Individual Placement Support: A Social Impact Bond Model

Evaluation Report

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Violette Gadenne, Martina Maglicic, David Nolan, Hazel Wright, Johanna Frerichs

THE BEHAVIOURAL INSIGHTS TEAM

Contents

Executive summary

The Mental Health and Employment Partnership (MHEP) Social Impact Bond (SIB) was designed to create partnerships between agencies to drive innovation and collaboration. It sought to increase investment in Individual Placement Support (IPS) with the aim of better supporting unemployed people with severe and enduring mental health conditions back into employment.

Using the outcome-based SIB model, The Mental Health and Employment Partnership (MHEP), CCGs, Local Authorities and providers collaborated to deliver IPS across six locations over the period of the evaluation. The Behavioural Insights Team (BIT) was commissioned to conduct an impact evaluation of the service, which took place between March 2016 and September 2019. Participants were aged 18 to 65 and out-of-work, with severe and enduring mental health conditions.

While the methods originally scoped for an impact evaluation included an RCT and quasi-experimental designs, these were later ruled out on the basis that a suitable control group could not be constructed. The quantitative element of the evaluation instead employs descriptive statistics to present outcomes for participants in IPS under the SIB model. While these methods do not allow conclusions to be drawn as to the effectiveness of the IPS programme or the relative efficacy of each IPS service, they do provide a picture of service-level outcomes.

Data for 1926 participants were included in the evaluation. The primary outcomes for the study were entry to, and sustainment of, employment. Evaluation data were supplied by Social Finance. A further primary outcome examined benefit off-flow using self-report data elicited and recorded by IPS providers. Secondary outcomes looked at job sustainment, and the number of hours worked.

Quantitative findings show that over the lifetime of the contract, 31% of participants engaged (590) achieved a job start, with 22% of these participants maintaining work for at least 6 weeks, and with 75% working 16 hours or more per week. Performance against service outcomes by the number of ES employed varied, with some ES taking on much larger caseloads and achieving many more employment outcomes than their counterparts in other areas.

Qualitative findings provide details of the delivery models and their differences, and present participant and partner perspectives on the efficacy of these models.

Participants reported benefits of the service that went beyond jobsearch support, including to their sense of confidence and to their jobsearch skills. They also reported auxiliary benefits to obtaining employment, particularly those associated with their emotional wellbeing.

The implementation of the service was explored, with findings outlining the impact of the complexity of each model, and setting out what has already been put in place to address these impacts. Challenges experienced during the commissioning of the SIB are also discussed, with an account of how these are currently being addressed, and how they could be managed in the future. Finally, the benefits of a proactive approach to collaboration are explored, with case-studies utilised to set out how this proactive approach is currently being put into practice.

1. Introduction

1.1 Background

Context

Social Finance Ltd commissioned the Behavioural Insights Team (BIT) to conduct an independent evaluation of the outcomes delivered by IPS services operating as part of the MHEP programme, to expand the evidence base for an integrated mental health and employment support service that is capable of scaling to a national level. This report presents the findings of that evaluation. This first chapter describes the background of the work and the objectives of the evaluation. The second describes the methods employed, and the third and fourth set out quantitative and process evaluation findings respectively.

Employment support for people with mental health conditions

Rates of employment in the UK for people with mental health conditions remain very low. At October 2019, DWP data indicates that 51%[1] of Employment and Support Allowance (ESA) claimants (approximately 1,053,342 individuals) and 38%[2] of Incapacity Benefit (IB) /Severe Disablement Allowance (SDA) claimants had a main disabling condition described as Mental and Behavioural, with almost a quarter of recent Jobseeker's Allowance (JSA) claimants indicating they have a common mental health condition. The effect of unemployment at the individual level can be substantial. It is found to be both corrosive to wellbeing and to have long-term scarring impacts (persistent negative effects) on a person's future employment prospects and earnings[3]. The effect of unemployment on health is also well documented, particularly its tendency to contribute to poorer mental health and higher rates of mortality[4].

There are a number of different approaches to help people with mental health conditions into paid employment, but they can be broadly divided into two types of support: 'train and place' and 'place and train'. Train and place approaches focus on the provision of training, and opportunities for sheltered employment (a setting in which people with disabilities receive services and training to develop work-related skills and behaviors) with a view to building up a jobseeker's skills to obtain competitive employment in the future. This is the traditional model applied by employment providers working with people with complex health issues or disabilities.

[1] Department for Work and Pensions, [DWP]. (2019). Welcome to Stat-Xplore page. Retrieved December 19, 2019, from https://bit.ly/2sEOFO3
[2] [DWP]. (2019). Welcome to Stat-Xplore page. Retrieved December 19, 2019, from https://bit.ly/2sEOFO3
[3] Clark, A., Georgellis, Y., & Sanfey, P. (2001). Scarring: The Psychological Impact of Past Unemployment. *Economica*, 68(270), 221-241
[4]Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* London: The Stationery Office.

In contrast to train and place, place and train models rapidly place people in paid employment so they can experience its benefits and challenges, then provide additional training and support to help the transition and maintain employment. The Individual Placement and Support (IPS) is an example of a 'place and train' type of support. The model is based on eight evidence-based principles which include: IPS employment specialists providing support centred around service user preferences, strengths and work experiences; a rapid job search with service users being conducted within a month of starting the programme; supporting service users to gain competitive employment paying at least the minimum wage; and ongoing support to help service users maintain employment once it is secured.[5] The IPS model also involves employment specialists building close relationships with employers in order to understand their needs, and with the mental health teams who support the target group.

Where IPS services are delivered with high fidelity, they have been shown to have a positive impact on employment outcomes of people with severe and enduring mental illness[6][7]. A meta-analysis of 11 high fidelity IPS programmes for individuals with severe mental health conditions has shown the pooled (or combined) employment rate to be as high as 61% compared to 23% for controls[8].

The IPS services included in this evaluation have all been delivered through the Mental Health and Employment Partnership (MHEP) SIB models, under a contract co-commissioned by The Cabinet Office and Big Lottery Fund. The program is the first of its kind to provide social investment to deliver IPS through a SIB.

Social Impact Bonds

The SIB model offers a transformative approach for the delivery of public services. They work by employing a type of payment-by-results contract, whereby service providers are paid by commissioners (usually Local Authorities or Clinical Commissioning Groups) based on the social outcomes they deliver. While SIBs use funding from investors to cover the set-up costs and reduce risk for providers delivering a service, investors then receive a return on their investment based on the providers performance on these outcomes.[9][10] As IPS is designed to support those with severe and enduring mental health conditions, the model in this context increases access to funding by bringing together funding streams from partners interested in health and/or work outcomes.

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[5] IPS Employment Centre. (2019). What is IPS? Retrieved December 19 2019, https://bit.ly/2M94C5G

[6] Bond, G., Drake, R., & Becker, D. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. *World Psychiatry*, 11(1), 32-39.

[7] McKee-Ryan, F., Song, Z., Wanberg, C., & Kinicki, A. (2005). Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study. *Journal of Applied Psychology*, 90(1), 53-76.

[8] Bond, G. R., Drake, R. E., & Becker, D. R. (2008). An update on randomized controlled trials of evidence-based supported employment. *Psychiatric rehabilitation journal*, 31(4), 280-290.

[9] Government Outcomes Lab. Impact Bonds. Retrieved from URL, https://bit.ly/36Nlib1

[10] Knowledge Box. Guidance on developing a SIB. Retrieved 19 December 2019, https://bit.ly/2M94R0A

The Mental Health and Employment Partnership

MHEP is a Special Purpose Vehicle established by Social Finance Ltd., a not for profit organisation that partners with the government, the social sector and the financial community to find better ways of tackling social problems in the UK and beyond[11]. Alongside MHEP, Social Finance manages IPS Grow, which provides support to IPS services to expand and develop effective practice across the UK.

MHEP was launched in 2015 with the aim of driving the expansion of employment programmes for people with mental health conditions. In order to expand the IPS offer, MHEP uses the SIB model to create new partnerships between agencies and socially motivated investors to bring together national, outcomes-based funding with local health and Local Authority funding.

To date, MHEP have set up vehicles for the commissioning and funding of six IPS services across the UK, in partnership with local commissioners including Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Five of these are currently in operation in Enfield, Camden, Tower Hamlets, Haringey and Barnet. There are two variants of the SIB model, which we refer to as the 'single commissioning model' and the 'co-commissioning model'. Further detail on the structure and operation of these models is presented later in this report.

The evaluation of the programme was designed and implemented following service set-up, and as such is a descriptive study of programme outcomes.

1.4 Evaluation objectives

The evaluation set out to provide insights on the models themselves, and how the SIB mechanism might contribute to outcomes at provider level. The specific quantitative and qualitative evaluation research questions are outlined below.

Quantitative Research questions

The quantitative evaluation sought to describe the performance of each service.

The specific research questions were:

1. How many clients did services engage and how did this vary by size of service?
2. How many job starts, 6-week job sustainments and (and in services where this was recorded) 6-month job sustainments were achieved in each service? How did this compare to the size and duration of the service?
3. What were the range of outcomes achieved by services?

[11]Social Finance. About Us. Retrieved 19 December 2019, https://bit.ly/35PycoA

4. Are there differences in employment outcomes, off-benefit outcomes, length of employment and hours worked for participants depending on their benefit type, gender or age?

The descriptive design employed for this evaluation does not allow us to draw conclusions on the efficacy or effectiveness of the IPS programme. Quantitative data from each site will be used to describe the outcomes achieved by each service. The absence of a counterfactual group limits our ability to account for external factors that may influence outcomes in each area, meaning changes in outcomes or across groups cannot be attributed solely to a causal link between the service activities and outcomes.
Further, comparisons across providers cannot be made to assess their relative efficacy, due to the potential presence of confounders. It is not possible with the current study design to determine what effect if any confounders may have on both the direction of changes observed in outcomes, or the scale of these changes. These constraints will be discussed further later in the report.

Process evaluation questions
The aim of the qualitative component of the evaluation was to understand how the two variants of the SIB model work in practice and to identify the barriers and facilitators to successful commissioning and delivery of the model, from the perspective of commissioners, service providers, service users and MHEP.

The specific research questions were:

1. What are the perceived strengths and weaknesses of the two commissioning models?
2. What are the facilitators and challenges to implementing an IPS service delivered through a SIB model?
3. What are the facilitators and challenges to building relationships between commissioners, service providers and MHEP?
4. What are the participants' views on how to successfully scale IPS services delivered through SIBs?

The methods used to address these questions are discussed in the next chapter.

2. Methods

2.1 Quantitative Evaluation

A descriptive study design was chosen following consideration of a number of different evaluation approaches. Ideally, individuals would be allocated to receive IPS or not, or IPS specialists would be allocated at random to suitable mental health care teams so as to prevent selection bias. As services were commissioned and set up before evaluation work began, it was not possible to integrate experimental procedures into the model. The selection of teams for IPS is subject to a number of factors, including the preferences of the NHS Trust and the service commissioners, as well as practical staffing considerations. Moreover, participants are deliberately referred to IPS because of their interest in going back to work, and are often transferred between teams as their needs change. These procedures could not be adapted for the purpose of the evaluation. While IPS has previously been evaluated using experimental methods, it was not possible to conduct an RCT to examine the impact of the SIB model itself, given the limited number of delivery sites. For these and other reasons, it was determined that a service evaluation would provide more value in terms of initial insights into the outcomes achieved by the services.

The socio-demographic characteristics of participants were explored, alongside engagement rates for each provider, and participants likelihood of maintaining a job for 6 weeks or 6 months. Further analysis was conducted to determine how quickly the average participant entered work once enrolled in the programme and, for those who achieve a job outcome, the number of hours they worked per week.
All findings are intended to be descriptive only, as conclusions cannot be drawn as to the efficacy of the services involved, or their relative efficacy.

Participant eligibility

Participants comprised all clients who provided consent to have their data included in the study and engaged with the IPS providers between November 2016 and April 2019. Participant eligibility for IPS was assessed by local mental health teams. In addition to being a current client receiving mental health support, participants had to be unemployed, aged between 18-65 yrs and referred to the service during the evaluation period.
Within this period, each of the five providers operated for varying lengths of time, with some launching or closing services earlier than others.

It was not possible to obtain participant level data from Barnet, as the service only operated for 12 months, though MHEP were able to supply aggregate data for some of the required

evaluation outcomes. In some cases, individual level data supplied by providers could not be provided for the full length of the programme. Service delivery dates and data availability for each provider are set out in **Table 1** below.

Table 1

Service Delivery Timelines			
Provider	**Area**	**Service Delivery**[12]	**Data Provided**
Remploy	Enfield	January 2018 - ongoing	Up to April 2019
Twining	Haringey	January 2016 - April 2019	Up to April 2019
Twining	Barnet	April 2017 - March 2018	Data unavailable
Working Well Trust	Tower Hamlets	April 2016 - ongoing	Up to April 2019
Hillside Clubhouse	Camden	October 2017 - ongoing	Up to April 2019
Making Space	Staffordshire	April 2016 - October 2018	Up to June 2017

Procedure

Clients who were already in the process of entering the IPS service were asked by their mental health clinicians to consent to participate in the evaluation. For participants entering the service who were not content to provide consent for their data to be used, these data were excluded from individual level analysis. Once consent was obtained, participants were provided with an information sheet, which described the nature of the research and personal data collected, and clarified that refusal to participate would affect neither benefit payments nor the mental health services offered. Consent was recorded using a signed hard copy consent form collected by the mental health team staff member. Participants were then referred to an IPS Employment Specialist (ES) who worked to support them into employment, whilst co-ordinating this support closely with the relevant clinical team as per the IPS model. At entry to the service, the ES recorded basic demographic data, including age, gender, and benefit type and status. Self-report outcome data was collected by IPS specialists at six weeks and six months following entry to the service. These data were collected routinely by ES as part of their role, and shared with BIT for the purpose of the evaluation.

[12] During the period of service delivery covered by the evaluation, new contracts were put in place for two of the five providers.

2.2 Outcome measures

Quantitative service outcomes are set out in **Table 2** below.

Table 2

Quantitative Outcomes	
Outcome	**Description**
Employment	Whether or not the participant has moved into any form of paid employment
Sustained Employment	Whether or not the participant has sustained any form of paid employment for at least 6 weeks Whether or not the participant has sustained any form of employment for at least 6 months[13]

The evaluation also looked at participants demographic characteristics (age, gender and benefit status), differences between providers in the length of time it took participants to find work, and how many hours they worked.

Employment outcomes were chosen on the basis that providers routinely collected each item at the 6 week and 6 month point following participant engagement with the service. Routine touchpoints between participants and ES were identified as providing the most reliable form of data collection for this cohort, as regular contact was provided throughout the programme as part of the programme support offer. ES collected data on their outcomes at 6 weeks and 6 months either face to face, by phone or by email. Where ES were not able to establish contact with their clients at these points, contact would be established later and data for these periods subsequently updated. In many cases, ES contact with their clients was lost and it was not possible for these data to be collected. The prevalence of missingness in the data for each provider is discussed later in this report.

Data were only collected where participants had provided fully informed consent. In addition to individual level participant data collected from providers, aggregate data were provided by MHEP. Throughout the remainder of this report, the five providers who participated in this evaluation are referenced anonymously as Provider 1, 2, 3, 4 and 5.

2.3 Process Evaluation

Overview/Design

Process evaluations are used to understand how programmes work when implemented in real-world settings and to inform optimal programme delivery. Qualitative methods are

[13] Three of the six areas were not required to measure employment outcomes at 6 months for their participants

particularly useful as part of process evaluations for answering 'how' and 'why' questions and for illuminating the complex process of implementation[14]. In this evaluation, qualitative methods were used to gain an in-depth understanding of the views and experiences of different groups of stakeholders in relation to the commissioning and delivery of the model, as well as to inform potential scale-up.

Data collection

Thirty-one participants took part in the evaluation. This included: two commissioners; twelve employees of service providers; six service users; and eleven MHEP employees/members of the MHEP board. The two commissioners were selected to ensure representation of both variants of the SIB model. We spoke to employees at two of the four participating service providers, capturing variation both in the type of SIB model used and past experience meeting targets. Only two providers were able to take part due to a period of exceptionally high workload for the other two. For service users, a convenience sample was used. Within the constraints of the evaluation funding, it was determined that a smaller number of service users would be required given the focus of this work on the SIB model, which was less transparent to the service users. We also spoke to all members of the MHEP board present at their August board meeting; additional interviews were carried out with those members of MHEP most directly involved in IPS service set up and implementation.

Data were collected using interviews and focus groups between August and September 2019. Data collection was semi-structured, meaning that there were a series of planned topics and questions, but the researcher(s) followed this flexibly, responding to emerging topics discussed by participants. Data were collected in-person on health service, MHEP or service provider premises. The exceptions to this were an interview with a service user, both interviews with commissioners and one of the interviews with a MHEP employee, which took place over the telephone. All data collected was audio-recorded and transcribed for analysis.

Data analysis

Two researchers analysed the data using the Framework approach[15], which is an established approach within applied policy evaluations. The first stage of the analysis involved data familiarisation to identify the range of topics discussed in the interviews and focus groups. This was used to construct an analytical matrix, in which each column represented a different topic and each row represented an individual interview or focus group. Data were then systematically summarised into each cell of the analytical matrix, ensuring that the summary stayed close to the original account of the participant/participant group. The final stage of the analysis involved looking both within each case (in other words, along each row) and across topics (in other words, down each column) to draw out the diversity of views and experiences in relation to the evaluation objectives and other emerging ideas.

[14] Gov.uk. Process Evaluation. Retrieved 19 December 2019, https://bit.ly/2sMu8H2

[15] Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. sage.

Ethics
All participants were provided with an information sheet and gave their written consent to take part in the evaluation. During the focus group with service users, an employment specialist was on hand (although not present in the room), in case safeguarding or other issues arose. All identifying information has been removed from the quotes presented in this report to protect participant confidentiality.

2.4 Analysis of Costs

Method
Data on costs were collected directly from providers and from the MHEP team via interview. Of the five IPS providers who participated in the evaluation, four provided cost data.
Providers supplied information on the cost of their service overheads, staffing, equipment and any unexpected costs generated through the delivery of the IPS service. These costs were calculated per year for the implementation period between the launch of the service, up to April 2019.

MHEP provided data on all other payments, including performance-based outcome payments, payments from commissioners, funders, MHEP and investor returns. Five sets of analyses were conducted from various perspectives, with inputs and outputs specified as per **Table 3** below. Costs per unit were calculated on the basis of the following outcomes achieved by IPS providers:

- Engagements: defined as the number of participants who following referral completed a vocational profile with the provider
- Job starts: the number of participants who entered employment
- Sustained job outcomes: the number of participants who sustained employment for 26 weeks

Where data were available, these calculations were repeated to provide an insight into what costs would have been, had the anticipated targets for each been achieved.

Table 3

Cost Analysis	
1, Margin/loss by provider	
Outcome	**Inputs**
Overall margin or loss per provider	- Spend includes ES wages, overheads and unexpected costs. - Income includes block payments and outcome-based payments from commissioners including MHEP.
2, Unit cost per outcome (provider spend and income)	
Unit cost per outcome (actuals vs target) by providers total spend	- Spend includes ES wages, overheads and unexpected costs.
Unit cost per outcomes (actuals vs target) by providers total income	- Income includes block payments and outcome-based payments from commissioners including MHEP.
3, Unit cost per outcome with and without central costs	
Unit cost for engagements, job starts and sustainments across programme	- 3a, by all costs to providers - 3b, by all funding received by providers By total outcomes achieved, including and excluding central costs (MHEP spend on performance management, investor returns, special purpose vehicle costs and evaluation)
4, Local co-commissioners: proportion of available funding spent	
Proportion of available funding spent by co-commissioners	- Total spent on each provider as a proportion of the total contract value
5, National top up funders: proportion of available funding spent	
Proportion of available funding spent by national funders	- Total spent on CBO and Social Outcomes Fund as a proportion of the total contract value

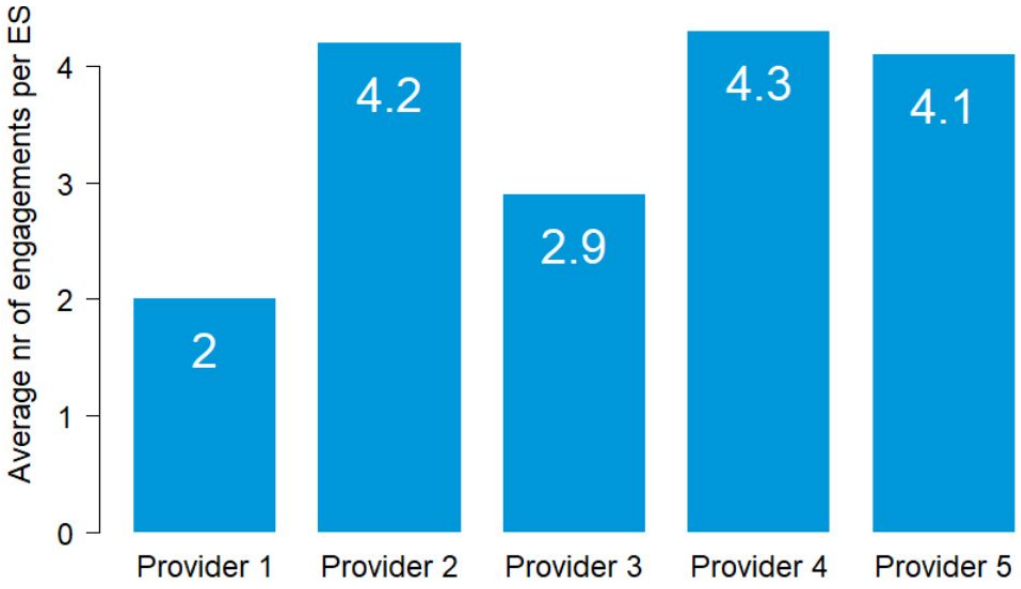
Providers costs are calculated in each case on the basis of key cost drivers for providers and are not intended to include exhaustive accounts of minor expenses incurred during delivery.

3. Evaluation Findings

3.1 Engagements

1926 people were engaged across all sites. While some providers engaged large numbers of participants (each recording over 500 engagements) Provider 1 and Provider 4 reported lower engagement rates (around 150 engagements in total). The variation in the size of each service, and particularly the number of ES employed by each service, dictate in part the number of people that can be supported over the course of the year. The number of ES in each site also varied due to staff turnover, with most sites reporting that at various stages of the programme they were either in the process of recruiting new staff, or running without their full complement of ES. **Figure 1** (below) sets out the average number of engagements per ES for each provider per month.

Figure 1. Average number of people engaged by providers per ES per month



As it has not been possible to account for any of the potential confounders that may be at play, comparisons between providers cannot be made.[16] Note that for Provider 5, only data for April-September 2018 was available.

[16] Confounders are any influencing factors associated with changes in both the independent and dependent variables, and in the current study, could include factors that influence both the characteristics of the cohort and the likelihood that they will find work.

Qualitative Findings: Experience of engaging with the service

Service users identified two main reasons for engaging with the service: one was being in the right state of mind at referral point, the other was being introduced to the service within an appropriate context.

An important facilitator to engaging with the service, as outlined by service users, was being in the right place mentally to receive employment support. They identified this as being willing to go back to employment as well as accepting of their need for support to do so. Their mental health status at the time played into whether they felt they were in the right state to engage with the service. This manifested in two main ways for service-users. Firstly, it was felt that their mental health condition made them feel overwhelmed at the prospect of looking for work, and insecure about their ability to do so. A second way in which this manifested was through the mental health support they received, and the perceived improvements in their condition, which also positively affected their desire and ability to look for a job.

"My mental health improved, and I got to the point where I was asking for support in getting back into work" Service-user

This introduction to employment support, whilst in a mental-health related environment, contributed to service-users trust that the service would be tailored to their condition. A secondary factor positively affecting service users' decision to engage in the service was being introduced to it in an appropriate context. This relevant setting was described to either involve being introduced to it by a member of their NHS support team, meeting an employment specialist or seeing information about IPS at the place they were receiving treatment.

"For me it is very reassuring that there is this connection between my employment support and the mental health service in looking after me" Service user

The clear link between their employment and mental health support sources, as outlined above, contributed to building trust in the IPS service, and confidence that it would be tailored to their condition.

3.2 Employment Outcomes

Across all sites, 30.6% of participants engaged obtained a job. **Table 4.1** presents an aggregated overview of programme participants and outcomes (based on data compiled by Social Finance) between January 2016 and March 2019. All figures represent the total number of unique participants who achieved each outcome.

Table 4.1

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	All providers
Number of participants at each stage of the programme between January 2016 - March 2019						
Engagements	156	566	535	142	527	1926
Job Starts	68	196	149	31	146	590
6-week outcome	42	127	128	21	97	415
6-month outcome	9	82	N/A	N/A	56	147*(across Providers 1, 2 and 5)*

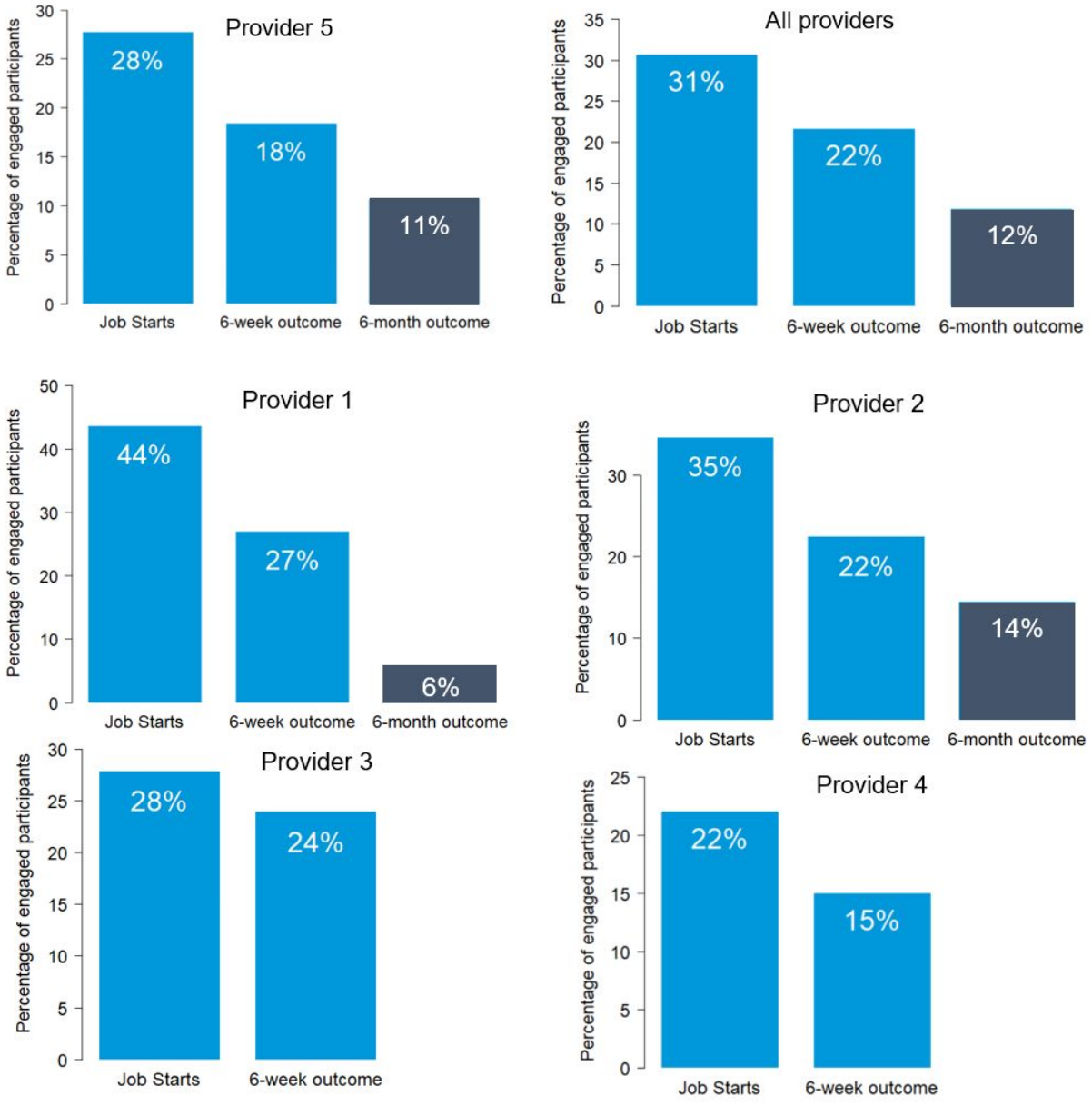
We see that 70% of individuals who find a job sustain it to the 6 week mark. Across the providers who gathered this data, 21.5% of participants engaged achieve a 6-week outcome, a figure which is fairly consistent across providers, ranging from 14.8% for Provider 4 to 26.9% for Provider 1. It should be noted that Provider 3 and Provider 4 did not record 6 month sustainments, and the remaining providers who did found it difficult to sustain contact with participants who had found work at this stage. This issue was also borne out in a telephone audit of outcomes conducted with participants across four services in March-April 2018, which generated response rates ranging from 19 - 34% for each area. The data that providers were able to collect for the evaluation from participants who remained responsive suggest that at least 37% of those who obtain employment remain in work for at least 6 months.

When looking at differences between the providers, Provider 1 has the highest percentage of engaged participants starting jobs with almost half of the participants engaged entering work, and 61% of those starting jobs sustaining them for 6 weeks. While six month outcomes are reported, a limited number were evidenced as during the first year of delivery, Provider 1 experienced a major service failure which reduced its team of ES from 3 to 1. This affected service delivery for the best part of a year, limiting the team's ability to support clients and

collect data. Further, the requirement for 6 month outcomes to be evidenced ceased at April 2018 for this provider.

Conversion rates across the full length of the programme are presented in **Figure 2** as a percentage of the total number of engagements achieved for each program.

Figure 2. Job starts, 6-week outcomes and 6-month outcomes as a percentage of engagements, January 2016 - March 2019[17]



[17] Here and in all other graphs 6 month outcomes are plotted in grey to reflect the reduced reliability and quality of the data. The 'All Providers' graph reflects 6 month outcomes across providers 1, 2 and 5 only.

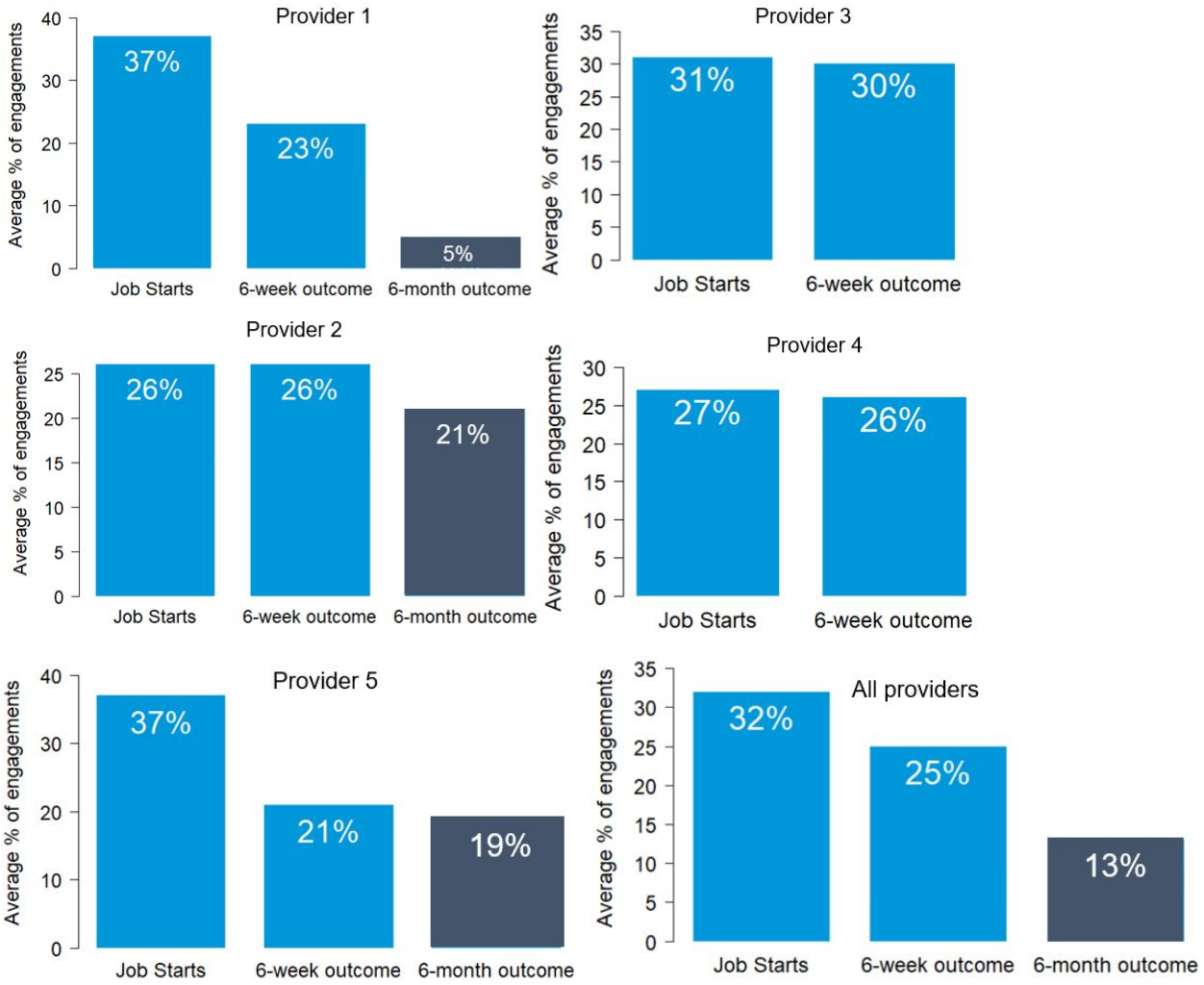
As previously discussed, there are a number of reasons why comparisons between areas may not be indicative of the true performance of IPS in that area. The presence of unknown confounders, and the relative age of each service are likely to impact performance against these outcomes. The geographic location of each of these sites is also likely to affect participants characteristics and the availability of work, which in combination are likely to influence outcomes. As discussed previously, service outcomes are also indicative in part of the capacity of each service, determined by the number of ES employed by each.
Taking one year of delivery (2018/19), the average number of participants per ES at each stage of the program is presented below in **Table 4.2**.

Table 4.2

	Provider 1	Provider 2	Provider 3	Provider 4	Provider 5	All providers
Average number of participants per ES at each stage of the programme, April 2018 - March 2019						
Engagements	18	54	87	28	42	45.8
Job Starts	7	14	27	6	10	12.8
6-week outcome	4	13	25	4	7	10.4
6-month outcome	1	11	N/A	N/A	6	6

For the same year, these figures are expressed in **Figure 3** as the average conversion rate across the ES who were active during that year.

Figure 3. Outcomes per ES as a % of engagements, April 2018 - March 2019



Looking at service outcomes by the number of ES employed reveals substantial variation in productivity across areas, with the average number of engagements per ES much higher in some areas, and large differences in the proportion of participants achieving employment outcomes. This is likely to reflect a number of challenges faced by providers, from difficulty recruiting and retaining ES teams, to differences in team practice and performance management across areas. Similarly analysis of engagement periods (discussed later) suggest that across sites, there were substantial differences in the length of time it took for participants at different sites to enter employment, with job search activity ranging from ten weeks to up to seven months.

3.3 Employment Status

A key question of interest was whether participants were more or less likely to achieve 6-week or 6-month continuous employment depending on which service provider they were

with. We find the likelihood of being employed for both periods of time does significantly differ between providers. As discussed previously, due to the study design it is not possible to determine whether the differences between providers are driven by other, external factors. Noting this, Provider 1 achieved the best employment outcomes for individuals over the short term and Provider 2 over the long term. In contrast, individuals allocated to Provider 1 had the lowest 6 month employment outcomes, whilst those with Provider 4 had the lowest job sustainment over 6 weeks. Data on 6-month outcomes are missing for Providers 3 and 4.

Subgroup analysis

All analysis presented previously used aggregate data supplied data provided by Social Finance, however this did not include individual level characteristics for the cohort. For all sub-group analysis presented below we make use of individual level data supplied from service providers. These data provide in-depth information on job characteristics in addition to participant characteristics, allowing us to explore how the latter affected the likelihood of achieving a 6-week or 6-month outcome. As noted above these data are incomplete, and do not perfectly match aggregate data, which potentially affects the interpretation of our main analysis findings.

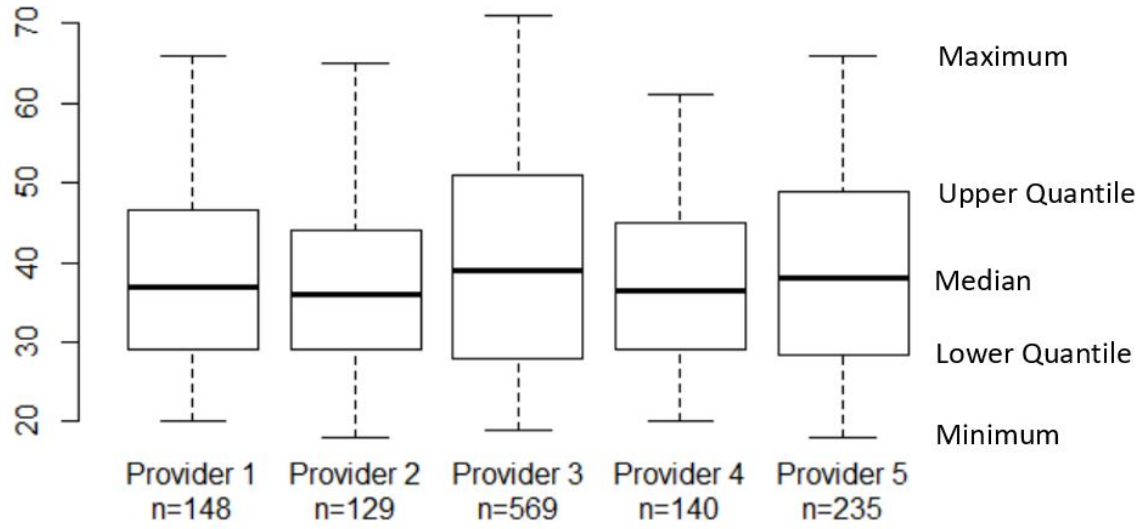
Age

Figure 4 shows the age distribution of participants across providers.[18] Across all service providers, individuals participant ages (range of 18 to 66, average of 39). While the median age, indicated by thick black bars, was similar across providers (late 30s), age distributions do vary between providers. Participants' ages at Provider 2 and Provider 4 were concentrated between late 20s and early 40s, Provider 3 had attracted a broader range of age groups, with most participants being between 30 and 50 years old.

We find that age has no effect on employment outcomes for individuals, and does not significantly predict whether participants enrolled in the programme will be enrolled continuously for either 6 weeks or 6 months. In other words, there are no significant differences in 6 week and 6 month job sustainments between participants age groups, however we should also note that a proportion of age data were missing from the dataset (21.92%).

Figure 4. Age distribution of participants across providers. 'n' represents the total number of valid data points per provider. Note that maximum and minimum indicate the highest and lowest recorded value respectively. 50% of values are greater than the median (also understood as the middle of the data set), 25% of values are greater than the upper quantile, and another 25% are lower than the lower quantile.

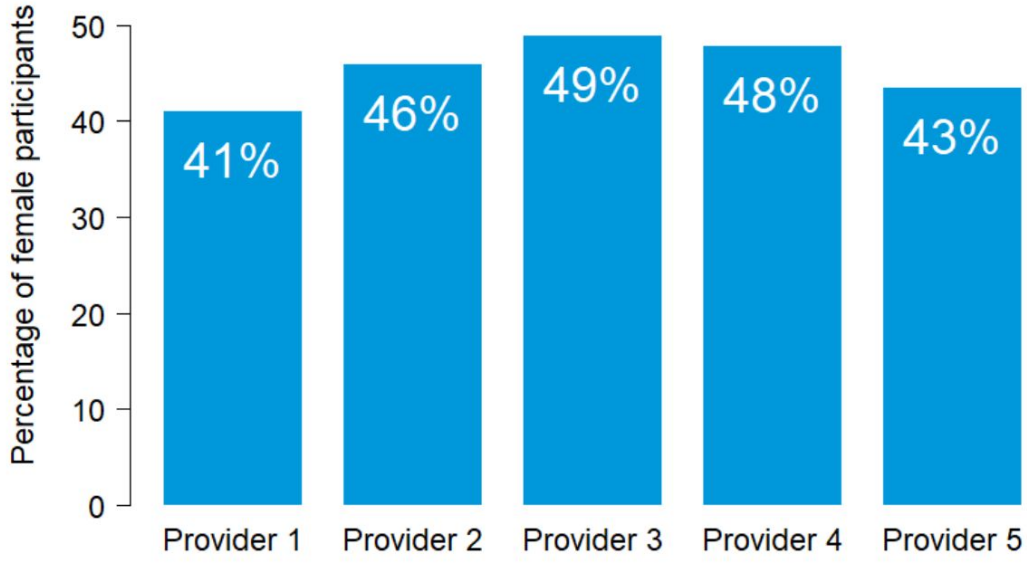
[18] 16% of age data across all providers is missing.



Gender

Figure 5 shows the gender distribution by provider, indicating that both genders were represented equally across all providers. Note that some of these data are missing (45.26% for Provider 2, 6.82% for Provider 3, <5% for Provider 1 and Provider 5). Similarly to age, we find that gender has no effect on employment outcomes for individuals.

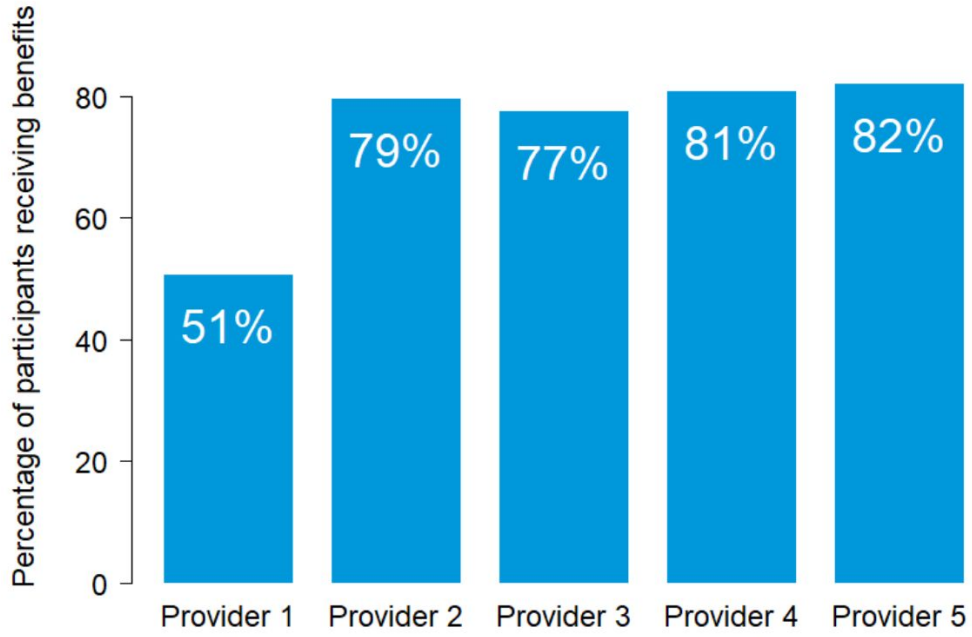
Figure 5. Percentage of female participants across providers.



Benefit status

The majority of participants with each provider reported that they were receiving benefits on programme commencement (see **Figure 6** below), however this does vary between providers. Most notably, only 51% of individuals with Provider 1 are receiving benefits relative to roughly 80% individuals across the other providers[19].
The most common type of benefit across providers was Employment and Support Allowance (ESA) aimed at people whose ability to work is affected by a health condition, with 66.8% of the benefit recipients receiving this. Participants also reported receiving other types of benefit including Income Support, Job Seekers Allowance, Universal Credit and Personal Independence Payment (PIP).

Figure 6. Proportion of participants reporting receipt of benefit at the start of the programme.



Qualitative Findings

Service users outcomes

Unsurprisingly, job outcomes were seen to be the main focus of the support service users were receiving. However, service users saw job outcomes as a wider category than simply getting a job: they included completing up-to-date CVs, attending interviews, and gaining

[19] 50% and 60% of benefit status data are missing in Hillside Clubhouse and Tower Hamlets respectively

knowledge of how to look for employment. They viewed these as outcomes comparable to gaining employment, as they had positively impacted their ability to find employment.

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

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

"I was able to talk about it, but it wasn't – we don't go deeply into my mental health issues. I think it's great because then if it's going to a place where [...] we are going to be talking about it and it's not going to be overwhelming." Service user

"The phone is always open, and I think it's a big trigger to kind of deflect my anxiety and so it doesn't build up." Service user

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

Service users' perceptions of the benefits of employment

Service users discussed three ways in which they felt employment would impact their lives: **practical, relational and emotional.**

Practically, employment was seen to add routine and stability to their lives, both financially and in terms of structuring their days. However, employment was also associated with lessened opportunities for creativity and flexibility. This tension led to service users expecting they would need to compromise between flexibility and structure if they were to find employment.

"Sometimes in jobs you can't take your creativity and you can't change the environment." Service user

Employment was also seen as having **relational impacts**. It was seen to bring opportunities for socialising and contributing to society. Service users described suffering from the isolation by not being part of the workforce, and saw increased socialisation through working as a positive outcome. However, service users also saw potential challenges coming from increased socialising. For example, they described feeling uneasy at the prospect of discrimination due to their mental health condition. Both positive and negative discrimination,

resulting from disclosure of their mental health condition, were viewed negatively, as a way to '*single them out*'.

"I find socialising difficult and I can be quite isolated [...] It does mean a lot to me, so I wouldn't want to go and find myself a job where I was working with just one other person. I want to be part of a fairly large team." Service user

Gaining employment was also anticipated to impact on **emotional wellbeing**, which in turn could potentially positively affect mental health. Service users felt they would gain a sense of achievement from the effort put into finding an employed position, and then sustaining this position. Employment was also seen as making them more independent, which they felt would heighten their sense of self-respect.

3.4 Length of Unemployment

We aimed to measure and examine any differences in participants' length of unemployment prior to enrolling in the programme. However, prior employment dates were not provided (except for Haringey), we therefore have pivoted to looking at how quickly participants find employment once enrolled in the programme.

We find substantial differences in the length of time spent finding a job between providers. Individuals were quickest to find employment with Provider 5, within an average of 10 weeks. This increases to roughly 4 months with Providers 3 and 4, and up to 7 months with Providers 1 and 2. Labour markets are highly complex and these differences may reflect the different approach taken by providers in combination with variation in local labour market conditions, however it would be interesting to conduct further research with Provider 5 to unpick the mechanisms driving their success in this area.

3.5 Hours worked per week

We find working hours are fairly consistent across providers and time points (average of 20 and 21 hours per week at 6 weeks and 6 months respectively)[20]. Across all providers roughly 75% of individuals worked 16 hours or more weekly. See **Figures 7** and **8** for the distribution of weekly working hours amongst participants across providers. Note that maximum and minimum indicate the highest and lowest recorded value respectively. 50% of values are greater than the median (also understood as the middle of the data set), 25% of values are greater than the upper quantile, and another 25% are lower than the lower quantile.

[20] Although most providers recorded exact hours, for some we received categorical data (ie. 1-15, 16+ etc)

Figure 7. Distribution of weekly working hours across service providers at 6 weeks (and at job start for Provider 5).

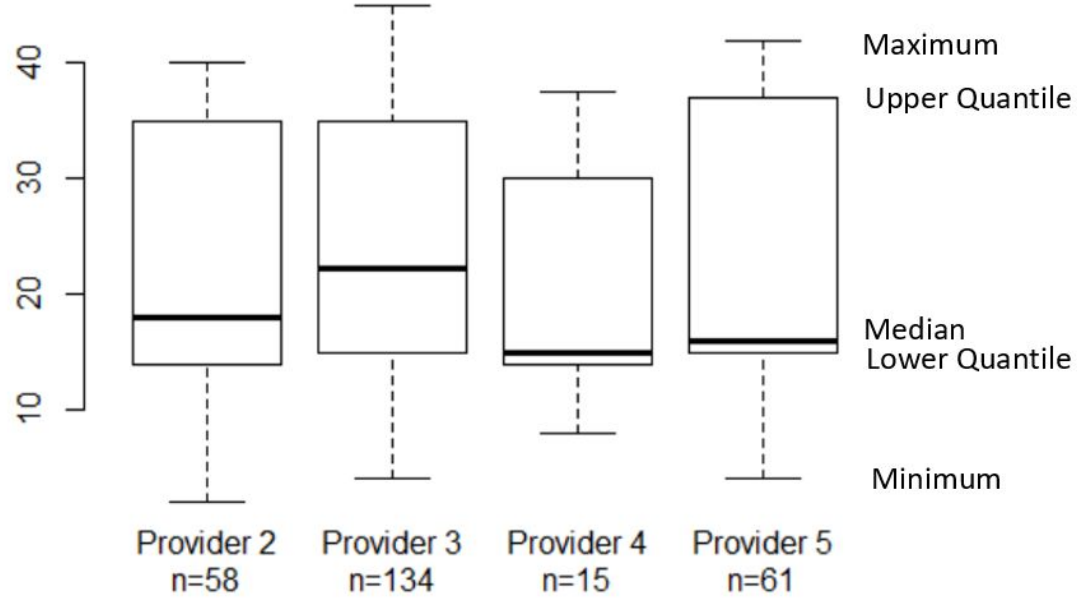
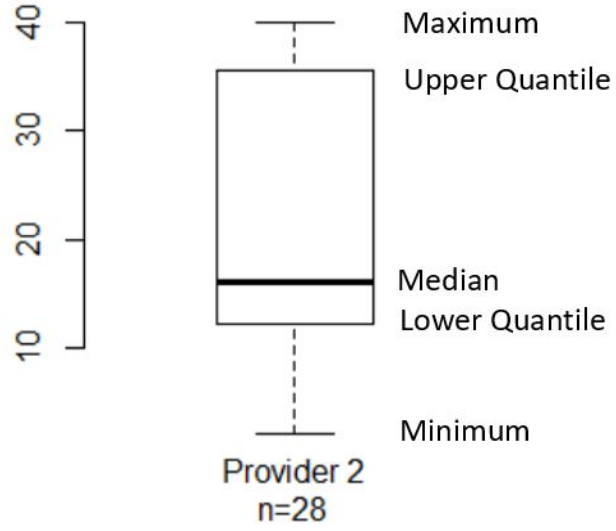


Figure 8. Distribution of weekly working hours at Provider 2 at 6 months.[21]



[21] Provider 2 was the only provider from whom we had precise data for those who achieved the 6 month outcome.

3.6 Cost analysis

Provider costs

Analyses of provider costs are based on data from all providers barring Provider 5, and barring the Barnet site for Twining, which had shut down. While each provider has delivered services from different points (2016 onwards), calculations are conducted to take into account revenues and costs for the financial years 2017/18 to 2018/19 only. During 2017/18, two providers were only operational for part of the year, and inputs have been adjusted to take this into account. **Table 5** below presents the overall margin or loss made by providers in this period, excluding central costs associated with MHEP. This represents the difference between providers total income and their expenditure, and includes contributions to overheads.

Table 5

Cost Analysis	
Margin/loss by provider	
Provider 1	Overall, this provider made a loss of £42,650
Provider 2	Overall, this provider made a loss of £16,967
Provider 3	Overall, this provider made a loss of £953
Provider 4	Overall, this provider made a profit of £5,859

During the cost interviews, all providers wished to make it clear that figures provided their reported spend were as accurate as the quality of the data they were able to access. Some also mentioned both unexpected costs incurred and some significant savings. Large savings were associated with office space, where one IPS team was able to co-locate with a Community Mental Health Team (CMHT). Unexpected costs included costs for recruitment, with some providers noting that turnover was high, and that the IPS service required staff with different skills.

The size of providers teams varied, and wages were a key cost driver. Provider 4 had the smallest team (2 ES and a Team Leader) while the team at Provider 3 included 12 practitioners and two Team leaders when fully staffed, though many of these staff were also performing work under another contract. Provider 2 employed 5 ES and a Team Leader, while Provider 1 employed 3 ES and a Team Leader. Across the services, there was some variation in wages with most salaries falling between £23,000 and £28,000 for ES staff.

The total loss across the four providers (excluding central costs) was £54,711.

Table 6.1 below presents the unit cost in thousands, based on providers total costs (and excluding central costs) of each of the three core outcomes, alongside unit costs had the targets for these outcomes been realised. In most cases, targets were not achieved and unit

costs are subsequently smaller for target outcomes, barring engagements for Provider 4, which exceeded targets. Across all providers (noting that data for Provider 5 are excluded here), average unit costs were lower for target engagement and jobstart outcomes than for those that were achieved (actuals).

Table 6.1

Cost Analysis						
Provider Spend - Unit costs per outcome (£K)						
	Actual Engaged	**Target Engaged**	**Actual Job Starts**	**Target Jobstarts**	**Actual 6-week**	**Target 6-week**
Provider 1	£1.8	£1.2	£4.5	£3.8	£5.1	£6.7
Provider 2	£1.2	£0.7	£3.6	£2.2	£4.8	£2.4
Provider 3	£1.2	£0.9	£4.3	£2.6	£4.2	£3.8
Provider 4	£1.0	£1.2	£5.3	£3.9	£7.6	£13.4
Average	£1.3	£1.0	£4.4	£3.1	£5.4	£6.8

A second version of this analysis was conducted in which unit costs were derived as a function of all funding received by providers. Incoming funding included block payments, outcome-based payments from commissioners and outcome based payments from MHEP. These results are presented in **Table 6.2** below.

Table 6.2

Cost Analysis						
Funding received - Unit costs per outcome (£K)						
	Actual Engaged	**Target Engaged**	**Actual Job Starts**	**Target Jobstarts**	**Actual 6-week**	**Target 6-week**
Provider 1	£1.4	£0.9	£3.6	£2.9	£4.0	£5.2
Provider 2	£1.2	£0.7	£3.5	£2.1	£4.7	£2.4
Provider 3	£1.2	£0.9	£4.3	£2.6	£4.2	£3.8
Provider 4	£1.0	£1.3	£5.5	£4.0	£7.9	£14.0
Average	£1.2	£0.9	£4.3	£2.9	£5.2	£6.4

IPS services provided for this programme were targeted at participants who were out of work, and had severe and enduring mental health conditions.

Central Costs

A further calculation was conducted to examine the impact of the addition of central costs associated with MHEP, to the average unit costs for the three key outcomes. Central costs include the following:

- Performance management: the cost of MHEP staff wages. This includes collecting and analysing data from providers, preparing Board reports and supporting the Board to take decisions and execute on them, reporting to central outcomes funders, managing the relationship with partner commissioners, and managing other elements of the programme (such as company audits, evaluation and validation, organising events for providers and commissioners, and contract variations).
- Special Purpose Vehicle (SPV) costs: These include audit, insurance, and board costs and exceptional use of consultants, for example to support events

- Operational Expertise: This included the cost of time for a specialist team member, providing operational advice and guidance to providers to improve performance
- Investor returns, include debt interest payments and any additional project surplus
- Evaluation costs

The total value of central costs over 2017/18 and 2018/19 was £319,000. **Table 7.1** below presents the cost per outcome for four providers over these two years, based on total provider spend, with and without central costs.

Table 7.1

Cost Analysis			
Provider costs - Average unit cost per outcome across all providers (£K)			
	By total engagements	By total jobstarts	By total 6-weeks
Including central costs	£1.6	£5.5	£6.6
Excluding central costs	£1.3	£4.4	£5.4

A second version of this analysis is conducted below **(Table 7.2)** based on all funding received by providers (including block payments and outcome payments). This is presented for all outcomes achieved, both with and without central costs.

Table 7.2

Cost Analysis			
Funding received - Average unit cost per outcome across all providers (£K)			
	By total engagements	By total jobstarts	By total six weeks
Including central costs	£1.8	£6.1	£7.3
Excluding central costs	£1.5	£5.1	£6.3

Contract Value

The table below (**Table 8**) presents the proportion of the total contract value spent by co-commissioners from 2017/18 to 2018/19. In other words, in terms of the co-commissioners contributions to each contract, the amount they spent against what they could have spent (what had been put aside for the contract).

Table 8

Cost Analysis			
Proportion of available funding spent			
Provider	**Spend**	**Total Contract Value**	**Proportion of contract value spent**
Provider 1	£155,600	£180,000	86.4%
Provider 2	£348,626	£421,340	82.7%
Provider 3	£537,323	£540,000	99.5%
Provider 4	£100,715	£112,500	89.5%
All providers	£1,142,264	£1,253,840	91.1%

Table 9 below presents what was drawn down from the two funds used for this contract. The programme drew from the Social Outcomes Fund (SOF) until March 2018 before switching to the Commissioning Better Outcomes fund (CBO), which will run until March 2022 in place of SOF. While the National Lottery Community Fund (NLCF) manages The Commissioning Better Outcomes Fund, The SOF was managed directly by the Cabinet Office. The calculations below are for all sites, including Staffordshire (delivered by Making Space) and the site in Barnet (delivered by Twining). These data include costs that run to the end of March 2019.

Table 9

Cost Analysis			
Proportion of available funding spent			
	Spend	**Total Contract Value**	**Proportion of contract value spent**
Top up funder 1: Social Outcomes Fund (SOF)	£525,760	£986,899	53.3%
Top-up funder 2: Commissioning Better Outcomes Fund (CBO)	£578,680	£1,291,039	44.8%
Total across all funders	£1,104,440	£2,277,938	48.5%

The total proportion of the contract spend to date is 48.5%. The contract for one area is intended to run to March 2022, and given this, projections suggest the entire value of the contract will not be utilised by its completion.

4. Process Evaluation

4.1. An evaluation of two types of SIB models applied to IPS services

To provide context to the findings of these evaluations, we begin by outlining the two types of SIB models evaluated. We set out who is involved in the programme, how commissioning, outcome targets and payments work, and details the key changes that have been made to the models over time.

Objectives

One of MHEPs core objectives was to combine sustainable sources of funding to grow the provision of IPS services, which they set out to do through the SIB model. Part of this process involved bringing together new sources of funding, combining national funding (through the **National Outcome Payer**) and local health and Local Authority funding (through the **Commissioner**) to provide additional funds to IPS services. By securing social investment, the model aimed to move the risk inherent in payment-by results contracts to the investors and away from providers, creating more room for innovation and a stronger focus on outcomes.

As the first SIB of its kind to be applied to IPS delivery, MHEP sought to use the first stage of this programme to identify how best to structure and improve the commissioning and delivery of IPS services, and where and how central programme management could best support a model with this level of complexity. Ultimately, the learning from this first stage model is intended to act as a stepping stone for further expansion and delivery of IPS through additional funding and investment, with the broader aim of creating fiscal savings by reducing government spending on health and welfare.

Roles and Responsibilities

Across both variants of the SIB, there are five main actors. These are:

1) **Service Providers** - organisations providing IPS-based employment support to those with mental health problems. Of the four services evaluated, one has received an 'exemplary' IPS fidelity rating from the Centre for Mental Health, the highest rating available, and is a designated Centre for Excellence. The other three providers have not yet undergone assessment.
2) **Commissioners** - either a Local Authority (LA) or Clinical Commissioning Group (CCG), who commission the service providers
3) **Social Investors** - who provide the upfront capital for the IPS service to MHEP
4) **The Mental Health and Employment Partnership (MHEP)**, a Special Purpose Vehicle that pools the funding for the service and organise block and outcome-based payments

5) **The National Outcome Payer** is a non-departmental public body, which pays MHEP based on the outcomes achieved by the provider, as agreed in a separate contract to the commissioner and provider contracts

The Commissioning Process

Two variants of the SIB model are included in this evaluation. Prior to setting up the SIBs, MHEP closely collaborated with potential commissioners of IPS. Commissioners expressed different preferences regarding the commissioning process: either wanting to co-commission the provider with MHEP in one contract, or wanting MHEP to have a separate contract with the provider. This led to the two variants of the SIB model currently under operation. We refer to these as the *co-commissioning* model and the *single commissioning* model:

- in the *co-commissioning* model, MHEP and a Local Authority or Clinical Commissioning Group (CCG) jointly commission the provider;
- in the *single commissioning* model, the commissioner has a commissioning contract with the provider, and MHEP has a separate contract with the provider which outlines the payment structure as well as the nature of the relationship between MHEP and the provider.

Four SIBs were included in this process evaluation, two of which were operating on a co-commissioning model, and two operating on a single commissioning model. Diagrams 1 and 2 offer a visual representation of the two models.

Fig. 1: Co-commissioning model

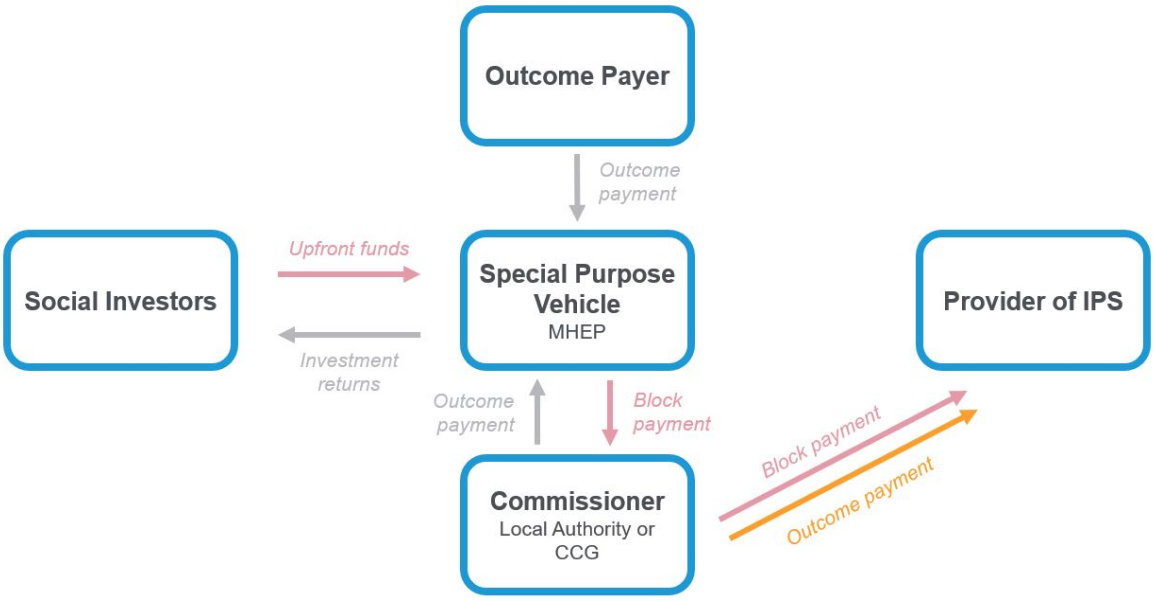
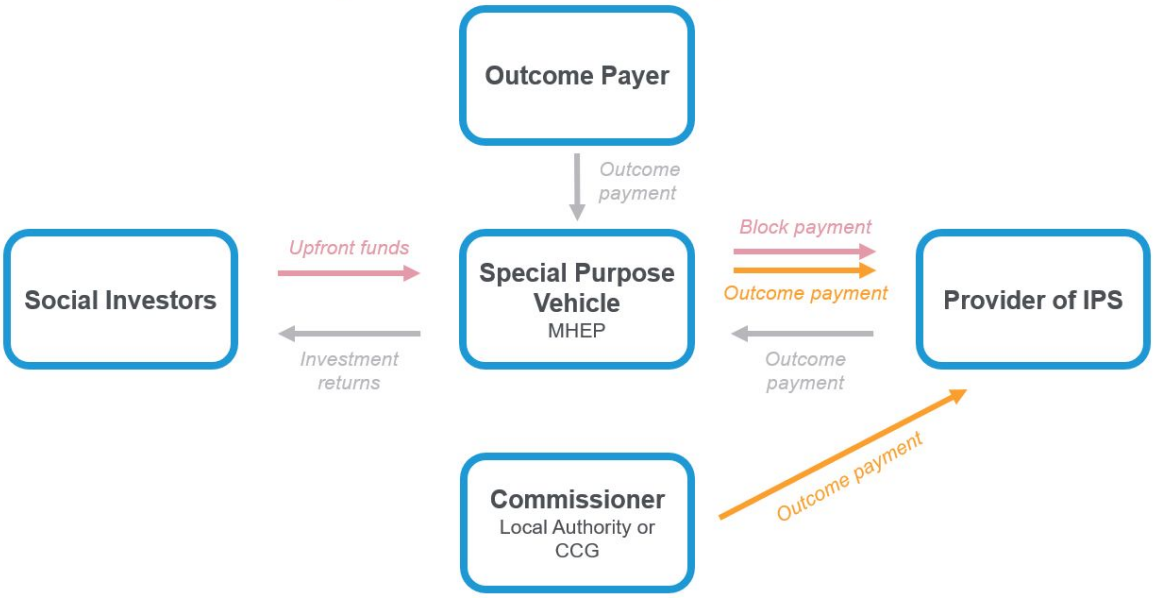


Fig. 2: Single commissioning model



Outcome targets

Service providers within MHEP's SIB models provide employment support to people with mental health needs according to IPS principles and receive outcome-based payments depending on different types of outcomes. Outcomes typically include one or more of the following: *engagement outcomes*, where providers are paid based on the number of clients referred to and formally engaging with the service; *job outcomes,* where providers are paid depending on how many of their clients have (re)gained employment, and *job sustainments*, where providers receive a payment if their clients remain employed for a specific amount of time after starting employment.

Outcome targets are based on past experience of delivery of IPS. Initially, outcome targets were set based on estimations forecasting providers' performance. Early experience suggested that the past data used for this forecasting was not appropriate for these models, and providers were underperforming on their targets. As a result, efforts were made over time to lower the targets, either through MHEP lowering their own outcome targets, or by directly amending contracts with the commissioners when re-commissioning.

Payment structure

The payments in these models are either *block* payments (pink arrows), paid regardless of performance or outcomes, or *outcome-based* payments (orange arrows for payments to the providers, grey arrows for payments to MHEP / Social Investors), paid according to the performance of the provider on such outcomes.

Block payments
In the first instance, the social investor makes an upfront investment to MHEP. MHEP uses this investment to provide upfront funds to providers. These are paid directly by MHEP in the single commissioning model, but are paid indirectly via the commissioner in the co-commissioning model. In all cases, the upfront funds sent to providers are not funded by the commissioner, but by MHEP and its social investors. Some commissioners were initially making payments part in block and part based on outcomes. This was not in accord with the outcome funder's requests that all commissioner payments be based on outcomes, and as a result all contracts have been amended. Now, all payments made directly by commissioners are outcome-based.

Outcome-based payments
All outcome-based payments are linked to the provider's performance on the contracted outcomes. For each individual outcome achieved, payments are made. Contracted outcome targets are put in place to represent what providers are expected to deliver, used as a forecast of the total amount of outcome-based payments made in the SIB. The ways these payments were made in each of the two models are outlined below.

- In the co-commissioning model, all outcome-based payments to the provider were made by the commissioner. In addition, block payments from MHEP were passed down to the provider via the commissioner. The commissioner and the outcome payer both also made outcome-based payments to MHEP, which were then used to create the investment returns for the social investors. In addition, block payments from MHEP were passed down to the provider via the commissioner.

- In the single commissioning model, the provider received block payments from MHEP and outcomes-based payments from the commissioner. MHEP also received outcome-based payments from both the provider and the outcome payer, which were then used to create the investment returns for the social investors. Payments made by the provider to MHEP were, in effect, a pass-through of commissioner outcomes payments to MHEP.

Summary of Findings

We identified three factors that affected the implementation of the service: **complexity, implementation challenges, and proactivity**. Section 3.2 explores participants' experiences of the complexity of the models, outlining the impact of this complexity, what has already been put in place to address these impacts, and what more could be done in the future. Section 3.3 discusses the commissioning and implementation of the SIB, and offers an account of how challenges are currently being addressed and could be mitigated in future. Section 3.4 puts forward the proactive approach to collaboration as a positive factor affecting

its processes, and identifies case-studies where this proactive approach is currently being put in practice.

The themes of collaboration, relationships and communication have been woven throughout these three sections, as interlocking and interacting with the other factors discussed. This evaluation also covers all stages of operation of the SIB models: from creation of the models, to the commissioning of providers, set-up of the service, and implementation of the models.

4.2. Experience of complexity

In order to deliver IPS at the intended scale and to address traditional challenges in the public sector linked to well established, siloed services, the model required the formation of new co-commissioning partnerships between Local Authorities and CCGs. The combination of funding streams created a necessarily complicated set of contractual requirements, which highlighted the importance of the central support and programme management provided by MHEP and the need for commissioning expertise.

The complexity of the contracts and outcome-based payments was perceived by stakeholders to present some challenges to service delivery. Strategies put forward to address this included increasing the involvement of the provider team in discussions around contracts and payments and further readjustment of outcomes, based on the experiences of delivering the models. We will also discuss how adoption of the co-commissioning model could help address some of the specific issues experienced in the single commissioning model. It should be noted that all accounts aggregated and analysed in this section are coming directly from actors within MHEP's SIB model structure, and not from any other IPS-funding programme. The experience of complexity in this model can not be assessed in comparison with other models, such as those previously delivered through ESF.

Contracts

The complexity of the SIB contracts was seen as affecting the delivery team's ability to provide the service. This complexity comprised two elements, the first relating to the models requirement to monitor their performance on outcomes and provide more evidence of outcomes. The second was the need to satisfy elements of the contractual relationship by managing their own risk through a new, more complex financial arrangement based on their performance, which combined block payments with outcome based payments.

Specifically, commissioners expressed concern that the complexity of the models placed a great deal of burden on providers, while providers themselves described having to spend an excessive amount of time on contract-related tasks, paperwork, and on making sense of the

implications of the contracts. This took time away from focusing on the delivery of their service.

"You spend a lot of time these days on bureaucracy, contract management and data and all that kind of stuff. That has been particularly relevant to this contract." Provider staff

"I struggle to understand it. It's a really complicated contract." Provider staff

Complexity of contracts and reporting requirements also had an adverse effect on the relationships between the actors involved in the models, especially in the context of high staff turnover. Current actors explained that staff turnover across all organisations involved had led to a lack of understanding of why the specificities of each contract had been originally put in place. This was described as a '*lack of institutional memory'* by MHEP, and it affected the actors' ability to create more positive working relationships with each other. The amount of upskilling needed to '*bring one up to speed*' was felt to be excessive, and resulted in a lack of shared understanding of the contracts.

"People change on our side, people change on their side, and everyone has forgotten why we have this particular contract set up in this way. [...] So even the basics actually you know, people are not engaging with the detail of how it works." MHEP staff

" [Commissioners] *are changed so often, then they move away with the knowledge that they have [...] so we need to upskill somebody else with that knowledge"* Provider staff

Suggestions for addressing the complexity of the contractual arrangements included reducing the number of contract variations post-commissioning to increase clarity, and including providers in the contract discussions as soon as possible after commissioning so they could input into decision-making. It was felt this could also help providers better understand the need for additional contract-related tasks, which would improve the relationships between service providers and the stakeholders involved in the commissioning.

Payments and outcome targets

Performance-based outcome payments were of core part of the model, nevertheless service providers reported that it could make planning and budgeting more difficult because of the unpredictability of future performance. Although outcome-based payments are also used outside of SIB contracts for this type of service, it was explained that the proportion of these compared to block payments was higher than most other contracts. For the first three contracts set up under this model, it was anticipated that by encouraging providers to take on more risk and align their incentives with MHEP, their capability and capacity to deliver under payment-by-results contracts would develop, allowing them to consider bidding for larger scale, national contracts in future. In this first tranche of contracts, being part of the SIB payment structure created additional financial risk for providers compared to most other payment models. Provider risk share was reduced in the second tranche of MEP contracts in

light of feedback/concern that too much risk had been transferred to providers initially, with one provider in the first tranche of contracts making a loss of over £40,000.

"It was the same service but just a different funding stream, so we got lottery funding and we got the contract and that wasn't paid by results." Provider staff

"Generally across the NHS and mental health [paying 100% on outcomes] *that's not typical. Usually it could be between 5% and 30% paid on outcomes"* Commissioner

This additional financial complexity affected providers in two main ways. Firstly, it affected the providers' confidence in being able to appropriately plan their financial outlook. Delivery teams described feeling pressured to meet outcome targets in order for their service to be viable financially. Basing payments on job starts increased concerns during '*unlucky months*' where job starts fell through, and led to delivery teams feeling that payments were removed from the reality of their work. However, providers also described outcome-based payments as a positive factor affecting their delivery. Delivery teams recognised that they were a motivating driver to perform well in the delivery of IPS, and did not think that removing performance targets altogether was the best solution to address the financial complexity.
Instead, it was suggested the outcome payments could be further tailored to the reality of delivering IPS by adding in additional outcome measures: for example, outcome targets on referrals, on interview attendance, or on employer engagement. There was agreement within delivery teams that this wider variety of outcomes could also help them better plan their financial outcomes.

*"[*On the introduction of additional targets] *the motivation is still there, and we would find it still motivating because we have still got targets, but they won't be just focused on the job starts because it's not necessarily fair"* Provider staff

"We've had a lottery grant as well, but it's kind of squeezing those funds more and more almost to the extent that you subsidise contracts." Provider staff

Secondly, as outlined above, in the absence of a well established evidence base as to referral numbers and employment outcomes which meet the evidence criteria, commissioners, MHEP and providers initially over-estimated expected performance, which led to actual performance initially being lower than expected, and providers receiving lower payments than they had originally anticipated. This unexpected gap between the payments that had been planned for and the reality of performance led to a bigger financial strain than expected on the delivery partners. This was experienced as an additional stress for providers during the set up phase, which rendered the set up period particularly unstable.

"That means this provider budgeted to get more money, but because of [the target outcomes]*, they are not able to get the money. It's a huge problem"* MHEP staff

The process of rectifying these targets seems to have started to address this issue, with MHEP working to adjust targets to the providers' experience of delivery performance.

This highlights the importance of proactive, central programme management and the role of MHEP in the development of data collection standards and procedures that can be applied across the program to improve analysis of provider performance and support program expansion.

Case study: single commissioning model and payment structure

Within the *single commissioning* model, providers are required to pass on part of the payments they receive from commissioners to MHEP. While this enables MHEP to recover part of its block payment to the provider, it created some unease, as MHEP was uncomfortable adding an additional administrative burden onto the providers' financial teams. Providers in the single commissioning model also struggled to understand the reasoning behind some payments. Those operating within the single commissioning model expressed interest in a model where this particular payment - from the provider to MHEP - could be avoided. On the commissioner's side, there was also agreement that such a change could positively affect providers. It was pointed out that in a co-commissioning model, providers do not have to make payments, which could simplify the financial relationship between all involved.

"Essentially at the contract meetings we would talk about the money flow. It was just a general sense between all parties that it was a bit complicated because [the provider] *flow money back to MHEP. [...] I don't know if they have that arrangement with any other contract they have"* Commissioner

The SIB model has several features that inevitably increase its complexity. The need to combine different forms of funding, introduce outcome based payments as incentives for providers and as a result additional, more rigorous performance management creates a tension for small providers who are also taking on more risk. While introducing all of these elements concurrently is ambitious, development strategies can take into account the tension between delivering an effective service under the SIB model, and the added complexity required to do this by examining and prioritising requirements to simplify the process for providers as IPS services are scaled.

In line with this, beyond a shift towards the co-commissioning model, it was felt that other solutions could be put in place to address the effects of a complex payment structure, across both models. The process of rectifying outcome targets so they are more directly correlated with the observed performance within a SIB is a step that has already been taken, alongside moves to reduce the administrative burden for some providers by eliminating the requirement for the monitoring and validation of six month outcomes. If continued, it was felt that this could positively affect the provider's capability to accurately budget and make financial plans.

Another step suggested by commissioners was to build in additional tools to keep better track of what has been paid to providers, to better understand the financial situation of providers and as a way to flag the need for more support.
Providers suggested increasing their share of block payments to further minimise their share of the financial risk, and MHEP has taken steps to address this.

4.3. Implementation challenges

This section explores the frictions and misalignments observed in these models, and how they affected both the implementation and the relationships between actors. We first explore the different perspectives on objectives for the commissioning stakeholders, and the effect of this on working relationships as well as delivery. Next, we discuss how the objectives of IPS and that of the SIB models diverged. Finally, we explore the importance of having a clear and aligned line of accountability, through a comparative case study of the two types of models.

Partner objectives

The commissioning of both types of SIB involved both MHEP and the commissioners. While the collaboration between the two parties was described as a positive, it transpired that their objectives were not perfectly aligned. Providers felt that the focus of the IPS service was on the delivery of a high-fidelity support service, which requires job outcomes in the form of paid, competitive employment, while the commissioners described their focus to be more on delivering positive mental health outcomes. Commissioners considered job outcomes as an important part of wider mental health outcomes, but mainly as a lever towards better mental health. This left providers feeling torn between the guidance of commissioners which was not always in line with IPS principles, and delivering a high-fidelity IPS service. The relationships between the provider, MHEP and the commissioner were affected by this lack of alignment in views about IPS, which led to some challenges for providers in particular.

When additional stakeholders are involved in the commissioning process, as observed in the case-study below, there is the potential for greater friction because of the somewhat differing objectives of each.

Case-study: Provider with multiple funding streams
For one of the providers, MHEP's SIB was one of two funding streams involved, meaning that the provider had to be accountable to instructions from both. The provider had also been instructed by the stakeholders in the second funding stream to include clients currently in work, as well as those outside of work. This is different to the SIB's objective of delivering high-fidelity IPS, only for those currently unemployed. The provider found this situation difficult, as they couldn't fully comply with the requirements of the SIB part of their contract. In turn, this meant they could not achieve the desired outcomes within the SIB contract, as job

outcomes were not tailored to those already in work. The provider's delivery team morale was affected by their inability to meet these outcome targets, as was the provider's ability to implement the SIB as originally intended. Participants suggested that it would be helpful for there to be more communication between the different stakeholders involved in the commissioning of the service, and a realignment of the objectives communicated to the provider about expectations regarding delivery of the service. Commissioners also suggested avoiding the commissioning of IPS services via multiple funding streams in the future to avoid conflicting objectives altogether, alongside the need to consider how best to navigate the wider landscape, where multiple services and existing investment may already be operating in target areas.

"[It's] not only that we've got too many cooks, but the cooks keep changing different recipes."
Provider staff

The use of job outcomes as a proxy for assessing the performance of the service as a whole also had an impact on implementation. While the introduction of outcome-based payments linked to job entry increased the importance of work-ready clients to IPS, an additional, important aim for providers was to guide clients towards mental health recovery. Providers felt that the focus on job outcomes to calculate outcome-based payments was not representative of the entirety of the support they provided. They explained feeling torn between their desire to support all clients equally, versus having to prioritise those they felt would help them achieve their job outcomes faster in order to meet targets and receive payments. As outlined in section 3.2., there were calls for a bigger variety of outcomes against which to measure providers' performance. However, this should be weighted against a requirement of SIB models, which is that outcome measures have to be easily measurable and deliverable[22] and IPS fidelity, which has a clear focus on job outcomes. As an anticipated challenge of the current model, the role of the central team in adapting mental health outcomes into clear and achievable outcomes, and the importance of finding a compromise between the experience of providers and other actors in the model is further highlighted.[23] In response to providers concerns, MHEP and commissioners subsequently worked to increase the share of block payments, with providers having a minority of their contracts paid on outcomes.

Frictions linked to accountability

MHEP saw their role in the SIB models as that of an "*honest broker*", which they described as implying extensive involvement with both the provider and the commissioner during setup, implementation and delivery of the service, to ensure high fidelity and help with performance. MHEP's involvement was welcomed at the time of this evaluation by the commissioners and

[22] Knowledge Box. Guidance on Developing a Social Impact Bond. Retrieved 19 December 2019, https://bit.ly/35FheJw

[23] When presented with this suggestion, MHEP shared that there had been attempts to capture mental health outcomes in the past, and that providers had not been able to capture any wellbeing data. They had also been told by providers at the time that this was an added burden on them.

providers, who appreciated MHEP's expertise and advice. The development of a clear line of accountability between MHEP and providers in the past was required to resolve previous tensions in the relationship, with some confusion over MHEP's role and responsibilities. A case-study on the experiences of setting up this line of accountability with providers gives us insights into its importance for building relationships within the model.

Case study: achieving accountability

Over time, MHEP's role has been clearly outlined to and broadly accepted by providers. MHEP was described as a supportive partner, providing expertise and recommendations on the operational side of the delivery, helping to address team and managing issues. In the co-commissioning model, the provider initially saw their line of accountability to be to the public sector commissioner, as their contract was with them, not with MHEP. As a result, they sometimes struggled to understand MHEP's role during the set up phase, which led to friction around the time and effort required to address MHEP's requests for information. The relationship was described at the time of set up as '*micro-management*', but was also said to have significantly improved over time.

"I feel that they [MHEP] hold off a bit more than they used to, and they seem to understand our challenges. [...] Although we are under target in the jobs, they seem to get the reasons why." Provider staff

Within the single commissioning model, however, no confusion was described regarding MHEP's level of involvement, and MHEP were recognised as holding expertise in the development and delivery of IPS and SIB models. MHEP's input and advice into building a new team, and tips on how to achieve high IPS fidelity, were described by the provider as key facilitators to the implementation of the model into their service over time. There is value in ensuring MHEP's *honest broker* role is fully understood and accepted by providers from the start to address any confusion during the set up phase.

4.4. A proactive approach to collaboration

The proactive approach to collaboration between actors in these models is explored here, highlighting its positive influence on model implementation, particularly with regards to responding to issues as they arise during the set up. As a result of this flexibility, the models could develop and evolve, at the same time contributing to best-practice recommendations for the expansion of IPS services. When thinking of scaling, this proactive approach should be replicated, and lessons learned from previous experiences of implementing the models should continue to be integrated within the structure of the SIB.

'Being proactive' at the core of the approach

A key facilitating factor to collaboration was the proactive approach to working in partnership. This manifested throughout the SIB lifecycle, starting from the construction of the models, and continuing through ongoing efforts to remain proactive during implementation of the models. Close collaboration was originally built in to MHEP's approach to this SIB, which was created with substantial input from commissioners. The SIB model was well received by commissioners, who described feeling enthused at the model's focus on job outcomes, and by the model's ability to fund a service which they felt would not otherwise be considered for statutory funding. MHEP also identified this proactive approach to collaboration during the set up phase as positively affecting their collaboration with commissioners for the duration of the SIB contracts. Commissioners described being invited to contribute to ongoing discussions on model options, and feeling like their input was both supported and valued by MHEP. Commissioners also exhibited high levels of trust in MHEP, feeling confident they could take a step back and let MHEP advise them regarding contracts and payments in the models.

"Overall, I find MHEP really approachable and helpful, and they always seem quite willing to give extra information if we need something." Commissioner

An ability to be proactive was also encouraged by other actors in the models. As a requirement partly from the social investors, quarterly meetings were taking place, to which providers, commissioners, MHEP and MHEP's board representatives were invited. These meetings were felt to be constructive and helpful in pulling all together towards a single goal. Commissioners and members of MHEP's board in particular were pleased at being able to hear from providers in these meetings. Providers expressed similar views, describing these meetings as an opportunity to air their worries and explain their experiences to all stakeholders at once.

"Every other board meeting we have a meeting with actually in situ with a provider, hopefully with people who are using the services as well." MHEP Board Member

"I think we all have mixed experiences around the table but I find those meetings helpful" Provider staff

We explore the effect of the actor's ability to remain proactive during the implementation phase of the models in two case-studies below: SIB reporting processes and integration of the IPS service with NHS teams.

***Case-study:* Addressing teething issues on SIB reporting processes**

As described by MHEP, one of the aims of applying a SIB to the delivery of IPS was to gather further evidence about IPS's value as an employment support model for people with mental health issues. In order to achieve this aim, comprehensive reporting plans were built-in to the models. However, when the SIB was first implemented, there was a realisation

that these reporting plans might have been too ambitious. For example, it was described by MHEP that obtaining evidence for the six month sustainment outcomes was difficult.

"You hope to get decent amounts of data from the providers. [...] The reality was getting the absolute minimum data around how many people have come into the service and how many got jobs proved to be very difficult." MHEP staff

Providers also experienced issues adapting to this new reporting model, explaining that they had to create different reports for MHEP and the NHS, which necessitated spending a significant amount of time training their teams to report in such a way.

In order to address this unexpected issue and identify the source of these problems, all parties involved collaborated on building up new systems for future reporting. MHEP and commissioners focused on narrowing down the amount of data required from providers and had multi-way conversations about performance and reporting with providers. This process was ongoing, and providers described continuing experiencing issues with accessing the correct database, or updating their reporting processes accordingly. However, progress had been made, and the reporting tools created to address these issues were felt to be successful. MHEP explained the data collection tools built for this SIB model were being replicated in IPS Grow, an initiative supporting the development of IPS services across England.

Case-study: integration of IPS within NHS teams

One of the cornerstones of IPS is that it involves working closely with clinical teams. Providers explained that this close integration with NHS services was necessary in order to obtain referrals to their service. Providers further explained that they had to overcome multiple obstacles to achieve full integration with NHS teams, meaning their set up process took longer than expected. The first obstacle was directly related to the culture in NHS teams, which was described by providers to be very protective of patients, and thus reluctant to refer them to an employment service in fear that they weren't '*ready'* for such a change. A further obstacle experienced was the NHS team's lack of awareness of what IPS was, meaning that providers had to progressively build this awareness in order to gain NHS buy-in.

Multiple factors were identified by providers as facilitating this integration over time. The proactive approach to collaboration between all involved in the model was one of these. Because of the regular check-ins, all parties were aware of the issues, and providers were offered advice and training on how to integrate with NHS teams by MHEP and commissioners, which they said has helped over time. A second factor identified by providers was the co-location with NHS teams, as it was felt that integration had been particularly impacted by the physical structure of the co-located building. It was felt that close spaces

and separate offices didn't allow for the amount of communication needed to achieve full integration. In contrast, the open-space nature of offices was felt to help achieve integration. Although the proactive approach didn't directly address all of the challenges relating to the integration of IPS delivery teams with NHS teams, it played a role in the successful integration of services over time.

"Integration doesn't happen overnight. It takes two or three years to get fully integrated and we are in our second year now." Provider staff

The analysis of these two case studies shows how the flexibility of the SIB model, achieved through a proactive approach to collaboration, positively affected the delivery of IPS services. Although the work on both the reporting process and the integration with NHS teams was described as ongoing by the parties involved, the flexibility of the model had allowed solutions to be found. These lessons were also contributing to building best-practice recommendations for wider future expansion of IPS services, for instance, through contributing to IPS Grow, by providing evidence on how to integrate IPS with NHS services.

5. Recommendations

The transformative approach that the MHEP SIB model seeks to provide brings with it challenges. Alongside the advantages afforded by the model, it is important that those managing the relationships between commissioners, investors and providers take into account and plan for the effects of the additional requirements the model creates. The current evaluation suggests that for such a model to evolve further, the relationships between partners are of as much importance as the contract structure. The range of perspectives between commissioners and providers on the prioritisation and importance of health and work outcomes reflect the challenge of bringing together funding for sets of outcomes that are not normally aligned, and the importance of strong, central programme management in providing expertise and guidance for partners at every level.

While the transfer of risk to providers and rigorous long-term measurement of outcomes are key components of the model, in practice, each requirement introduces new challenges for small providers. By prioritising elements of the model and recognising where providers may need more support with data collection and performance management, it is possible to more gradually build providers capacity to meet their contractual requirements. In response to these lessons, some steps have already been taken with the current model to change and simplify contracts to vary the scale of targets and block payments, reducing the risk to providers.

Descriptive data on costs and provider output suggest that services delivered under this model have the potential to deliver on difficult outcomes for hard to reach groups. While the quality of the data and the evaluation duration and design do not allow strict conclusions to be drawn, they suggest considerable variation in performance across providers on engagements and job outcomes. Analyses suggest that while some providers strengths appear to lie in engaging members of the community, others are more effective at helping individuals find and sustain work, and that this process is much quicker for some providers than for others. This variation in performance suggests real value in facilitating learning across regions and improving practice by examining what works and in which context. Further, implementation of a more consistent data collection method or standardised administrative tool across providers would facilitate cross-provider aggregation and analysis, and create opportunities for a more robust study to be delivered in future.

Refining the model based on the Process Evaluation

Based on the process evaluation, we make the following recommendations for model development:

- **Proactive collaboration:** the model should continue to be proactive in its approach to collaboration, and flexible in addressing issues as and when they arise. It should

also incorporate lessons from past experiences within the structure of the model, regarding issues like the integration with the NHS as well as reporting.

- **Simplified and clearer structures:** while remaining flexible, future iterations of the model should involve delivery teams in discussions regarding model structures as early as possible after commissioning, and should try to minimise changes to the structure during implementation to avoid confusion. All providers participating in this evaluation faced challenges in managing a significant share of the risk under their contracts, and in managing workloads alongside new monitoring and reporting requirements. In response, changes were made to simplify contracts for providers and to reduce their risk. Keeping a clear written record of why contract decisions like this were made could allow the collection and dissemination of learning to support implementation at scale, and aid the onboarding of future staff working on this model.
- **Formally defined roles:** defining MHEP's role as the *honest broker* from the start, and when there are changes in management, ideally in the contract for the provider. Informal confirmation of this role, as well as explanations for MHEP's involvement, should also be provided to lend MHEP legitimacy.
- **Tailored outcomes:** in order to both engage commissioners and to entice providers, a compromise needs to be found. Finding the right balance between achievable and measurable outcomes and providing a variety of outcomes to mirror the complexity of the work delivered should be a priority.
- **Appropriate targets:** the process of adjusting targets to the experience of providers' performance should continue, to find the level of target that is both motivating without being unachievable.

MHEP's preferred model for scaling: co-commissioning

When asked about which model would be best to scale, MHEP expressed a clear preference for the co-commissioning model. They described the co-commissioning model as:

- more streamlined payment-wise, meaning less time spent on administrative tasks
- placing a bigger share of the financial responsibility and risk on MHEP and the commissioner, helping minimise financially-related anxiety for providers

This process evaluation provided further evidence in favour of this model, as described above. Providers and commissioners currently operating under the single commissioning model were also open to a shift towards co-commissioning.

The co-commissioning model does address some of the current challenges discussed in this evaluation, specifically regarding the experience of complexity. However, some challenges remain, such as the relationship challenges specific to the co-commissioning model, as outlined in the process evaluation. Taking a lesson from the single commissioning model, it could be useful to contractually and clearly define the relationship between MHEP and the provider in the co-commissioning contract. As MHEP's IPS and SIB expert involvement is seen as a facilitator in the implementation of the models, defining roles within the

co-commissioning model at the point of commission could positively affect the set up process of these models in the future, by;

- formally defining the role of MHEP with the provider
- reconsidering the outcomes measured so they represent the full reality of IPS
- tailoring the outcome targets to the evidence of providers' performance so far

The recommendations in this report provide an initial insight into how this could be done within the co-commissioning model should it be put forward as the preferred model for the scaling of IPS services.

Key Conclusions
1, In addressing the fragmentation of public services and funding, the model provides useful early learning as to the importance of partner relationships, performance management, central support and risk management. The implementation of a single, consistent commissioning model could facilitate more effective iteration and development of support provision as the SIB model evolves.
2, All providers successfully engaged and supported individuals to find employment to a varying degree, while long-term job sustainment remains a challenge. There is value in increased knowledge sharing across providers with different delivery strengths.
3, Further research into the core drivers of differences in the outcomes achieved by providers would provide valuable insights. This would require a richer, standardised dataset across sites.

Limitations

There are limitations both to the evaluation design, and the conclusions that can be drawn from this. With regard to the evaluation approach, this precludes any claims as to the efficacy or effectiveness of the programme itself owing to the lack of a credible comparator group. In addition, there are substantial differences between services with regard to the length of time they have been operational, their geographic location (and as such the characteristics of the cohort they work with), and their operational set-up. These, and other potentially hidden confounding factors prevent any conclusions being drawn as to the relative efficacy of these services. While this report presents comparisons of the performance of each site for key outcomes, these findings are intended to be descriptive only and cannot assess the impact of each providers services, or the direction of that impact. The reader should avoid drawing conclusions from any comparisons of these sites and their relative performance for this reason.

The quantitative data summaries presented in this report also suffer from limitations. Data collection methods are inconsistent between providers making monitoring and evaluation methods challenging across the programme as a whole. Individual-level data was incomplete in many places and only available for select time periods within the study programme. A formalised data collection practice guide implemented across all providers could overcome this challenge, allowing more resources to be focussed on harnessing the data for findings and recommendations.

Similar challenges were encountered during cost analyses, given it was not possible to obtain data from some providers, and the data available were likely incomplete. There are additional complexities associated with the variation in operational periods for each provider.

Finally, it must be noted that there were also challenges within the process evaluation. Some providers and commissioners declined to participate in the interviews and focus groups owing to their existing work commitments allowing us to interview only one actor for each type of commissioning model. This limits the diversity of perspectives and views we were able to learn from, and the evaluation would benefit from speaking to a wider pool of practitioners. Given the sensitivity of the research, recruitment of service-users was facilitated by the providers. Whilst we accept this is the most appropriate approach, we also acknowledge that this may result in an incomplete view of the service provision as a whole as we couldn't ensure a good representation of variety in background, views and experiences of service users.

6. Authors

Violette Gadenne – Associate Research Advisor

Violette is an Associate Research Advisor specialising in qualitative research. She supports research and evaluation across a range of policy areas including children's social care and mental health. Prior to joining BIT, Violette worked as a qualitative researcher in the market research sector, with a specific interest in the third sector and international development. Violette holds a Bsc in Government and Economics from the London School of Economics.

Martina Maglicic – Associate Research Advisor

Martina is an Associate Research Advisor specialising in data science. She works on trial evaluations and predictive analytics projects across a wide range of policy areas, including gender equality, financial decision-making and health. Prior to joining BIT, she worked in academic research at the University of Warwick where she supported data analysis and documentation for a longitudinal study on the development and health of very preterm born children. Martina holds an MSc in Behavioral and Economic Science from the University of Warwick.

Johanna Frerichs – Qualitative Research Advisor

Johanna is a Research Advisor specialising in qualitative research across policy areas including education, financial capability, health and social care. Before joining BIT, Johanna worked for three years at a a mental health charity on qualitative projects relating to loneliness and social connections, peer mentoring, paranoia and suicide bereavement. She also worked as an analyst at the Care Quality Commission and on a trial of mental health crisis care at University College London. Johanna holds a BSc Psychology from the University of Bath and recently completed an MSc in Implementation Science at King's College London.

David Nolan – Research Advisor

David is a Research Advisor working across BIT's research, evaluations and data science teams. His work focuses on trial design, analysis, statistical modelling and product development. Prior to joining the team, David worked for the University of Bristol testing behavioural science applications to the field of charitable giving using randomised controlled trials. David holds a degree in Economics from the University of Bristol.

Hazel Wright – Senior Research Advisor

Hazel is a Senior Advisor in the Research and Evaluation team based in London. She joined the team in 2015 and works on intervention development, trial design and the implementation of quasi-experimental methods. This has included the development of trials in health, employment and crime prevention. Prior to joining BIT, she worked for the Department for Work and Pensions, in the Cabinet Office and most recently for the Department of Communities and Local Government to pilot new approaches for supporting the hardest to help back to work. Hazel holds a BSc in Psychology and an MSc in Economic and Consumer Psychology from the University of Exeter.