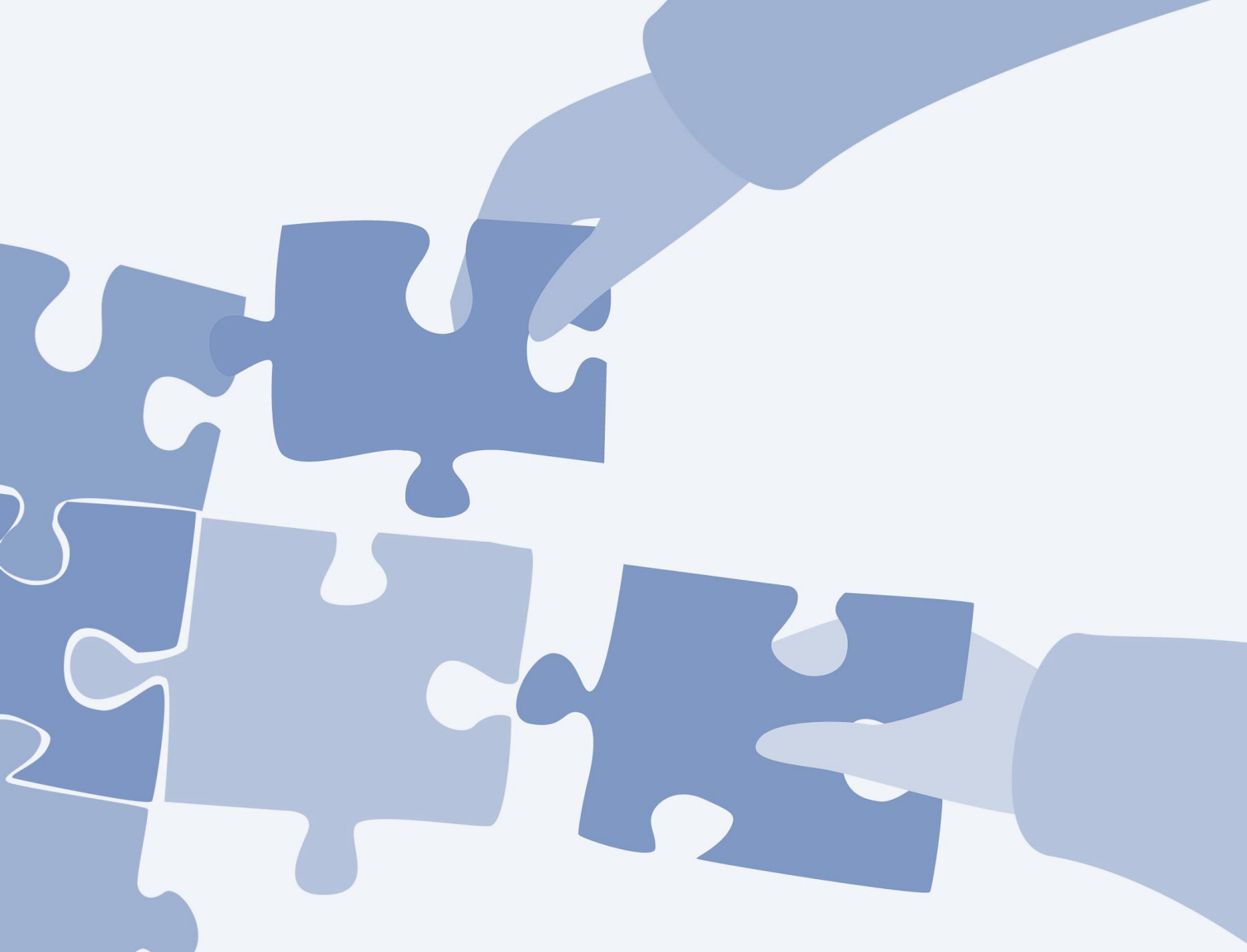

Mental Health and Employment Partnership evaluation for the Life Chances Fund

BLAVATNIK SCHOOL OF GOVERNMENT
UNIVERSITY OF OXFORD
GOVERNMENT OUTCOMES LAB

Second interim report November 2024

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About the Government Outcomes Lab

The Government Outcomes Lab (GO Lab) is a research and policy centre based in the Blavatnik School of Government, University of Oxford. It was created as a partnership between the School and the UK Government and is funded by a range of organisations. Using qualitative, quantitative, and economic analysis, it investigates how governments partner with the private and social sectors to improve social outcomes.

The GO Lab team of multi-disciplinary researchers have published in a number of prestigious academic journals and policy-facing reports. In addition, the GO Lab hosts an online global knowledge hub and data collaborative and has an expansive programme of engagement and capacity-building to disseminate insights and allow the wider community to share experiences with one another.

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I. Acknowledgements

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II. Glossary

Cohort The targeted population of beneficiaries, participants, or service users.

Commissioning The cyclical process by which entities assess the needs of people in an area, determine priorities, design and contract appropriate services, and monitor and evaluate their performance. This term is used widely in the UK public sector context, but less so elsewhere. It is sometimes used interchangeably with "contracting".

DCMS The Department for Culture, Media and Sport (DCMS) is a department of the United Kingdom government. It hosts the Civil Society and Youth Directorate and Public Sector Commissioning Team (formerly the Centre for Social Impact Bonds), which holds policy responsibility for this area within the UK central government. In 2016, DCMS launched the Life Chances Fund (LCF), within which it acts as the central government outcome payer.

Intermediary Impact bonds are often supported by experts that provide specific advice. These are typically all referred to as "intermediaries" but this term can encompass at least four quite different roles: consultancy to develop business cases, social investment fund managers, performance management experts, and special purpose vehicles.

Investor or Social Investor An investor seeking social impact in addition to financial return. Social investors can be individuals, institutional investors, and philanthropic foundations, who invest through their endowment. In UK SIBs, these assets are often managed by 'investment fund managers' rather than the original investing institutions or individuals who provide the capital.

IPS (Individual Placement and Support) involves the integration of employment specialists in mental health teams to promote the return to work for people experiencing mental health and addiction issues. It is a strength-based approach and individually tailored support to help people find the right job with ongoing support. It is based on eight principles which includes a focus on competitive employment, zero exclusion, and providing unlimited support and integrated services regardless of diagnosis, symptoms, or substance misuse.

IPS Grow is a national programme designed to support the expansion of Individual Placement and Support (IPS) services in mental health, primary care, and drug and alcohol teams across England. Includes operational support, workforce development, and tools to improve data and outcomes reporting. The programme is led by Social Finance in partnership with the Centre for Mental Health. It is funded by NHS England and Improvement (NHSE/I), the Department for Work and Pensions (DWP), and the Office for Health Improvement and Disparities (OHID).

Life Chances Fund (LCF) The LCF is a £70m outcomes fund committed in 2016 by UK central government (DCMS) to tackle complex social problems. It provides top-up contributions to locally commissioned outcomes-based contracts involving social

investment, referred to as Social Impact Bonds (SIBs) - also known as social outcomes partnerships (SOPs).

Outcome (outcome metrics/outcome payment triggers) The outcome (or outcome metric) is a result of interest that is typically measured at the level of service users or programme beneficiaries. In evaluation literature, outcomes are understood as not directly under the control of a delivery organisation: they are affected both by the implementation of a service (the activities and outputs it delivers) and by behavioural responses from people participating in that programme. Achieving these outcomes 'triggers' outcome payments within an outcomes contract or SIB arrangement.

Outcome-based contract (OBC) A contract where payments are made wholly or partly contingent on the achievement of outcomes. Also known as an outcomes contract.

Outcome fund Outcome funds pool capital from one or more funders to pay for a set of pre-defined outcomes. Outcome funds allow the commissioning of multiple impact bonds under one structure. Payments from the outcomes fund only occur if specific criteria agreed ex-ante by the funders are met.

Outcome payer The organisation that pays for the outcomes in an impact bond. Outcome payers are often referred to as commissioners.

Outcome payment Payment by outcome payers for achieving pre-agreed outcomes. Payments may be made to investors in an impact bond or to service providers in other forms of outcome-based contracts.

Service provider Service providers are responsible for delivering the intervention to participants. A provider can be a private sector organisation, social enterprise, charity, NGO, or any other legal form.

Service users See Cohort.

Social Impact Bond (SIB) A type of outcome-based contract that incorporates the use of third-party social investment 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 and the investor is repaid only if these outcomes are achieved. Increasingly, SIBs are also referred to as social outcome contracts (SOCs) or referred to as social outcomes partnerships (SOPs) by the UK government.

Special purpose vehicle (SPV) A legal entity (usually a limited company) that is created solely for a financial transaction or to fulfil a specific contractual objective. Special purpose vehicles have been sometimes used in the structuring of impact bonds. In the MHEP case, the SPV is staffed and plays a role in performance management and contracting.

The National Lottery Community Fund (TNLCF) The Community Fund, legally named the Big Lottery Fund, is a non-departmental public body responsible for distributing funds raised by the National Lottery. The Community Fund aims to

support projects which help communities and people it considers most in need. The Community Fund manages the Life Chances Fund on behalf of DCMS.

Top-up fund(ing) An outcomes fund may provide a partial contribution to the payment of outcomes where the remainder of outcomes payments are made by another government department, local government, or public sector commissioner. In the LCF the partial contribution from DCMS 'tops up' the locally funded payment for outcomes and is intended to support the wider adoption of social impact bonds (SIBs) commissioned locally.

1. Introduction

1.1 Mental Health and Employment Partnership: development over time

The Mental Health and Employment Partnership (MHEP) was initially set up in 2015 to help launch the first-ever social impact bond (SIB) designed to help people with mental health issues into paid employment. The initial partnership was between MHEP and three delivery locations: Haringey, Tower Hamlets, and Staffordshire. This partnership helped secure £1.3 million in additional top-up funding from the Big Lottery Fund (now The National Lottery Community Fund), under the Commissioning Better Outcomes Fund (CBO) and the Cabinet Office-administered Social Outcomes Fund (SOF).

Now funded through the Life Chances Fund (LCF), there are five MHEP SIB projects: in Haringey and Barnet, Shropshire, Enfield, and Tower Hamlets (where there is one mental health project and another learning disabilities project). MHEP functions as a special purpose vehicle (SPV, see glossary) and platform that supports multiple SIB projects. Key features of the LCF MHEP projects are outlined below.

Table 1: Key characteristics across LCF MHEP projects

Key Characteristics	Haringey and Barnet	Shropshire	Enfield	Tower Hamlets (Mental Health)	Tower Hamlets (Learning Disabilities)
Policy Focus	Severe Mental Illness	Severe Mental Illness	Severe Mental Illness	Severe Mental Illness	Learning disabilities
Service Delivery Start	April 2019	April 2020	April 2020	April 2020	July 2020
Service Delivery End	April 2023	April 2024	April 2024	April 2024	September 2023
Service Provider	Twining Enterprise	Enable	Working Well Trust	Working Well Trust	JET
Local commissioner	London Borough of Haringey & Barnet (Local Authorities)	Shropshire Council (Local Authority)	Enfield Council (Local Authority)	Tower Hamlets Clinical Commissioning Group	Tower Hamlets Council (Local Authority)

Outcome payment measures in MHEP

In the MHEP SIBs, a local authority or clinical commissioning group pays through an outcomes contract, where payment is contingent upon achieving specific and measurable outcomes (as listed below), including user engagement, job entry, and job sustainment. Unlike other SIBs that adopt a 'black box' model, allowing significant discretion in defining the service offer, each MHEP project is expected to deliver Individual Placement and Support (IPS) as a prescribed intervention. Big Issue Invest serves as the fund manager, providing working capital to MHEP for allocation to SIB projects. As part of the locally commissioned outcome-based contracts, each feature three payable outcome measures:

Table 2: Outcomes in MHEP

Description	Engagement	Job Start	Job Sustainment
Individual or Cohort level	Individual	Individual	Individual
Measure	Commencement of a vocational profile	Individual starts competitive paid job	Pay slips or letter from employer
Metrics	Started vocational profile; or Evidence of three completed appointments	Achieved when a client spends at least one full day (4 hours part-time) in paid competitive work	Individual sustains competitive employment for at least 13 weeks where they work < 16 hours a week OR > 16 hours a week

1.2 Individual Placement and Support

The MHEP SIB projects each provide a service based on the Individual Placement and Support (IPS) model, which is extensively researched both nationally and internationally. The IPS model is supported by a well-defined operating framework (Frederick & VanderWeele, 2019; Burns, White & Catty, 2009). It involves the integration of employment specialists in mental health teams to promote the return to work for people experiencing mental health (and addiction issues). It is a strength-based approach and provides individually tailored support to help people find the right job with ongoing support.

The IPS services at MHEP sites adhere to the eight IPS principles, including:

- Competitive employment
- Zero exclusion
- Integrated services
- Worker preferences
- Benefits Planning
- Rapid job search
- Unlimited support
- Systematic job development

Where traditional employment support interventions, such as vocational training and sheltered work, follow a 'train and place' model, IPS employs a 'place then train' model, which is believed to be more effective (Areberg & Bejerholm, 2013; Modini et al., 2016). In studies where IPS has been offered to individuals experiencing moderate to severe mental health issues, IPS demonstrates employment rates ranging from 30-40% on average, a notable contrast to the

control group's rates of 10-12%.[1]

Employment Specialists (ESs) play a central role in IPS service. ESs carry out all six phases of an IPS employment service: programme intake, engagement, assessment, job development/job placement, job coaching, and follow-along support. Following the IPS "place then train" approach, experts assist individuals in securing employment swiftly and then offer ongoing support to ensure the sustainment of their employment. The IPS model aims to maintain a low caseload, typically 20-25 individuals per employment specialist (NHS, 2022; Rinaldi et al., 2008). This limited caseload enables specialists to deliver personalised assistance.

According to a UK study, implementing Individual Placement and Support (IPS) may result in individual savings of up to £6,000 annually for the mental health system (Gadenne et al., 2020). Furthermore, supporting an individual who receives disability employment benefits in the UK into secure employment can lead to savings of £12,000 per year in taxes and benefits. This is in contrast to the average cost of running an IPS service, which is estimated to be £1,300 per engaged person per year (Gadenne et al., 2020).

In May 2018, the Institute for Employment Studies (on behalf of the Department for Work and Pensions) carried out the most extensive global trial evaluating IPS services (UK, 2022). Part of the trial sought to determine IPS's effectiveness and cost efficiency for individuals with diverse health conditions utilising primary and community care services in the Sheffield City Region and the West Midlands Combined Authority. In both cases, IPS participants were found to be more likely to be in sustained work than a control group (by 3 and 4 percentage points respectively)[2]. This initiative at the intersection of health and employment resulted in the NHS, through Improving Access to Psychological Therapies (IAPT), extending support targets to 24,000 individuals by 2021.

1.3 Changes to IPS services & funding landscape

A number of different agencies commission IPS in the UK, including the Office for Health Improvement and Disparities (OHID), the National Health Service (NHS), the Department for Work and Pensions (DWP), and local authorities. All of them have varying rules and expectations. The Five-Year Forward View for Mental Health report, from the independent Mental Health Taskforce to the NHS in England, committed to double the access to IPS. This means expanding the availability of IPS and supporting an extra 35,000 people with severe mental illness (SMI) to find and retain employment by 2023/2024, totalling 55,000 individuals benefiting from IPS services. However, there have been challenges in scaling. In 2022, only 20,850 people with SMI accessed IPS (NHS, 2023).

The latest research shows that effective implementation of IPS services requires both organisational change and embedding ('integrating') the IPS team into the wider health system (IPS Grow, n.d.). Services are encouraged to develop strong,

[1] IPS support have increased monthly working hours, higher earnings, and more stable job tenure. Also, some individuals experience reduced hospital admission rates and spend less time in hospitals. Long-term follow-up studies spanning 8-12 years validate the sustainability of these positive outcomes. Programs have demonstrated cost-effectiveness (NHS, 2019).

[2] Although the findings for the Sheffield City Region were only significant at a 90% confidence level.

meaningful relationships with Community Mental Health Teams (CMHTs) in their local NHS Trusts working in a variety of mental health treatment sectors such as Early Intervention (EI), Early Intervention Psychosis (EIP), and Enhanced Primary Care (EPC). Recent announcements from NHS England and Improvement (NHSE/I) have also suggested services branch out into Primary Care and adopt a strong focus on building relationships with local GP practices.

As a result of these trials, the IPS model evolved and was scaled up to include employment support, not just for people with severe mental illness, but also for those with drug dependency and moderate physical and mental health concerns in primary health care. Figure 1 illustrates the patient cohorts who can receive access to IPS through the NHS. People with physical health problems access IPS through primary care. People with anxiety and depression has access both through NHS Talking Therapies and IPS in primary care. People with severe mental illness is via IPS for SMI and any population with drug and/or alcohol dependencies has access via IPS for D&A services.

IPS Grow was created as a national programme in 2019 designed to support this expansion of IPS services in mental health, primary care, and drug and alcohol teams across England. The programme was founded and led by Social Finance in partnership with the Centre for Mental Health. It is funded by NHSE/I, the Department for Work and Pensions (DWP), and the Office for Health Improvement and Disparities (OHID). IPS Grow provides operational support, workforce development, and tools to improve data and outcomes reporting.

Ultimately, there are questions about how to commission and scale high-functioning IPS rollout appropriately. While the initial MHEP project did not initially aim to provide a solution, this report reveals how the MHEP SIBs contributed to improved commissioning practice and supported the scale-up into the wider IPS sector, including influencing the creation of IPS Grow.

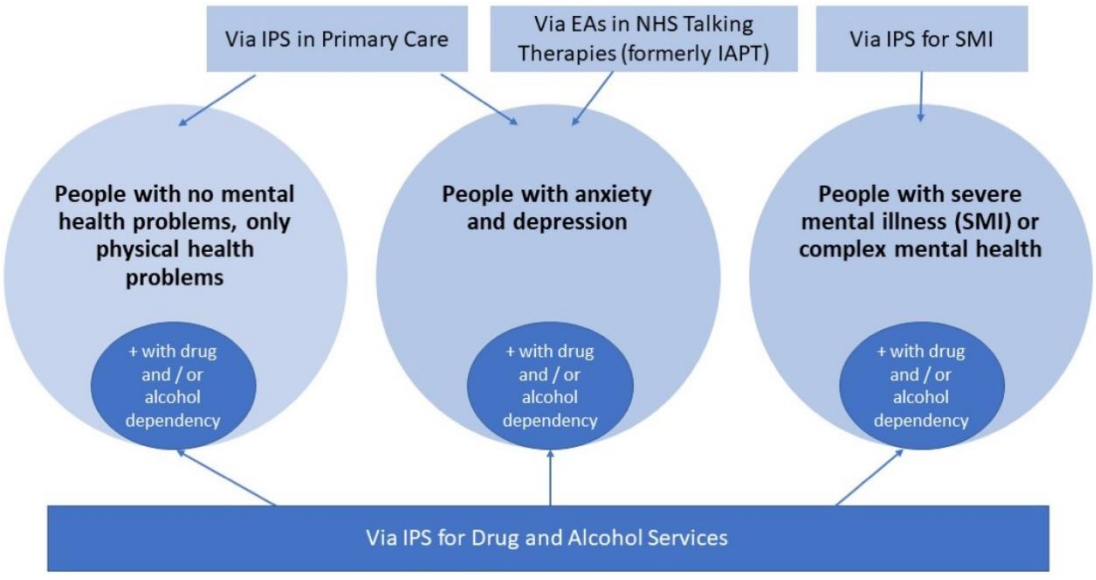

Figure 1: Various cohorts of individuals currently accessing IPS services (Source: NHS England)

2. Research Method

2.1 Aims for the second report

This report is part of a longitudinal study of the MHEP Project, funded by the Department for Culture, Media and Sport. The overarching evaluation question is: ***Did the MHEP social impact bonds make a difference to the social outcomes achieved, compared to alternative commissioning approaches?***

And, following this, the secondary evaluation questions are:
Through what mechanisms does a SIB-backed IPS service contribute to any evidenced impacts? Do the benefits of a SIB approach outweigh the costs?

This report describes the process evaluation, which asks:

What are the perceptions of the implementation of the MHEP SIBs on financial resources, collaboration, and performance management?

The aim of the report is to explore the implementation experience of the MHEP SIBs according to providers, commissioners, investment fund managers, and the SIB management team. The secondary aim was to further test the theory of change mechanisms revealed in the first Interim Report (Hulse et al., 2023) and to understand how the MHEP SIBs compare to traditional commissioning/funding arrangements.

We conducted a process evaluation that combined three sources of qualitative data collection to unpick the lessons learned from the MHEP project via interviews, participant observations, and documentary analysis.

As seen in Table 3, we completed 27 semi-structured interviews with MHEP stakeholders and participant observation for over a year (August 2022-January 2024) with 31 hours of recorded data. We also collated and analysed a range of documents.

The interviews covered all the main stakeholders across the five MHEP SIB projects. Interviewees were selected for their experience in setting up, delivering, or managing the MHEP contracts (through purposive sampling). Maximum variation sampling was also used to ensure sufficient coverage across all stakeholder types. Interviews took place from March 2023 to September 2023. Further detail on the qualitative data collection and the analysis can be found in the Appendix. The chapter headings were inductively developed from the themes found in the interviews.

Table 3: Phases of the data collection

Phases of the qualitative data collection	Description	Aim	Timings
Interviews	27 interviews: commissioners (n=3), service providers (n=8), MHEP management team (n=4), MHEP development directors (n=4), IPS Grow (n=2), the investment fund manager (n=2), MHEP board (n=3), and the LCF management team (n=1).	To understand the perceptions of performance management, financial resources, and collaboration in the MHEP SIBs.	March-September 2023
Observations	Contract Review Meetings (n=13/15) MHEP board meetings (n=2/3), site visits (n=2), provider catch-up (n=1)	To understand more closely stakeholder relationships and live service delivery challenges/successes.	2022-2024
Documentary Analysis	Shareholder Agreement; Outcome-based contracts between MHEP and commissioners; LCF Grants; MHEP Articles of Association; Annual Business Plans; CRM agendas, All Performance Packs, and Performance Improvement Plans.	To triangulate interview data on design choices, contract specifications, low-performance periods, and the background of MHEP projects and their stakeholders (project structures, stakeholder relationships, original targets, performance information).	2023

2.2 Limitations and considerations

The qualitative nature of the data collection generates rich insights into the experiences within the MHEP projects. Findings are not generalisable to other SIB projects' experiences.

While interviewees are encouraged to participate in the evaluation due to LCF grant stipulations, the risk of optimism bias cannot be ruled out. Time constraints and research fatigue posed challenges for recruitment to interviews. Those who took part may have differing views than those who chose not to participate. While every commissioner involved in the project was invited to participate, only three consented, while six were eligible to be included.

Each participant was interviewed at different time points in the lifecycle of their outcomes-based contract, ranging from four months post-MHEP involvement to 12 months prior to contract end.

3. Results

Part 1: Is there greater accountability in SIB-funded IPS compared to traditional commissioning?

There is a perception of greater accountability in the MHEP SIBs relative to traditional funding of IPS. This occurred due to broad improvements in commissioning practice rather than solely from the use of outcome payments.

Improvements in the commissioning practice of IPS under MHEP occurred as a result of four factors: continuous performance monitoring by the MHEP team; more contractual levers to respond to underperformance; high commissioner involvement; and active problem-solving through a focus on collaboration and learning. Providers and commissioners appreciated this approach and contrasted this to historical contracting experience which left providers feeling disempowered by commissioners' lack of attention or interest in their performance. Participants described a shift to learning in service delivery.

Despite general improvements in accountability some aspects of the programme were perceived to undermine this progress. This included periods of high staff turnover from MHEP's management team and a lack of understanding for the justifications behind design choices in MHEP.

Fortunately, due to the lessons learned on the support required for providers and commissioners to deliver high-quality performance, IPS Grow has been created by Social Finance. Many hope this will hold actors accountable for both performance and quality in the future implementation of IPS.

One of the major proposed benefits of SIBs is greater accountability. In the MHEP SIBs, research participants described varying forms and degrees of accountability between the different SIB actors. SIB providers, commissioners and MHEP staff perceived a greater level of accountability in the SIB arrangement of IPS service delivery compared to traditional funding arrangements of IPS. Many described accountability constraints in historical, non-SIB IPS contracts.

Importantly, the enhanced sense of accountability was not attributed to the punitive enforcement of outcome payments. It was seen to emerge from *improvements in the commissioning practice* of IPS delivery. This was due to high involvement, more developed contractual levers for monitoring performance, continuous monitoring and active review, and collaborative problem-solving with a cultural shift towards learning.

The accountability experience in MHEP contrasts heavily with previous traditional contracts for IPS. Providers specifically commented on the limitations of conventional contracting, including the frustrations of short-duration contracts, insufficient resources to pay staff at the market rate, and limited opportunities to engage with commissioners. While some providers saw the use of outcome-linked

payment as a heavy-handed form of accountability (akin to the large-scale payment-by-results contracts). MHEP through its collaborative culture and focus on capacity development of both providers and commissioners helped mitigate this risk. Both providers and MHEP staff agreed that good outcomes come from close relationship management and understanding the historical under-resourcing:

"So you are managing your relationship, whereas in a lot of government commissioning, government contracting, they don't manage their relationship. And it just becomes a reporting mill." - MHEP

What commissioners appreciated: continuous monitoring and more levers to uphold performance

Firstly, MHEP served as an external accountability partner, ensuring providers were prevented from "coasting" by holding them to account for performance. This was described in stark contrast to traditional contracts which lacked frequent and rigorous monitoring, allowing underperformance to persist without timely intervention. Commissioners admitted that previously they would not intervene for poor performance as quickly as they did with MHEP. Both commissioners in local authorities and in the NHS commented that this was one of the biggest lessons from their experience with the MHEP SIB. These commissioners suggested that they would now intervene within the same quarter as the initial record of poor performance, with the mindset of finding out the cause to help support the provider.

The formal accountability levers in MHEP, including the use of outcome payments and a series of planned steps for under-performance (Figure B in Appendix), were regarded positively by commissioners. Local authorities admitted that they are "*not very good at penalty clauses for underperforming*". With a series of planned steps for a situation of under-performance, the MHEP arrangement was seen as better prepared and more proactive. In traditional contracts, a key sanction is to terminate the contract, but this is rarely used. Therefore, according to commissioners, when the contracting is done right, the performance payments and multiple steps to deal with underperformance in SIBs mean that "*it's in everyone's best interest to perform.*"

"[In conventional contracts] You have a year's worth of poor performance before you actually start to think about exiting the contract. And that could take another year to get another [provider] if I have to go back out to tender. Whereas the MHEP provider is saying 'if I achieve this, then I'm going to get this performance-related payment, that's what I'm going to focus on', then they will deliver that. I don't think it works in all contracts. I think it works on things like this." - Commissioner

What providers appreciated: high involvement and problem-solving

Since providers expressed high levels of intrinsic motivation and felt less motivated by the outcome payments themselves, they appreciated an alternative form of accountability than that described by commissioners. Provider interviewees

indicated feeling that they would already be operating at *"98% of effort and MHEP pushes you for that extra 2%"*. Providers perceived that the dedicated involvement of MHEP had a significant effect in driving accountability; also that the MHEP management team's ability to problem-solve helped drive performance.

Provider staff described feeling demoralised in previous contracts due to a sense that commissioners were disinterested. Several provider staff drew attention to the recognition and praise offered by MHEP during periods of high performance or performance recovery. The MHEP team's ability to ask the right questions was a skill that providers valued. IPS Grow staff highlighted that meaningful accountability conversations arise when commissioners know IPS well and therefore know why performance may fluctuate.

"Because when you feel like commissioners are disinterested...There's so much that goes into running an IPS service, it's a very busy job. There's probably not an appreciation of that because it isn't the traditional model of employment support. So you do want a commissioner to be interested, and I felt that MHEP have been interested. And that helps to have the relationship, you end up having some really nice discussion." - Provider

The other aspect of accountability that service providers appreciated was the active problem-solving in MHEP contracts. This was related to MHEP's ability to use data analytics in managing performance. For instance, the MHEP team started to break down employment outcomes per employment specialist. This facilitated more targeted conversations with the provider teams on what you can learn from staff members who are doing well. The MHEP team hoped that this would set a new precedent for providers and commissioners on the cultural shift from compliance to learning.

"Historically, we've absolutely loved working with MHEP…the person who was the contract manager when I first started with MHEP was really collaborative, really helpful, very understanding and really wanting to work out issues." - Provider

"But I think sometimes it's about commissioners who come in with a learning mindset, like 'I don't understand what pressure this service faces and I would like to understand more so that I can support them,' feels like the thing that unlocks a really productive conversation. That does generate a list of actions for the Commissioner, which feels a little bit new and different from the provider's perspective. I think getting the Commissioners to feel like they're not just there to grill the provider, but they're there to like, actually generate their own list of actions is a big culture shift." - MHEP Manager

However, there were moments when this greater perception of accountability was tested. These included periods of high staff turnover, lack of shared ownership, not identifying with or understanding the original arrangements that were put in place at the start of the SIB, and information asymmetry between commissioners and providers.

However, while MHEP's accountability was perceived to be greater than in previous contracts, it is notable that the IPS commissioning landscape has changed quite dramatically in recent years since MHEP began in 2016. Interviewees linked this change partly to the advocacy work that took place initially under MHEP, but now within the remit of IPS Grow. Since 2019, IPS Grow has become the national quality assurance team, with a mandate to support all IPS providers across the country whether they operate through a SIB or other contracting arrangement. The interplay between IPS Grow and MHEP is explored in Part 5: Does MHEP have a legacy?

The question of how to maintain accountability alongside a more collaborative approach to commissioning was a source of interest amongst commissioners and represented a cultural shift they wished to be a part of in new partnership arrangements. This idea was reinforced by providers who felt commissioners needed more support to undertake effective commissioning.

"I definitely think commissioners need allies and supportive influences. When you bring the power of MHEP to these types of interventions it makes a huge difference for Commissioners who ...need a bit of help." - Provider

"We know what we're doing. The main pieces for us are recruiting and retaining excellent staff and that makes a huge difference obviously to how well things go. That obviously needs to be supported by good commissioning. So commissioners setting the tone, convening the systemic space and working that through has a huge impact." - Provider

Part 2: Does the MHEP SIB affect service quality?

Relative to traditional commissioning, there were four perceived improvements in service quality as a result of the MHEP SIBs: i) more rigorous caseload management, ii) more emphasis on integration with clinical teams, iii) greater attention to a wider range of outcomes, and iv) continuous discussions on fidelity and service quality. MHEP also raised expectations about what an IPS service could achieve for a local authority area allowing for enhanced accountability for service quality and performance. This differed to traditional contracting arrangements where commissioners may not fully understand IPS and thus may not know "what good looks like".

However, there were also periods during implementation when service managers perceived that outcome payments could contradict service quality. Research participants described a trade-off between the time needed for a fidelity (quality) assessment and staff time needed to deliver the service (and hence, support employment outcomes). Delivery staff described challenges in securing job retention and in meeting the 6 per week face-to face employer engagement requirement. Nevertheless, most of these challenges exist in traditional commissioning of IPS (although it was felt that outcome payments could have been better structured to support longer-term job retention).

The low proportion of outcome-linked payments (ranging from 25% to 0% of contract value in the 5 sites) was perceived to reduce the risk of gaming or cherry-picking clients.

As a result of the MHEP experience, two innovations have now been introduced into wider implementation of IPS. Firstly, commissioners expressed that all IPS contracts should now include more checks and balances on performance and quality. Secondly, an indicator of outcome performance is included in the fidelity framework of all IPS providers regardless of funding. These innovations are viewed as a positive learning from MHEP's work.

Service quality in traditional commissioning

For all IPS Services, a 25-point fidelity scale has been developed to measure adherence to the IPS principles. Evidence suggests that there is a correlation between high scores on the fidelity scale and the achievement of employment outcomes.[3] All MHEP services targeting severe mental illness (SMI) are expected to adhere to IPS fidelity in the delivery of the service.

Service providers are expected to assess the fidelity of their service using an independent assessor with training and experience in fidelity assessments. Service providers are expected to maintain a score of at least 100 ("good") out of the maximum fidelity score of 125 throughout the service. Good practice suggests that

[3] Bond, G.R., Becker, D.R. and Drake, R.E. (2011), Measurement of Fidelity of Implementation of Evidence-Based Practices: Case Example of the IPS Fidelity Scale. Clinical Psychology: Science and Practice, 18: 126-141. https://doi.org/10.1111/j.1468-2850.2011.01244.x

providers should also assess their fidelity every six months to identify areas for improvement.

Improvements in service quality in MHEP's SIBs

There were four perceived improvements in service quality as a result of the MHEP SIBs: i) more rigorous caseload management, ii) more emphasis on integration, iii) greater attention to the achievement of wider outcomes, and iv) continuous discussions on fidelity.

In MHEP contracts, the service specification brought clarity on the activities required and encouraged more rigorous caseload management (caseloads of 20-25 clients). The urgency of securing outcome payments brought a realisation of the importance of commissioners unlocking integration (a key fidelity item)[4]. According to participants, the importance of measuring and valuing integration for smooth handovers and referrals is a key lesson learned. The other positive effect was the higher attention to Key Performance Indicators (KPIs) from the MHEP team compared to traditional commissioners in previous contracts. Providers remarked that traditional commissioners either do not have an explicit outcome focus or only emphasise the engagement outcome (also referred to as the access target) as a main KPI, which differs from MHEP. MHEP has a more comprehensive list of outcomes and is distinctive in valuing longer term employment outcomes. In MHEP, payable outcomes include engagement, job starts, and job sustainment, which all interviewees agreed was the appropriate focus for an IPS service.

Compared to traditional commissioning, MHEP's more intense performance management via regular meetings, allowed for continuous discussion of key challenges or successes in the service provision. These performance conversations would then influence delivery teams' service quality (or fidelity score). For instance, in the regular performance meetings with MHEP and the providers, many of the fidelity items are discussed indirectly, especially caseload management, wider employer engagement, employment service staff, integration, and being present in the community. Partly as a result of this experience, commissioners expressed that all IPS contracts should now include more checks and balances on performance and quality.

<u>Accountability for service quality in MHEP</u>

Ultimately, MHEP also changed the perception of *"what good looks like"* amongst the provider organisations, commissioners, and referring teams. MHEP raised expectations on what an IPS service could achieve for a local authority area, allowing for greater accountability. The MHEP team projected a belief that the provider (with the right support) would drive the desired social impact. This set a

[4] IPS services should be "*integrated with clinical teams and multi-disciplinary teams to promote referrals and ensure clinical involvement and oversight of their clients' mental health needs whilst seeking and retaining employment*." This could mean co-locating with early intervention in psychosis teams, community mental health teams, and primary care networks (PCNs). The level of integration has a direct impact on referrals. Source: https://www.england.nhs.uk/long-read/individual-placement-and-support-for-severe-mental-illness/ Integration is assessed in the 25-item fidelity scale predominately in item 4 *"integration of supported employment with mental health treatment through team assignment"* and item 5 *"Integration of supported employment with mental health treatment through frequent team member contact"*.

new precedent even for traditional commissioning and future IPS contracts. Third-party quality assurance and close contact facilitate quality discussions, especially with an evidence-based manualised intervention. A service provider explains the value of close communication:

"The clinician's perspective was amazing because they had operated with the non-outcomes [IPS] contract for years up until that point. When we shifted to the outcome-based contract, they were "oh, this service works, you actually get people jobs", and would start referring." - Provider

This greatly differed from traditional commissioning:

"Do commissioners know what good looks like? Do they know what they should be looking at in terms of tendering a service design? Do they know? No, I don't think they do, some do but not all. I was quite shocked really to come into this role and realise how some commissioners just don't get IPS." - IPS Grow

Tensions in service quality in MHEP's SIBs

On the other hand, research participants described a risk of quality slippage due to the IPS model in MHEP. This pressure was largely due to the time commitment required for formal assessment of quality in the fidelity scale, which affected the workload of the frontline staff. During a fidelity review period, it is not possible for a service to operate at full capacity. Although this is an issue for all IPS services, in MHEP this time pressure has a knock-on effect for outcome-based payment levels and income for providers. *"We just put it in the budget that we're going to at least lose 25 % of that payment by result income because of the fidelity assessment." - Provider*

Outside of that fidelity assessment, there were still perceived moments of quality risks if MHEP providers followed fidelity to the book. Key points of tension include:

- **Job retention:** Supporting people to retain their jobs is typical in most IPS services. However in the MHEP outcome contracts, there is no direct payment linked to longer-term sustainment (as no payment is made beyond 13 weeks of sustained employment). This changes the type of service that providers might deliver. Guidance allows up to 20 retention clients and an IPS professional would typically include these clients in their caseload but this was challenging to maintain in MHEP.

- **Employer engagement vs MHEP outcomes**: There were challenges with the employer engagement fidelity item in MHEP. This item requires face-to-face employer engagement which was seen as inefficient and impractical. There is a feeling that the most efficient way to achieve the MHEP outcomes was to meet employers virtually and this was in tension with this outdated definition of the fidelity item.

Risks of Gaming

However, despite these potential threats to quality, MHEP exposed service providers to comparatively low levels of outcome-related payments. This low level of Payment by Results (PbR) for providers was agreed by providers and MHEP staff to have reduced perverse incentives for gaming or cherry-picking clients. This differed from the previous experiences under CBO where providers were exposed to a higher percentage of payment that was contingent on demonstrable results. The MHEP team described this as a learning process, and commissioners have now incorporated a more subtle level of outcome payments to prevent quality drops and gaming (explored further in Parts 2 and 3).

Innovations as a result of MHEP's influence on IPS service quality

Key learnings from the MHEP experience have now been integrated in IPS Grow. For example, there is now a new performance requirement, a new recruitment strategy and a raised awareness for the need for third-party assistance for quality assurance. IPS Grow has effectively acknowledged that the original fidelity framework is an insufficient tool for assessing quality and has drawn on MHEP experience to set a minimum performance level (at least 30% of participants achieving employment entry) that is now applied more widely. These changes will last beyond the MHEP contracts to improve the quality of IPS delivery, encourage outcome achievement and refine the formal fidelity mark.

Part 3: How did the structure of the SIB affect service delivery?

MHEP operates as a special purpose vehicle, with Social Finance acting as the intermediary responsible for contract monitoring and performance management. “Complex” was the main term used to describe the MHEP SIB contracting structure. The complex payment arrangements were perceived to have consequences on staff motivation, mission alignment between actors, and losses in outcome payments. The perception of complexity was exacerbated by the turnover of MHEP managers and analysts. This high-cadence turnover within the core MHEP team was seen as somewhat destabilising by providers and the board, especially in times of performance issues. The main sources of complexity were:

- **Requirements of the Life Chances Fund**: since national-level LCF outcomes fund and local commissioners make payments on a different basis, there were challenges in understanding how to appropriately claim for payments.
- **Local variation on payment preferences:** each MHEP project is structured with different outcome payment values and maximum payment levels.
- **Lack of clarity on justifications for design decisions:** stakeholders were unclear on why the project had been set up with such particular payment arrangements.
- **MHEP analyst's interpretation of financial modelling**: there were repeated attempts to reprofile performance expectations.

As a result of the MHEP experience, interviewees reflected on what an ideal IPS contract would look like. There are five main innovations that stakeholders would like to see in future IPS contracts (SIB or non-SIB):

- Longer contract duration (3 years and 2 years extension);
- In-built technical assistance funding for performance management;
- Dedicated mobilisation phase (6 months);
- Regular meetings with the commissioner;
- Holistic approach to IPS for mental and physical health rather than split IPS into separate disease areas.

For future outcome contracts, interviewees described an ideal structure with 5% of provider contract value linked to outcomes, investors providing a minimum of three to six months of providers’ working capital, and progressive payments in an outcome chain weighted for time and cost-savings.

Developing an ideal contract structure for outcomes-focused IPS delivery

Since its conception in 2015, the MHEP team has — largely through a process of trial and error — gained an understanding of best practices in the design of payment structures. As a result, MHEP has made several iterative changes through CBO, SOF, and LCF SIBs to improve the design of its payment structure. Providers and MHEP staff alike viewed these changes favourably.

As seen in Figure 2, the payment structure of the MHEP SIBs involves several payment flows. Upfront social investment from Big Issue Invest is channelled through MHEP to providers. Quarterly outcomes claims are submitted to local commissioners, and outcomes funding is paid out following approval of claims. DCMS provide 'top up' outcomes funding through the LCF which serves as minority funding alongside outcomes funding from local commissioners (composed of local authorities and clinical commissioning groups). The outcome-contingent funding is subject to contract caps which are set at different levels for each of the projects. MHEP leads the reporting of outcome achievement to commissioners, facilitates independent validation of outcomes, and manages funding flows to relevant partners, including the repayment to Big Issue Invest.

While frontline employment specialists may not need to understand all the intricacies of the payments (according to MHEP directors), the key partners (provider executive teams, provider service managers, local commissioning leads, investment fund managers, performance management team) arguably do. However, many interviewees were so detached from the original development phase that they did not understand the justification for payment structure choices. In light of this, this chapter section outlines the justifications according to those directly responsible for the development of LCF's MHEP SIBs as well as key partners' reactions to the implications of these choices. A section on the complexity of the payment structure follows. The chapter concludes with an explanation of the performance management with MHEP and the ideal characteristics for providers and commissioners under a SIB.

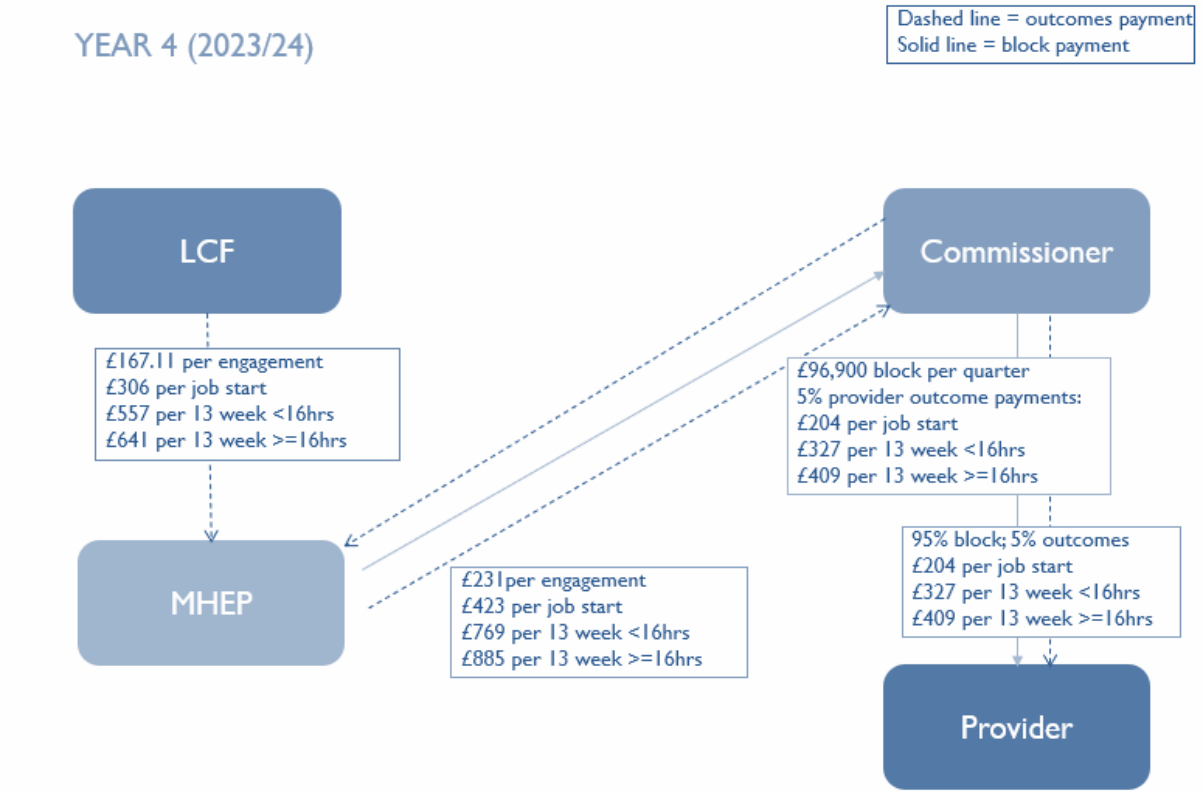

Figure 2 describes one of the payment structures of the MHEP SIBs

Note: This figure only shows one SIB in the MHEP project. There are variations across sites on the level of outcome targets, price, ratio of outcomes and block payments, and caps due to contract negotiations. Note that in the Tower Hamlets' learning disability SIB, the provider receives block payments and is not paid on outcomes. In the Haringey and Barnet SIB, the outcome-based contract sits between MHEP and the provider. Source: adapted from Social Finance's Who Pays Who.

MHEP developers' justification for design choices:

In the first series of MHEP SIBs, supported by CBO, a high proportion of provider payment was linked to outcomes achievement. However, the MHEP team discovered that providers needed more certainty to hire staff and deliver IPS to service users who might be the hardest to get into work. Therefore, in the design of LCF SIBs, MHEP was keen to lower that proportion of outcome-linked payment (ranging from 30% to 0% across the five sites) to reduce the previous perverse incentives. The developers' rationale for keeping a partial outcome payment was that providers having *"skin in the game"* increased their likelihood of understanding the importance of collecting good data on outcomes and understanding shared financial implications. In other words, the outcome-linked payments signal that MHEP's ability to pay back the investment depends on the income from the outcome achievement. The MHEP team described a secondary rationale: upskill the provider organisations on the experience of working under an outcome-based contract since the *"big money in employment typically comes from DWP and is paid on outcomes."* This capacity building is further explored in Part 5. Both commissioners and providers under the new LCF design agreed that the lower percentage of outcome-linked payment facilitated service stability.

The outcome targets were hotly contested. MHEP managers interviewed agreed that the targets are "wrong". The majority of providers agreed that the targets were too high, even compared with previous contracts for similar SMI clients. A provider explained: *"50% job outcome conversion rate is really high for this type of work."* One provider even expressed that they would never say to Social Finance directly that the targets are unrealistic, but it was clear from the fact that they had never met some of the targets throughout the entire contract.

The developers' rationale for choosing the current LCF targets was that they were born from evidence in trials and then derived from data collected throughout the MHEP portfolio over time. So, over time, an understanding of the outcomes a certain team structure could or should be working towards became more and more standardised. Interviewees admitted that CBO targets were also set at an inappropriate level. MHEP developers expressed the difficulties in choosing an appropriate level, since although IPS was well-evidenced in trials, there was seen to be little 'real world' implementation data to inform performance expectations. There had never been a programme with independently validated outcomes for IPS. MHEP developers reveal that they have learned a lot, and hope to build this learning into improved future programs.

"I think there were huge expectations in CBO about what could be achieved from each service. Then we had LCF ... and we had more data. They had a better idea about what went into a good service and had started to identify what good looks like. This drove the assessment of what could be achieved down i.e. the number of outcomes per team member was lower." - MHEP

Ideal design choices

The outcome payment weighting, maximum return to the investor, upfront investment, and maximum outcome payments are key features of a SIB's structure. As seen in Tables 4 and 5, in MHEP, the average upfront capital from the investor was £237,000, with a preferred return of 8%. Actual return will be reported in the subsequent evaluation report. The percentage of outcome payment relative to the contract value ranges for each project site from 0% for THLD to 30% for Enfield. The annualised caps and the maximum outcome payments also vary greatly across sites as shown in Table 4. In light of the current LCF MHEP structure, interviewees reflected on what an ideal structure might look like (Table 6).

Table 4: Caps for each site and each stakeholder

Caps for each site and stakeholder	Commissioner to MHEP (for the whole service)	LCF to MHEP (for the whole service)	MHEP to LA/Commissioner (or provider for Haringey and Barnet)	LA to provider
Haringey & Barnet	Annual: £215,036 Total: £412,158	Annual: £155,715 Total: 298,459	For block: £401,854 For outcomes: £133,951	200,500 in first year (2019/2020)
Tower Hamlets SMI	Annual: £300,000 Total: £1,200,000	Annual: £217,241 Total: £868,966	For outcomes: £81,600	Annual: £20,400
Enfield	Total: £360,000	Total: £260,690 Annual: £65,172	For outcomes: £142,560	
THLD	Annual: varies Total: £758,094	Annual: varies Total: £548,965	Total: £985,522.56	
Shropshire	Total: £600,000	Total: £434,483 Annual: £108,621	For block: £810,000	

Source: Co-commissioning Protocols between Mental Health and Employment Partnership Limited and Local commissioner, Social Finance's Who Pays Who Document.

Table 5: Outcome split per quarter split for providers

	Haringey & Barnet	Shropshire	Enfield	THSMI	THLD
Split per quarter (block: outcomes) to providers	75:25	In-house	70:30	95:5	100:0
Block per quarter	£52,416 every quarter (but March 2021: £34,944 – 'tariffs') to provider	£50,625 block per quarter to commissioner	£20,790 block per quarter to commissioner	£96,900 block per quarter to commissioner	£77,804.40 block per quarter to commissioner
Upfront capital from investor	£227,000	£204,000	£126,000	£300,000	£328,000

Source: Life Chances Fund (LCF) full award documents, Social Finance's 'Who Pays Who' Document.

Interviewees commented that some design choices in MHEP were already ideal for an IPS contract. Mainly: the contract duration being 3 years, in-built technical assistance funding for performance management set at 5-10% of the contract value, and meeting quarterly to review contract performance. Providers expressed a desire for future contracts to have these same design features regardless of whether the project was structured as a SIB.

For SIB-specific features, the ideal outcome weighting was expressed as one that was "progressive" such that payment across the chain of outcomes (engagement, job start, and sustainment) was weighted according to time and potential cost-savings. Upfront capital was stated to be ideally a minimum of three months of working capital. Long-term outcomes were recommended to be a maximum of three months since the ability to evidence 6-month sustainment outcomes was perceived to be low. These ideal features were seen in the LCF MHEP contracts.

However, research participants suggested that other design choices could be improved. Specifically, participants wanted to revise the percentage of outcome payments, payment cap specifications, time of invoicing, in-built buffer for performance tolerance, and which actor received the social investment. Providers and commissioners indicated an ideal outcome payment at 5% of the contract value, this only occurred for the THSMI site. MHEP expressed ideally receiving outcome payments from commissioners, however in the Haringey and Barnet site, the providers paid for outcomes. Annual caps were preferred to overall caps for providers, while those managing the SPV found that an overall cap worked better. Similarly, annual outcome payment invoicing was preferred by providers, while quarterly outcome payment invoices were preferred by those managing the SPV.

This may reflect the different cash flow pressures experienced by the different organisations in the partnership.

Finally, some providers and investors expressed a desire to have more flexible contracts, allowing for adaptation over time. For instance, some providers expressed a desire to introduce additional payable outcomes (for example, in-work support and employer engagement). One provider suggested that a mobilisation period of six months with no outcome payments would be ideal to encourage newer services to feel confident under an outcome-based contract. There were also divergent views on where the social investment should be pooled. While MHEP staff and investors were positive about the SPV structure since it allowed quick scale-up of MHEP SIBs with reduced costs (from CBO to LCF development periods), some suggested that pooling the social investment into local authorities would be more effective for scaling up interventions for the long term to promote sustainability.

Table 6: Lessons on ideal design choices for SIB funded IPS, according to interviewees

Design Feature	Recommended design
Contract duration	3 years + 2 year extension.
Staff	10 employment specialists paid at competitive NHS salary rate (employment specialists are banded at NHS Band 5 level or equivalent for non-NHS organisations, and team leaders are banded at NHS Band 6 level or above or equivalent for non-NHS organisations).
With in-built technical assistance	Set at 5-10% of contract value.
In built buffer for performance tolerance	6 months for a new service as a mobilisation-period.
% of Outcome Payment to providers	5% of contract value. This depends on provider willingness, number of other contracts held, staff, and capability of commissioners to price outcomes.
Which actors are paid for outcomes	Both MHEP and providers (received from commissioners).
Total upfront capital/loan from an investor	Minimum three months of working capital, but ideally 6 months.
Investor funnelling investment into SPV vs council to provide working capital	Mixed views. Funnelling the investment into the SPV scaled SIBs quickly with reduced costs. Yet funnelling investment into councils were

	perceived to scale up interventions for long-term.
Outcome weighting	Progressive payments in outcome-chain for time and potential cost savings.
Existence of caps/maximum payments	Mixed views. Overall cap was more ideal compared to annual caps for SPV. Annual cap is preferred to overall cap for providers.
Annual vs quarterly outcome payment invoicing	Annual preferred by providers. Quarterly preferred by SIB contract manager.
Long-term outcomes	Maximum three-month outcomes since 6-month outcomes are difficult to demonstrate.
Meeting with commissioner/co-commissioner	Ideal to meet quarterly.
Scope	Holistic IPS for mental and physical health is preferred rather than splitting IPS into separate disease areas.
Flexibility in co-designing more new outcomes	Possibility for employer engagement or in-work support.

Complexity

One of the major criticisms of Social Finance's approach to managing the MHEP SIBs is the excessive complexity of the contracts and funding flows. The actors in the MHEP project, including the commissioners, providers, the investor and TNLCF[5], expressed difficulties in understanding and navigating the complex structures of the contracts. While some perceived that complexity can be expected in a new contracting structure, many believed that much of this was unnecessary or avoidable. MHEP staff were quicker to defend the complexity as inevitable (as the team arguably most responsible as the lead applicant to the LCF) than commissioners who had less ownership over the design.

The implications of the complexity were stark, resulting in losses in outcomes payments, reduced motivation, and frictions in mission alignment. For example, one provider organisation stated they would have had more sustainment outcome payments if there was more detail on what was required to capture this, as *"it feels like it's only recently we've known."* The perceived complexity also influenced the effectiveness of the incentives (explored in Part 4). One MHEP staff member stated that the complex and often misunderstood financial arrangement could distract from the actual mission of the SIB. While many directed blame to the requirements of different actors, all concluded that the complex arrangement was derived from institutional inflexibility (e.g. parameters for payment caps) rather than due to the actor relationships (or collaborative structures).

<u>Sources of complexity:</u>
Several sources contributed to the perceived complexity identified:

1. **Negotiations in the LCF**: MHEP staff emphasised that complexity resulted from negotiations and LCF not being flexible especially regarding predictions and caps. However, many disagreed with this opinion. Especially the investor, who stated it was because of Social Finance's often undisclosed requirements.

"A source of complexity is delivering against the Life Chances Fund, which has its own models and reporting requirements. And so, there's a whole separate set of assumptions, metrics, and ways of talking about things that are different from the way we talk about things. So sometimes, LCF have a set of targets and we're not always sure where they came from." - MHEP

2. **Local variance**: Different local commissioners wanted payments to function in certain ways or at certain times due to internal budgeting processes or requirements.

[5] The National Lottery Community Fund (TNLCF) is a non-departmental public body responsible for distributing funds raised by the National Lottery. The Community Fund aims to support projects which help communities and people it considers most in need. TNLCF manages the Life Chances Fund on behalf of DCMS.

"The MHEP ecosystem is a lot more complex because there are a lot more Commissioners, there are providers in different areas and each site is set up a bit differently." —MHEP

3. **Lack of clarity on the reasons for payment flows:** Some commissioners didn't understand the unfamiliar payment flow. However, the number of commissioners expressing this view has reduced since the last interview round in 2022. In 2023, only one commissioner had some confusion. This is something that MHEP has acknowledged and continues to work on, noting that there is a learning curve for only paying for what works. The MHEP team admits "*we still haven't fully cracked how to remove that confusion completely.*"

"So, the complexity about how money flowed between the two organisations, I suppose that was my reflection that actually we got the same goals and the funding models could potentially be a bit more simplified." -Commissioner

"At times, it has been difficult to understand the contracting arrangements in the various MHEP SIBs. The MHEP contracting models are complicated, and often the response to queries relating to this remains unclear." -TNLCF

4. **Analysts' interpretations & financial modelling:** Who pays what, under what conditions, the level of the payment cap and under what conditions a cap kicks in was perceived as complex. However, this was exacerbated due to the considerable variation from contract to contract. This is reflected in the complex financial models that MHEP have created for each project.

"So, we have a different financial model for each SIB, and each of those models has different rules. They've existed for five years, they're built in Excel, and many stakeholders have contributed to them over the years." -MHEP Manager

<u>Possible solutions to reduce complexity:</u>

Several potential solutions and mitigations to reduce complexity were suggested by MHEP actors:

1. Ensure early buy-in for the principles and design justifications of SIBs and remind new members if there is turnover.
2. Acknowledge that adaptability and a learning mindset are essential in dealing with unexpected events like NHS Transformation and COVID.
3. Acknowledge the challenges in forecasting outcomes in complex social areas and recognise that these may change over time. Manage expectations over the monitoring requirements of the MHEP board and LCF.
4. Address the issue of annualised payment caps in outcome-focused partnerships, as outcome-based contracts may not be compatible with a requirement to spend in line with forecasts.

Communicating the rationale behind design or negotiation choices and cultivate a learning culture to reduce misunderstandings between actors during the implementation phase was seen as an important area for improvement. This is illustrated by a provider:

"So maybe the people who had negotiated the contract, it would have been good right at the beginning to have that really clear introduction and understanding for the operational side of what the contract means and how it's going to work. Upon reflection, it took us a year to properly get used to it and to understand MHEP." - Provider

Interestingly, when asked if complexity reduces over time, many MHEP actors stated that, in fact, it increased for several reasons. Firstly, because of staff turnover amongst all involved organisations: providers, commissioners, and Social Finance. Once a key player leaves, the new staff member lacks the rationale behind a design choice, so the original set of principles is lost. Secondly, due to the duration of MHEP projects, there was a perception of more room for error over five years of modelling as projects deviated from initial forecasts and invoicing instructions were complicated.

Thirdly, there were difficulties in forecasting outcome performance, especially for the complex social area at the intersection of employment and mental health. In provider sites, the MHEP projects rely on NHS teams to guide participant referral pathways. Senior-level support from ICBs was seen as crucial for enabling referrals and securing ongoing service integration in a changeable NHS delivery landscape. For example, research participants noted that, the assumptions written into service specifications in the outcome contract about your relationship with the health system, "… *probably won't hold for five years."*

Finally, there was the argument from MHEP that SIBs do not get easier over time because they *should not* get easier over time. This was due to the belief that SIBs should involve constant adaption to respond to the outcome variation over time using data. There was a worry from MHEP that if you shrink resources and reduce the administrative oversight over time, then you are reducing the capacity to adapt and resolve issues. There is a consensus among the actors interviewed that traditional commissioners with current resource constraints may struggle to match the same level of performance management as MHEP (further explored in Part 5).

"More generally, the cost of running a SIB, I think should be large and fixed, because actively managing a contract well, with a learning mindset, is an expensive thing to do." - MHEP

Finally, financial administration should get easier over time in theory, as actors become more familiar with the model. However, invoicing for different amounts depending on performance still calls for a cultural shift.

Effectiveness of MHEP's performance management

In terms of performance management arrangements, the MHEP SIB agreement is managed in two ways:

- **Performance reporting**; and
- **Contract review performance meetings (CRMs)**.

The service provider, within five days of the end of each month, submits to MHEP a report (the "Outcomes Report") detailing the outcomes achieved during the relevant month. This should be exported directly from the service provider's case management systems and will not require any data analysis or additional written reports. The service provider is required to provide supporting evidence for **four key outcomes**:

- Number of service users successfully engaged in the service,
- Number of service users successfully starting work,
- Number of people referred into the IPS service who sustain a job outcome for 13 weeks (working, on average, <16 hours per week), and
- Number of people referred into the IPS service who sustain a job outcome for 13 weeks (working, on average, ≥16 hours per week).

Every quarter, the service provider must attend contract review monitoring meetings with the commissioning authority, and the MHEP team (the manager and at least 1 of the two analysts).

In addition to the requirements listed above, service providers are required to:

- participate in 6-weekly calls with MHEP's managing agent to review performance, staffing, integration, issues and outcomes;
- develop a robust outcomes framework that will monitor outcomes and set goals for service development;
- submit complete, accurate, and timely monitoring returns to the authority and MHEP;
- consent to the disclosure of all relevant information and data to MHEP; and
- consent to MHEP's attendance at all meetings between the authority and provider in which information pertaining to the services is discussed and reviewed.

Providers generally considered the performance management package offered by MHEP to be "supportive," however this differed over time and varied according to the specific manager in post. Over the course of the contracts, providers have experienced six different MHEP managers, with a turnover of 8 to 9 months in the position. This high-cadence turnover within the core MHEP team was seen as somewhat destabilising by providers. With the caveat that this brought 'fresh energy' according to Social Finance, all other actors (providers, MHEP Board, TNLCF) considered this to be a potential barrier to the relationship development that is a crucial foundation of performance management.

“We were never quite sure how long we were going to have them for. And it did get a little bit confusing. We didn't have anyone for a long while.” - Provider

The most effective performance management was the individual and team goal setting providers did internally, but which was heavily informed by CRMs and the MHEP data dashboard. For instance, on the back of CRM or data provided by MHEP, providers would then take these lessons to either individual employment specialists or team meetings to discuss. As identified in the previous MHEP evaluation report, the data analytics was perceived to be *above and beyond* what a traditional commissioner would provide (Hulse et al., 2023). However, the reason this was effective was because of service adaptation and because commissioners responded to the data-led insights. This gave providers more evidence to help them apply for other funding (this is discussed further in Part 5).

An additional helpful performance management tool was the development of communities of practice within the MHEP provider network. This notably only occurred a couple of times. However, when such provider exchanges did occur, it was described as “brilliant” and offered a level of collaboration that providers had never experienced before. Many providers wished they had been in contact with their peers more. For example, one service that experienced MHEP as their first outcome-based contract sought external support from other organisations who have been through outcome-styled contracts.

“We would have liked to have been in touch with other services on this contract. I think the feeling has been … why wouldn't there be some forum or a get-together to share learning or experiences? Why is the advice always coming from MHEP, rather than from these services? It always seems to be filtered through MHEP... which is a little bit puzzling.” - Provider

<u>Performance reporting</u>

The MHEP core team uses a template to present quarterly project-level information in a ‘performance pack’. The MHEP team compiles this information each month from the provider’s outcomes report. The standardised report takes the format of 4 slides where data is presented:

1. **Descriptively**: Service update describing performance (high months, targets, different outcomes), staffing & integration, and employer engagement.
2. **Numerically**: Quarter’s performance report of all outcomes as well as referrals overall, per employment specialist, average year to date compared to contract target.
3. **Visually**: The actual outcomes versus contractual targets in the past six months.

In attempts to develop a learning culture, MHEP has changed the performance pack over time to be more useable by the provider. In 2019, it looked quite different to its current format. MHEP simplified and created quite a standard version from 2020 through to 2021. In the last year of the contract in 2023, the MHEP manager asked the analysts to start experimenting to strip out some of the details, based on what they had learned about what is useful for providers. The MHEP team realised that what the board needed to see was different to what the providers needed to see. The ability to be experimental over time with the performance pack in reaction to what is useful for providers was viewed positively by MHEP but negligible for the providers. In fact, many providers revealed that they do not pass on these packs to the frontline employment specialists due to the language being potentially "demotivating." Instead, all the service leaders consciously choose to instead "absorb" the information and then translate it themselves to their team. This has important implications for the translation of SIB performance incentives. This is discussed further in Part 4: Through what incentives do MHEP SIBs operate?

Providers largely viewed the performance reporting to be the biggest asset of MHEP's performance management offering. This was due to two main reasons: 1) MHEP brought clarity in defining KPIs, targets for employment specialists, and reporting expectations; and 2) providers had never experienced any traditional commissioner providing this level of analytical support. Similarly, commissioners greatly appreciated the performance reporting since many of them were time-poor and resource-constrained. A commissioner stated: *"I don't have a contract monitoring service team behind me, it's just me."* In fact, some commissioners said that MHEP's work on creating figures and benchmarking helped free up their time and cognitive load to be more present commissioners.

"What it does is it … frees up my time to talk and engage, do those sorts of things rather than worry about [the provider]." - Commissioner

"MHEP KPIs are really clear, they collect the data well and communicate it well." - Provider

"Comparing that to non-MHEP services…I was so shocked to find out that some services literally don't give anything [reporting] to their commissioners." - IPS Grow

<u>Contract review meetings (CRMs)</u>

CRMs focus on that quarter's performance led by the provider. The CRMs interpret and contextualise performance and may also cover other business (e.g., contract updates, checking invoicing, demographics or ethnicity data). The MHEP explained that they are not IPS experts themselves, so they were cognisant of respecting providers' inherent expertise. This was appreciated by providers and helped to build trust.

"They have never kind of professed to being the fountain of all knowledge when it comes to IPS, and I think that's good because we are the people who know that inside out." - Provider

When asked about the experience of CRMs in MHEP, providers overwhelmingly compared it to the historical lack of awareness, interest, and accountability of traditional contracts in IPS commissioning. Providers explained that previously they felt like they were in the "secret service", having to shout for attention in busy commissioning bodies. This experience in MHEP, of more involvement and close personal relationships from frequent meetings, made providers feel empowered in a sometimes disempowering/demanding job in social work. After working with MHEP, providers began to question the effectiveness of traditional commissioning.

Providers valued the way MHEP staff brought new skill sets and asked different questions. At times, MHEP's continuous questioning did appear "Big Brother" or seemed repetitive. The repetition of the same questions with little follow-up was a source of annoyance but was exacerbated under specific managers. Especially in a period of high performance, some providers began to feel *"… it is just a question for a question's sake"*. However, most providers felt MHEP asked "*great questions that we don't always think of*" which kept delivery teams *"on their toes"*. This differed from providers' previous commissioning experiences, where the commissioner would *"let us kind of just go along and hope for the best"*. This perceived increased level of accountability was captured in some emotive revelations:

"The traditional commissioner, as far as I can see, doesn't have that kind of involvement. And you might think that's a nice thing, that they're not there to pick apart what you do, but then you're left thinking, am I doing a good job? Are we doing OK? I think having a commissioner who takes a healthy level of interest in what you're doing, is much more positive really. And I think if we hadn't had that level of interest from MHEP, I do wonder if we'd be running as well as we do now." - Provider

"But, without that, not so much monitoring, but ***without that relationship, I don't see how you can be confident that you're getting the service that you commission really****. So, I think in IPS, it is integral to have that relationship between the Commissioner and people who are delivering the service" - Provider*

Is MHEP needed for high-performing sites?

- If a service provider was consistently high-performing and always overperformed against the targets, there was a perception of diminishing returns on the effectiveness of the performance management offer. Multiple stakeholders questioned whether MHEP (and thus the SIBs structure) is needed for high-performing sites.
- Providers noted that even experienced organisations could benefit from MHEP if they are expanding to a new area or there is a period of transformation. Many established providers said that MHEP contributes to organisational development so would still consider an outcome-based contract.
- Providers and MHEP concur that MHEP provided access to additional funding through LCF. The structure shifted some of the financial responsibility for underperformance onto MHEP and investors rather than commissioners. MHEP also helped providers to secure contract extensions and this was valued even amongst high-performing services.

Ideal characteristics for providers and commissioners under a SIB
Since its conception in 2015 and the start of LCF contracts in 2019/2020, several interviewees noted characteristics that enabled providers and commissioners to thrive under a SIB.

In terms of the ideal characteristics of commissioners under a SIB, providers valued dedicated time and responsiveness, while commissioners themselves highlighted skills in partnership working and knowing referral pathways. MHEP staff were quick to praise the commissioners' ability to be a learning partner and an active manager of the contract. All MHEP stakeholders agreed that an ideal provider for a SIB would be a third-sector local organisation as they would be closer to clients and thus make it easier for referrals and *"are more community-based."*

In selecting delivery organisations, MHEP was quick to highlight that there would be no prerequisites for data systems or level of service leadership since MHEP would build that with them and "*go on a journey together,"* but they were *"obviously a plus."*

However, MHEP staff did reveal that some of the choices in identifying partners came down to opportunism in the early years. The MHEP team would not necessarily advise others to follow the same path when identifying and developing partners within SIBs.

"We were opportunistic... we'd take any service wherever there was Commissioner who was interested." - MHEP

"There was an important reason why that provider was included. The service was considered by other experts and other providers in the market to be a very good service. But actually the outcomes were not matching what we expected by MHEP standards. And the NHS funding was about to come in or it was on the horizon, so it was seen to be a good point within that local ecosystem to intervene.... to connect with the service and understand the mismatch in external perceptions and service outcomes ... in order to bring up the standard, as all the other services expanded locally." - MHEP

Table 7: Ideal actors within the SIB funding IPS

Ideal provider characteristics for SIB-funded IPS	Consensus across stakeholders	Divergence across stakeholders
	• Third sector with a strong local presence • Familiarity with IPS model, known across the local health system, ideally with fidelity quality mark • Financially healthy and delivering multiple contracts with different end dates	• Providers emphasised the importance of being transparent and operating with a high level of engagement towards funders • Providers which are already undergoing transformation are not suitable (provider view) • MHEP team members were more likely to emphasise service leadership
Ideal commissioner characteristics for SIB funded IPS	**Consensus across stakeholders**	**Divergence across stakeholders**
	• Responsive and highly engaged with the performance of the service • Strong working relationships with the mental health sector and wider partners in the referral pathway • Knowledgeable on the local job market to give constructive advice • Capable in navigating intricacies of an outcome-based contract	• The MHEP team valued the spirit of learning and active problem-solving rather than taking a punitive approach • Commissioners mentioned an ideal belief in the strength of partnership working • Providers valued commissioners that engage with people who are experts-by-experience

Part 4: Through what incentives do SIBs operate?

MHEP SIBs were expected to operate through strong traditional financial incentives linked to outcome payments. However, in reality these financial incentives were more muted than expected due to four main reasons:

- **Outcome target design problems:** providers did not internalise some of the performance targets especially if they were deemed too high and not feasible. Where the annual payment cap was too low, the payment threshold would be met earlier in the year meaning that outcome achievement beyond this point was not rewarded.
- **Greater intrinsic motivation:** front-line staff in provider organisations were "very client-focused". Provider leadership teams felt the need to shield frontline staff from outcome targets so that employment specialists could focus on delivering IPS well. Managers made a conscious choice to absorb the pressure.
- **Lack of direct payments:** front-line staff were not directly rewarded for outcome achievement. Outcome payments were not bonuses for staff but for the organisation. Even at the organisational level, the incentive of outcome payments was moderated by the low proportion of outcome-linked payment and payment caps.
- **Lack of clarity:** many frontline staff initially did not understand the amount of payment per outcome nor the need to provide evidence of outcome achievement.

However, the incentives that were effective in motivating providers were:

- **Internal benchmarks of success or personal best:** by comparing a provider's performance to their 'personal best' meant MHEP could set more realistic goals and provide more personalised positive feedback. This encouraged provider teams to view themselves as competent.
- **Autonomy or perceived efficiency gains:** MHEP's clarity of data requirements meant that providers' processes and data systems improved, creating more efficiency.
- **Mission pride or trust:** building trust between the MHEP team and the providers was seen to be a successful motivator when MHEP could align values, acknowledge external pressures, and recognise providers' intrinsic motivators.

Providers were split into advocates or sceptics for future outcome payments. Interviewees were mostly in favour of future outcome-based contracts provided that outcome payments were a low proportion of contract value and targets were achievable yet ambitious.

Incentive flows and accountability mapping

Theoretically, SIBs align incentives for performance by linking payment to the achievement of outcomes.

In reality, the incentives are often muted in MHEP projects because of:

- **Design problems**: Target outcomes and payment caps are not set appropriately.
- **Intrinsic motivation:** Provider front-line staff are not motivated by financial incentives and instead identified with a value-based intervention.
- **Not direct enough**: Staff members in provider organisations and MHEP analysts do not receive direct payment linked to the achievement of outcomes.
- **Lack of clarity** on the financial or other consequences of underperformance.

Design problems

MHEP staff were surprised at how muted financial incentives were for providers. This often occurred because the cap on outcome payments was hit earlier in the year as it may have been set too low. Yet, even when the cap was not reached, outcome-linked payments were not seen as the "primary motivator." The percentage of outcome payments across sites had no correlation with performance, i.e. a site with a high percentage of outcome payments performed relatively poorly, while a site with zero outcome payments appeared highly incentivised to perform well (see Appendix A for updated quantitative performance data). There was a clear disconnect between payments and provider's behaviour in that the providers did not internalise the targets. Targets became meaningless if they were deemed too high and not feasible, which would in turn demotivate provider teams.

"We've actually realised that sometimes the contract targets are less useless to us, because ... they do not necessarily always reflect what is truly achievable for the service. Where they are too unrealistic, the service provider can become a little disconnected from them." - MHEP manager

"The point was that the outcomes are wrong, and it would have been interesting to shift the outcome because it would have shifted behaviour." -MHEP manager

Intrinsic motivation

Since providers are "very client-focused" service managers felt that outcome payments would not motivate their staff. There was a common belief among service managers/team leaders that staff need to be shielded from targets to do IPS well. Managers made a conscious choice to absorb a lot of the pressure/data from MHEP and not necessarily pass it onto the frontline staff. Many did not pass on the performance packs to frontline staff much to the surprise of MHEP. One

manager admitted that the language in some of the performance packs could be interpreted as demotivating for teams so would purposively not show it to them in MHEP's format. This manager translated performance information so the frontline staff could feel more understood, by using the same terminology and value-based language seen in IPS or social work. Shielding also occurred due to fears that the outcome payments would affect quality and introduce gaming practices. Managers again relayed negative stories of harsh historical contracts and were keen to avoid that culture.

"It's a lovely idea and I completely get the idea behind it. But I do think it's a lack of understanding of how these services operate and how you can get the best outcomes and long-term outcomes for people so that they stay employed and stay off benefits." - Provider

"The MHEP manager asked "do you share what we talked about in the meetings". I thought "oh I don't", but I want the employment specialists to do the IPS job really and collect evidence to show and prove what we are doing to keep that contract alive rather than make it about the model really." - Service manager

Not direct enough

While outcome payments were perceived to contribute to the financial health of the service provider organisation, that did not necessarily trickle down to frontline staff. While CEOs and Senior Directors often felt the urgency of outcome payments, the people actually holding a key driver to affect outcomes (the frontline staff) did not experience this pressure directly. This was most clearly described by a former employment specialist turned service manager who stated *"it's not like they're bonuses for you."* Furthermore, due to the high turnover of staff in Social Finance, commissioners, and even provider organisations, the responsibility was often diluted.

"I think in the vision of SIB like they care, you care... but in reality, someone sets it up, someone else manages it, and they don't really have any stake emotionally in it... I think the reality of that is different to what you think coming in." - MHEP manager

"[Outcome payments] might matter to the board, but it doesn't matter to the team so much." - Provider

"Day-to-day, as an employment specialist who's actually the one who's going to get the outcomes, that doesn't motivate you because those payment by results, it's not like they're bonuses for you." - Provider

Lack of clarity

Some providers notionally knew about the financial consequences of results-based payments, however practically did not fully understand the financial consequences of different performance levels for their organisation. Exacerbated by high

turnover and a steep learning curve, initially many frontline staff did not understand the amount of payment per outcome or the need to provide evidence.

"Obviously we're very aware that there likely would be consequences, but there hadn't been any clarity around it." - Provider

What did incentivise actors in MHEP?

In contrast to expectations, there were three key variables that ultimately motivated providers to perform.

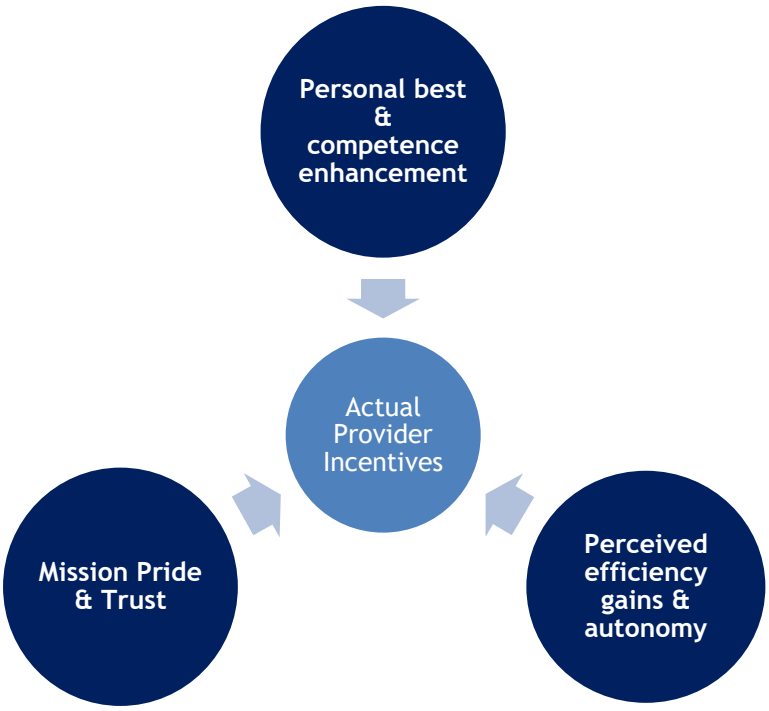

Figure 3: Incentives for providers

- **Personal best & competence enhancement**

Given the lack of resonance with the contractual targets, MHEP began to share with providers their 'personal best' data. This would describe how their current quarter's performance would compare to their team's best performance across the four years of the contract. Interviewees described this as facilitating a substantial shift in motivation. Furthermore, it allowed the actors to overcome challenges with previous indirect and impersonal contractual targets. This leads to competence enhancement by setting more realistic goals and providing more personal, positive feedback. Personal best data challenged service provider (and commissioner) expectations on what was possible and encouraged teams to get back to pre-pandemic levels. Frontline workers were thus more motivated and perceived themselves and their service as competent.

“We found it was very powerful to provide the service with a sense of its OWN best performance … like hitting their highest ever or exceeding our highest ever. It felt like something that they could mobilise behind. So having all the data that reflected all of those different benchmarks felt like a more useful way to talk about success.” - MHEP manager

“Until you have that shared view of success, I think it's quite hard to pass on the incentives to the frontline team members, who you know that is where the outcomes are achieved. And if your frontline team members don't connect with or understand where the target came from, and are not able to feel a sense of achievement when they meet the targets, I think whatever targets you set can be too academic.” - MHEP manager

- **Perceived efficiency gains & autonomy.**

In light of previous IPS contracts having unclear KPIs or definitions of success and monitoring, providers revealed that MHEP’s clarity over data requirements facilitated concrete action. This clarified their inputs and activities and what to prioritise in order to achieve results. This was often seen in more rigorous caseload management. Commissioners highlighted that MHEP’s model stopped other neighbouring boroughs from moving staff i.e., the MHEP arrangement served to protect team sizes. Furthermore, even though there was an initial challenging “learning curve phase”, providers found that their processes and data systems improved, creating more efficiency. Service providers often described this as a “streamlined” data and management approach. Clarity over the achievement of job outcomes was seen as a benefit of engaging with MHEP and could drive further improvement. For example, one service stated that referral teams began more actively referring to their service due to service user’s feedback. One participant had been engaged pre-SIB and post-SIB and stated *“oh you actually got me a job.”* This perceived increase in capacity meant that frontline staff felt like they were helping more clients and as a result of the new process could be more autonomous after the MHEP contract.

“So you can introduce processes … if you get them right, they just tick over like clockwork and it's amazing. From a management perspective, it's amazing because you can get these really well-oiled teams operating, everybody knows what the goal is, how things need to be done and it's really clear, consistent, and benchmarked so we know what good looks like ... everyone's on the same page with that.” - Provider

- **Mission Pride & Trust**

Once MHEP began to improve its trust with providers, there were “breakthroughs” in incentivising staff to reach for higher performance. This was often through aligning values, acknowledging external pressures, and recognising intrinsic motivators. One of the core beliefs that facilitated building trust was the MHEP performance management team realising that strong relationships were pre-requisites to motivating staff to achieve outcomes. Furthermore, MHEP adopting

similar language to the providers helped frontline staff see them as more collaborative. For example, although a subtle distinction in language (often initially missed by MHEP analysts,) the delivery staff were more motivated when discussing clients rather than data or outcome numbers, as one provider explains: *"Data doesn't motivate ES [employment specialists], what motivates ES are clients."* Additionally, trust developed through MHEP management recognising the provider's staff pressure of maintaining quality, especially since fidelity was seen as a badge of honour amongst delivery teams. Candid conversations about service pressures and in-person site visits were seen as important for cultivating trust.

"I feel it's been important to be conscious of being a collaborator and facilitator of providing support rather than as somebody who is just causing a headache..." - MHEP Manager

Appetite for the future use of outcome payments

There were mixed views on the appetite for the use of outcome payments in all IPS contracts. Regardless, all stakeholder types indicated that they were in favour of the use of outcome payments provided that the contracts are "set up right." In other words, similar to the MHEP arrangement, many stakeholders would use an outcome-based contract in the future if it had a low percentage of outcome payments to overall contract value and a collaborative culture of equal partnership.

Table 8: Views on outcome payments according to MHEP's providers and commissioners

Views on Outcome Payments	Providers	Commissioners
Positive	• Drives efficiencies in data monitoring • Changes mindsets to be more outcome-focused	• Offers reassurance since commissioners only pay for what works • Can lead to greater outcomes achievement and increased effectiveness
Negative	• Exerts stress on delivery teams • Can be financially risky, especially for small providers • May be less motivating than expected as providers derive motivation through values and professional norms • Outcomes could depersonalise service users	• Can be ineffective with high weighting on outcomes leading to gaming practices

Commissioners' views on outcome payments

Commissioners were mostly positive about outcome payments. All interviewed commissioners indicated that they would consider using outcome-based payments in their future contracts, as long as this was kept at a low percentage of the total contract value, specifically around 5-10%. Some commissioners reflected on ineffective outcome-based contracts and gaming practices that they have seen in their career and urged caution to get the design right.

Commissioners in the NHS found that outcome payments were a way to *"reassure the cynics…that at least we're not going to pay for services that aren't delivering."* This was especially important in convincing executives who question the introduction of employment support interventions within the NHS. Additionally, the history of ineffective employment support interventions before IPS increased the perception of the risk of service failure, for which outcome payments could appease the more sceptical commissioning bodies or commissioners.

However, questions were raised on how outcome payments can fit in the integrated care system approach, which prioritises more partnership work. Some commissioners worry that outcome payment may seem like an *"old commissioning approach,"* that feels formal with a direct commissioner-provider split. Culture was viewed as a decisive factor on the appropriateness of outcome payments. As long as outcome payments are not taken as a *"punitive approach rather than real equal partnership working,"* many commissioners were happy to introduce 5% in future contracts. There was also an increasing recognition of commissioners *"no longer being at the head of the table"* but being one of several other actors at the table (commissioners, providers, external bodies, and population health bodies). So, an outcome-based contract was viewed as a positive way to convene additional partners to support commissioning.

Commissioners commented that their original motivation for being involved in MHEP's outcome-based contracts was to supplement the funding of their locally delivered services. However, ultimately the perceived value of outcome-based contracts for them was greater effectiveness:

"Hopefully [in outcome-based contracts] more people get more outcomes as a result. That should truly be the point, right? So though you do need their support and action to make them happen, whether the commissioners or the providers like it is slightly moot. But does it increase outcomes? I'm hoping you'll tell us." - Commissioner

Commissioners reflected that the type of providers that they want to work with in the future could operate under outcome payments:

"There was a concern other providers might not be able to step in and do that. I think now to be honest, if they're not comfortable with outcome payments, they're not the kind of IPS provider I'm looking for anyway." - Commissioner

Providers' views on outcome payments

Unlike commissioners who were mostly positive, providers were split into advocates or sceptics for outcome payments. Advocates emphasised that outcome payments meant that the targets kept them on track, accountable and led to more regular contact with the commissioners. Sceptics highlighted the stress and financial risk (especially being small organisations) and were cautious of onerous targets.

It is important to note that many of the sceptics expressed that their views were genuine worries for future use. Interviewees suggested that they would change their minds if the payments were made through well-designed outcome-based contracts. Even when interviewees were sceptical of payments tied to outcomes, they still saw value in MHEP's approach as a co-commissioner. In other words, all providers appreciated MHEP's style of working to improve commissioning practice, so would do another outcome-based contract with MHEP just to continue receiving that support:

"We as an organisation and as a team, everyone knows that no one likes outcome payment by results contracts because it's just not what motivates our staff... of course we would consider it because the collaborative style of working is really helpful." - Providers

The relative appetite for outcome payments varied by the level of seniority within the provider organisation. Frontline staff were more inclined to view it as overly corporate, with worries the arrangement would become a more rigid outcome contract like their previous historical contracts from DWP. Notably, in one provider organisation, all levels of management (CEO and service managers) were more hesitant towards outcome payments but stated they would always consider this due to their need for sustainably funded contracts as a third-sector provider.

Unsurprisingly, providers were less likely to speak positively about outcome payments if their service was underperforming at the time of the interview. While more established teams with a larger referral footprint were more confident in the use of outcome payments.

However, those providers that were hesitant towards future outcome-based contracts, did admit that they are more prepared for taking on this approach in the future, as a result of changes to their organisation processes (explored in Part 5). Some providers emphasised that a larger organisation with more bespoke databases may find outcome-based contracts easier due to reduced set-up requirements.

On the other hand, other providers had more positive views about outcome payments. When asked if they wanted to deliver another outcome-based contract, one service manager exclaimed:

"Oh yes, please! Have you got one? Why do I sound so glowing about it? I can certainly draw a distinction between the traditional contract and MHEP contract. I would say that the MHEP style is healthier for a service."

Providers that emphasised this positive view towards outcome-based contracts indicated that it put more "*rigour*" into their service delivery, especially due to

the increase in data and evidencing. Advocates often commented on the journey they undertook as an organisation and as individuals where initially they may not have "*appreciated this different way of contracting*", but found it was *"a satisfying way of working"*. Key benefits determined were often regarding organisation development, such as more efficient monitoring and recruitment processes, and data-driven learning, which interviewees described as a new approach.

All providers that were advocates emphasised that this desire for more outcome-based contracts was contingent on the targets and weighting being appropriate:

"I like that style of outcome-based contracts when the outcomes aren't too onerous. Because the danger is that you're swinging all the other way and targets become impossible, where the life and soul are sucked out of the model or you're doing it for the wrong reasons. But I never felt that with this MHEP contract."

Providers also highlighted the importance of maintaining the right culture under an outcome-based contract, since "*when a person stops being an individual but a unit, that is where it doesn't work."*

MHEP's views on outcome payments

Unsurprisingly, the MHEP board and MHEP staff all saw value in the use of social investment and outcome-based contracts in local commissioning. Many interviewed expressed that they wished the MHEP vehicle supporting these delivery sites would continue.

"It's a shame [MHEP is finishing] because I think it is right to test different ways of working and bring together different funding pots to achieve something that has never been achieved before. It means that there is no risk borne by any single organisation. Plus, you increase your amount of funding available and that becomes a testbed for future services, I think that is a great model to follow. How do we get there? You can't get there without resources and someone with a vision and somebody with an appetite to make it happen." - Big Issue Invest

Part 5: Does MHEP have a legacy?

MHEP likely has a legacy for both the current providers and commissioners and the wider IPS sector.

For the wider sector, Social Finance created IPS Grow in 2019 and this was heavily shaped by learning within MHEP on supporting IPS services. IPS Grow helps with standardisation and coordination nationally across all IPS sites, attempting to reduce the fragmentation in historical IPS commissioning. The work of IPS Grow is expected to continue with support from the NHS and Department of Work and Pensions (DWP) and backed by the Office for Health Improvement and Disparities (OHID) to be the national quality assurance for all IPS.

Providers and commissioners expect that the capacity development through MHEP will have a legacy. For providers, the professional development from training supplied by MHEP was expected to endure. Additionally, organisational development under MHEP, such as enhanced IT and monitoring systems, will allow providers to track outcomes and self-monitor in the future. Commissioners gained skills in partnership working with a third party and the creation of a new baseline in the expectations of IPS service delivery in terms of outcome achievement and support required. These expectations are likely to continue and will inform future commissioning.

However, some functions of MHEP are unlikely to continue, especially the intensity of data analysis, technical support for performance management, verification of outcomes, and the coordination function of pooling central and local government funding. Ultimately, despite the steep learning curve of the MHEP SIBs and notable periods of tension, providers and commissioners were grateful for its legacy.

This section refers to the capacity building that occurred through MHEP SIBs. It describes the legacy beyond the MHEP contract, with particular focus on how MHEP has informed the scaling of IPS in England and Europe.

Capacity building

As identified in the first interim evaluation, commissioners and providers highlighted that MHEP helped them around three core areas compared to traditional commissioning: i) additional financial resources, ii) additional performance management capacity, and iii) an emphasis on collaborative working. However, there remains a question as to whether these perceived benefits will be long-lasting. Once the contract terminates, will capacity or skills be transferred and sustained?

Even in non-SIB contracts, one of the major challenges concerning IPS implementation is the lack of stable funding after the project period. Commissioners expressed concern about reaching a cliff edge in the provision of what is now considered an essential and high-priority service for those with mental

illness. Similarly, MHEP managers did not want to *"see the bottom fall out on performance"* and were anxious about delivery staff turnover if future contracts were not secured. Providers were concerned that due to the national scale-up of IPS, the IPS market may balloon *"so it can really stretch provider capacity … and there become real recruitment challenges."*

Providers hoped that the MHEP experience would leave a legacy of innovation in service delivery. The MHEP team aspired for "MHEP to be forgotten and IPS to be the star." While there were varied beliefs on whether the benefits were long-lasting, stakeholders consistently described the types of capacity development experienced as part of the project:

For providers, MHEP brought enhanced capacity through:

- Talent pipelines for staff recruitment and progression;
- IT systems;
- Efficient and dependable data routines to evidence outcomes.

For commissioners, MHEP brought enhanced capacity through:

- Creation of a new baseline for expected IPS services;
- Experience in partnership working.

One provider stated that for the first time, they started thinking about talent pipelines and rehauled their IT system during the MHEP project. This organisation explained that MHEP built their capacity quickly, allowing them to be competitive for other bids since they could demonstrate agility in being "well set-up." MHEP managers expressed their attempts to get providers to self-manage post-MHEP. For instance, an operational director of a service remarked that MHEP *"rehauled our entire performance monitoring policy and process. We refined that over time, and now that's being used in other parts of the organisation. And it's only evolving over time, getting better and better."*

"The bones of the organisation [are] becoming healthy on the back of how we learn to operate under an outcomes-based contract. We had so many examples that we were able to use in other bids." - Provider

Providers described their enhanced ability to evidence service outcomes as a crucial type of capacity development. MHEP's insistence on evidencing first job outcomes and following up job sustainment outcomes provided them with *"a really good, solid discipline."* One service manager revealed that MHEP was *"ahead of the curve on what was expected nationally"* in other IPS contracts. Satisfying MHEP's requirements, although initially burdensome, gave providers an unexpected legacy.

"I would say if you're not used to that, then I'd say be prepared because there's more to do in terms of evidence in the outcomes. But it's proven to be a healthy thing because I think there is going to be more of that in IPS commissioning.

Commissioners want outcomes to be evidenced, and it's forced us, for a lack of a better word, to look at the data and be guided by the data." - Provider

"MHEP insisting on 1st jobs was ahead of the curve, [based] on what was expected nationally really. So, I feel that working with MHEP has kind of given us a little bit of a head start in many areas... I don't think we would be flying as high as we are now if it wasn't for that really." - Provider

In comparison, commissioners were positive in expressing that they are *"not looking to reverse the provision that MHEP has allowed us to have"*. In fact, the experience of redefining what good looks like for an IPS service has created a baseline that commissioners expected to build from. The extra staff that the MHEP funding provided meant that services could be "ambitious," according to NHS commissioners, in building co-location with statutory mental health services. Furthermore, commissioners noted that the training MHEP implemented with provider staff would have a long legacy.

"There's the obvious one with the additional funding, which in a cash-strapped NHS system at the moment has been invaluable, and it has allowed us to move forward with our workforce plans to ensure that we have the right level of workforce to meet our co-location ambition. Looking at the workforce and the number of people entering service, we realised that we are going to have to ensure that we retain the workforce provision going forward and our target is to very much expand this out." - Commissioner

"Knowledge and skills development does have legs. Policies and organisation processes that have been put in place sustain, so you've got a legacy there. I think you certainly see that in the wider market, so as part of scaling IPS, those skills are out into the workforce and that does have quite a long ripple out, quite a long legacy." - Commissioner

Finally, although MHEP staff described an improved relationship between providers as a desirable development, providers, and commissioners did not attribute this development exclusively to MHEP. Providers all stated they would have had a relationship with the commissioner with or without MHEP. One very well-established and high-performing service did not perceive a major capacity development benefit through working with MHEP, stating instead that capacity development support was most needed on the commissioner side.

Some functions in MHEP will not be directly transferred or taken forward in future commissioning arrangements. Many commissioners explained that they would not be able to match the level of analytical support provided by MHEP, given their resource constraints. However, one provider had hired a performance improvement officer for a role similar to the function offered by MHEP. At the time of the interview, one commissioning team was completing an extensive scoping exercise to assess how they might fund IPS in their borough. This included seeking evidence on the finances that MHEP had brought and how to bring the

same capacity to assess the providers' data (verification and quality checks). This highlighted that actors were investing in these functions for future non-MHEP contracts due to their perceived value in having them during MHEP's SIBs.

"We don't want to reduce that envelope. So, we are going to have to start a scoping piece of work quite quickly and think about how we prioritise IPS going forward. So MHEP sense checking the quality and the accuracy of the provider-submitted data and that's something as the statutory commissioner, we've not been doing. There are various functions, data analysis and support that we would need to make sure we build into our arrangements going forward." - Commissioner

Legacy beyond the MHEP contract

Although some of the functions and contributions from the MHEP team will continue beyond the LCF-supported outcomes contracts, this is not the case for all features. The likelihood of the functions in MHEP continuing in the project's sites can be seen in Table 9. Interviewees expressed that the professional development (e.g., staff service leadership) and organisational development (e.g., IT infrastructure) that were enhanced under MHEP, have a high likelihood of continuing in their future IPS services. The continuation of these functions is conditional on available resources, especially amongst local commissioners. However, some functions of MHEP are unlikely to continue, especially the intensity of data analysis, frequent technical support for performance management, verification of outcomes data, and the function of pooling central and local government funding. Many of these functions were unique because MHEP acted as a co-commissioner, supporting both the provider and local commissioner. As stated in the section above, many MHEP providers and commissioners are currently undergoing scoping exercises to find resources to fill the gap around data analysis and outcome verification beyond the MHEP contract.

Table 9: RAG rating or likelihood of MHEP function continuing to exist beyond the contract as a result of capacity development

Key functions available through MHEP as proposed legacy elements	Likelihood that function continues in the sites' future IPS service	Notes
Coordinating function: the pooling of central and local government funding	Unlikely	Local commissioners would like to see more regional coordination to harmonise and bring together government departments that are currently funding IPS (DWP, OHID, NHS) who historically have limited coordination. Local commissioners did not identify alternative options for joining up IPS funding.
Data analysis and data management	Continuation at risk	Commissioners questioned whether they would have the capacity to continue with the high levels of data analysis offered via MHEP in future IPS contracting.
Performance Management: Technical support and active problem-solving	Mixed, continuation only likely if commissioner has capacity	The two MHEP sites which will continue with an outcome-based contract will *not* have a dedicated performance management function. Many providers note that traditional contracts do not have an intensity of performance management comparable to that of MHEP.
Verification of outcomes: validating the quality and accuracy of provider-submitted data	Continuation at risk	Historically, commissioners have not validated output or outcomes data for IPS services.
Service leadership, including talent pipelines and retention of staff skills as a result of MHEP's training	Likely to continue, but some aspects are reliant on IPS Grow	The MHEP operational director was responsible for training the providers. The aim of the training was described as creating bubbles of excellence that would have ripple effects across the entire industry. Service managers and commissioners agreed the training supplied during MHEP has a legacy.
IT infrastructure to support high levels of data monitoring, evidencing outcomes and	Likely	IT infrastructure and data routines are in place and are well embedded in MHEP providers. MHEP provided a framework to *"kind of grease the wheel from a grant-funded model to more of a contracting model."*

supporting organisational processes		
Clear KPIs	Likely	IPS Grow KPI guidance contains definitions of KPIs to help resolve inconsistencies. These KPIs are influenced by the MHEP experience and these indicators are now embedded into contract service specifications promoted by IPS Grow. Nevertheless, some discrepancies in definitions still remain across various IPS sites in the country.
Advocacy function: sustainable longer-term contracts	Likely, but still at risk	MHEP has indirectly supported providers in preparing bids to win sustainable contracts and integrate service user feedback to make improvements. Providers agreed that they are in a much better position to win sustainable IPS contracts due to their experience with MHEP. Yet, contract insecurity remains a risk for third-sector providers, and the ongoing use of short-term contracts means that sustainability expectations may not be met. Many providers explained that while they are in a good position to secure future contracts and funding, the amount of funding does not feel proportionate to the NHS Long Term Plan access target demand.

MHEP's legacy in scaling up IPS

MHEP's has contributed to the widespread scaling of IPS and the development of IPS Grow. The MHEP team highlighted that they feel like they have *"done the job for severe mental illness…the scale-up is happening, and there's a quality assurance platform [via IPS Grow]."* IPS Grow was created in 2019 to support the scaling and expansion of the IPS services across England in mental health, community drug and alcohol services, and health-led trials (IPS Grow, n.d.). This project was led by Social Finance in partnership with the Centre for Mental Health, commissioned by NHS England & Improvement and Department of Work and Pensions (DWP) and backed by the Office for Health Improvement and Disparities (OHID) (IPS Grow, n.d.). According to IPS Grow, the UK is at a *"turning point due to NHS England making a commitment to expand access over the next ten years"* via the NHS Long Term Plan (IPS Grow, n.d.).

Furthermore, due to IPS Grow's perceived value, OHID, which is expanding IPS in primary care, is now using IPS Grow to support their technical support of providers. This displays IPS Grow's wider recognition as a system steward for IPS services, regardless of whether services are funded through outcome-based contract or traditional funding.

"The Government made a commitment to deliver IPS within primary care... they recognised that all has to happen with IPS Grow around it which is à la MHEP....good data management, good mobilisation support, technical support, drop-in problem solving, people brought together to share good practice, knowledge tool, resources and tools people can use." - MHEP

Timeline

In 2015, MHEP entered the IPS sector at a time when, although there were promising local projects, implementation was still small-scale. Reflecting on IPS trial data, there were concerns that the UK experience of IPS was not *"meeting expectations"* in terms of effectiveness.

Due to the greater monitoring and collection of data, MHEP began to collect evidence of effective IPS delivery. Social Finance believes that they demonstrated that the IPS model is effective *"but required certain kinds of support to make sure that it maintained the high level of outcomes that you would expect from the academic literature and the early pilots."* This insight was used to inform the creation of IPS Grow. While IPS Grow was "fortuitous," it has become the largest success story from MHEP. MHEP developers explain:

"IPS grow itself – the fact that it exists – comes from an evidence base that MHEP helped create. Those early SIBs showing IPS, like there was already evidence that IPS worked internationally and probably some domestic evidence, but the creation of IPS Grow as a thing has been pushed forward and evidenced by early MHEP SIBs." - MHEP

The first stage of IPS Grow involved the MHEP operational director bringing non-MHEP IPS providers together to form communities of practice and build knowledge management. The second stage, funded by DWP and NHS, allowed IPS Grow to be formalised and hire a national manager and seven to eight staff members to create a footprint around the country to support all local services. Tasks were similar to those of MHEP such as "*building up their capability to deliver on IPS, but also knowledge management, sharing of practice, workforce development, and data management.*" Now, IPS Grow offers three main types of support: technical implementation support (fidelity), workforce development (staff recruitment and training, e-learning, online guidance documents, IPS workspaces within FutureNHS Collaboration Platform), and data tools and performance standards (IPS Grow Toolkit) (RAND Europe, 2021). See Figure 4 for how IPS Grow supports IPS implementation. IPS Grow's key inputs are regional leads, workforce development, and its web-based reporting tool. As a result of these inputs, IPS Grow aims to have three key outputs: 1) sites can manage efficient, responsive and flexible service; 2) IPS workers gain skills, knowledge, confidence and implementation expertise; and 3) the use of evidence for learning, commissioning, delivering and improving quality.

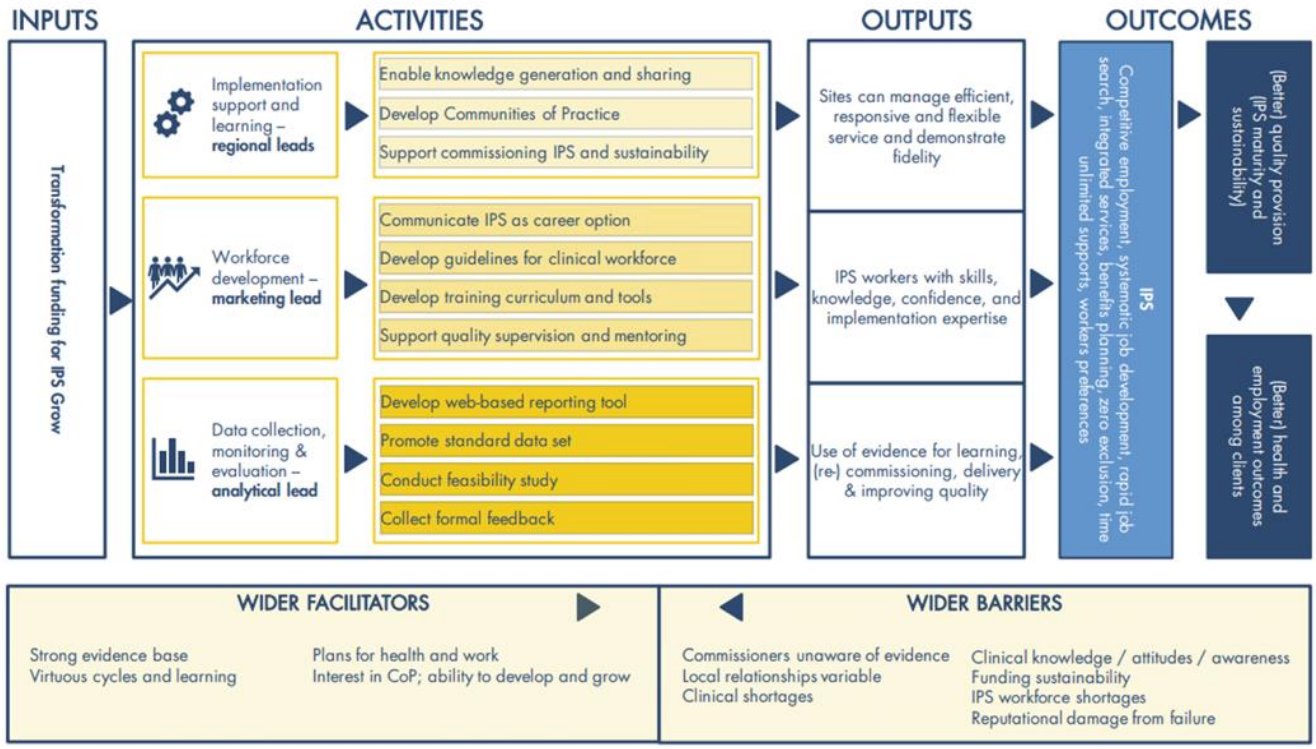

Figure 4: The logic model illustrating how IPS Grow supports IPS implementation

Source: Picken, N., Hofman, J., Gilder, L., Gloinson, ER., Ling, T. Evaluation of IPS Grow: Final Report. 2021: RAND Europe

In 2019, IPS Grow's first task was to standardise data and develop the standard data spreadsheet, which can be uploaded into an IPS Grow toolkit that provides performance management charts and information for services. Even though IPS Grow does not have a remit to offer performance management, the idea of IPS Grow is to provide a tool for data standardisation to support providers – through benchmarking – to better manage their own performance. This will create the ability to benchmark services over time, which was stated as a previously unmet need in the IPS sector. Providers had expressed that they wanted to *"know how they're doing… how am I doing compared to my neighbour? ... bringing that level of peer pressure is a powerful thing"*.

Most IPS providers are now reported to use the standard spreadsheet to capture their data even if they do not use the full functionality of the IPS Grow toolkit. This was perceived to rectify the previously poor and fragmented quality of data collection in all IPS sites across the country. An IPS Grow manager explained: "*there are some services that don't record data very well, and I don't think they're very confident about what they're doing with data*." Interviewees in MHEP and IPS Grow highlighted that if all IPS sites across the country use the IPS Grow Toolkit, then accountability for performance (as seen in MHEP) can spread across all IPS sites, regardless of how and where they are commissioned. According to IPS Grow, there is still some work to be done to encourage all IPS providers to use the toolkit.

Utility of IPS Grow according to providers

Prior to IPS Grow, many interviewees stated there was a "*void of advice and guidance and no centralised point.*" Providers valued IPS Grow's advice and the utility of its guidance within the IPS sector. IPS Grow was positively seen as supporting scale-up and acting as the IPS sector steward.

MHEP providers interviewed revealed that they use the IPS Grow toolkit and would seek out their regional IPS Grow lead for support on anything that is client-experience-focused. Providers would also lean on IPS Grow to problem-solve. Providers highlighted the benefits of the IPS Grow network, noting that it fosters a sense of 'community' by linking with other services through regional forums. In fact, all MHEP providers were extremely positive about IPS Grow and were complimentary of the support offered:

"I think IPS Grow has certainly done a good job in rolling it out and getting those links between services." - Provider

"We will continue to use the IPS Grow spreadsheet. You upload it to the reporting tool, and it analyses everything for you. So that's what we use, and that then helps us report to our commissioners." - Provider

Providers also commented positively that IPS is funded in the mainstream now and is in a good position for sustainably funded contracts. For instance, providers stated: "*Prior to this huge national expansion, we were going round to anyone who would listen and just saying, look, can you help us with some funding? DWP was*

saying that's not our responsibility. NHS was saying that is not really our responsibility. So it has changed an awful lot in quite a short time."

Capacity development for scale-up

As the application of the IPS model has grown, increased oversight through fidelity assessments and the capacity and skills within the sector to deliver quality IPS has spread.

In the MHEP project, commissioners felt that MHEP support for staff development would have a "ripple effect" on the wider IPS market. MHEP provider staff were described as becoming "shining beacons" or "leaders" in the IPS space. As a result of MHEP, IPS Grow training, and mainstream funding, IPS Grow staff explained that the sector is in a position now where there is a *"market of experienced providers…previously there was barely any"*. A strong provider landscape was regarded as a successful driver of scale-up.

The experience of evidencing outcomes has helped MHEP providers to be ahead of the curve for national benchmarking targets for scale-up. One provider reflected on attending an IPS Grow regional forum and stated that other non-MHEP services seemed to only be *"waking up to first job starts"* and that by working with MHEP, the providers felt *"we've been doing that already."*

Relevance for other evidence-based interventions

Commissioners and Social Finance staff argued that MHEP acted like scaffolding for an evidence-based intervention. In other words, a MHEP approach could benefit other evidence-based interventions where there was an aspiration for delivery to be operationalised or scaled up. Even providers commented that an MHEP approach is beneficial for services: *"I would say that MHEP style is probably healthier for a service."*

"There is a legacy from MHEP around building the evidence base for these interventions and securing knowledge that has been useful in the wider scale-up of employment interventions. And I think [outcome-based contracts] are a really fruitful way of testing and learning what works in a way that is really low cost to government because they are not taking on the risk of these services working" - MHEP

Scaling of IPS in Europe

Due to Social Finance's success in contributing to the scale-up of IPS for severe mental illness via the MHEP project and IPS Grow, they were commissioned to support the scale-up across Europe.

"That scale-up didn't happen in other countries, which is why we won this money to try and help [European countries] scale IPS and do exactly what we did with MHEP." - MHEP operational director

At the end of 2020, Social Finance UK and Social Finance NL were awarded funding as part of the European Social Catalyst Fund to explore the possibility of scaling IPS services to five European Countries (including Croatia, Czech Republic, Denmark, France, and Spain). As part of this project, which ran until September 2021, Social Finance UK created working groups with members of the five countries to create a roadmap for the expansion and rollout of IPS services. Additionally, various IPS experts were brought together and consulted throughout the process.

While most of the European sites received public funding to deliver IPS, they lacked the support that MHEP provided, impacting the effectiveness of the scale-up. According to the Social Finance staff leading the Europe scale-up, what was missing was quality assurance and data management. In other words, this scaling endeavour lacked "*a MHEP approach*."

"The result of our project, which was an MHEP approach of getting people together, showing data, proving the case, building relationships, finding other funding opportunities, we got scale and got things moving. So, the MHEP approach was really useful and proven in other countries where nothing had ever happened." - MHEP Operational director

4. Discussion

Ultimately, MHEP stakeholders revealed a greater sense of accountability in the SIB-funded IPS service delivery compared to historical traditional commissioning. This occurred principally through improvements in commissioning practice, with outcome payments only seen as a marginal part of the MHEP experience. Accountability under MHEP was seen though four key areas: continuous monitoring, more contractual levers to uphold performance, high commissioner involvement, and active problem-solving.

Continuous monitoring and more contractual levers to respond to underperformance were appreciated by commissioners, as the MHEP arrangements overcame the constraints of blunt (rarely used) penalty clauses in traditional contracts. **MHEP's high levels of involvement and problem-solving** were greatly appreciated among providers. This enabled front-line staff empowerment and prevented service drift, which was a common risk in traditional contracts. MHEP also successfully set new baseline performance expectations for employment outcomes, so it became much clearer what was expected for effective IPS delivery.

Despite the benefits of enhanced accountability, there were issues in the MHEP SIBs. These included **high complexity, brief periods of tension in service quality, periods of poor performance, and muted incentives**. The consequences of MHEP's complexity were loss of staff motivation, mission (mis)alignment and occasionally failure to realise outcome payments of job sustainment due to a lack of clarity on the evidence requirement.

Nonetheless, there are solutions available to combat these issues. Commissioners interested in SIBs for social care could take inspiration from the **ideal SIB contract design** (in Table 6) described by interviewees and procure with awareness of characteristics for outcomes contract readiness (in Part 3). Future SIB projects should be aware of the benefits of making performance management more useable (in Part 3) and collaborative capacity building of providers and commissioners (Part 5). Participating in a SIB may enable commissioners to develop **new skills and capabilities**, such as collaborative partnership working and active, data-led management with service providers. Through participating in MHEP, providers have gained skills in evidencing outcomes, building talent pipelines for workforce development, and developing efficient organisational processes through IT monitoring systems.

Reducing the complexity of the MHEP SIB arrangement was identified unanimously as an area for improvement. This could be pursued by ensuring wide buy-in for design justifications, adopting a learning and adaptability mindset, improving forecasting, and addressing issues related to annualised contract caps on outcome payments early on. In MHEP, the financial incentives provided by outcome payments were not as strong as expected due to the intrinsic motivation of provider staff, complex funding flows, inappropriate target setting, and lack of clarity on performance-linked payments (Part 4). Practitioners interested in SIBs should note that many of these experiences are particular to MHEP's project structure.

Ultimately, the **legacy effects of MHEP** will be felt in the wider scale-up of IPS and other outcome-based funding initiatives. So far, elements (especially of staff service leadership, IT infrastructure, use of IPS Grow Toolkit, and outcomes embedded into the fidelity framework) are likely to continue in future IPS services. However, some functions of MHEP are unlikely to continue, especially the intensity of data analysis, technical support for performance management, verification of outcomes, and the coordination function of pooling central and local government funding.

In this report, MHEP SIBs showcase clear benefits for improving commissioning practice. The MHEP special purpose vehicle is the longest-running SIB contracting platform (since 2015) and represents a **successful model for the scale-up** of an evidence-based intervention. Many actors had an appetite to be involved with outcome-based contracts in the future with a similar arrangement to MHEP (especially if outcome-related payments were a limited proportion of the contract value). Many providers believed that the experience was challenging and stressful at times, especially with the steep learning curve in MHEP's way of working, but were ultimately grateful for its legacy. The litmus test will be how the actors involved in the MHEP project will respond and cope post-contract.

To find the answers to the key questions of the report, please see the sections below for the summarised answers.

- **Is there greater accountability in SIB-funded IPS compared to traditional commissioning?** Yes, improvements in IPS commissioning practice were observed via continuous monitoring, additional contractual levers for upholding performance, high involvement of stakeholders and active problem solving.
- **Does the MHEP SIB affect service quality?** There have been mixed improvements and tensions in service quality, although not unlike a traditional contract.
- **How did the structure of the MHEP SIBs affect service delivery?** Pooled funding from the SPV unlocked several benefits in service delivery. However, complexity was a detrimental characteristic of the SIB structure.
- **Through what incentives do SIBs operate?** Stakeholders described both financial imperatives and other motivations for delivering effective services. Financial incentives were more muted than expected.
- **Does MHEP have a legacy?** Yes, MHEP has contributed to the development of IPS Grow and the broader scaling of IPS. MHEP has also contributed to organisational and professional development within provider organisations.

5. Recommendations

This final section presents recommendations and implications for different audiences:

For Local Government:

- **Consider strengthening commissioning and contracting practice** by offering IPS providers longer-term, outcomes-focused contracts, with dedicated resources for technical assistance. In practice, this could mean contracts that are 3 years in duration with 2 years for extension. There is an increased likelihood of effective outcome performance if there is a reduction in contract insecurity and better resourcing.
- **Consider fostering the cultural shift towards learning and collaborative governance** with providers. There are clear accountability benefits for providers if local authorities are closely involved and actively problem-solve with IPS providers.
- **Manage the performance of IPS providers actively and intervene earlier during periods of underperformance,** rather than assuming that performance will improve without support.
- **Consider alternative partnership arrangements** such as social impact bonds (social outcomes partnerships), which offer the possibility to provide services with earmarked additional funding for extra staff. In the MHEP case, this meant co-location goals could be achieved alongside resource constraints. When designed well, outcomes partnerships can be an effective tool to convince sceptics of the value of employment support interventions as payment is linked to well-defined, measurable outcomes.

For Central Government

- **Enable more standardisation and coordination across departmental funding boundaries**. Several distinct central government departments and agencies are funding IPS (i.e. DWP, OHID, NHS) and there is limited standardisation around KPI definitions, contract design, baseline targets, and resources to hit the national IPS access targets. The NHS Long Term Plan's target of 55,000 people accessing IPS for several mental illness service users is not expected to be reached. Meeting this target will require strategic thinking and coordination.
- **Consider the use of outcome funds** to help pool central and local funding. The approach adopted by the LCF may offer a helpful model for how outcomes funds can be developed and used to leverage additional funding. The LCF, through £70 million of central government funding, brought approximately £114 million[6] in the local commissioner budget to the table. The MHEP Board and social impact investors considered the use of outcome funds as supportive of building the landscape for future investments into public services. Outcome funds may play an important role in facilitating local SIBs in the absence of engagement from all relevant commissioning parties. In future, it may be beneficial to more intentionally pool outcome payers around a shared policy challenge or issue area in order to secure sustainable, long-term service arrangements.

[6] The LCF maximum outcome payments for all projects according to the grant baseline forms was £114,169,638 for LA. This excludes LCF projects that were awarded funding but never launched or withdrew at the early stage.

- **Consider resourcing technical assistance** for improved commissioning. Stakeholders indicated that effective contract management requires 5 to 10% of the contract value to be dedicated to management and technical support.

6. Conclusion

MHEP SIBs offered a marked contrast with conventional IPS commissioning by enabling greater accountability, organisational development of providers, and effective performance management. Nevertheless, MHEP's contracting structure appeared complex which left incentives muted and several stakeholders needing clarification. Despite this, MHEP and providers have worked together collaboratively to form new approaches to motivating teams and driving performance.

There is a “time and place” for SIBs, according to the commissioners, providers, and MHEP staff interviewed. As long as the SIB design was set up correctly with a low percentage of outcome payments for providers and with quality assurance for services, many actors had an appetite to be involved with a similar outcomes-based approach in the future.

Many providers found the MHEP project experience challenging and stressful at times but were ultimately grateful for its legacy. Providers noted that they had developed new skills, and commissioners were keen to adopt MHEP’s data analysis and verification functions. The litmus test will be the extent to which, and in what form, these projects will continue after the end of LCF funding.

7. Next Steps

At the time of the report, two providers have finished service delivery (March 2023 and October 2023), and the other three providers are finishing in March 2024. All providers are continuing to deliver IPS, with some continuing immediately with OBCs. All providers would consider involvement with an OBC in future.

Table 10: Providers' continuation of IPS service and outcome-based contracting

Providers	Continuing with IPS?	Continuing with OBCs immediately?
H&B Twining Enterprise	Yes (with expansion into primary care)	Yes
Enfield Working Well Trust	Yes (with expansion into primary care)	No
Shropshire Enable	Yes (with expansion into drug and alcohol addictions)	Yes
THSMI Working Well Trust	Yes	No
THLD JET	Yes (with expansion into autism)	Yes

The MHEP evaluation involves further stages. The achievement of outcomes in MHEP sites will be analysed in a quantitative impact evaluation and economic evaluation. We will use a quasi-experimental methodology to assess the magnitude of effects associated with the SIB model compared to a non-SIB counterfactual (IPS funded via traditional commissioning and contracting). This quantitative estimate of SIB effects will provide a foundation for the economic analysis. The economic analysis will focus on the research question: 'Do the benefits of a SIB approach outweigh the costs?.' This will enable an assessment of the 'value for money' of the SIB mechanism.

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9. Appendix A: Interim performance data

Below we provide an updated quantitative analysis of project-level outcome performance from the start of the second quarter of 2019 to September 2023. We extracted project performance data from Social Finance and the DCMS data portal. Targets are medium scenario targets as set per the co-commissioning protocols, whereby medium scenario targets are assumed to reflect average expectations of performance.

To measure performance, we assessed two metrics, namely:

1. Success rate against targets was calculated as a ratio by dividing 'the number of outcomes that were achieved' by 'the number of pre-defined targets' (actual outcomes/target outcomes).

2. Outcome conversion rate was estimated as the rate at which one type of outcome transitions into the next successive outcome in a causal chain, e.g. engagement to job start. At each quarter, this measure was estimated by summing job starts for each project up to that point, then divided by engagement achievements for the same period, and lastly multiplied by 100 to derive the rate. This is a standardised metric and 'job outcome rate' is widely used in measuring the effectiveness of vocational programmes, including IPS, enabling comparison to other non-MHEP IPS programmes.

MHEP's effect on outcome performance

Performance of the employment outcomes from the start of the contract until September 2023 are reported below. Targets are medium scenario targets as set per the co-commissioning protocols. Current performance data finds that MHEP SIBs are mostly performing at medium scenario targets, besides Enfield's and THLD's lower than expected engagement outcomes.

Table A1: Success rates of actual performance versus medium scenario target from start of contract to Q2 2023/2024

Outcome success rate	Haringey & Barnet	THSMI	Shropshire	Enfield	THLD
Engagement	104.5.%	114.0%	135.3%	43.8%	29.3%
Job starts	89.5%	91.6%	102.1%	67.0%	96.0%
Job Sustainment	80.6%	77.9%	73.3%	68.1%	369.0%

Job outcome rate on average for SMI was 32.3%, meaning nearly a third of clients engaging with the IPS services are achieving job employment. This has improved from the average of 29.0% up to December 2021. As reported in Report 1, the IPS implementation literature suggests 30-50% (Hulse et al., 2023). NHS formal guidance suggested a new IPS service should be achieving a minimum of 30% – 40% of clients into jobs, while mature, high-performing services (higher fidelity scoring

services) would be expected to achieve job outcome rates of between 40% and 55%.[7] However, some providers felt that the benchmark for mature services may exceed what is possible for a service that deals with vulnerable clients. One provider explains: *"50% job outcome conversion rate is really high for this type of work."*

The MHEP SIB's job outcome rate is meeting the benchmark for a new IPS service, although performing below the upper ideal benchmark of 55%. Across SMI services, there is a range from 28.8% to 35.8% job outcome rate. Enfield's service has the highest job outcome rate, despite its lower engagement.

Table A2: Conversion rates from start of contract to Q2 2023/2024

Outcome conversion rate	Haringey & Barnet	THSMI	Shropshire	Enfield	SMI average	THLD
Average job outcome rate (Engagements to job starts)	31.9%	28.8%	32.9%	35.8%	32.3%	215.0%
Difference to lower benchmark for a new IPS service (30%)	+1.9%	-1.2%	+2.9%	+5.8%	+2.3%	+185.0%
Difference to upper benchmark for an established IPS service (55%)	-23.1%	-19.2%	-26.3%	-22.1%	-22.7%	+160.0%

Note: conversion rate is the rate that one type of outcome converts into another that follows it successively in a causal chain, e.g. engagement to job start or job start to sustainment. Benchmarks came from NHS England Guidance

Limitations

For the quantitative project-level outcome analysis, data was collected until September 2023. Therefore, findings are tentative, and performance may have changed over the last 6 months of service delivery.

[7] NHS England. (2023). Outcomes in Individual placement and support for severe mental illness. Available from: https://www.england.nhs.uk/long-read/individual-placement-and-support-for-severe-mental-illness/

10. Appendix B: Qualitative data collection and analysis

Given the semi-structured nature, interviews followed six key discussion areas: 1) Background; 2) Comparison to previous commissioning experience (in IPS and OBCs); 3) Perception of (added) financial resources and incentives; 4) Perception of (Collaborative) way of working; 5) Perception of Performance management; and 6) Legacy. The theory of change of MHEP SIBS that was developed in the first interim evaluation report (Hulse et al., 2023) was used to create the interview topic guide.

All recorded interviews were transcribed using Microsoft Teams transcription and then checked for accuracy. Given the exploratory nature of the qualitative research, data coding was inductive and interpretive with iterative comparison across interview data, fieldnotes, observations, and documents. Hence, all qualitative data was analysed using interpretive policy analysis (IPA). IPA is an approach that enables us to see how the SIB project may have been implemented differently than intended, whilst being sensitive to context. Themes were identified in iterative steps: a) data familiarisation; b) first-order coding per transcript, across sites, and across stakeholder type; c) second-order coding; d) triangulating across comparisons with documents and observations, interview fieldnotes; and e) defining high-order themes. All data, especially discrepant results in interviews were compared to that of similar actors (i.e., provider to provider) to ensure validity in the final themes.

Qualitative interviews were chosen since it seeks to generate rich data and 'thick descriptions', which can be described as detailed and complex accounts from participants. This method seeks patterns, explores divergence within the data, and allows for inductive theory generation. It is also important to situate the sample; therefore, interview fieldnotes, preliminary codes, reflections, contextual information, and participant background characteristics were all captured.

In terms of ethics, prior to participation, research participants received an information sheet, outlining the study's purpose and conditions for participation and consent was sought and provided for every interview. Ethics were approved via Blavatnik School of Government Research Ethics Committee (DREC). All stakeholders received an information email and provided their written consent, which was confirmed at the start of each interview. All quotes have been anonymised and identifying information has been redacted to protect stakeholders' privacy and confidentiality.

A number of participants interviewed in Phase 2 had already been interviewed in earlier phases of the research. Interviews were conducted one-to-one in order to cultivate trust and rapport to encourage deep reflection on experience with the MHEP program. This was particularly necessary to elicit individual, rather than organisational, perspectives.

11. Appendix C: Performance Improvement Plans (PIP)

Summary of the lessons learned as a result of the formal PIP process

- The performance improvement action plan was very effective in driving widespread action across the provider organisation (especially at an executive level).
- The financial consequence of low performance was "powerful" in getting attention and buy-in at senior level.
- Underperformance can accumulate and both co-commissioners (CCG or LA) and MHEP need to be quicker in explicitly raising the flag to providers and providing more clarity on support and consequences. Traditional commissioners realised they would now flag underperformance after one quarter when they were previously more optimistic for recovery and would wait over three quarters.
- The commissioner should have been more quickly informed by MHEP on the severity of the underperformance. MHEP and local commissioners should have problem solved together more collaboratively on the bottlenecks in the local area (e.g., NHS transformation, and the setting up of a large number of new referral teams).
- There was a realisation that it was inappropriate to reprimand a service manager for underperformance when the more effective lever was senior members of the team who *"controlled the purse strings."*
- There is a more effective hierarchy of levers to pull in response to poor performance. Interviewees explained that performance concerns should be escalated incrementally, "*from showing the data; telling them they are underperforming; going in in-person as a team member; putting the IPS operational specialist in for a workshop; getting funding for the IPS specialist to go in more permanently for a bit; raising a letter to the CEO; pulling the SIB.*"

This section discusses the performance improvement plans during the MHEP projects, which was a part of the performance management function in the SIBs.

A key tool for ensuring performance in MHEP projects is the contract Service Level Agreements. Where a MHEP service provider fails to meet Service Level Agreements, the Outcome Service Level Failure framework applies so that:

- MHEP may, at its discretion, withhold the part of its Block Payment that funds the payment by the Local Authority to the Service Provider where there is a drop in Staffing Service Levels; and

- If the service provider does not meet Outcome Service Levels and fails to address them in accordance with the framework, MHEP has the right to terminate the contract.

In MHEP's history under LCF, three providers have been under a Performance Improvement Plan (PIP). One provider organisation was in a formal PIP, but since this was during the COVID-19 pandemic (stipulation in the contract "*In the event of Health Crisis, paragraph 7. I shall not apply*" of not withholding payments) and performance quickly recovered, it was not brought up again. Another provider was on an informal PIP but never eventuated into a formal PIP due to performance recovery.

In 2023, one provider organisation was the first site to go through the formal PIP process where the financial consequences could apply. Low performance was driven mainly by low referrals into the service, with the integration of employment specialists within clinical teams a particular issue. It is worth noting that referrals were also a previous issue in MHEP SIBs under CBO. While there is guidance in the contract describing the PIP process, how providers and the MHEP staff understood and reacted to the PIP diverged. The MHEP manager at the time was unaware of the steps in the framework and relied on word of mouth of predecessors or directors.

Research participants offered lessons learned through the PIP process (see summary box). It is understood that the provider which underwent the PIP in 2023 continues to have a "positive" relationship with MHEP so this experience did not cause relationship rupture. However, this period was marked by miscommunication, a lack of clarity around consequences, as well as "frustration," "stress," and "crossed wires."

Table C1: Actual timeline of the formal PIP process

Timeline	Formal PIP process steps
July-December 2022	Severe underperformance in two quarters raised concerns.
November 2022	MHEP Board raised concerns about the direction of travel financially due to the growing loss on the contract.
December 2022	Service provider was informed of consequences of outcome service level underperformance.
February 2023	The board approved an additional £10,200 investment in providing more frequent engagement and operational support through the IPS specialist.
March 2023	Commissioner formally notified of consequences of outcome service level underperformance.

Early April 2023	Close engagement between MHEP and provider continues and first evidence of an upward trend begins as a result of joint-efforts.
Late April 2023	Action plan formal draft sent to MHEP team.
Early May 2023	Action plan sent to board for discussion.
April – May 2023	Continued operational support workshops with service leaders in provider organisation.
June 2023	Performance recovery in the quarter since this performance improvement plan, with the highest outcomes since contract commencement (Q1 2023).

Overall, the process outlines a journey of challenges and then joint efforts to rectify the provider's performance issues:

A. Challenges

Staffing changes: Various MHEP analysts and managers managed the project over different periods. There were uncertainties about the duration of their involvement, leading to some confusion within the service provider.

Performance challenges: Before Christmas, the team took numerous actions to resolve low referrals and engagements without immediate results. There were concerns that the outcomes were not aligning with efforts, causing frustration between MHEP and the provider.

In November 2022, the board expressed concerns about the provider's financial direction. During board meetings and catch-ups, there were repeated explanations of actions taken, but KPIs were still not improving.

"The board were actually quite clear in that they really wanted to avoid a situation where we cancelled the contract … And we're in a position where we had to pass that pressure on to the provider to say actually this contract is really not financially viable for MHEP, so we have to, together do something about it." —MHEP manager at the time

Communication issues: The consequences of underperformance were not clearly communicated, and the sudden discussion caught the provider off guard. The team struggled to understand the sudden drop in collaboration and felt unprepared when the idea of reducing employment specialists was introduced.

"There wasn't much collaboration on it for a while, and there wasn't much kind

of back and forth with it. It was just asking us to explain and then leaving it there, and we'd say, have you got any suggestions or any other services that you know of that have had the same issues that we could talk to and MHEP would say 'oh well, you know, obviously you're the experts." —Provider

In December, a contract review meeting revealed doubts about the team's actions, with MHEP questioning the lack of tangible explanations for the reasons for low performance on engagement and referrals. The provider staff expressed frustration over the ambiguity of consequences for underperformance.

The team received late notifications about MHEP's concerns and the possibility of contract termination. The urgency and potential impact on the contract were not communicated clearly in advance, which was poorly received by both the commissioner and provider. The issue of the commissioner being notified too late was exacerbated due to the timing of re-procuring at the end of the financial year and considering the different priorities in MHEP (all four outcomes) and the local authority (job starts and sustainments).

"Consequences of underperforming was never really brought up massively until kind of this one meeting where it felt like it came quite out of the blue.... I don't think it was even really implied before." - Provider

B. Joint efforts to rectify performance issues

In February 2023, a recovery plan was initiated, involving collaboration with the organisation's CEO. Additional support and investment were proposed to address performance issues, which the MHEP board approved conditional on the provider matching the investment. The front-line staff developed a Performance Improvement Plan, collaborating with MHEP. Monthly calls and additional support from an IPS expert were introduced. The plan mainly aimed to address referral and engagement challenges (see Table C2). Numerous drafts were created before the provider and MHEP settled on the final plan, and it is currently used as a working document.

"I think that's why having those conversations with the senior team within the provider organisation may have unlocked a little bit more resource and backing for the frontline team and the team manager to have the support and resources that they needed to address it." - MHEP manager

In June, performance had improved, with notable achievements in KPIs and job starts. Regular calls and the action plan provided a more informed and supportive environment.

"We made this performance plan, and then three weeks later, our results were way higher and that obviously wasn't entirely the case, that had been coming for quite some time… but then the training we had and the stuff that was in the action plan has been really helpful as well." - Provider

The formal process concluded with reflections on the need for quicker decision-

making, involvement of key individuals, and a structured approach to addressing underperformance.

"I think all of those levers are quite subtle. And I was taking too long to call them, but that's okay. I mean, so that's my learning lesson from it." - MHEP manager

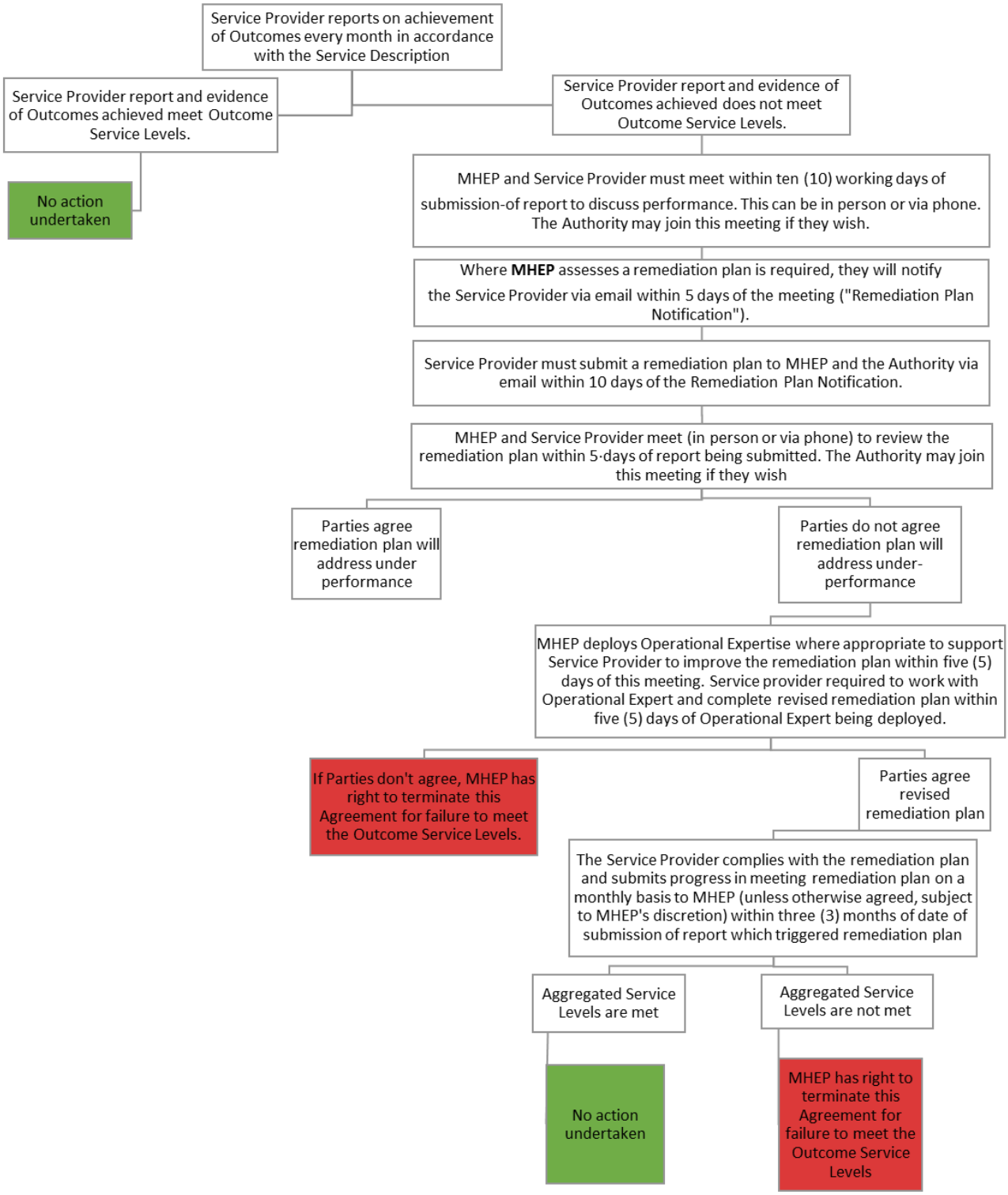
Reasons suggested by provider for performance improvements post-PIP:

According to the interviews with staff at the provider organisation affected, all the action items in the improvement plan started to pay off.

The new action items in the PIP, designed by the provider and approved by the MHEP team, brought large success. The **biggest reason** for improvement was when the commissioner put the provider in contact with different IPS team leads and the ICS transformation lead in the borough. This was now seen or realised to be the biggest blocker in referring. These new contacts from the Transformation Lead allowed them to attend mental health transformation events to meet new referral teams. Receiving positive feedback from clients who were referred to the provider and were then successfully able to find jobs was a catalyst for a positive feedback loop of the referees.

The **second largest reason** for performance recovery was the new information and training given to the provider due to the increased investment. For instance, the social media training for employer engagement run by the Operations Expert was positively received by all stakeholders in the provider organisation (from employment specialist to manager to CEO). This training was perceived to help create a new strategy for employer engagement and helped with job starts. In addition, MHEP put the provider in touch with another MHEP service who had previously experienced low referrals due to transformation. This was seen as a very effective strategy and providers lamented that they wished they had been in contact earlier since it was so helpful.

Figure C1: Outcome Service Level Failure Framework in the OBC



Source: Adapted from Schedule 7 of Co-commissioning Protocols between Mental Health and Employment Partnership Limited and Local commissioner

Table C2: New action items added to the service provider's MHEP Action Plan

Actions	Associated MHEP KPI
Location of ES in new team	Referrals
Assertive outreach to past referrers	Referrals
Operations director dedicating extra time to: IPS Steering committee and senior executive buy in to IPS	Referrals
Expert by experience roles, WWT clients who have been through IPS service employed to come to clinical meetings, steering group etc - suggestion from another MHEP Provider B	Referrals
Monthly update to all referring teams with breakdown of their referral stats	Referrals
Dedicated resource as part of expert by experience roles for chasing non-engaging referrals & older referrals	Engagement
Joint meetings with clinicians in the case of non-engaging clients	Engagement
Setting minimum target for individual ES of 70% conversion rate from referral to access	Engagement
Voucher for job start confirmation - motivate people to stay engaged if they have a quick job start *	Job Start
Industry focuses for EE - Each ES has a focus industry to gain long term contact	Job Start
Field mentoring for phone EE	Job Start
Sales Training for EE - waiting to Bridget to come back with details	Job start
Using social media for EE Training	Job Start
Team lead field mentoring training with IPS Grow	Job Start

Job week - focus on job starts first week of each month	Job Start
Closely monitor to ensure current practice continued	Sustainment
Team lead meeting with IPS specialist/operational expertise to identify any further areas for change & development	N/A (service improvement)
Link in with service with similar concerns	N/A (service improvement)
MHEP team to provide some additional performance management structure and reporting to support implementation of the plan	N/A (service improvement)

Source: Provider's Action Plan snippet from Excel, this does not represent the action plan in its entirety which also includes targets, previous actual numbers, attached resourcing in times and additional costs, status of actions and responsibilities. *= action considered but not taken forward since evidence collection was not an issue. EE = employer engagement; ES = employment specialist; KPI = key performance indicator; IPS = individual placement and support; MHEP = Mental Health and Employment Partners; WWW = Working Well Trust

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