permanent challenge that, despite efforts to address it supported by MHEP contract management team, was never overcome. We note that staff retention and turnover is often an issue in the VCSE sector but there appear to have been specific factors in this case: according to provider stakeholders the PbR mechanism had a detrimental effect on both morale and revenue; according to SF stakeholders the pay structure of Making Space was a key issue, since the majority of its contracts nationally were in social care, where salaries tend to be lower,

In some of the other SIB contracts that we have reviewed under this evaluation, the provider leadership teams have made conscious efforts to shield front-line key workers from the SIB's outcomes payment pressure and allow them to deliver unencumbered by such pressures. In Staffordshire performance was so far short of initial expectations that visibility of the financial pressures was clear to all, and. it was clear by the end of the first year that the original contract expectations (in all three areas) were too ambitious and would have to be reset, MHEP responded by raising the block payment, relative to the variable engagement payment. to alleviate the financial pressures, but it could not make more fundamental changes in Staffordshire due to procurement restrictions, which did not permit major changes to the bid as submitted by the provider during delivery.

A further factor was that an alternative provider, Step On, along with NHS funding, were available to offer a route out for all parties from an otherwise potentially fractious situation. Step On had an advantage over Making Space in that it was the NHS in-house provider and so had less difficulty establishing working relationships on the ground. Step On was reported by commissioner stakeholders as *"performing well"*. – a perception which is likely to have made it easier for the commissioning team to terminate the contract.

In addition there had been staff turnover on the commissioning team, with the original lead commissioner leaving to join the CCG. Some

33 TUPE stands for the Transfer of Undertakings (Protection of Employment) Regulations and its purpose is to protect employees if the business in which they are employed changes hands. Its effect is to move employees and any liabilities associated with them from the old employer to the new employer by operation of law.

stakeholders suggested that this might have lessened Staffordshire's resolve to persist with the SIB, but others argued that the commissioning team made an entirely valid strategic decision given the performance and staff retention issues, and the option to move provision to another provider and to a conventional contract.

4.1.3 Tower Hamlets

4.1.3.1 Key events

Tower Hamlets let a three-year contract[34] for IPS services starting on 1 April 2016 with Working Well as its chosen provider. The contract was block funded in part during its first two years to help the provider get the new IPS service off the ground and to allow payments based on user engagements to start to flow to the provider.

Working Well experienced a similar challenge to Making Space in Staffordshire on mobilising the new contract but for different reasons. Unlike Making Space, Working Well had not delivered IPS before and the learning curve proved to be much steeper, and implementation challenge greater, than it expected. This appeared to be mainly because the traditional model of overcoming a mental health client's barriers before talking about employment is completely turned on its head in IPS with its 'employment first' approach. The team all had more experience of traditional employment support programmes, and this appeared to be a major factor in why they were not able to meet performance requirements under IPS.

To meet this challenge, Working Well concluded that it needed to change its entire recruitment process and policies to attract key workers able to deliver IPS. It introduced a two-panel recruitment process – one made up of service users and the other of Working Well staff, both of which had to agree on a candidate's suitability for an employment offer to be made. It also introduced peer support and mentoring for clients both in the pre-employment and post-employment stages.

Alongside these operational changes, the funding and payment structure between MHEP and Working Well was again changed to include payment for job-starts rather than just for engagement. This change, adopted for all three contracts, was first initiated by Working Well which thought that it better reflected the end outcome they wished to achieve with service users.

By January 2018, the contract performance was closer to re-set expectations, due, in the view of Working Well stakeholders, to the recruitment of the right kind of key worker that could work effectively within the IPS model. Staff turnover and maintaining team size remained an ongoing challenge, however, and it is worth noting that both Working Well and Twining stakeholders thought that staff retention was a challenge because of the range of similar employment opportunities in London, and the need for younger staff to 'move on' from smaller organisations like Twining and Working Well in order to develop their careers.

Despite these challenges the end outcome was different for Working Well. Senior stakeholders reflected at the end of the contract that the experience and been positive, were happy with the organisation's capability to deliver IPS, and reported a sense of satisfaction in having pushed through the difficulties and come out well on the other side.

Stakeholders' perception that the operational and contract changes were successful in improving performance appears to be confirmed by CBO monitoring data, which shows the Tower Hamlets contract achieving 113% of planned engagement in its final year compared to 59% across MHEP as a whole.

In addition the commissioner chose to extend the contract and sought CBO funding for an extension, originally for two years. This was later changed to a one-year extension so that both Tower Hamlets and Haringey could together enter into further contracts with MHEP with the same providers and extend them by a further year, until March 2020.

34 The original contract was set to run until March 2019 but was subsequently extended by one further year, with CBO funding to 31 March 2020 – see further discussion later in this section

4.1.3.2 Analysis

It seems clear from both our second review, and further research for this review that Working Well had not fully understood the challenge of transitioning to delivering IPS. The organisation had delivered IPS components before, but the Tower Hamlets contract brought it all together and it emerged that Working Well, in stakeholders' words *"could not automatically or easily shift to delivering full IPS"*.

It also seems clear that the Tower Hamlets contract faced similar issues of optimism bias to those in Staffordshire, with performance expectations set too high and the provider bidding bullishly to meet them. Several factors led to a different outcome for Working Well, however, including a new recruitment processes to ensure staff of the right calibre, significant improvements in employer engagement, and learning from other IPS providers through being part of a pan-London network of such providers that shared information on a planned and regular basis.

A further factor appears to have been that the senior commissioners at Tower Hamlets CCG were very understanding about the original targets being unrealistic. This appears to have made a huge difference to the scope for resolution.

4.1.4 Haringey

4.1.4.1 Key events

Haringey CCG had already commissioned a two-year IPS service from Twining Enterprise (Twining) and moved that service under the MHEP umbrella in January 2016.

Twining experienced similar challenges to Making Space and Working Well, and eventually its IPS service "fell over", in the words of a commissioner stakeholder, due to significant operational issues. The team faced similar skills and leadership issues as the other providers, and the performance of Twining's client-facing team did not withstand the pressure and extra scrutiny that comes with an outcomes-based contract, with their funding linked to the achievement of engagements under the terms of their contract with MHEP, and only 25% of payment being provided by MHEP as an upfront block. According to commissioner stakeholders all staff and the manager left for different reasons and as engagement numbers fell, the payment mechanism meant that there was a funding shortfall and higher risk for Twining to invest in re-building the team.

In the end, Haringey served a performance notice on Twining as it appeared to them that the service had *"collapsed"* –and there was effectively no service being delivered.

In response Haringey, MHEP and Twining re-negotiated the terms of the contract and MHEP reset the payment terms so that 50% of payment was upfront in a block and only 50% was linked to outcomes The renegotiated payment structure was somewhat different to that agreed with Staffordshire and Tower Hamlets, but similarly based on a switch to job start outcomes rather than payment on user engagements. In Haringey the commissioner agreed to pay a fixed sum of £3,850 for the first 20 job starts (and six-week retentions), and £1,600 for each subsequent start up to the £90,000 contract cap.

4.1.4.2 Analysis

The reasons why Twining were able to turn around its contract (apart from the renegotiation of terms to make targets more realistic) appear to have echoes of the experience of Working Well, and to be a combination of cultural adaptation to the challenges of payment by results and more straightforward operational changes related to the ability to recruit and retain high quality staff.

Key to both of these appears to have been the recruitment of a new CEO at Twining who helped to ensure that the various changes introduced in 2017 were sustained thereafter. In this stakeholder's view, the performance management element in the MHEP SIB helped force a culture change on Twining, so that it was able to manage and deliver services under outcomes performance pressures. In their view, the

experience positions the organisation to take on future PbR contracts where appropriate. Indeed, they described such contracts as 'the only game in town' although the implementation of IPS with direct funding from the NHS (see section 6) suggests otherwise.

Looking more widely at the delivery of IPS, stakeholders took the view that Twining 'got lucky' with its recruitment and found three particularly good employment advisors who, while each not staying long before moving on, were highly effective.

The downside issues Twining faced in delivering IPS were also largely related to personnel. Staff retention was a challenge for Twining, as for Working Well, in part because of the range of similar employment opportunities in London and also because of the tendency of younger staff to move on to develop their careers. It had to change one team leader at the start of 2019. and unplanned turnover and recruitment of a decent calibre of employment advisors remained consistent challenges.

Overall, there are factors similar to those observed in Tower Hamlets and noted above, that appear to have helped ensure that the Haringey contract was able to turn around successfully. These include that the Haringey commissioner was supportive, that there was wider NHS momentum behind the use of IPS, and that the MHEP Central Team provided good support throughout.

The key factor, however, appears to have been the specific change programme introduced by Twining's CEO. This created a performance culture that suited outcomes contracts and thus enabled Twining to meet the requirements implicit in the payment structure for this contract. The end result, according to stakeholders, was that Twining emerged from this contract with increased capability and as a relatively confident provider of IPS services.

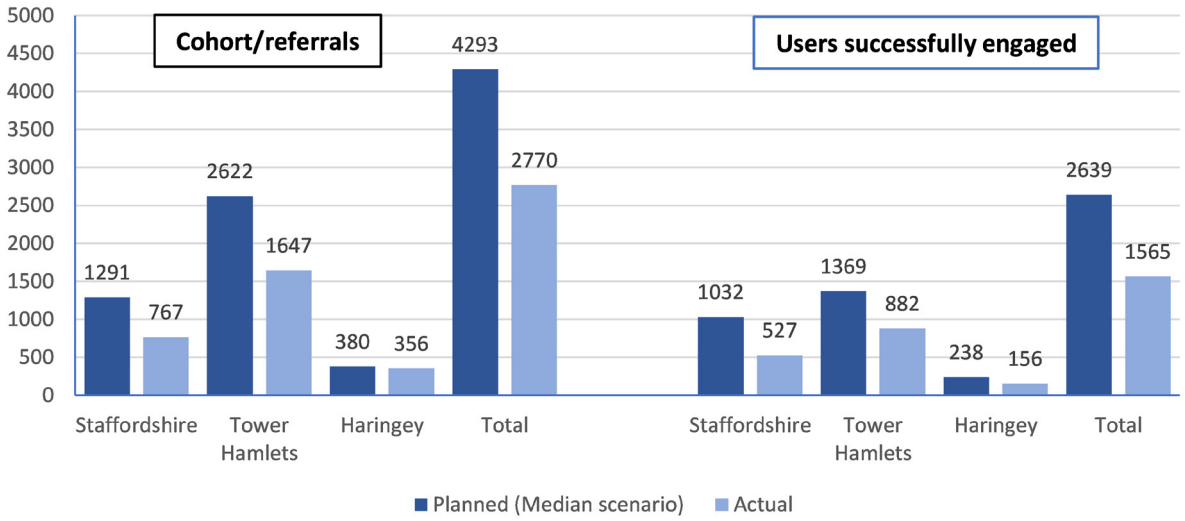
4.2 Project performance

This section details how MHEP 1 performed in total and by individual contract, based on data provided to the CBO Fund as part of End of Grant (EoG) monitoring and reconciliation processes. As we have already explained above, all the projects performed below expectations and the data confirms this.

4.2.1 Volume targets

Figure 10 below shows how MHEP 1 and individual contracts performed against original plan (based on the Median scenario presented in its initial application to the SOF and CBO). As this shows performance in terms of both total cohort referred to the intervention and total users engaged was well below plan at Median scenario and was, at End of Grant, below the Low scenario. This mattered especially in relation to the user engagement target because user engagement was a key driver of payments to service providers. User engagement was between 51% and 66% of plan, and 59% overall.

Figure 10 **Volume target performance by contract and in total**



Source: CBO End of Grant (EOG) monitoring information as reconciled with data provided by MHEP

A major reason for the shortfalls across all three contracts appears to have been that the original forecasts were set high and have been described by stakeholders, especially commissioners, as 'unrealistic'. This is despite IPS being selected as the intervention to be funded through MHEP because it had the strongest evidence base, in terms of both number of studies conducted and the positive results of them. However stakeholders from SF commented that there was relatively little performance data on IPS available from previous studies on which to base forecasts and also that, as previously observed, the targets in Staffordshire were set by the commissioner based on previous (reported) performance. Stakeholders also reported that they had taken account of likely optimism within reported IPS outcomes, noting that *"We did reduce our targets for IPS to reflect optimism bias and the fact that academic studies often report higher results [due to] the Hawthorn effect "*[35].

In light of actual outcomes it seems reasonable to observe, however, that the designers might have de-risked their forecasts further (where commissioners allowed) if they were so uncertain about likely performance.

A further factor mentioned by stakeholders was that the difference in performance was greater than they thought it would be between an established service and a new one. One of the providers (Working Well, in Tower Hamlets) was implementing IPS for the first time, while the others had not implemented it in the expectation of such high scrutiny of performance, even though at least one (Making Space) had been delivering IPS in Staffordshire for five years. As we observed in our second review, this previous experience appears to have made Making Space over-confident and added to the problem, because its reported performance influenced the targets set, and it then chose to bid at a discount against the user engagement tariff proposed by Staffordshire and MHEP, and thought it could deliver IPS sustainably at these lower payment levels.

With the benefit of hindsight, therefore, it can be argued that both SF as the designers and promoters of the SIB model (and specialist advisors to the local commissioners on procurement) and the providers themselves were at fault here. The former should perhaps have tested more carefully whether providers were aware of the risks involved in a new type of contract with inherently greater scrutiny, while the latter should (for similar reasons) have been especially wary of overbidding either to deliver an intervention with which they were unfamiliar, and/or to deliver through an unfamiliar and more challenging contract mechanism.

35 The Hawthorne effect refers to people's tendency to behave differently when they become aware that they are being observed. As a result, what is observed may not represent 'normal' behaviour, undermining the validity of research. See for example https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969247/

It also appears that referrals were affected at local level by the service not being as embedded in CMHTs as was envisaged and to the extent that is seen as essential for IPS to work properly, especially in Staffordshire and Tower Hamlets. As we note in section 3.3 above, IPS requires high fidelity in implementation and integration with mental health teams is considered a key factor. In Staffordshire, the assumption was that two cases a year would be referred by each CMHT worker, which was not seen as ambitious but proved hard to implement. This was because the CMHTs re-organised and appeared to view IPS as an external service to which they should refer rather than seeing an integrated part of the core team (which fidelity to the IPS model requires).

The commissioner, MHEP and Making Space took action to correct this, but it seems likely to have had an impact on referrals. especially in the first year.

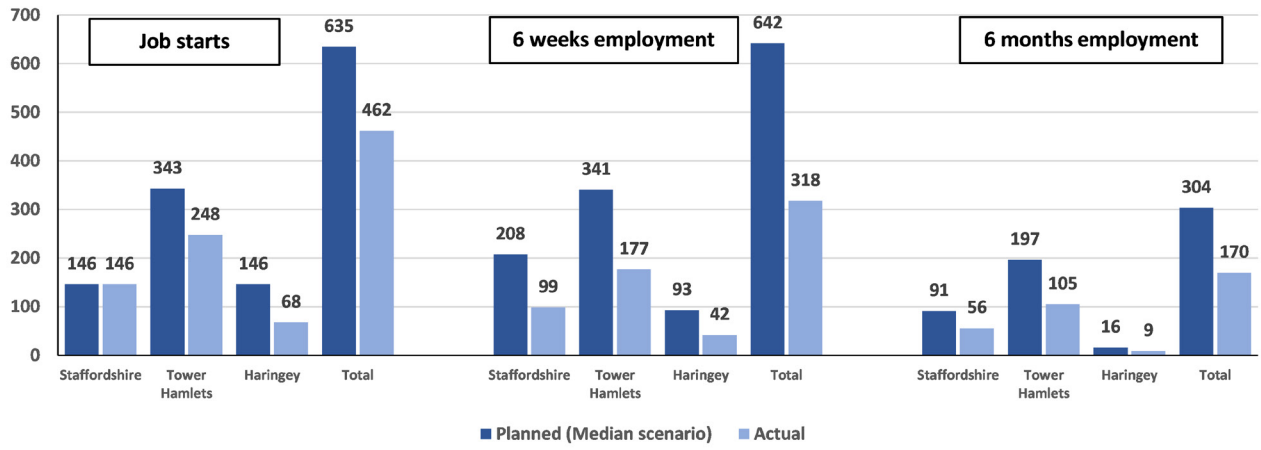
Similarly, Working Well experienced lower referral volumes than expected due to reorganisation of CMHTs, with smaller-sized Wellbeing and Recovery Teams dealing with a reduced caseload per team member, and other less critical cases referred to the Enhanced Primary Care Teams who conversely had much higher caseloads. Since IPS users are not crisis cases, this led to a similar dilution in focus on employment outcomes (albeit for different reasons) that the MHEP central team and Working Well had to address.

4.2.2 Outcome performance

Figure 11 below shows how MHEP 1 and individual contracts performed against the key outcome targets including job starts (introduced in April 2018 and paid by local commissioners) and the original entry to employment (6 weeks) and sustained employment (six months) outcomes that SOF and CBO paid for throughout.

Since user engagement was below plan it is not surprising that these subsequent outcome targets were also not achieved, although it is interesting to note that both Making Space and Working Well (who instituted the change to this outcome) did better against the job start outcome than the entry and sustainment outcomes. Indeed, despite later having its contract terminated, Making Space achieved 100% of its target of 146 starts (and Working Well achieved 72% of a target of 243).

Figure 11: **Key outcome performance by LA contract and in total**



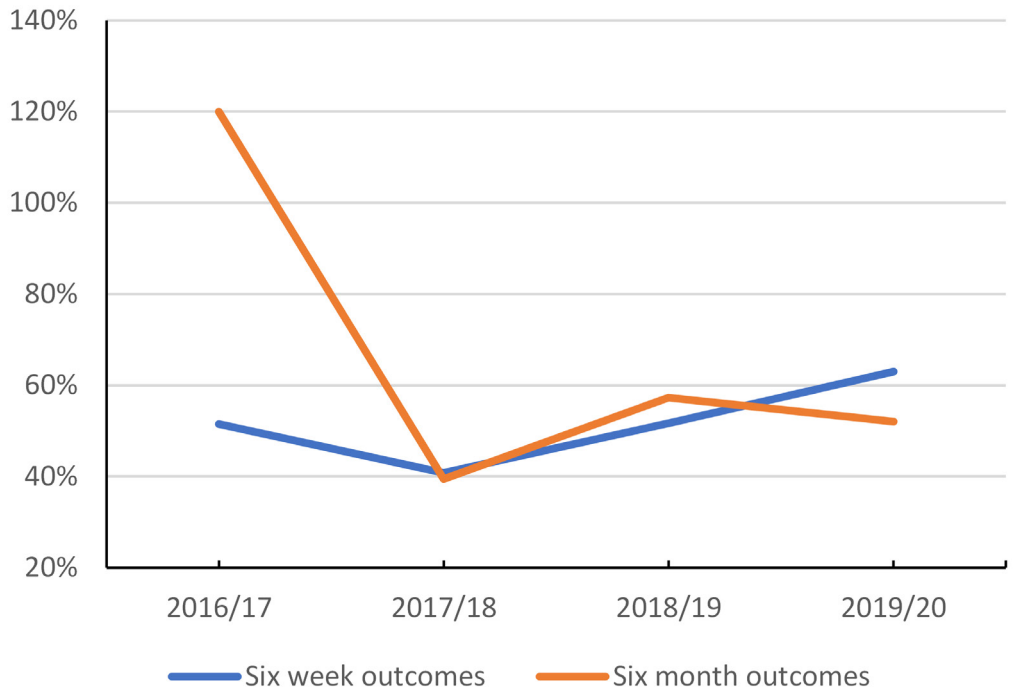
Source: CBO EOG monitoring information

While the shortfall in referrals and engagements will no doubt have been a major factor behind the subsequent missing of job outcome targets, other key factors as highlighted above are likely to have been the quality and quantity of management and staff, and the extent to which providers had successfully

adapted to what we sometimes refer to as an 'outcomes culture' – i.e. the capacity and capability to operate successfully under the additional scrutiny and expectations of PbR and an outcomes contract.

Both provider and MHEP stakeholders thought that performance improved once providers had adjusted to an outcomes contract and had recruited staff with the right skills and attitude, though there is only weak evidence for this in the data. Figure 12 shows how job entry and sustainment performance against plan changed over time, and as this shows performance reported at the end of 2016/17 was actually higher than subsequently (and in the case of the six-week outcome exceeded target). There was some improvement from a low point in 2017/18, but it was small and performance against the six-month sustainment outcome actually fell back slightly. It is thus difficult to argue that the time and cost of performance management was justified by results, although the support from the MHEP Central Team may have been well received by most stakeholders.

Figure 12: **Overall performance (%age achieved vs plan) by key outcomes over time**



Source: CBO EOG monitoring information

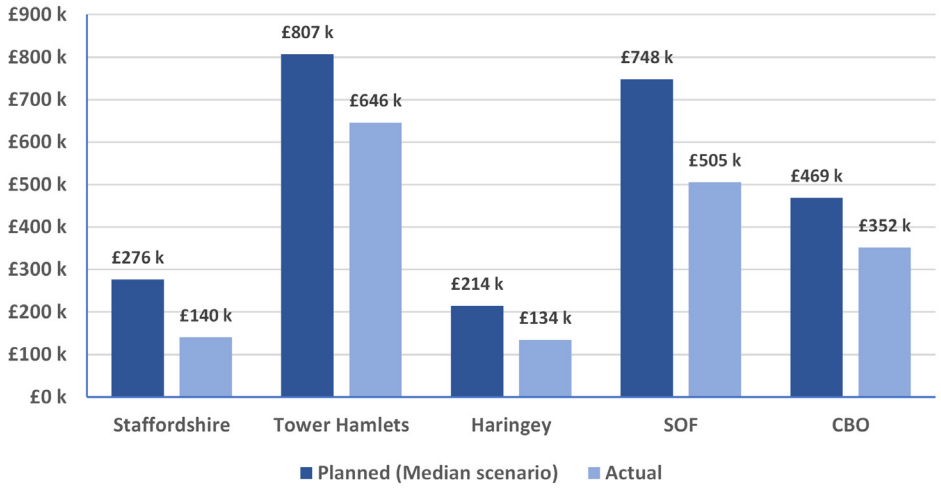
4.2.3 Commissioner payments and investor returns

4.2.3.1 Commissioner payments

Since outcome payments were in large part linked to user engagements and employment outcomes, both of which were below plan, payments made by both local commissioners and by SOF and CBO were also significantly below plan and agreed outcomes caps. Figure 13 compares payments against plan for each commissioner and co-commissioner, excluding some further fee for service and performance payments made by each commissioner.

As might be expected since they terminated the MHEP/Making Space contract early, Staffordshire spent the least relative to plan (51%) and Tower Hamlets the most (80%).

Figure 13: **Commissioner and co-commissioner payments**



Source: CBO EOG monitoring information

The fact that engagements and outcomes were below plan also affected the savings and avoided costs achieved by the project. As noted earlier previous reviews did not identify payback to commissioners, on an invest to save logic, as a significant driver of commissioner involvement. Total savings and avoided costs achieved by local commissioners were however significantly below plan at Median scenario (£1.2 m vs £2.1 m) with savings being only 9% and avoided costs 55% of plan. Net savings and avoided costs were £56k compared to a plan to achieve £624k. At individual commissioner level, only Tower Hamlets achieved net savings and avoided costs that exceeded outcome and block payments. Wider savings to other agencies – notably DWP in reduced benefit payments – were similarly disappointing at only 24% and 42% of Median scenario for cashable and non-cashable savings respectively.

4.2.3.2 Investor returns

The issue of investor returns is slightly complicated by two factors :

- The mix of equity and loan investment injected by BII. Although a total of £400k was available to MHEP, £40k of this was equity used to purchase shares in MHEP Ltd and this remains invested in the vehicle. .
- As already explained above, BII lent MHEP a further £360k to support both MHEP 1 and a subsequent contract family, MHEP 2, to which MHEP Ltd subsequently allocated £250k. Returns for the two projects (MHEP 1 and 2) cannot, therefore, easily be disaggregated

Taking account of these issues our understanding of the overall position as reported to and agreed with the CBO team is as follows:

- If based solely on MHEP 1, BII had made a return of £15.6k at the time the project closed, equivalent to an internal rate of return (IRR) on the £110k invested of 4.5%. This is less than BII would have received at this point if repaid in full largely because it had (at project close) been repaid only half the principal invested (£55k).
- If based on returns across both MHEP 1 and 2, .the position is more positive. The original loan of £360k invested by BII has now been repaid in full. In addition BII has made a total return of £117k, equivalent to a Money Multiple (MM) of 1.29 on the total investment of £400k. According to the End of Grant information reconciled with MHEP the Internal Rate of Return was 8%. Both these are in line with or slightly ahead of plan at Median scenario.
- In addition, a surplus of £103k was retained by MHEP Ltd and applied to subsequent projects.

4.3 Stakeholder experiences

This section provides an overview of stakeholders' key experiences of being involved in this project, and in particular their experience of the SIB mechanism as opposed to delivery or commissioning through a conventional contract.

4.3.1 Service provider experiences

Providers had different experiences of their involvement in MHEP, with Making Space, provider in Staffordshire, having the least favourable experience and outcome. Stakeholders in Making Space made clear that they *"breathed a sigh of relief"* when the contract was ended as the organisation had been struggling to deliver sufficient volume from the outset and the contract was loss-making. They acknowledged that MHEP had tried to relieve the pressure on Making Space, especially by increasing block payments but *"this wasn't enough in the end and may have been too late"*. Even though block payments were increased they were still only covering a relatively small proportion of total costs, and the increases in block payment were not large enough to cover falling performance, with user engagements declining from 243 in year 1 to 200 and then to 84 in year 3, and as a percentage of plan from 78% to 35%.

The other two providers both reported a much more positive experience despite having similar challenges both during mobilisation and thereafter. Working Well had a positive view of the contract and while *"it has not been an easy journey"* senior stakeholders were happy with the organisation's increased capability to deliver IPS. They commented that but there was clearly a sense of satisfaction in having pushed through the difficulties and come out well on the other side. As one senior Working Well stakeholder observed *"We are pleased with where we are now."*

Much of this experience appears related to the SIB mechanism, and to the effect of increased scrutiny of outcome performance in both encouraging Working Well and Twining to raise their game, whereas Making Space found it much more challenging to adapt. The SIB mechanism also enabled and funded the external performance management role of the MHEP Central Team. Working Well reported that the support received from the team was an important factor in encouraging them to move forward with the contract. They also commented that support from both the MHEP Central Team and Tower Hamlets CCG commissioners was key to persuading Working Well's Trustees to agree to continue to run at a loss whilst the IPS team was re-built, and service improved. It is interesting that the MHEP Central Team appears to have made a significant difference with Working Well in Tower Hamlets but less so in Staffordshire with Making Space. The reasons for this are unclear, but since the MHEP team and its commitment and support would be broadly constant across all sites it seems likely that the team's support was complementary to other positive factors in Tower Hamlets, but could not overcome less favourable conditions – notably weaker commissioner commitment and the availability of a ready alternative means of provision – in Staffordshire. Making Space was performing well by the end of the contract, but by that stage wider developments in the IPS delivery landscape in Staffordshire had become the primary consideration.

Working Well stakeholders also observed that the focus on 'employment first' meant that IPS contracts were well suited to outcomes contracts. They commented that the outcomes element (or in year one the user engagement element) gave a positive focus to delivery but also thought that the amount linked to outputs or outcomes should be no more than 25% of total payments. In Working Well's experience, too high a proportion of payment linked to outcomes for the service provider meant that there was *"no breathing space"* for unplanned team turnover or short-term sickness. The financial impact was instant, and this was not sustainable for a small charitable provider This was exacerbated in the second year of the contract when a higher proportion of Working Well's payment from MHEP was tied to user engagements. The impact of under-performance thus became more evident more quickly.

Some of Working Well's positive experience appears to have reflected their ability to recruit and retain enough staff of the right calibre, which might have applied if the project had not been a SIB (although we cannot be certain how much the increased outcomes scrutiny and support from the MHEP Central Team). The front-line team observed that "things improved a lot" once they changed recruitment processes and the team in place by 2019 (recruited using the two-panel process outlined earlier) "has gelled well" and was delivering a high quality of IPS support to patients. The team also observed that the key recruitment criteria were core values and beliefs, attitude, and character rather than prior employment support knowledge and experience. Practitioners felt IPS needed support workers that believed in the work as part of the recovery process for patient, and commented that:

"the quality of support isn't better because of the SIB, it's a given of [the] IPS fidelity approach and Working Well's recruitment philosophy".

The experience of Twining stakeholders in Haringey was similar to the other providers in that the issues encountered related partly to their ability to deliver IPS rather than of working within a SIB and PbR structure, but at the same time there had been benefits from the outcomes and performance culture encouraged by the SIB mechanism. Stakeholders' assessment was that despite the difficulties experienced with the Haringey contract, Twining was on a good journey of improvement and, in stakeholders' self-assessment *"Twining was only a grade E/D provider before and now a solid C and looking to become even better."* At the time of fieldwork for this review it employed 30 Employment Support staff delivering across various contracts and *"IPS is a core skill set that the organisation now knows how to manage and deliver"*.

In stakeholders' view, the performance management element in the MHEP SIB had also helped support and encourage a culture change on Twining, so that it is now able to manage and deliver services under outcomes performance pressures. They thought that PbR, whether under a SIB or not, required a particular style of performance management culture, and work ethic across staff to ensure successful delivery of outcomes.

Stakeholders also reported that Twining Trustees and leadership team liked the contract performance management discipline that the MHEP SIB brought to the delivery of services. In Twining's view, PbR is making the sector more accountable for its performance and outcomes delivered. Fee-for-service (FFS) contracts were never scrutinised, in their view, and so poor performance was hidden or not dealt with. They drew a contrast between MHEP's highly pro-active performance management and its prior experience of FFS employment support services contracts. In their view commissioners do not usually offer equivalent levels of contract scrutiny – they expect it to be delivered as a Quality Audit process within the contract.

Twining did not, however, enjoy the financial impact when the service was performing below expectations and, like Working Well, has arrived independently at a similar conclusion that the maximum proportion of payment at risk to the providers under contracts such as this should be 25%. This does not account for the possibility of other SIB structures where a greater proportion of financial risk (sometimes 100%) is taken by the social investors to insulate providers and may reflect Twining's (and the other two providers') so far limited experience of SIBs. We explore this further in Section 5.

4.3.2 Commissioner experience

Commissioner stakeholders also had different experiences and views on the effectiveness of a SIB approach. As reported in our first review, all three commissioning organisations had welcomed the additional funding and stability that MHEP and the SIB brought to the delivery of IPS services – both because it enabled them to budget with confidence for three years and because it brought in significant

additional funding from SOF and CBO. However, in Staffordshire the experience had turned somewhat sour, and commissioners had sought a way of maintaining IPS while addressing the performance issues that they faced. Stakeholders reported that there were numerous operational issues for Making Space which they were not able to overcome, as already described above, including high turnover of staff, CMHT engagement and embedding with the local mental health teams

Staffordshire reported that they might consider outcomes-based contracts again and would look to learn the lessons from this experience. Their priority had, however, been to 'rescue' this service which they thought they had achieved. In their view, this was a good outcome for both service users (because the service continued) and for Making Space – because it stopped losing any more money and the remaining staff stayed in their jobs after transfer to Step On.

Haringey commissioner stakeholders reflected in an interesting and considered way on both the strengths and weaknesses of the SIB mechanism. As reported earlier, Haringey was part of MHEP 1 and its contract was then extended as part of MHEP 3. Based on both these experiences, Haringey commissioner stakeholders saw a trade-off between the costs of negotiating and setting up a SIB and its operational overhead, and the benefits of pro-active contract performance monitoring and support that the SIB funded. In their view tthe trade-off might be marginal given the extra work that commissioners have to do to agree contracts, but it is a *"question of what are you prepared to do"* to secure additional funding (in the case of MHEP 1 from SOF and CBO, in the case of MHEP 3 from LCF).

This stakeholder also commented that ongoing commissioner time and administrative input was much higher than for other contract types, observing that they committed more time to the £90k p.a. MHEP contract through quarterly review meetings than to a £35m NHS services contract which only reviews performance annually. This should be set against the fact that the MHEP contract was untried and innovative, while NHS service contracts are very much business as usual. It seems clear that commissioner stakeholders decided that the additional administrative time and cost was worth it, given their commitment to MHEP 3.

The commissioner also reported that the data set available to commissioners was narrowly focused on the contractual outcomes. This meant that Haringey's commissioners found it harder to establish whether the project had met their wider social objectives, such as widening equality of access. They also did not want to ask for further information from the provider as they were aware of how significant a burden the reporting on outcomes data was already. Arguably therefore, this is a weakness of the SIB approach and its focus on specific outcomes. Haringey commissioners could of course have asked for more qualitative data to be collected when negotiating the contract, and may have been inhibited from doing so because this contract was effectively sold to them as a pre-configured package.

Commissioner stakeholders reported that Haringey Council and CCG are exploring other areas where they might apply an outcomes-based contracting approach and that given the effort involved in setting them up, it is looking at larger scale programmes which can justify the extra inputs and new models of service where current services are poor. The commissioning team also said that they felt more confident in looking at new opportunities now that they understood the potential for social investment better.

4.3.3 Social Finance experience

As reported earlier and in previous reviews, SF played a pivotal role in the development of MHEP as a vehicle and continues to play a key role in the development and management of existing and new MHEP contracts. SF's views and experiences reflect a position that emerges earlier in this report and in previous reviews, which is that MHEP 1 was to some extent a proving ground for both the MHEP concept and for the IPS intervention delivered through outcomes contracts; it is therefore legitimate to consider MHEP 1 in the wider context of other MHEP contracts and their subsequent success.

First, stakeholders accepted that the forecasts of performance – described variously by other stakeholders as 'unrealistic' - reflected a degree of inexperience. Even though IPS was an established intervention with a relatively strong evidence base, there was, as reported above, relatively little performance data on which to base the business case for MHEP. In addition, according to a senior stakeholder, at the time of MHEP 1:

"We had less experience of what could go wrong, how to support services to turn around quickly, and how to manage that risk from a contractual and financial standpoint. Since MHEP-1, our forecasts have been much more accurate and our financial and impact performance more consistently positive. We also have much deeper experience in the IPS model and have been able to support services to improve performance much more effectively over time, bringing our own operational experts in to support."

Second, stakeholders concede that the unusual and innovative payment structure that underpinned MHEP 1 might not have been the optimum structure and that MHEP has learnt from this experience. In particular, it has adapted subsequent payment structures so that providers bear less risk, and receive more funding in advance, without the risk of engagement or outcome targets not being achieved. This is interesting in the light of the views of both Working Well and Twining that they could not bear more than 25% outcomes risk. According to SF stakeholders:

"Our initial idea was that MHEP, and the commissioner would pay for relatively low-risk outcomes (engagements) whereas SOF/CBO would repay MHEP's investors for higher-risk outcomes [relating to gaining and sustaining employment]. However, we found over time that paying on engagements didn't reduce the risk for providers sufficiently and created a misalignment between the goal of the programmes (jobs) and what we were paying on. Therefore, over time, we have shifted provider payments towards block payments. In most of our more recent contracts, the provider receives 75-90% of their payments on block. The remainder is linked to job starts (and remaining 6 weeks in the job), the lowest-risk job outcome payment"

SF has thus shifted MHEP contracts towards what we would consider a more traditional model, where the bulk of provider cost are funded from MHEP (via social investment), and the balance of risk lies much more with MHEP Ltd than with providers.

Finally, SF stakeholders emphasise that MHEP 1 has provided valuable lessons for subsequent contracts and has enabled them to build an extendable platform. An example is the retention of the 'job start' outcome which was added to MHEP 1 contracts on renegotiation but was built into later contracts from the outset. This is despite, and to some extent because of the complexity of MHEP contracts at ground level and variation between them. Stakeholders told us that MHEP's structure is complicated because it is a multi-geography

programme where each commissioner has the ability to commission independently from the others. This means that each geography often looks a bit different in terms of e.g. structure and payment model. However:

"the very substantial benefit of this has been the ability to expand over time with new commissioners joining the programme. As a result, we now operate in seven independent geographies, one of which covers eight boroughs in West London. We believe this is one of the most geographically expansive SIBs globally; the longest-running operational SIB; and the only SIB that has managed to expand its footprint over multiple, consecutive years".

SF also argue that it has refined and standardised the MHEP model so that *"new contracts are much cleaner, simpler, and more consistent"*. Stakeholders argue that the strengths of its approach have been *'continuous improvement based on experience and testing, leading to a well-oiled model that is cheaper to set up and run'*. It is however questionable whether and to what extent this easy replicability has been achieved in practice, as we analyse further in section 5.1.2.3. It is also a relatively expensive model, as we note in assessing value for money in section 5.2.

4.3.4 Investor (BII) experience

A similar distinction can be made between the long-term experience of BII in investing in MHEP as a whole and its experience of investing in MHEP 1 as a project. Over the longer term, BII's actions speak for themselves, and it has retained ownership of MHEP Ltd and invested repeatedly in new MHEP contracts, in most cases from its Outcomes Investment Fund.

Taken in isolation, BII's views of MHEP 1 were more mixed, in part because at the time we spoke to stakeholders the performance issues around MHEP 1 were still front and centre. As one stakeholder commented at the time:

"It [MHEP 1] doesn't always feel like it will meet expectations as Board meetings are always discussing performance issues".

However, stakeholders were reasonably satisfied because they had been paid interest on the loan to MHEP as due and were expecting to be able to restructure the repayment of principal as already outlined in section 4.2.3.2 above – i.e. BII expected that the principal would be repaid in due course, but from MHEP 2 revenues rather than MHEP 1. As we note earlier, BII's capital was later repaid in full and it also made a reasonable return. In addition, BII had already invested further to support both the IPS Addiction Services project and to provide working capital for the Haringey / Barnet extension (MHEP 3) which started on 1st May 2019.

4.3.5 Service User experience

While we did not interview service users for this review, there are some useful insights into users' views of MHEP and the IPS Support model from the local evaluation undertaken by BIT and referenced earlier in this report,[36] This evaluation covers both MHEP 1 and 2, and in the main provides insights into service users' views of IPS rather than of MHEP's delivery of it through a SIB (an understandable limitation, since we acknowledge that exploration of the SIB effect; with any group of service users, is inherently problematic).

That said, the evaluation does have useful insights across the six MHEP sites and providers that were involved (which we believe include the three MHEP 1 sites[37]): The BIT evaluation found that:

36 See Gadenne, Violette et al (2020) pages 23- 25.

37 Note that the BIT evaluation refers anonymously to six sites and providers, so it is impossible to disaggregate the performance of MHEP 1 providers and contracts

- Service users saw job outcomes as a wider category than simply getting a job: they included completing up-to-date CVs, attending interviews, and gaining knowledge of how to look for employment. They viewed these as outcomes comparable to gaining employment, as they had positively impacted their ability to find employment.

"I've had two interviews, and the applications I'm putting in are getting stronger, and getting stronger to the point where I can get an interview."

Service user

- Service users also described feeling increased confidence, a newly found sense of independence, or reduced anxiety as a result of receiving this support. Receiving employment support from staff trained in mental health meant that service users could discuss their mental health with their employment specialists if they wanted to, and felt supported when they did so.

"I was able to talk about it, but it wasn't – we don't go deeply into my mental health issues. I think it's great because then if it's going to a place where [...] we are going to be talking about it and it's not going to be overwhelming." "The phone is always open, and I think it's a big trigger to kind of deflect my anxiety and so it doesn't build up."

Service user

- The support service users received was described as striking the right balance between keeping a focus on employment support, while still being flexible enough to respond to issues relating to people's mental health, when needed.

The BIT evaluation also identifies three ways in which service users felt employment would impact their lives, practical, relational and emotional:

- Practically, employment was seen to add routine and stability to their lives, both financially and in terms of structuring their days. However, employment was also associated with lessened opportunities for creativity and flexibility. This tension led to service users expecting they would need to compromise between flexibility and structure if they were to find employment.
- Employment was also seen as having relational impacts, and to bring opportunities for socialising and contributing to society. Service users described suffering from the isolation by not being part of the workforce, and saw increased socialisation through working as a positive outcome.
- Gaining employment was also anticipated to impact on emotional wellbeing, which in turn could potentially positively affect mental health. Service users felt they would gain a sense of achievement from the effort put into finding an employed position, and then sustaining this position. Employment was also seen as making them more independent, which they felt would heighten their sense of self-respect.

The Tower Hamlets provider, Working Well also shared some case studies with the CBO team which provide further insight into individuals' experiences. Box 2 below describes the experience of one user, anonymised as 'JA' and Box 3 provides a case study of a second user, 'TM'

Box 2: **Case study of JA**

JA was referred by a consultant psychiatrist to the IPS service in December 2018 after he expressed interest in finding part-time paid employment. He had been under the care of the community mental health team since 2004 with a diagnosis of severe depression and anxiety with psychotic symptoms. JA had previously worked as a Customer Service Assistant for a large supermarket, but he had found that the early starts mixed with his medication were not suitable and only stayed in the role for a couple of months. JA had been in and out of jobs before this, but had gaps on his CV and felt low in confidence. Initially, he struggled to engage with the IPS service as he was finding it difficult to get out of bed and leave the house.

The Employment Specialist engaged JA over the phone at first, building rapport and explaining how the service could help. JA then attended appointments in person and engaged in the vocational profiling process to identify a job role that would suit his support needs. He spoke positively about a previous job working in a car dealership, but found the high pressure associated with the target-driven environment quite overwhelming. Together, the ES and JA identified the optimum shift pattern for him being a start time after 9am and no more than 25 hours per week. A back-to-work calculation was completed to confirm that JA would be financially better off with this income.

The ES identified a local employer, a hardware store that not only offered retail positions but delivery driver positions too that could be suitable for JA. The ES met with the manager and discussed their business needs and the type of candidates they look for. The ES spoke to the employer about JA, his strengths and how he could contribute to their business. A week later, the manager contacted the ES about a full-time role that JA might be interested in. The ES negotiated that the role be split into part-time contracts and it was organized for JA to attend an interview. The ES accompanied him to the interview and JA left saying he had felt comfortable and supported.

JA was offered the role shortly after and started work in May 2019. The ES assisted JA to formulate a plan with his new employer to support his well-being at work. JA is receiving in-work support from his ES and is enjoying his role. Since working, JA reports stability in his mental health and increased confidence.

"IPS has given me the confidence to pick myself up and realise that I can find work and move forward with my life without feeling pressured or inadequate. I have been given a new belief system which has had a positive impact on my life. I am really enjoying working and contributing to society."

Box 3: **Case Study of TM**

TM was referred to WWT by her psychologist at the end of September 2019. She had the goal of securing a job as a Stockroom Assistant in a retail environment, or as a Sales Assistant in a quiet shop, as she reported that interacting with a lot of people can make her anxious. Additionally, she reported having previous negative experiences in employment where she felt that she was not treated well. TM was open to disclosing her mental health to an employer, so the ES utilized some local retail links that the organization had and set up some interviews with them for TM for stockroom roles. TM was unsuccessful in these interviews but persisted with her motivation and engaged in interview practice and preparation.

The ES made a few visits to a local candle shop in order to speak to the manager about their opportunities and get a feel for the environment. Although they did not have stockroom roles at the time, the shop seemed particularly quiet and TM was informed of this as it was in line with her preferences and she said she'd be open to a customer-facing position there. Once it had been confirmed with the Manager that there were positions available, TM attended an interview in early November with the store and was successful in securing a role with them and had her first shift shortly after.

The ES has continued to check in with both the employer and TM to ensure that things are going well. She is being provided with support within her role by the ES, particularly with regard to managing her anxious feelings when serving customers and fears that she might make mistakes. In a follow-up meeting, TM reported that she was still feeling anxious about being on the tills, especially with Black Friday coming up which was going to be busy. The ES and TM discussed how she could make this less stressful, and TM highlighted that it would be good if she could be on the tills less just for that day. This was discussed and the ES suggested that as TM was open to disclosing her mental health she could have a discussion with her manager about her anxiety and that it would be helpful to be on the tills less that day and instead do other jobs. TM was happy with this idea, and after doing this said her manager was very understanding and that she had been helpful throughout the day.

TM has since reported that she is feeling much more confident now than when she started work and feels that working has been good for her. She also has just found out that she is being kept on to a permanent contract which TM said she was extremely happy about. TM stated that she would still like some support, but it was decided that this would be good on a monthly basis as she is now feeling very settled.

"Now being in work has given me a bit of confidence. Even though I am scared of working with people and meeting new faces, I have come to realise that with some support I can handle that."

4.3.6 The National Lottery Community Fund experience

Stakeholders in The National Community Lottery Fund observed that there were a number of inherent complexities to the MHEP structure and its funding that made it challenging to administer. These included:

- The switch of funding from SOF to CBO after the first two years of the contract;
- The associated challenges of ensuring compliance with CBO grant procedures, which required some changes to the way payments were made, and consequent renegotiation of grant funding agreements;
- The differences between the three contracts, each of which had its own operating and payment structure;
- The fact that in two of the three contract areas (Haringey and Tower Hamlets) there have been successor contracts (an extension in Haringey and new contracts in Tower Hamlets). This required some realignment of contracts with the Haringey extension being curtailed to one year (having originally agreed at two years); and
- The fact that the investment by BII was in MHEP Ltd rather than in a specific SIB or contract, and was allocated across two separate projects (MHEP 1 and MHEP 2). This has made it more challenging to reconcile overall financial performance at project conclusion.

CBO stakeholders also made the following observations about other aspects of the project:

- Despite the apparent misgivings of some commissioners about the additional administrative burden of SIB design, implementation, and management (compared to other contracts), they do appear to have had significant benefits from MHEP (both social and financial) and have in two cases sought further support from CBO and LCF for further MHEP contracts.
- The CBO team was disappointed that levels of referral and engagement were well below target, but welcomes the fact that subsequent projects have been more realistic in their expectations, and therefore more achievable.
- This has however been an argument for successor MHEP projects having required high levels of subsidy (from LCF) than they were granted under CBO. The model is in any case heavily dependent on commissioner funding and does not appear to be viable without it. This does suggest that direct funding of IPS by the NHS (as now in place) is likely to be a more sustainable model in the longer term than a SIB/SOC-based approach.
- The CBO team also expressed some disappointment that there hadn't been more learning from the project, and in particular a robust local impact evaluation had not been commissioned. In their view while the BIT evaluation contains some useful insights, it does not provide strong conclusions about the effectiveness of MHEP either in its own right or compared to alternatives.

5.0 Successes, challenges and impacts of the SIB mechanism

This chapter discusses the overall learning, in terms of the successes, challenges and impacts, of funding the IPS intervention as a SIB and via MHEP, compared to funding this project through another mechanism (such as fee for service or PbR). It also addresses overall value for money, as judged by both stakeholders and, so far as possible, independently by us as evaluators.

In this section we focus on the impact of MHEP 1 although for reasons that we explain in previous sections, it is challenging to completely disentangle the impact of MHEP 1 from MHEP as a whole in some areas.

5.1 Successes and challenges of the SIB mechanism

5.1.1 Ability to create and promote a replicable model

MHEP was explicitly created as a vehicle that would enable multiple commissioners to purchase IPS through an outcomes-based model and to do so with sufficient flexibility to be able to reflect local preferences and structures. Both this flexibility and the ability of MHEP to scale were identified as benefits in our first review but were at that time unproven. It now seems reasonable to conclude that this objective has been realised, with seven core MHEP projects in place or completed and a further related project – Addictions – covering eight commissioners on its own.

We think it unlikely that such a model could have been constructed and implemented without the use of a central delivery vehicle and the deployment of social investment. While MHEP could theoretically have been constructed to deliver conventional contracts, it would have been difficult both to develop the model and to deploy it without social investment to provide working capital, although this argument is somewhat circular: the need for investment would have been lower without the PbR element, and part of the attraction of the SIB (both to its developers and to its commissioners) was the availability of CBO and SOF support.

On balance, however, we think it right to view it as a clear SIB effect and benefit of the SIB mechanism, that MHEP was able to initiate new contracts across a number of commissioners in different geographies. However, this benefit was not as obvious when MHEP 1 was initiated and implemented as it appears now – in large part because MHEP was a 'work in progress' and providers bore more risk in MHEP 1 than they do now. We discuss these issues further under disadvantages below.

5.1.2 Strong and additional performance management

Most (but not all) commissioner and provider stakeholders told us that they valued the role played by the MHEP Central Team in providing external and additional performance management of contracts, and support to providers when they faced challenges – as all did in MHEP 1. in the second review, one provider thought the support was *'head and shoulders above the usual contract management experience'*. Commissioner stakeholders – especially in Haringey – also valued the Team's support and the Haringey provider – Twining – expressed a clear view that this level and quality of performance management would not have been present in a conventional Fee for Service contract.

In their view it was also a specific benefit of this being a SIB – which provided additional funding for the contract management team from social

capital – that would not have existed in a PbR contract – where it would be more likely that the provider would themselves manage performance.

As the second review of MHEP also identified, the investor thought that

"If there were just an investor to provider direct relationship, then it would be different, probably slower and the provider would likely to be in a worse position before remedial actions were taken'.

The benefit of this level of additional performance management was not however clear to all stakeholders, with feedback from Staffordshire stakeholders being more mixed. What is also unclear is whether, despite the value placed on it, the MHEP Central Team was always able to make the difference required across the MHEP 1 contracts. While supporting and enabling changes in a range of areas, it appears that the issues faced by providers were largely due to providers' inability to recruit or retain enough staff of high calibre, and that these issues were exacerbated by the pressures providers came under on these contracts because they could not generate enough user engagements and/or job outcomes to cover their costs.

It is thus arguable that the problems faced by these contracts were more structural than operational – and could not entirely be solved by performance management however effective it might have been. This issue is again most obvious in Staffordshire, where the active performance management of the contract could not save it, and the contract was terminated before its planned end date.

Finally, it is worth noting – as we discuss further in section 5.2.1 below – that this performance management came at a high cost, with performance management and other overheads accounting for 23% of total costs. These costs need to be set against the benefits outlined above, though MHEP stakeholders observed that:

- A significant cost is accounted for by the need to meet SOF/CBO reporting requirements rather than working with commissioner and providers and reporting to the MHEP board; and
- Any contract with a prime contracting structure will have overheads to cover contract management – although we are unable to evaluate whether these would typically be higher or lower than those incurred here[38]

5.1.3 Enabling a wider outcomes-focused culture among providers

Both Working Well and Twining stated explicitly that they had benefited from the additional discipline and scrutiny of delivering an outcomes-based contract. This had improved their culture and ability to deliver future contract on an outcomes basis, with the clear caveat, in both cases, that they would not want more than 25% of payment to be linked to results.

It is slightly difficult to disentangle the extent to which this is a result of working in a SIB context (and responding to the pressures of regular and better reporting, for example, and the external challenge and scrutiny of the MHEP central team) or was a natural by-product of the providers improving their recruitment and retention processes – i.e.: they simply had better staff with the right behaviours, rather than staff undergoing a significant culture shift. The comment of one senior provider stakeholder that they 'got lucky' with recruitment, somewhat suggests the former. On balance, however we think that both providers, and especially Twining's, clearly benefited from working in an outcomes-based environment.

38 Stakeholders reported that similar programmes have seen prime contractors take margins of up to 30% but we have been unable easily to find evidence to support this

5.2 Challenges and disadvantages of the SIB approach

5.2.1 Optimistic modelling and forecasting of engagements and outcomes

All three contracts quickly fell behind targets for both user engagement and job outcomes. This had significant consequences for the overall viability of providers and for commissioner perceptions of project success. All three contracts had to be renegotiated and reset. A substantial part of the reason for this – alongside other factors such as providers being not as well prepared as they should have been for rapid contract mobilisation, or simply being unable to retain staff – was that the original performance targets were widely thought, and proved in practice to be unrealistic.

In our view there is evidence that both the business case forecasts prepared by MHEP/SF, and the bids by the providers to deliver the targets implied by those forecasts, exhibited optimism bias[39] As we observe in section 3.2 of this report this seems somewhat surprising when a major reason for selecting the IPS intervention was its strong evidence base – with no fewer than 22 randomised control trials demonstrating its effectiveness.

Such an evidence base does not guarantee avoidance of optimism bias – and SF point out that the evidence contained relatively small amounts of true outcomes data on which to base forecasts. We would, however, argue that the forecasts should have been deliberately de-risked, in line with Treasury Green Book guidance, which advises that 'appraisers should make explicit, empirically based adjustments to the estimates of a project's costs, benefits, and duration. to avoid optimism bias[40].

Providers also exhibited optimism bias when they bid to deliver targets that rapidly proved unachievable, and in one case bid under the proposed outcomes tariff. This arguably shows either naivety or a deliberate tendency to over-promise on the part of providers. We would certainly argue that a bid which undercut the proposed tariff should not have been accepted – as stakeholders, with hindsight, conceded in our second review. Essentially bidders could and arguably should have been invited only to bid on quality – i.e. how they would deliver targets at the specified tariff, rather than also bid under that tariff if they wished to do so. There does not appear to have been any requirement to inject competition on price at this point, and experienced advisors on SIB development should have been aware of the risks in an outcome contract of driving intervention costs down, rather than trying to maximise engagements and outcomes achieved.

A final point is that even if the under-performance of providers against targets could not have been foreseen, it might have been prudent to anticipate it as a possible risk and build a 'test and learn' approach into the contracts, with regular review points. Instead, contracts were allowed effectively to 'fall over', in the words of one stakeholder, and then had to be completely reset.

5.2.2 Inappropriate balance of risk between providers and MHEP

A second key issue was that the initial design of MHEP - which envisaged providers receiving funding only from user engagements, albeit supported by an initial block payment on account – appears to have been flawed and to have passed an inappropriate amount of outcomes risk to providers. Once block payments were expended, providers appear rapidly to have fallen into deficit, so compounding the issues they were already facing in mobilising challenging contracts and retaining management and staff. As we have explored in all three reviews of MHEP 1, the plan to fund providers solely on outputs had to be abandoned, and block payments both reintroduced and increased. Even with larger block payments, however, the majority of delivery costs were still linked to outputs– with less than a third of payment to Making Space in

39 The Treasury has issued guidance that supplements the 'Green Book' and defines optimism bias as 'a demonstrated, systematic, tendency for project appraisers to be overly optimistic'.

40 See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/191507/Optimism_bias.pdf

Staffordshire being in a guaranteed block, for example. Although performance targets were also renegotiated there appears to be a view among some stakeholders that these changes were 'too little too late'.

As we observe in section 3 this funding structure was innovative and unusual; it was also an attempt to both help providers get used to PbR which partly succeeded, and aimed to find the right balance of upfront and variable, outcomes-based funding by a process of trial and error. However, SF now appear to realise that the amount of upfront funding needs to be much greater and set at around 75%. This is exactly the same proportion that MHEP 1 providers also concluded to be appropriate.

This imbalance of risk is further demonstrated by the fact that the social investor – BII – continued to receive interest payments on its loan capital and has made a small return on MHEP 1 and a more significant return (slightly ahead of plan at Median scenario) on its investment across MHEP 1 and 2. In addition MHEP retained a surplus according to end of project data. To casual observers of SIBs – which are often advocated as beneficial because investors bear outcomes risk while providers are funded to deliver free of outcomes pressure – this might seem counter-intuitive.

5.2.3 Complex operating and commissioning structures

A third disadvantage of the MHEP approach is that it appears to have very complex structures, arguably unnecessarily so, with a high degree of variation at local and individual contract level. This means that the replicability of the MHEP model as discussed above is arguably overstated, and . Commissioners told us that there was a significant challenge in agreeing contracts, and that this did not diminish when agreeing successor contracts. They also said that the model and individual contracts are extremely hard to understand even by the standards of SIBs and SOCs, which are necessarily complex structures. This to some extent relates to the issue of payment structures discussed above: a simpler structure with less convoluted payment arrangements might also be more easily replicable.

SF argue that the structure of MHEP contracts is necessarily complex and unique in order to accommodate local preferences as regards payment etc, as well as the vagaries of local commissioning arrangements. Such complexity does however mitigate against transparency and any attempt to assess whether individual contracts were truly good value for money. Moreover our in-depth reviews include examples of multiple contract structures – notably the Positive Families Partnership[41], and to a lesser extent HCT Travel Training[42], where intermediaries and providers have been able to replicate contracts with arguably less complexity and local variation, and more standardisation – though we do not underestimate the challenges that these projects also faced in engaging commissioners and accommodating their requirements.

5.3 Value for money of the SIB mechanism

This section provides an overall assessment of whether the MHEP 1 family of projects provided value for money, based on the views and experiences of stakeholders and, so far as possible, our own independent evaluation.

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

41 See https://www.tnlcommunityfund.org.uk/media/insights/documents/CBO-Positive-Families-Partnership.pdf

42 See https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO_Indepth_reviews_HCT_independent_travel.pdf?mtime=20190320122439&focal=none

5.3.1 Economy

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

Economy, and keeping costs to a minimum, is generally of less importance than the other VFM dimensions in SIBs and Social Outcomes Contracts (SOCs). This is because keeping costs down can work against the overriding objective of maximising outcomes achieved – especially when those outcomes are intended to create savings or otherwise justify the spending on the intervention. Indeed, CBO guidance made clear that it would not fund models whose primary purpose was to reduce costs.

It is however still important that costs are as low as they can be while being consistent with this overriding objective, and it is clear that economy was an important issue at various points within this project

First, a primary economic consideration is whether the additional costs of delivering the IPS intervention via MHEP, and therefore through a SIB structure, were proportionate and reasonable. Table 2 sets out the delivery and other costs incurred by MHEP 1, as reported to the CBO team at end of grant.

Table 2 **MHEP 1 project costs**

Type	Description	Amount	% of Total
Core costs	Delivery by providers	£1,296,896	73.4%
	Generic Project costs	£29.192	1.6%
SIB costs	Delivery support by MHEP	£230,442	13.0%
	Investment Return (incl £15K investment set up)	£85,804	4.9%
	MHEP SIB Management – SPV costs, Data analysis, SIB perf oversight, *	£69,295	3.9%
Other	Evaluation	£54,709	3.1%
Total		**£1,766,258**	

* SPV - £40,133; SIB performance oversight and data analysis £29,162

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

As this shows SIB Overheads – management, evaluation and investment costs, were low as a proportion of total delivery costs. However total delivery costs include a substantial cost related to the MHEP Central Team – shown here as MHEP support to delivery. If these are regarded as delivery costs, the total 'on cost'- of the SIB was only around 10% of total costs. As we note earlier in this section, however the MHEP Central Team was regarded by nearly all stakeholders as an additional cost (and benefit) that only existed because of the SIB structure, and it was effectively a requirement of participation in MHEP that these costs were paid. If these costs are included in the additional cost of the SIB, as we

believe they should, the total on-cost increases to around 17%, and to more than £300,000 in total.

Much depends, therefore, on whether this extra cost is viewed as worthwhile. According to most stakeholders – both providers and commissioners – the general view is that the support was valued but its total cost may not have been obvious, making it less certain that they thought the support was good value for money. Staffordshire stakeholders also did not value the central team as much as others. It is also unclear that the central team made a degree of difference to outcomes that justified this level of cost. As we note in section 4.2, the improvement in outcome performance once the central team became more active was not significant, and it is arguable that the central team was expending significant time and money attempting to resolve issues whose root causes lay elsewhere – notably in chronic understaffing and providers and commissioners not maintaining fidelity – especially with regard to integration of IPS provision within CMHTs.

From a wider stakeholder standpoint, commissioners clearly thought the contracts presented good value for money at the outset, while freely admitting that much of that value was in the subsidy from SOF and CBO. They also appear to have been happy with the amount they were expected to pay for individual outputs and outcomes – initially user engagements and latterly job outcomes. However, they were also contributing to block payments, and therefore not offered one key benefit of some SIBs – that they would have to pay nothing unless the outcomes were achieved.

5.3.2 Efficiency

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

Efficiency, like economy, is in broad terms less important than the effectiveness dimension in assessing SIBs and SOCs. However, one critical aspect which falls under the efficiency dimension is whether the project was able to deliver the right number of referrals and engagements, since these are a critical output which in turn drives outcomes.

As we note in section 4.2, this is a key area where all the projects did not meet performance expectations, and, therefore, the subsequent performance of all the projects was adversely affected.

What is less clear is whether these issues are a consequence of the SIB model or would have occurred if these projects had been conventionally funded. As we argue in section 5.1.2 above, referral and user engagement targets were missed partly because they were unrealistically optimistic, and it is unlikely that these targets would have been so challenging – or even existed – if this had not been an outcomes contract, not least because the providers had no previous experience of such tight scrutiny of outputs and outcomes in any other contract. At least some of the shortfall was, however, due to some of the providers finding it challenging to deliver IPS to the standards required of a high-fidelity intervention, and such standards would (or certainly should) have been a condition of any contract for IPS.

It also seems reasonable to conclude that the action taken to address these issues, - supported by the MHEP Central Team – was both quicker and more intensive than it would have been in a conventional contract, though we cannot be certain of this. The MHEP Central Team also helped support providers in attempts to improve the referral rate and better integrate IPS into reorganised CMHTs, especially in Staffordshire and Tower Hamlets, as stakeholder feedback confirms.

However judged objectively the cost per referral was high, since referrals and engagements were lower than expected throughout and remained low despite the input from the Central Team, which itself added considerably to costs.

5.3.3 Effectiveness

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

Since effectiveness is a measure of outcome, it is almost by definition the key dimension for an outcomes-based contract. In this case it is clear that the project did not, in most cases, meet its outcomes targets and both overall and by contract the project fell below the Low/worst case scenario presented to the CBO team at contract start (with the exception of the job start outcome introduced at 2018 contract renegotiation, where performance was as planned per contract in Staffordshire and Tower Hamlets. Engagements were also ahead of target in Tower Hamlets in 2019/20.)

Again, however, it is difficult to be certain whether the MHEP structure and, in particular, the MHEP Central Team made a significant difference to overall performance. First, outcomes were always likely to be below target once user engagement fell short of expectations. While this is a very simplistic comparison, performance against plan across the three main outcomes (job starts, six-week employment and six months employment) was almost exactly the same as user engagement performance against plan (60% of plan for outcomes, 59% of plan for engagements). This mirrors our experience of other reviews, where referral and/or engagement is the key driver of overall performance, and projects are almost invariably unable to increase outcomes if engagements fall short.

Secondly, all the providers faced varying degrees of challenge in maintaining full capacity and, therefore being able to deliver the IPS intervention with full effectiveness. The evidence suggests that the MHEP Central Team could not make a substantial difference to this challenge, and it is at least arguable that the payment and funding structure of MHEP 1 – which left all the providers facing cashflow issues - could only have made it more difficult for them to deliver effectively.

Under the effectiveness dimension we also consider whether the contract met its wider objectives as set out in its business case and application to the CBO. The most important of these is whether MHEP succeeded in its objective of creating a platform for further IPS contracts, and as we comment in section 5.1.1 above it seems clear that this has been achieved.

5.3.4 Equity

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

The main group affected by the equity dimension is service users – i.e. people with mental health issues needing intensive support to gain employment. As already explained in section 4.3.5 we did not conduct research with service users as part of this review, but there is some evidence for the impact of MHEP on service users from the separate local evaluation conducted by BIT This found that users had identifiable personal and relational benefits from being supported into employment, and ultimately finding and retaining jobs, although this evaluation did not look specifically at the equity dimension.

A second equity consideration is whether the operating structure of MHEP could be seen as fair to all parties. As we discuss in section 5.1, it was arguably inequitable to providers to a degree, since they were bearing more outcomes risk, and therefore financial risk, than they might have expected, and also experiencing losses while others, including the investor, were not. We note that the BIT local evaluation also includes an analysis of provider costs and shows that across four anonymised providers, Provider 1 made a loss of £42,650, Provider 2 a loss of £16,967, Provider 3 a loss of £953, and only Provider 4 made a profit, of £5,859.

Against that, two of the three providers of MHEP 1 had a positive view of their involvement, and believed that they were better equipped both to deliver IPS and to do so through outcomes-based contracts at the end of MHEP 1 than they were at the start. Indeed, both the Tower Hamlets and Haringey providers have won further MHEP contracts with the same commissioners (via MHEP 3 and MHEP 6 respectively).

5.3.5 Overall cost effectiveness

Short definition: The optimal use of resources to achieve the intended outcomes.

Overall we find it hard to conclude that MHEP 1 on its own represented good value for money. Commissioners were attracted to it by the promise of SOF and CBO funding, and by the opportunity to maintain and expand existing services which were under cost pressure. However, the outcomes achieved fell well short of what they were led to expect, and they had to put considerable effort into maintaining services or, in Staffordshire's case, rescuing the service by absorbing it into another contract. While the commissioners other than Staffordshire, and all three providers valued the support provided by the MHEP central team, this support added considerably to costs and it is hard to see how these costs can be justified in terms of additional impact for local commissioners or service users. In addition, the payment structure and the way funding was channelled to providers also made it more difficult for them to deliver effectively.

Taking a wider perspective, it is easier to argue that MHEP as a whole has been and will ultimately prove to be good value for money. SF certainly take this view, and argue that MHEP's model should properly be compared to other multi-funder models for commissioning IPS, since if compared it to a single commissioner funding IPS services on a fee-for-service basis, it will always look more complicated and expensive. Taking this wider perspective, SF argue that MHEP has been able to:

- Combine local and national funding to achieve multi-commissioner collaboration – in one case (in 2019) bringing together 19 independent commissioners.
- Operate initially across three commissioning partnerships (expanding over time to seven), adapting the model to the needs of each commissioner.
- Develop a platform with enormous IPS expertise which it can bring to all the commissioners and providers in the MHEP portfolio – this included expertise on service specifications, targets / performance levels, outcome metrics, IPS fidelity, operational support, and shared learning across providers.

As a senior stakeholder from SF who has been involved in MHEP from the start commented:

"I'm very confident we have supported our commissioners and providers to access significantly more funding from a much wider range of sources and to deliver significantly better outcomes than they would have been able to without MHEP"

As is usually the case it is difficult to test the validity of such claims without knowledge of the counter-factual – i.e. where and to what extent any and all of the MHEP commissioners might have implemented IPS without MHEP providing a channel for them to do so. Some commissioners were not attracted to the IPS intervention even with MHEP sponsorship (for example Birmingham) but on the whole it did attract commissioner interest and has so far created eight projects.

On balance, therefore, we think it unlikely than many or all of these commissioners would have commissioned IPS on their own, and therefore MHEP did, to that extent offer them value, especially in enabling them to access funding from SOF, CBO and LCF. It is however less certain that they would not have got better value if they had not gone it alone – and themselves commissioned IPS through an outcomes contract and applied directly for the central funding.

6.0 Legacy and sustainability

As will be clear from analysis in previous sections, MHEP scores well in terms of both local legacy and national sustainment, In particular:

- MHEP as a model has now been replicated across a further seven projects, including Addictions, though each one has had to be adapted to local conditions, limiting the easy replicability and scalability of the MHEP model;
- Two of these projects are extensions or new projects initiated by commissioners of MHEP 1, Haringey (extended into MHEP 3) and Tower Hamlets (commissioner of both MHEP 6 and 7);
- Although Staffordshire did not conclude the MHEP contract it has continued to commission and fund the IPS intervention. In addition, the County Council has since commissioned other outcomes contracts, though we cannot be certain whether its experience of MHEP was a positive influence in it doing so. For example, it commissioned the Integrated Family Support Service (IFSS) which aims to improve outcomes for children in need and avoid escalation to them being looked after[43].

A wider legacy of MHEP is in the positive effect and influence it appears to have had on the wider adoption and funding of IPS as an intervention by NHS England (IPSE), through an initiative known as 'IPS Grow'. To explore this we interviewed NHSE stakeholders and in summary identified that:

- SF and the MHEP team were consulted during the development of NHSE's plans (see Box 4 below for further details); and
- SF has been actively involved in the implementation of IPS since 2019, following selection through open competition.

It is thus reasonable to conclude that MHEP provided valuable learning to the IPS roll out and the experience of the early MHEP projects was important in highlighting the potential pitfalls of an IPS roll-out and what support could help mitigate the risks around it. In MHEP stakeholders view, the rollout took learning from MHEP on three specific issues:

- The need for operational support to ensure fidelity to the model and quality delivery
- The importance of support for the workforce as a key success factor for good outcomes from IPS; and
- The need for effective tools to monitor outcomes

We would note, however, that NHSE has not adopted the outcomes-based contracting and PbR model that underpins MHEP. Although IPS Grow is measuring outcomes, outcome achievement is not a requirement of funding which is provided on a conventional basis. In addition there is little evidence that MHEP directly influenced the mainstreaming of IPS by the NHS, and the timing of both initiatives suggests that the NHS was already exploring the funding of IPS before MHEP was implemented.

43 See https://golab.bsg.ox.ac.uk/knowledge-bank/indigo/impact-bond-dataset-v2/INDIGO-POJ-0173/

Box 4 – **NHSE IPS Grow Roll-out**

In 2016 (around the same time as MHEP I started) NHS England published its independent Five Year Forward View into mental health services provision, the authors of which recommended making employment a mental health outcome, doubling patient access to IPS services across the country.

Both of these recommendations were accepted and taken up by NHSE, and as part of planning for wider IPS implementation NHSE consulted SF and the SF team, among others.

In January 2019, the Long-Term Plan was published which aims to increase access to IPS provision to 50,000 patients by 23/24 and 100,000 by 28/29. These are ambitious targets and again, SF/MHEP were helpful in providing input costs and modelling data to help inform NHSE planning to deliver these outcome targets.

Funding so far has been distributed through the Sustainability and Transformation Partnerships (STPs) in two Waves, with Wave 1 funding the extension of IPS in existing areas, and Wave 2 funding the introduction of IPS in areas where there has been no prior provision.

In March 2019, SF tendered and was appointed to deliver IPS Grow and provide implementation support to Wave 2 areas until March 2020, with potential to extend support thereafter. It support is being delivered via seven implementation leads/ champions (plus one national manager) providing mentoring to leadership teams and also helping with stakeholder engagement; setting up of Steering Groups to overcome implementation challenge; workforce training and development of employment specialists; and facilitating learning through regional communities of practice, and shared learning events / forums etc.

7.0 Conclusions

7.1 Overall conclusions and evaluative insight

Overall, it is difficult to disentangle MHEP 1 from MHEP as a group of projects promoted, designed, and managed through a single vehicle. MHEP 1 was the first MHEP project and effectively seems to have acted as a testbed for later projects. Stakeholders, especially those who are invested literally and metaphorically in MHEP, have admitted that there was a significant element of trial and error in MHEP 1, and that subsequent MHEP projects have benefited substantially from learning from it. Moreover MHEP 1 was not only the first SIB in health and employment globally, but also one of the first locally commissioned SIBs of all. It was perhaps the fifth such SIB to be commissioned, though other SIBs had been commissioned sooner using central funding (notably through the DWP Innovation Fund and the Fair Chance Fund).

This adds to the challenge of evaluating MHEP 1 as a stand-alone project and the benefits of it being a SIB. Many of the benefits cited by commissioners and providers throughout this cycle of reviews are not strictly benefits of the SIB mechanism. To commissioners they were largely benefits of additional funding (from SOF and CBO) and of commissioners having a mechanism by which they could procure IPS in a way that would almost guarantee access to that funding. To providers, they were benefits of them being able to improve their operational capacity and capability to deliver IPS – although there was also some benefit to them being more able to do so through outcomes contracts, especially after MHEP payments to providers were restructured in 2018.

Initially the only unchallenged benefit of MHEP being implemented through a SIB was that it was able to become the platform it was intended to be for bringing commissioners and providers together to deliver IPS (though it did have some lesser benefits in enabling providers to avoid some financial risk). This was however a very important benefit, and one central to MHEP's objective of combining local and central funding.

It has not, however, clearly demonstrated that by doing so it has achieved better or more outcomes than could have been achieved by IPS delivered through a different mechanism, in part because the project was not designed with a counterfactual measure that could prove additionality and attribution (and there was no comparison attempted in the local evaluation by BIT). Although some subsequent contracts may have achieved more outcomes than a fee for service contract or in-house service, it is outside the scope of this evaluation[44]. to make that judgement (and those later MHEP contracts also did not attempt to measure impact against a measure of the counterfactual). Moreover, future performance and replication does not of itself justify the three providers and commissioners of these contracts being part of what effectively became a pilot exercise to find the right balance of block and outcomes-based payment through trial and error – especially as the test mechanism was effectively to allow providers to fail and then reset the contracts, rather than adopt a true test and learn approach.

Furthermore the fact that both commissioners and providers were positive about MHEP, and that other MHEP contracts have been awarded, should not, in our view, disguise the shortcomings of MHEP 1. This SIB shows some of the potential pitfalls of SIBs that we have seen elsewhere. Most notably:

- Commissioners have understandably welcomed a mechanism which offers them a way to deliver services that might otherwise have been

44 We note that the evaluation of the LCF, as part of its supplementary evaluation, is aiming to address this question in relation to LCF-funded MHEP projects and to "answer whether and how MHEP Social Impact Bonds – specifically the outcomes contracts and/or performance management function – make a difference to the social outcomes achieved, compared to alternative commissioning approaches" See https://golab.bsg.ox.ac.uk/about/outcomes-based-contracting/our-role-in-evaluating-the-life-chances-fund/

unaffordable, but there must be some concern that a key attraction of MHEP for local commissioners was that it came with additional funding form SOF and CBO, rather than a strong attraction to a SIB approach per se or to the ability to test a combined central/local funding model... The funding was entirely justified, especially from SOF, because much of the direct financial benefit from MHEP accrues to the DWP, rather than to local mental health commissioners, and SOF was explicitly designed to help overcome this type of 'wrong pocket' problem. However this also means that the model is unlikely to be self-sustaining unless central funding is available (as it has been from the LCF for subsequent MHEP contracts) Since there is no successor to LCF on the horizon, the model is unlikely to sustain in the long term unless local commissioners are prepared to fund IPS in full, or DWP are prepared to part-fund an approach from which they are a key beneficiary

- Local commissioners were clearly also attracted to the social and health benefits of people with mental health issues finding and keeping work (as are NHSE nationally) but the levels of performance achieved by MHEP fell far short of what they were promised, and therefore the impact of the project on local communities and individuals was relatively disappointing. There was also a vicious circle of performance shortfall leading to lower-than-expected engagement payments and thus to an inability to recruit sufficient high calibre staff – damaging performance further.
- Providers have similarly faced challenges when they were unable to achieve the user engagement targets set. As we observe below, this was in our view largely a result of the contract design, but was also partly of their own making, since they accepted the targets set (and in one case bid below the proposed tariff). This is important context for the positivity that all the providers (even the one whose contract was terminated) have expressed about the MHEP central team. Providers who are used to being 'on their own' when contracts do not go as expected will rightly welcome this type of positive performance management and operational support, and we have found that such support is increasingly a feature of many SIBs. They may, however, not have needed so much support if the targets they were set had not been so challenging, and apparently incorrectly calibrated. Moreover, they only faced the financial pressures that created a vicious cycle because they were being asked to take on a high proportion of the financial risk of outcomes being achieved – and a much higher proportion than is now the norm across current MHEP contracts.

In our view the root causes of the performance issues lie in the engagement and outcome targets set, which proved to be optimistic. As already noted, it appears that the original assumptions around achievable levels of user engagement and employment outcome were either incorrectly calibrated or were not stress-tested sufficiently before MHEP 1 launched, and it was by no means a success in terms of achieving its original targets, achieving only 59% of planned levels of user engagement and 60% of planned employment outcomes overall.

The most important conclusion to be drawn from this is that forecasting referrals and outcomes is inherently challenging and therefore there is a high risk of targets being missed unless they are substantially de-risked and based on a pessimistic view of likely performance, SF was, by 2016, a relatively experienced designer of SIBs, and based MHEP on a recognised, high-fidelity intervention (already endorsed by NHSE) which arguably should have had a sufficiently robust evidence base to enable realistic forecasts of outcomes and social impact. In addition, as one provider observed during our first review, MHEP's targets for the level of successful engagement were higher than those that the Centre for Mental Health would recommend for achieving IPS Centre of Excellence status, which might have indicated caution.

Against that, stakeholders told us that the evidence base provided relatively little reliable data on which to base outcome forecasts, and confirm that they did de-risk those forecasts to take account of the quality of the data. While SF had experience, it was designing an innovative structure and approach and there was little previous experience of similar projects from which to learn. Commissioners were also involved in setting targets, and in Staffordshire asked for targets to be based on reported performance under previous contracts, which proved misleading.

We also note that national programmes have shown similar levels of optimism and over-estimation of performance, even when they had the opportunity to learn from previous programmes, An example is The Restart scheme for long-term unemployed people, commissioned by DWP. AS the NAO noted in their report on this programme[45], Restart built upon DWP's previous employment programmes including :the Work Programme, the Work and Health Programme (WHP), and the Job Entry Targeted Support programme (JETS), , but *"DWP overestimated both the number of claimants who would be eligible for Restart and the proportion of eligible people who would be found suitable for the scheme. DWP's forecast of the number of people who will participate in Restart has fallen from 1.43 million to 692,000"*

A further factor was that high performance through IPS depends on high compliance with its fidelity constraints but as we note above,. there was a lack of fidelity to IPS during implementation in some areas– especially as regards integration with mental health teams. The MHEP team worked hard to address this, but as we have found elsewhere those delivering an intervention (under a SIB or otherwise) have limited ability to influence how well it is integrated into a wider public sector system.

In this and in other areas of design there is no doubt that the MHEP team learnt much from this project which they have been able to apply to later MHEOP projects – especially those funded through the LCF – and thus enable them to achieve performance closer to expected levels. Changes made in later projects include more realistic targets, larger initial payments to providers, and closer adherence to IPS fidelity protocols.

The most important consequence of the design of MHEP 1 was that did not insulate the VCSE providers sufficiently from financial risk. At the low performance levels achieved this led to a downward spiral of additional pressure, increasing staff turnover and the creation of further undershooting of performance targets.

Since MHEP 1 could not learn from previous projects, it in effect became a de facto test and learn project after go-live but without the inbuilt design features of true 'test and learn', and providers, commissioners and MHEP therefore had to completely re-set, based on their initial experiences. This included a switch to or continuation of fixed block payments as it turned out that the risk borne by VCSE providers, in having to meet high engagement levels in order to meet service costs, was too high. This should not have been a surprise, since by 2014 there was already evidence that many VCSEs were not financially strong enough to take on PbR contracts, as we noted in our First Update Report under this evaluation[46].

In this context the efforts made by the MHEP central team to resolve the issues were admirable, but they beg two important questions which we have asked of other SIBs that we have recently evaluated. The first is that SIBs are good at resolving operational and performance issues, partly because they often have in-built teams to address them, and partly because commissioners, providers and investors often have a strong alignment of interest in resolving the issues and making the project a success. The moot point, however, is whether at least some of those problems are created by the SIBs themselves, through over-complicated contractual and payment structures and errors in contract design.

The second question is whether the additional cost and effort involved in this degree of performance scrutiny is justified by the additional social impact achieved – especially when compared to what might be achieved by a conventional contract or simpler SIB or other outcomes-based commissioning arrangement. This is a very difficult question to answer because an equivalent conventional contract is not available for comparison, and is part of the unknown counter-factual. Even so, in MHEP 1's case the results do not immediately suggest that the performance management overhead was justified, and if anything the linking of a proportion of user engagements, and later job outcomes to payment appears to have had more downside than upside for providers.

Finally, although it is partly outside the scope of this evaluation to consider the extent to which MHEP has been a successful replication model,

45 See http://files.localgov.co.uk/nao_638055778773112224.pdf sections 1.7 and 2.6 – 2.8

46 https://www.tnlcommunityfund.org.uk/media/research-documents/social-investment/CBO-Update-Report_Full-Report.pdf?mtime=20190215124522&focal=none page 28.

we would observe that it shows some of the benefits and disadvantages of such models that we have also seen elsewhere, and considered in detail in research for government in 2019[47].

- On the upside, such models make it easier for commissioners to engage at minimum risk and cost to them, compared to contracts that they lead and design themselves from the 'bottom up'. In this case they also had the opportunity to combine local and central funding in an innovative way that they could not easily have attempted alone.
- On the downside, commissioners may not fully consider the value for money of such a model, especially compared to alternative ways of contracting for the same intervention. Commissioners were attracted to this model and saw it as good value for them, but partly because it offered them the chance to fund IPS with additional funding from government (though SOF) and The National Lottery Community Fund (through CBO). The Haringey commissioner was explicit about this, and told us that they were interested in the MHEP proposition because it brought extra money to an IPS service that they had already commissioned.

The unanswered question is whether commissioners could have achieved both these benefits in different and more direct ways. As commissioners they could themselves have applied to CBO for development and to SOF and/or CBO for top-up funding, either for a simple PbR model or for their own 'commissioner-led' SIB[48]. They could also have themselves paid for independent contract management support rather than the service packaged into the MHEP proposition. They might still have had to spend more time and effort than usual negotiating bespoke contracts, but contracts were highly variable between sites under MHEP in any case, and they were not relieved of the burden of procuring and selecting providers, which remained their responsibility.

Commissioners might also have been able to strike a deal with providers that balanced the risk between them more appropriately. CBO or SOF support would only have been available for an outcomes contract with more than 50% PbR, but under MHEP 1 providers were paid initially for user engagements, and then a mix of fixed fee and job outcome payments, and any LA or CCG commissioner could have implemented a similar mixed fixed fee/outcome payment model direct with providers. Indeed, Haringey CCG already had a fixed fee contract with their provider, and were only attracted to MHEP because of the SOF and CBO funding that it brought.

It is also arguable that if themselves designing the contracts, commissioners might have set more achievable targets for providers, although this would have been unlikely in Staffordshire, where the commissioner themselves set the MHEP targets for Making Space based on previous reported performance.

Similarly, if contracts were constructed with a high element of block payment providers could have raised their own working capital directly form BII or another investor. Block payments to providers, like those implemented anyway through MHEP 1, would have insulated providers from excessive risk and made it easier for them to raise their own capital. This would likely have been simpler than the complex engagement and outcome - based arrangements put in place by MHEP, but would have required commissioners to do more of the work themselves (though they could, like SF, have applied for CBO development grant).

On this basis it is arguable that the true additional value of MHEP boils down largely to relieving local commissioners of the hassle of thinking through these issues for themselves, and then designing and implementing a SIB 'bottom up', rather than relying on an experienced intermediary to do it for them. It is clear that they thought these benefits worthwhile, but the balance of cost and benefit is not, in our view, as straightforward as it at first appears.

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

48 The majority of CBO-funded SIBs were commissioner led and in some cases models which were originally led by intermediaries and applied across multiple sites were later restructured to be managed by a lead commissioner

7.2 Achievement of CBO objectives

Despite our reservations about MHEP and especially MHEP 1, there is little doubt that it has made a positive contribution to the CBO's aim of growing the market in SIBs and other forms of OBC, having so far been the imitator and developer of eight projects across multiple commissioners and providers.

Against the specific CBO objectives we assess MHEP 1 as follows:

1. **Improve the skills and confidence of commissioners with regards to the development of SIBs:** Partly achieved. Since the MHEP SIB was developed with low commissioner involvement (indeed the need for low involvement is one of the model's strengths) it cannot in general be said to have achieved this objective. Commissioners will however have learnt from their involvement in the contract negotiations and subsequent contract resets, and may also have benefitted from observing the activities of a pro-active contract management team. It is also fair to add that one commissioner interviewed during this review commented that they would definitely feel more confident in looking at new service models now that they understood social investment better (but also commented that they thought the extra contract negotiation and management costs of the MHEP SIB made it doubtful value for money). We also note that two of the three commissioning organisations involved in MHEP 1 (Tower Hamlets and Haringey) either extended their MHEP projects or commissioned subsequent ones.

2. **Increased early intervention and prevention is undertaken by delivery partners, including VCSE organisations, to address deep rooted social issues and help those most in need: mostly achieved.** The term 'early intervention' in MHEP can be debated, as arguably it is mostly supporting people whose support needs are long established, but it is targeted at an issue which clearly has wide recognition as needing support by NHSE, and the SIB mechanism appears to have enabled the commissioners to fund services that might otherwise have been at risk due to budget constraints, including generating significant savings or avoided costs.

3. **More delivery partners, including VCSE organisations, are able to access new forms of finance to reach more people: partly achieved.** It is likely that the service providers could not have got involved in the project without the upfront funding that was enabled by the MHEP structure and social investment. The capital was, however, not entirely flexibly deployed to support them when they ran into delivery headwinds, and they initially had limited shelter from the financial risk of underperformance. Nonetheless, two of the three providers reported a positive experience and increased capability both to deliver IPS and to meet the demands of outcomes contracts

4. **Increased learning and an enhanced collective understanding of how to develop and deliver successful SIBs: partly achieved.** While they are not part of this evaluation, it seems clear that subsequent MHEP contracts and contract groupings have benefitted from lessons learnt by SF during MHEP 1. SF have also been able to feed their knowledge into the wider rollout of this intervention by NHSE via IPS Grow. Two of the providers also say that they have learnt much from their experience of MHEP 1, and have won extension contracts. These benefits were, however, only achieved because MHEP 1 effectively became a test and learn model from which all parties had to learn as they went along, sometimes at considerable expense and with much lower impact for commissioners and, more importantly, service users than originally predicted. The project did also commission a local evaluation from which some learning can be taken, although it does not offer as much insight as it might have done, especially on the impact of MHEP.

7.3 Lessons for other projects

Based on our findings, the MHEP 1 SIB highlights a number of learnings that might be applied to future SIBs. Again, many of these are not unique to this project. They include:

- **The risk of 'optimism bias' in developing a business case for a SIB and modelling its impact.** This matters not only because of the direct financial impact when projections are too high, but also because of the knock-on administrative burden on all players that is involved in agreeing and putting in place adjustments to mitigate those impacts and re-calibrate the modelling. The risk of optimism bias is arguably more prevalent when the contracts have no direct precedents, although the use of a high-fidelity, established intervention might and arguably should have helped the SIB designers reach robust conclusions in this case. Even so, the providers also exhibited optimism bias in both accepting and in one case bidding beyond the outcome requirements set.

  This tendency to over-estimate referrals, engagements, or outcomes, and sometimes all three, is a pattern that we have seen across a number of the SIBs that we have reviewed, including Ways to Wellness, Reconnections, and HCT Travel Training. It appears to reflect both a natural tendency for those committed to achieving social impact – especially providers – to 'aim high'; and a specific tendency for SIB designers (including commissioners) to stretch assumptions in order to make the financial and social case more compelling. We believe that this might be the single biggest lesson from this and other recent SIBs, since many of the problems that SIBs have shown themselves capable of resolving would not have arisen had they not been based on what turned out to be unachievable targets. We would however observe that central programmes have shown similar flaws, for example the Restart programme which, as noted above, overestimated demand by more than 200%.

- The importance of judging the true value of pro-active support from a performance management team. Such performance management has become a feature of many SIBs and it clearly has benefit in protecting the interests of investors and fund managers. Consistently in this case, both the providers and commissioners have said that they valued the support from the MHEP central team which, in the second review, one provider thought was *'head and shoulders above the usual contract management experience'*.

  We believe it is important for commissioners in particular to carefully consider the true value for money of such support, since in provider or intermediary-led SIBs such as MHEP it is sometimes presented to them as part of the package, and one which comes at a considerable cost. While such support clearly has value, commissioners are not in a position to consider alternatives such as themselves paying for independent contract management support directly, when performance management is built into commissioner-provider delivery contracts, without the option to opt-out.

- **The need for all parties to understand fully the balance of risk sharing between investors, intermediaries, and service providers, and whether these are commensurate.** A further observation from our second review (by the investor, BII) was that 'There has to be a balance of risk and reward to make PbR work. Risk cannot all be transferred to providers.' However, the MHEP 1 SIB transferred a significant proportion of risk to providers since apart from some limited upfront 'block' payments they would not be able to cover their service costs unless they achieved challenging targets for engagement with the IPS intervention. This proved to be too much risk for the providers and led to a downward spiral of increasing under performance, which ultimately had to be corrected by changes to the financing and payment arrangements.

This again is an important lesson for all those considering involvement in a SIB but more especially for providers. A common misconception (promulgated by some early advocates of SIBs, and some of their SIB models) is that SIBs entirely relieve providers of financial risk, which is borne wholly by the investors and/or their intermediary, with providers being paid a fee for service or simply being reimbursed for their costs. While some contracts do follow this model, in many of the SIBs we have reviewed we have found that provider revenue is linked to an aspect of performance, usually outputs such as the generation of referrals, successful engagement with users, and completion of the intervention.

This is not in and of itself a bad thing, since it incentivises provider performance - and some SIBs go much further, linking payment to providers explicitly to outcome achieved, and thus allowing them to share in the upside of the social impact they achieve. What matters is that providers and indeed all parties understand and accept the way risk is going to be shared with them, and are willing and able to bear that risk.

- **The importance of effective implementation of a proven intervention.** It seems clear that some of the challenges faced by the three MHEP 1 contracts were down to the way the contracts were implemented by providers and commissioners. Issues included poor adherence to defined fidelity protocols for IPS, inability to maintain staffing levels (again in line with IPS protocols) and the need to have in place effective operational managers.

None of these are SIB specific issues, and similar challenges are likely to. have been faced if the same providers and commissioners were delivering IPS through different contractual arrangements. We do however think it worth noting these issues as a lesson for other projects because:

- They are no less important in a SIB environment than in other contexts. The use of outcomes contracts will not reduce and may actually increase the need for effective implementation, since the risks for some parties, and especially providers, may be greater if they get it wrong; and

- Any shortcomings in implementation make it even harder to test the effectiveness of a SIB approach. One of the benefits of choosing an evidence-based, high fidelity intervention is that it should be easier to identify the additional benefits (or drawbacks) of a SIB compared to a similar contract, because the effect of the intervention itself should be very similar. It will not be possible to do this, however, if the protocols required by the intervention are not adhered to, and it becomes difficult to disentangle the effect of the SIB model from the effect of the intervention not being properly implemented.

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

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

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