# Towards strategic commissioning of VCSEs in mental health services: A context analysis in England

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## ABSTRACT

Since the introduction of Integrated Care Systems (ICSs) in England under the Health and Care Act 2022, responsibility for local healthcare commissioning has shifted to forty-two Integrated Care Boards (ICBs). These statutory bodies are tasked with aligning national directives such as the NHS Long Term Plan and NICE guidance with locally assessed health needs, in a system that increasingly emphasises prevention, integration, and equity. Yet, despite this structural reform, the practical realities of commissioning – particularly for mental health services – remain marked by complexity, variation, and persistent systemic constraints. In the mental health space, Voluntary, Community and Social Enterprise (VCSE) organisations play an increasingly prominent role in service delivery, specifically in providing community-based and preventative interventions. However, commissioning arrangements involving these actors remain fragmented and underdeveloped, often lacking clear frameworks for accountability, long-term funding, and integration with statutory services. Recent literature and policy reviews have highlighted a lack of methodological consistency in how commissioning decisions are made, with concerns over transparency, resource allocation, and the alignment between strategic planning and service delivery.

This thesis investigates the current commissioning landscape within two Integrated Care Boards located in Southeast ICB and East ICB with a focus on mental health. The study adopts a mixed-methods approach comprising three methodologies: (1) document analysis of board meeting minutes, annual reports and strategy presentations to assess institutional priorities, governance structures, and procurement frameworks; (2) semi-structured interviews with commissioners, VCSE representatives, ICB and Council executives to explore decision-making practices and implementation challenges; and (3) demonstration of assessing value for money of mental health services commissioned from VCSEs. Together, these methods provide a multi-dimensional understanding of how population needs are assessed and prioritised, how strategic intent is translated into service procurement, and how commissioning outcomes are measured across provider sectors.

By integrating strategic, operational, and economic perspectives, this thesis offers critical insights for commissioners, policymakers, and provider organisations. It supports the development of more consistent, transparent, and accountable commissioning processes particularly around investment in the VCSE sector and contributes to future frameworks for embedding value-based commissioning across Integrated Care Systems. The findings will inform both immediate practice and long-term strategic thinking, offering practical implications for policy, planning, and research in mental health commissioning.

## Presentations Related to This Thesis

*Presentations*

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## List of Abbreviations

API – Aligned Payment Incentive

BCF – Better Care Fund

CAMHS – Child and Adolescent Mental Health Services

CBT – Cognitive Behavioural Therapy

CCG – Clinical Commissioning Groups

CQC – Care Quality Commission

CSU – Commissioning Support Unit

DES – Direct Enhanced Service

DHSC – Department of Health and Social Care

HONOS – Health of the National Outcome Scales

HWB – Health and Wellbeing Boards

ICB – Integrated Care Board

ICS – Integrated Care System

INT – Integrated Neighbourhood Teams

JSNA – Joint Strategic Needs Assessment

KPIs – Key Performance Indicators

LVA – Low Volume Activity

MHCGG – Ministry of Housing, Communities and Local Government

MHCT – Mental Health Clustering Tool

MHIS – Mental Health Investment Standard

NHS – National Health Service

NHSPS National Health Service Payment Scheme

NICE – National Institute for Health and Care Excellence

PbR – Payment by Result

PCN – Primary Care Networks

PCT – Primary Care Trusts

ROI – Return on Investment

SDQ – Strengths and Difficulties Questionnaire

STP – Sustainability and Transformation Plan

TPP – Third-Party Providers

VCSE – Voluntary, community and social enterprise sector

WHO – World Health Organisation

# 1. CHAPTER: INTRODUCTION

## 1.1. Contextual Background

Over the years, several reforms and initiatives have been introduced in England to improve the local healthcare commissioning process in the National Health Service (NHS). Recently, on April 28, 2022, the Health and Care Bill received Royal Assent and became an Act of the UK Parliament. The Act abolished Clinical Commissioning Groups (CCGs) and replaced them with forty-two Integrated Care Systems (ICSs). As of July 2022, ICSs are operational as statuary bodies responsible for planning most primary, community and hospital care services, including urgent and emergency care in their local area (Dunn et al., 2022).

Each of the forty-two ICS has an Integrated Care Board (ICB), which took on the commissioning functions previously held by the CCGs. Alongside commissioning, ICBs are also in charge of improving population health, reducing health inequalities, integrating health and social care services. ICBs are directly accountable to NHS England, and operate as a unitary board, with membership at a minimum including a chair, chief executive officer, and at least three other members from the NHS and foundation trusts, general practice and local authorities in the area. In addition, at least one member must have knowledge and expertise in mental health services. All ICBs have the discretion to decide on additional members at the local level and must ensure that patients and communities are engaged in the planning and commissioning of services (Charles, 2022).

Given the local nuances, ICBs are ought to have some flexibility in how they commission health service providers but are bound to follow national guidelines including NHS Long Term Plan, National Institute for Health and Care Excellence (NICE) and Mental Health Investment Standard (MHIS) guidelines, and legal requirements to ensure services are equitable, integrated, and effective. They are also expected to be guided by local health needs assessments and the quality and capacity of available Voluntary, Community and Social Enterprise (VCSE) providers. Recent studies, however, have highlighted the lack of structured framework for local healthcare commissioning within the context of integrated care. Decision-making and priority-setting appeared to lack methodological rigor, often shaped by social value judgements and political tensions (Salazar et al., 2022). This underscores the need for a framework of commissioning that adheres to a rigid, orderly logic to enhance efficiency, transparency, and accountability.

Relatedly so, despite playing a significant role in care provision within ICBs in the UK, VCSE providers are not commissioned based on a consistent methodology. ICBs often rely on VCSE providers such as charities, non-profit organizations, and social enterprises to deliver certain aspects of health care. VCSE providers may offer flexibility for ICBs to scale services up or down depending on demand, bring innovative approaches to care delivery and fill gaps in mental health services by offering specialized areas like child and adolescent mental health services (CAMHS) and addiction services (Wickens, 2022).

As a pioneering effort, with a particular focus on mental health services, this research studied how commissioning of VCSE provider organisations in Southeast and East ICBs currently operate. These two ICBs were deliberately selected as they are at different points in their strategic commissioning journeys. By examining them, this thesis provided valuable insights for policymakers and commissioners into how the current commissioning process operates within the framework of the NHS strategic commissioning cycle, how implementation unfolds in practice, and the role and impact of VCSE mental health service providers. This analysis highlighted the distinct approaches and strategies each ICB employs at different stages of their commissioning journey, illustrating the adaptability required to address the unique challenges and demands of their respective regions.

### 1.1.1. Evolution towards Strategic Commissioning

Since the publication of the 2000 World Health Organisation (WHO) Report, there has been a growing recognition that health financing goes beyond merely raising funds for the use of healthcare services. This widely quoted report argued that countries should move away from passive commissioning, predetermined budgeting or settling presented bills, to strategic commissioning whereby proactive decisions can be made about which health care services should be purchased, how and from whom (WHO, 2000). Also advocating for strategic purchasing of healthcare services, the World Bank (2007) emphasised the importance of strong institutional environment and capable governance and management arrangements needed to regulate resource allocation and purchasing to protect social and economic interests in health care. Expanding on these foundational arguments, key contributors to health policy literature have further emphasized the importance of conducting thorough population health needs assessments to ensure that the gains derived from resource investments are maximized (Jarman & Greer, 2015);(McKee & Brand, 2005);(Glasby & Dickinson, 2014). These scholars also highlighted the critical roles of strategic healthcare service planning and design, the qualification and selection of appropriate providers, and the implementation of incentive structures and management practices to promote optimal provider performance. Although there is no standard definition for strategic commissioning, this thesis adopted the definition of the UK Cabinet office published in 2006 that defined strategic commissioning as the process of assessing the needs of people in an area, designing and then securing an appropriate service. Additionally, this research conceptualized strategic commissioning as an ongoing cyclical process, as outlined by NHS England, involving several interrelated stages, including assessing population needs, setting priorities, planning services and designing contracts, procuring services, and monitoring quality. This definition and framework align closely with the aim of this thesis to explore how local health commissioning architectures and processes are implemented within the chosen ICBs.

Even before the widely referenced WHO Report and the World Bank's advocacy for the use of strategic purchasing to reform health systems, a few countries had begun experimenting with early forms of strategic commissioning in the 1990s. By separating purchaser and provider functions, these nations aimed to concentrate resources on priority areas, giving purchasers an effective tool to improve provider performance. In New Zealand, for instance, major structural changes were introduced to separate the purchasing and providing functions that had previously been performed by area health boards (Ashton, 1995). Similarly, in line with quasi-market literature, Catalonia, Sweden and Finland adopted purchaser-provider split to increase efficiencies, responsiveness and quality of services (Tynkkynen et al., 2013); (Siverbo, 2004); (Gallego, 2002). England was also part of this movement, setting the stage for strategic commissioning to become a central approach to advancing health system performance.

In England, the concept of healthcare commissioning was introduced to the NHS in 1992, when the government created an 'internal market', whereby District Health Authorities and GP fundholders acted as 'purchasers' with the ability to manage their own budgets for the first time to procure health services directly from providers and make revenue from the provision of services (Giaimo & Manow, 1999). Cribb (2008) argued that through this purchaser-provider split, the government aimed to tackle system-wide challenges such as prolonged waiting times for elective surgeries, and regional disparities in treatment availability and quality. From an economic perspective, separating those responsible for purchasing healthcare from those providing it was intended to drive efficiency and cost-effectiveness through increased competition amongst providers based on price and quality (Gilbert et al., 2014). However, the introduction of the provider-purchaser split in mental health services had several unintended consequences. Rather than fostering efficiency, it contributed to fragmented care pathways, with competition between providers leading to service gaps and discontinuity for patients with complex needs (Simpson, 1998). Critics argued that the shift towards a market-driven model placed greater emphasis on cost containment rather than patient outcomes, often prioritizing financial efficiency over the delivery of long-term, holistic mental health care (Lang et al., 1999). Shepherd et al. (1996)

highlighted that the reforms adversely affected staff morale, as mental health professionals faced increased administrative burdens and the uncertainty of contract renewals. Moreover, the split resulted in inefficiencies and service duplication, mirroring challenges previously encountered in the American mental health system (*ibid*). While the introduction of GP fundholding initially expanded access to mental health services in primary care, concerns arose that it disproportionately focused on less severe cases, potentially disadvantaging patients with more complex needs (Corney, 1996). For instance, Muijen and Ford (1996) reported that GP fundholding uptake was heavily skewed toward affluent districts, while inner-city areas with greater mental health burdens lagged behind, and that 23.3% of acute in-patients were inappropriately placed, showing clear evidence that market-driven incentives widened inequalities and compromised care. These challenges underscore the limitations of market-based approaches in mental health care, where continuity, integration, and long-term support are essential to ensuring effective patient recovery and well-being.

The relationship between purchasers and providers were governed through contracts, offering the NHS a unique opportunity to observe contract choice (Chalkley & McVicar, 2008). Initially, the most common contractual model was the block contract, characterized by a lump sum payment from purchaser to provider, independent of patient volume. Despite being associated with low transaction costs, predictable budgeting, and simplicity, scholars have highlighted significant drawbacks of block payments. For instance, Mason et al. (2011) suggested that a primary concern with this payment structure is its inability to incentivize providers to reduce costs or increase activity levels. Sussex and Farrar (2009) echoed similar concerns for mental health services, noting that block contracts often fail to incentivize providers to improve service quality or efficiency, leading to stagnation in care standards. By the mid-1990s, sophisticated block contracts became prevalent in the NHS (Griffiths & Hughes, 1998). These contracts combined a lump sum payment with conditional provisions for adjusting payment if the number of patients treated or the treatment costs deviated from the expected range. Chalkley and McVicar (2008) offered a favourable analysis of sophisticated block contracts, contending that these contracts facilitate an optimal balance between fiscal control and operational flexibility. They posited that this approach supports the alignment of incentives and the efficient management of service provision, eliminating the necessity for excessively detailed output specifications. However, in mental health services, the application of sophisticated block contracts had mixed outcomes. While they helped mitigate financial uncertainty for providers, their reliance on retrospective negotiations introduced unpredictability in funding flows, making long-term service planning more challenging. Additionally, the flexible payment structure did not always incentivize improvements in access or quality, potentially leading to stagnation in service innovation (*ibid*). *The 1998 NHS Executive's Commissioning Specialised Services Consultation* (NHS, 1999) advocated for collective commissioning of specialized mental health services, recognizing that existing contracting models, including sophisticated block contracts, often lacked the financial safeguards needed to sustain niche services effectively.

In 2002, smaller locality-based purchasers were created known as primary care trusts (PCTs), succeeding the brief tenure of primary care groups (PCGs). PCTs took on responsibility for either directly providing or commissioning health care services within designated geographical areas (Wilkin & Glendinning, 2002). Although key health indicators, including life expectancy, infant mortality, and cancer survival rates showed improvements following the establishment of PCTs, they gradually attracted significant criticism (Confederation, 2011). Concerns emerged about their limited authority over providers, an increasingly bureaucratic organizational culture, and a decline in clinical engagement and support (*ibid*). Robinson et al. (2011) for instance argued that PCTs' limited autonomy restricted their capacity for long-term investment and service redesign as national short-term "must dos" frequently conflicted with local priorities. As for mental health services, some PCTs took an innovative approach by directly providing mental health services. This allowed them to experiment with alternative care models and address specific gaps in provision and care pathways that traditional commissioning structures struggled to resolve (Lester et al., 2004). These direct interventions enabled a more integrated and responsive approach to mental health care, fostering services that were more attuned to local needs. However, this dual role blurred the distinction between commissioning and provision, potentially

undermining market competition and raising concerns about efficiency, accountability, and long-term sustainability (Nurhayati & Allen, 2018).

It wasn't until 2004 that a true shift toward strategic commissioning in England began, marked by the *Every Child Matters* (2004) white paper, which introduced a commissioning approach more closely aligned with the procurement of services. This often involved pooling resources from providers and positioned commissioning within the management cycle, linking "planning desired services" with "planning for workforce and market development" (Bovaird et al., 2012). This pivotal document paved the way for the Children Act 2004 and led to the development of a strategic commissioning framework over 2005-2006 (Glasby, 2012). From this point, strategic commissioning has increasingly dominated political and practical discourse, especially in discussions about the state's collaboration with VCSE and other non-state actors in delivering health services (Rees, 2013). This shift also coincided with growing policy interest in the role of VCSE providers in delivering commissioned services, particularly in mental health and social care (Dickinson et al., 2012). This interest stemmed from the perception that VCSEs could offer more flexible, community-based, and person-centered approaches to care, filling gaps left by statutory services and fostering greater service innovation (Buckingham, 2009).

Also in 2004, Payment by Results (PbR) contracts were introduced in the NHS, as a replacement of block contracts, to finance healthcare providers fairly and reward work volume (Jameson & Reed, 2007). The implementation of PbR contracts in healthcare has generated mixed reactions amongst academics. Whilst some scholars such as Dixon (2004), McGuire and Van Reenen (2005) argued that PbR incentivizes providers to deliver more and speedier treatments, others including Wang (2016) contended that PbR is less effective for areas such as mental health, where treatment pathways are more complex, and outcomes are more difficult to quantify. Macdonald and Elphick (2011) further highlighted concerns about the accuracy and consistency of the Mental Health Clustering Tool (MHCT), acknowledging its effectiveness in promoting the use of outcome measures like Health of the National Outcome Scales (HoNOS) but suggesting that combining diagnosis and pathways could provide a simpler and more practical approach to gathering data for costing and tracking change.

To support the shift toward strategic commissioning, several new policies and numerous structural changes were introduced to increase the use of market mechanisms and to give commissioners more teeth. These included introducing external competition, particularly by sourcing additional capacity from the independent sector to reduce waiting times for elective procedures; enabling the NHS providers to become semi-autonomous Foundation Trusts with greater operational flexibility; revising payment systems to move away from block contracts with monopoly providers; and granting patients the right to choose where they receive care (Allen et al., 2012). In a related development, 2007 saw the introduction of the first national standard NHS contract, intended to be an essential tool for ensuring accountability between providers and PCTs, and for enhancing performance. Scholars such as Petsoulas et al. (2011) recognized the ambitious goals behind implementing a comprehensive and detailed standard contract, but still approached them with scepticism, noting that their practical efficacy still heavily depended on local relationships. Similarly, Hughes et al. (2013) argued that overreliance on formal contracts and market incentives created barriers to strategic commissioning as insufficient commissioning resources and sidelined relational norms hindered effective long-term NHS planning. As to commissioning mental health services with the NHS Standard Contract, the framework provided a structured mechanism for accountability, ensuring clearer service expectations and contractual obligations between providers and commissioners. However, its rigid and adversarial nature often clashed with the relational dynamics essential for effective mental health service delivery, where flexibility and collaboration are critical. While it aimed to enhance performance oversight, in practice, financial risk-sharing and dispute resolution frequently relied on informal negotiations, highlighting the ongoing tension between formalized contracts and the realities of mental health commissioning. Although VCSEs were widely regarded as essential for delivering community-based mental health support, particularly in engaging marginalised groups and complementing NHS provision, their involvement was also frequently hindered by the same limitations (*ibid*).

Despite the widespread influence of commissioning within the UK policy agenda, Wye et al. (2015) argued that the art of commissioning requires navigating power dynamics, managing competing demands, and drawing on personal inclinations to craft a persuasive and compelling case. Gray and Higgins (2012) similarly observed that commissioning processes are shaped by legacy and trust, with shifts in relationships significantly impacting strategic direction and innovation. Likewise, Marks et al. (2015) highlighted that the priority-setting process is inherently influenced by political tensions and social value judgments, while Williams and Bryan (2016) emphasized the limited role that economic evaluations play in shaping healthcare resource allocation. Petsoulas et al. (2011) highlighted that the NHS standard contract was designed to address these challenges by creating formal mechanisms for accountability and performance improvement. However, as Price and Majeed (2017) argued, persistent issues at the primary–secondary care interface such as unclear divisions of responsibility, inadequate communication, and weak enforcement mechanisms reveal the limitations of such contracts in practice. These dynamics underscore the need to balance formal policy aspirations with practical, relational strategies to ensure effective implementation.

*The English Health and Social Care Act 2012*, perhaps the biggest shake up in commissioning history (NHSE, 2012), abolished PCTs and transferred budgetary responsibility to GP-led Clinical Commissioning Groups (CCGs) for commissioning health services at local levels, including urgent and emergency care, elective hospital care, community and mental health services (Wan, 2020). The Act 2012 legally forced competitive procurement and tendering in service commissioning, replacing the previous approach of internally negotiated rules and guidelines within NHS organizations (Sanderson et al., 2017). In addition to the consensus that the 2012 Act enforced market mechanisms through the "erosion of the boundary between public and private provision" (Gilbert et al., 2014) the establishment of CCGs was viewed by some as a continuation of the decentralization process and a significant move toward enhancing integrated care initiatives (Timmins, 2012 ). However, the reform also faced widespread criticism. There were fears that exposing the NHS to competition law would lead to a loss of control over decision-making as the market for healthcare is "almost completely imperfect" (Olsen, 2009) due to asymmetry of information, specialist services, high entry costs and the need for equitable service delivery across the population. Toynbee (2013) similarly argued that providers are likely to compete to deliver profitable services, potentially diverting NHS resources away from essential but unprofitable services, such as those for individuals with complex needs including mental health illnesses. For instance, Patel (2019) observed that the Act's push for market diversification and competition scattered commissioning into numerous small mental health contracts, whereby 65.3% went to third-sector providers yet represented just 6% of overall spending, whilst NHS foundation trusts held a quarter of contracts but 70% of funding, providing strong evidence that competition diverted resources from complex, high-need care toward more profitable services.

In October 2014, NHS England published the *Five Year Forward View*, which outlined a strategic vision for the NHS centred around fostering closer collaboration between different healthcare providers (NHSE, 2014). The plan de-emphasized market competition and instead envisioned a range of integrated service delivery models such as alliance contracts, prime provider models, and outcome-based agreements, which have progressively gained prominence as preferred payment structures within the NHS (Sanderson et al., 2017). These models sought to break down organizational boundaries across primary, community, acute, mental health, and social care sectors, as well as between providers within each sector, to create a more unified and coordinated healthcare system (Lorne et al., 2019). Goodair and Reeves (2022) pointed to the rising treatable mortality rates, longer waiting times, and declining patient satisfaction, suggesting that the growing trend of for-profit outsourcing within the NHS might had been linked to worsening population health outcomes. This deterioration in healthcare indicators could, in part, explain the rationale behind the *2015 Five Year Forward View*, which aimed to shift the focus toward more collaborative, integrated care models and reduce reliance on market-driven approaches to healthcare delivery. In line with this, in November 2014, Health Secretary Jeremy Hunt suggested that patient choice and competition might not be the most effective means of improving

performance. This statement seems to back up the growing emphasis on cooperation, positioning it as the preferred approach for governing the supply of health care services (Jones, 2017).

Building on the foundations of the *Five Year Forward View*, the *2019 NHS Long Term Plan* further emphasized the move toward integrated care and collaborative partnerships. The plan even proposed removing language that highlighted "the counterproductive effect that general competition rules and powers can have on the integration of NHS care." This marked a significant shift away from the principles underpinning the purchaser-provider split, reflecting growing recognition that competition and fragmentation were often barriers to coordinated care. The COVID-19 pandemic further accelerated the shift towards integration, prompting local networks, voluntary organizations, community groups, and social enterprises to collaborate more closely (Sheaff et al., 2024). As Binks and Cunnett (2023) highlighted, VCSE organisations played a vital role in supporting communities during the pandemic, frequently acting as trusted intermediaries that have historically been underserved by statutory health and care services. According to Khan et al. (2022), the pandemic compelled many organizations to form ad hoc partnerships and rely on existing relationships to support integrated care that met the needs of individuals and communities. These efforts led to more deliberate partnerships, a temporary relaxation of bureaucratic regulations, and improved, streamlined communication (*ibid*). Simon Stevens, the CEO of NHS England, highlighted this trajectory, noting that accountable care systems and sustainability and transformation plans (STPs) would "effectively end the purchaser-provider split for the first time since 1990" (Hare, 2017) underscoring the ongoing policy shift from competition to collaboration as the cornerstone of NHS reform.

Most recently, on April 28, 2022, the Health and Care Bill received Royal Assent and became an Act of the UK Parliament. The Act abolished Clinical Commissioning Groups (CCGs) and replaced them with forty-two Integrated Care Systems (ICSs), which bring together the NHS, local government, and other system partners “to put collaboration and partnership at the heart of healthcare planning” (NHSE, 2022b). As of July 2022, ICSs are operational as statutory bodies responsible for planning most primary, community, and hospital care services, including urgent and emergency care in their local area. Most scholars welcomed the Act, with proponents contending that the reform would enhance integrated care through new governance structures, fostering more cohesive service delivery and placing a greater emphasis on patient-centered care (HEE, 2017). Toh and Haynes (2022) emphasized the Act’s potential to embed research within the NHS, enabling improved patient outcomes and reducing health inequalities, though they warned that workforce shortages could limit these benefits. Similarly, Richard Murray from The King’s Fund (2022) praised the Act’s permissive and flexible approach, allowing local leaders to shape integrated care based on local needs, but expressed concerns over the government’s failure to address workforce planning and social care funding challenges. Meanwhile, BMA (2024) argued that while the abolition of enforced competition and the emphasis on integration were positive steps, the Act fell short in ensuring adequate resourcing and safeguarding the NHS from political interference. The Act also brought significant implications for mental health commissioning. While this shift promises greater integration and cross-sector collaboration, concerns remain over whether mental health will receive equal prioritization amid broader system pressures. The removal of intellectual disability and autism from mental health legislation has sparked debate, with critics warning of potential gaps in care and reduced legal protections for these populations (Taylor & Burrell, 2023). Additionally, while service user involvement in shaping mental health services is increasingly emphasized, its practical impact on service-level outcomes remains underexplored (Ezaydi et al., 2023). These changes underscore the transformative potential of ICSs, but also highlight the persistent challenges of achieving true parity for mental health within the evolving the NHS landscape.

### 1.1.2. Current Governance and Funding Structures

Even after the most recent *2022 Health and Care Act*, local healthcare commissioning continues to be a multifaced process with many actors (Salazar et al., 2022). **Figure I** provides a summary of the current local health commissioning structures following the Act.

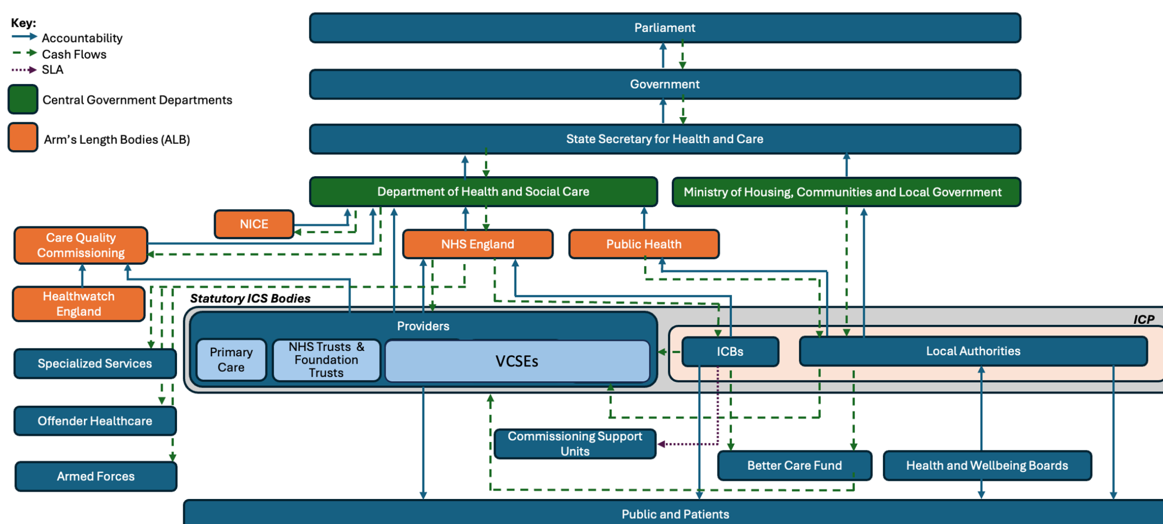


**Figure I:** Local Health Commissioning Context Following the 2022 Health and Care Act (own source, 2024)

The Secretary of State for Health and Social Care is accountable to both the Government and Parliament for ensuring the effective stewardship of the resources allocated to central government departments, namely the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities & Local Government (MHCLG). The DHSC allocates the majority of its funding to NHS England, with the remainder distributed across other DHSC agencies and programmes, including arm's length bodies such as the Care Quality Commission (CQC), the independent regulator of health and social care services in England, and NICE, executive non-departmental public body that provides guidance to improve health and social care. Additionally, the DHSC provides public health grants, which are subsequently commissioned to local authorities. According to the 2022/2023 resource budget, approximately 90% of the DHSC's budget was allocated to NHS England, which then distributed these funds, directing a small portion toward the direct commissioning of specialized services and allocating the majority to ICBs (THF, 2025). The determination of whether an NHS England or ICB is responsible for commissioning a particular service depends on the specific nature and scope of the service in question. NHS England retains direct commissioning responsibility for several specialized services, primarily due to their complexity and the need for centralized expertise and resources. These services include highly specialized care for individuals with rare and complex conditions, certain mental health services for offenders (e.g., in secure psychiatric facilities), and healthcare provisions for members of the armed forces. This allocation of responsibility reflects the need for specialized and often high-cost services that require national-level oversight, infrastructure, and funding mechanisms, which local ICBs are not structured to manage independently.

ICSs aim to unify health and care organizations to collaborate more effectively on broad, population-level agenda. They are responsible for promoting preventive care, reducing health inequalities, enhancing care outcomes, and optimizing resource management (Lalani et al., 2024). Thanks to the *NHS Long Term Plan*, primary care representation within ICSs is strengthened through the establishment of

Primary Care Networks (PCNs), which are a group of GP practices working closely together for service delivery (Baird et al., 2024). Whilst practices are not mandated to join a PCN, they will lose out on significant extra funding if they do not. Currently, there are around 1,250 PCNs in England, with over 99% of practices signing up to be part of a PCN through the network contract DES (NHSE, 2024a). ICS arrangements differ significantly depending on the scale and size of each system and may take the form of place-based partnerships or primary care networks, also known as Integrated Neighbourhood Teams (INT), which are responsible for planning and delivering coordinated services aligned with the NHS standards. Each ICS is composed of two key bodies: an ICB and an ICP.

ICBs are responsible for commissioning healthcare services for their local populations, either through direct contracts or by delegating functions to providers. They are accountable for the NHS spending and the overall performance of the healthcare system. To support their commissioning duties, ICBs often receive assistance from Commissioning Support Units (CSUs), which provide both transactional and transformational services. These services may include business support functions such as finance, human resource management, data analysis, health needs assessments, or media management. The relationship between CSUs and ICBs is governed by service level agreements (SLAs), outlining the expectations and responsibilities of both parties (HFMA, 2024).

Alongside primary care and NHS trusts and foundation trusts, ICBs also commission VCSEs. The role of the VCSE organisations is increasingly acknowledged as pivotal in the enhancement of health services, with many positioning them not merely as service providers, but as essential connectors to communities (Confederation, 2023). This role is particularly pronounced in the context of mental health, where VCSEs often operate at the intersection of formal care and community-based support. The Association of Mental Health Providers - the national representative body for VCSE mental health organisations in England and Wales - described these organisations as critical to the delivery of mental health services. They highlighted that VCSEs collectively provide over 3,000 services at local, regional, and national levels, supporting more than 8 million individuals annually (AMHP, 2022). This equates to approximately 1 in 8 people receiving care or support through VCSE mental health providers, underscoring their integral role within the broader health and care system.

ICPs, which are joint committees between ICBs and local authorities, are tasked with developing an integrated care strategy that addresses the health, social care, and public health needs of the system. They also act as a platform to promote partnership working across sectors. A portion of ICB funding is allocated to a pooled budget with local authorities, known as the Better Care Fund (BCF). With a mandate to collaborate with local authorities to optimize health and social care funding, the size of these pooled funds is expected to increase in the coming years (HFMA, 2024). Health and Wellbeing Boards (HWBs), meanwhile, continue to operate as statutory committees of local authorities and are accountable to public and patients (Gov.UK, 2022).

The Ministry of Housing, Communities and Local Government is a central government body responsible for overseeing local authorities whose responsibilities include delivering social care and public health services to their communities. If local authorities fail to provide these services or misuses public funds, the Secretary of State for Levelling Up, Housing and Communities has the power to intervene and take direct control of local services.

### 1.1.3. Payment Mechanism and Contract Arrangements

Another change that the *2022 Health and Care Act* brought was the replacement of the National Tariff Payment System with the NHS Payment Scheme (NHSPS). Since April 2023, the NHSPS has served as the main payment structure in the NHS, designed to facilitate more adaptable and integrated funding arrangements that align with the Act's vision for patient-centered care (NHSE, 2024c). Set as a two-year framework covering 2023/24 and 2024/25, the NHSPS contains guidelines for four distinct payment

mechanisms. These mechanisms govern financial flows from commissioners to healthcare providers across England, incentivizing desired outcomes and system behaviours as needed (HFMA, 2024). Payment mechanisms, while not a universal solution, play a pivotal role in enabling shifts in services and behaviours. They encourage a focus on earlier, preventative, and upstream interventions, which are essential for improving health outcomes and addressing financial sustainability. In the face of rising demand driven by demographic trends, such mechanisms support allocative and technical productivity, helping the health and care system achieve both cost-efficiency and better population health outcomes (Jones et al., 2024). These objectives are achieved through four distinct payment mechanisms, detailed below:

- *Aligned payment and incentive (API)* – Contracts with NHS Trusts and Foundation Trusts where the expected annual value of a funding flow is over £0.5m per annum. This is a form of blended payment with fixed and variable elements. The fixed element funds pre-agreed value for the expected level of activity and the variable element, which increases or reduces payment based on the actual activity and quality of care delivered. API applies to almost all NHS provider relationships with NHS England for any directly commissioned services.

- *Low volume activity (LVA) block payments* – Contracts with NHS Trusts and Foundation Trusts where the expected annual value of a funding flow is under £0.5m per annum. Commissioners pay providers the nationally set LVA value, based on a three-year rolling average, with no other transactions in-year.

- *Activity-based payments* – Contracts with non-NHS providers where services delivered with NHSPS unit prices

- *Local arrangements* – Contracts with non-NHS provider services without NHSPS unit prices and NHS provider activity excluded from API and LVA

Alongside payment mechanisms, contract arrangements are key to enabling and assuring effective changes driven through strategic commissioning. Payment mechanisms, such as those outlined in the NHS Payment Scheme, support the financial flows needed to incentivize outcomes and encourage preventative, integrated care. Complementing these, contracts serve as the formal framework for documenting decisions and actions between partners, backed by robust governance structures. Understanding and strategically using these contracts is essential for commissioners to drive improvements in service delivery and outcomes. Below are the types of contracts and grants used in the NHS system: several key arrangements include the NHS Standard Contract for secondary care, primary care contracts such as General Medical Services (GMS), Personal Medical Services (PMS), and Alternative Provider Medical Services (APMS), as well as grant agreements tailored specifically to the VCSE sector. Together, these mechanisms provide the financial and structural foundation for achieving the Act's vision of patient-centered, sustainable care (Hughes, 2024).

- *NHS Standard Contract* – A legally binding agreement mandated by NHS England, establishing the terms between commissioners and providers. This formal arrangement ensures providers adhere to national regulations, local agreements, and established rules while protecting all parties by serving as an official record of agreed terms (NHSE, 2024c). It also provides a structured framework for resolving disputes if challenges arise. Beyond compliance and governance, the contract serves as a strategic tool to drive service improvements, incorporating schedules that facilitate constructive discussions and actions aimed at enhancing care delivery. While the NHS Standard Contract is widely used, there are notable exceptions where alternative arrangements are more appropriate. These include primary care, which operates under its own set of primary care contracts; financial support provided to VCSE organisations, typically handled through grant agreements; and subcontracts between providers, which necessitate alternative agreements (Hughes, 2024). Additionally, the NHS Standard Contract is available in two formats. The full-length version,

encompassing all required provisions, is designed for larger organisations or complex services like Accident and Emergency or inpatient care. For smaller providers delivering a single, focused service such as a hospice, care home, or pharmacy a shorter form contract is used. This simplified version reduces administrative burden while maintaining essential terms but is not suitable for more extensive or multifaceted service agreements (NHSE, 2024c). The NHS Standard Contract can also be used in a lead provider model, where a single trust assumes contractual responsibility on behalf of a provider collaborative from the ICB for an agreed set of services and subcontracts to other providers as necessary. VCSE commissioning arrangements can also be formalised through NHS Standard Contract, some of which include tailored service specifications. These contracts extend to mental health services, provided the commissioned activities align with relevant national guidance and policy directives (Confederation, 2023).

- *GP Contracts* – GMS contract serves as the national standard, enabling commissioners to contract general practice services in a geographical area to deliver core services. Around 70 per cent of GP practices use this contract (Hughes, 2024). PMS contract allows for local variations and is negotiated between individual commissioners and GP practices. Approximately 26 per cent of practices use this form (*ibid*). APMS contract, on the other hand, provides a framework for private or third-sector organisations to deliver primary care services beyond what is offered under the GMS contract (NHS England, 2024). Alongside the NHS Standard Contract, local enhanced services (LES) can be commissioned from general practices using the GP contract as the contracting vehicle, providing ICBs with flexibility in their commissioning approach.

- *Sub-contract* – Any agreement entered by the provider or its subcontractors to fulfil the provider's obligations under the contract. This encompasses contracts with clinical service providers (commonly referred to as "provider-to-provider" contracts), suppliers of clinical support services, and agreements for goods and equipment essential for delivering the commissioned services in compliance with the contractual terms established with the commissioners.

- *Network Contract Direct Enhanced Service* – Participation in a PCN is incentivized through the DES contract, which provides funding for additional services delivered collectively through the network. While the DES contract is held directly between the ICB and individual GP practices, receiving funding is contingent on the practice being part of a PCN, underscoring the importance of collaboration in delivering comprehensive, integrated care (NHSE, 2024b).

- *Grant Agreements* - Grant agreements serve as formal documentation for arrangements that do not require a comprehensive legal contract but benefit from clearly defined terms and expectations. These agreements provide transparency and ensure alignment between commissioners and recipients. Typically, grant agreements are employed when commissioners allocate funding to support charities or services within VCSE sector. Unlike contracting arrangements, which involve the direct procurement of services, grant agreements focus on funding support to enable service delivery rather than establishing a transactional relationship.

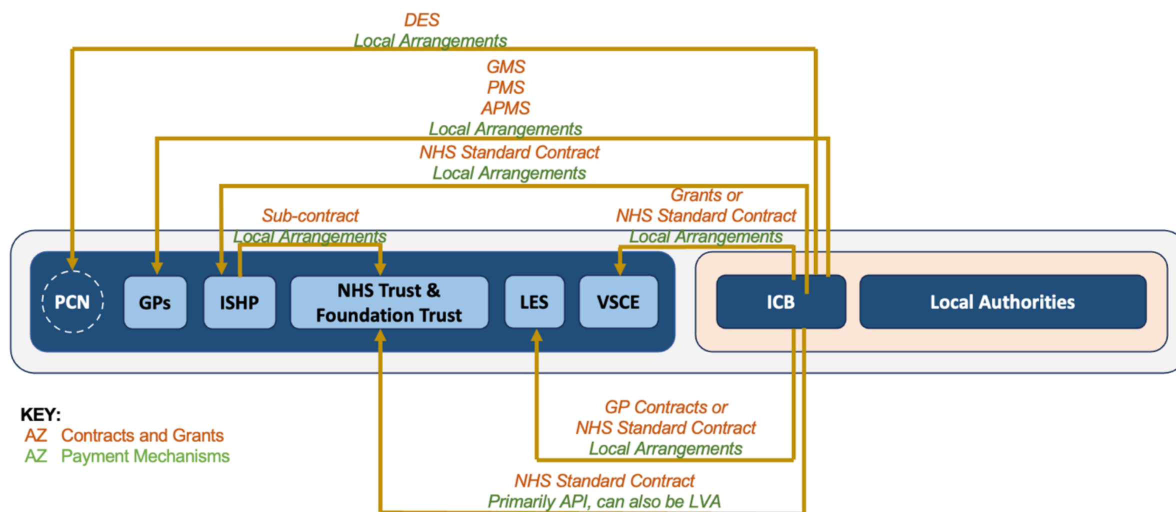


**Figure II:** Payment Mechanism and Contract Arrangements following the 2022 Health and Care Act (own source, 2025)

The evolution of payment mechanisms for mental health services in England mirrors broader changes in NHS financing strategies. Historically, from the establishment of the NHS in 1948 through the late 20th century, block contracts dominated the landscape, with lump-sum payments provided to mental health service providers regardless of patient volume. This approach, while offering financial stability and predictability, was criticized for failing to incentivize efficiency or improvements in service quality (Mason et al., 2011). In the early 2000s, the NHS introduced the Payment by Results (PbR) system, aiming to link funding more closely to service activity and outcomes. PbR was effectively implemented in acute hospital settings; however, its application in mental health services faced significant challenges. The inherent variability in patient needs, combined with the long-term and often complex nature of mental health care, made it difficult to standardize payments effectively. Attempts to adapt PbR for mental health included the introduction of patient clustering based on needs; however, these efforts faced considerable resistance due to concerns about fairness, complexity, and the suitability of such models for mental health care (Clark, 2011). More recently, there has been a gradual shift toward blended and alternative payment models. Blended payment models, combining elements of block funding with activity-based payments, have been introduced in some regions to provide flexibility while still encouraging efficiency. However, as of 2019, most mental health budgets in England remain under block contract arrangements, highlighting the sector's slow transition from legacy payment models (Jacobs et al., 2019). The introduction of the NHS Payment Scheme sought to replace PbR with more flexible, value-based approaches that reward outcomes rather than volume. However, mental health services have largely been exempted from these reforms due to the complexities in measuring outcomes and the diverse nature of mental health care delivery. Although pilot programs and integrated care initiatives have explored outcome-based funding and more localized payment arrangements, widespread adoption remains limited. This reflects the ongoing challenges in designing financing models that balance the need for flexibility, fairness, and accountability in mental health commissioning.

The contractual landscape for mental health service commissioning in England has also evolved significantly over the decades. Prior to the 1990s, relationship between commissioners and providers were governed by relatively informal agreements, often based on implicit expectations and professional trust rather than detailed, enforceable contracts. However, the introduction of the internal market reforms in the early 1990s brought a shift towards more formalized contracting, emphasizing clear obligations, accountability, and performance metrics between purchasers and providers. A major milestone in this evolution was the introduction of the NHS Standard Contract in 2007, designed as a comprehensive framework applicable across all NHS-funded services, including mental health. The

contract aimed to standardize terms and conditions, ensuring consistency in service delivery expectations, performance monitoring, and financial arrangements. While the NHS Standard Contract introduced detailed provisions for quality assurance, reporting, and dispute resolution, its practical implementation in mental health often leaned towards relational contracting, where trust, flexibility, and ongoing negotiations between parties remained crucial (Petsoulas et al., 2011). This flexibility was particularly necessary in mental health services, where the complexity of care and variability in patient needs made rigid contractual enforcement challenging. In addition to the NHS Standard Contract, other contractual models have been employed to accommodate the diverse nature of mental health service provision. General Practitioner (GP) contracts have increasingly included components for mental health care, especially with the rise of primary care-led commissioning. These contracts often feature sub-contracting arrangements, where GPs commission specialized mental health services from third-party providers, such as counselling services, community mental health teams, or peer support groups. Sub-contracts allow for more localized and tailored service delivery, enabling community-specific interventions that address cultural, demographic, or regional needs. However, they also introduce complexities in accountability and coordination, particularly within ICSs, where multiple providers must align their services to ensure seamless care pathways. Issues such as data sharing, performance monitoring, and financial risk allocation can become complicated, especially when subcontracted providers operate under different organizational standards or priorities.

Another notable contractual model is the DES contract, which provides additional funding to GPs for offering extended mental health services beyond their core obligations. DES contracts have been instrumental in integrating mental health support into primary care, promoting early intervention and holistic patient care. For example, GPs might be funded to offer mental health assessments, coordinate care plans, or provide direct therapeutic interventions. However, the variation in DES uptake across different regions has led to inconsistencies in service availability and quality, with some areas offering comprehensive mental health support in primary care, while others lag behind.

Grant agreements also play a crucial role in mental health commissioning, particularly for services delivered by VCSE organizations such as charities, social enterprises, and community groups. Unlike traditional contracts, grants often focus on outcomes and innovation rather than prescriptive service specifications. This approach fosters flexibility and encourages providers to develop community-based, patient-centered solutions that may not fit within the rigid frameworks of NHS contracts. For instance, grants have supported the development of peer-led recovery programs, culturally sensitive therapy models, and innovative digital mental health tools. However, the short-term nature of grants can pose sustainability challenges for providers, making it difficult to maintain consistent services or invest in long-term planning. This instability can affect the continuity of mental health care, especially for vulnerable populations who rely on these community-based interventions.

Sub-contracts, DES contracts, and grant agreements collectively highlight the complexity and adaptability required in commissioning mental health services. While standardized contractual frameworks provide a foundation for accountability and performance, the inherent variability of mental health needs necessitates ongoing flexibility and relational management. The balance between formal contractual obligations and adaptive, partnership-based approaches remains a defining feature of the current commissioning landscape, ensuring that mental health services can respond effectively to both systemic requirements and individual patient needs.

## 1.2. Thesis Objectives

This thesis aims to (i) examine the current commissioning process for VCSE mental health service providers by applying the strategic commissioning cycle framework to ICBs located in Southeast and East England, providing insights into how services are planned, procured, and evaluated within each

system (ii) assess the value for money of these VCSE providers, considering cost-effectiveness, service quality, and overall impact within the integrated care landscape.

Specifically, the following five questions are asked:

- What is the current commissioning process for VCSE mental health service providers?
- What are the perspectives of key ICB and VCSE stakeholders on the current commissioning process?
- What factors influence commissioners in selecting one VCSE provider over others?
- What contracts are used between ICBs and VCSE mental health providers?
- What is the value for money of VCSE mental health service providers?

## 1.3. Thesis Structure

Chapter Two (Methodology and Framework) provides an in-depth exploration of the quantitative and qualitative methodologies underpinning this thesis. Detailed descriptions of the datasets employed, including any adjustments or transformations made during analysis, are presented to ensure transparency and reproducibility. Furthermore, the chapter critically engages with the inherent limitations of the data and methods. This methodological discussion establishes the rigour and credibility of the research framework. Chapter Two also establishes the analytical framework that underpins the evaluation of strategic commissioning within the selected ICBs in subsequent chapters. The framework is based on the NHS strategic commissioning cycle, which comprises three core components: (i) strategic planning, (ii) service procurement, and (iii) monitoring and evaluation. Each of these components is explored in depth to provide a structured lens through which the commissioning activities of ICBs can be assessed and compared.

Chapter Three (Results) applies this framework to examine how strategic commissioning is operationalised within the selected ICBs. Drawing on READ document analysis and semi-structured interviews, the chapter investigates the current commissioning landscape, offering a detailed account of organisational structures, decision-making processes, and implementation strategies. It explores how each ICB approaches service planning, procurement, and performance monitoring, thereby shedding light on the practical realities of strategic commissioning. In line with the 'monitoring and evaluation' component of the framework, the chapter also introduces an evaluation model designed to assess the value for money of third-party mental health service providers.

Chapter Four (Discussion and Conclusion) presents the analysis of findings from Chapters Two and Three and a summary of strengths and limitations of the study. Future directions for research in this space are also discussed.

# 2. CHAPTER: METHODOLOGY AND FRAMEWORK

## 2.1. Overview of Methodology

To achieve a comprehensive evaluation, this study employed a mixed-methods approach, integrating qualitative analysis including document analysis and semi-structured stakeholder interviews with a quantitative assessment of financial and performance data. This approach enabled a holistic understanding of how commissioning operates in practice, how VCSE mental health service providers are selected and evaluated, and how value for money is assessed within the evolving landscape of integrated mental health care.

A key advantage of this approach is the ability to triangulate findings from both qualitative and quantitative sources, allowing for a more nuanced and complete understanding of complex healthcare phenomena (Smajic et al., 2022). In recent years, mixed-methods research has gained significant traction in healthcare studies, reflecting its ability to capture both the measurable and experiential aspects of service delivery (*ibid*). Mixed method has been applied and debated in several studies over the years (Baum, 1995); (Barbour, 1999); (McDowell & MacLean, 1998); (McPherson & Leydon, 2002).

Specifically in mental health research, where the complexity and multidimensionality of experiences demand integration of breadth and depth, a concurrent triangulation mixed-methods design was adopted to enable the parallel collection and comparative presentation of quantitative and qualitative findings, aligning with calls to advance robust, integrated approaches in the field (Demkowicz et al., 2025). In line with this design, the findings from both strands were systematically organised within the NHS England strategic commissioning cycle, applying a framework-based triangulation approach to compare and contextualise results while preserving the distinct contributions of each dataset. This thesis also benefited from this mixed-methods strategy to explore a previously underexamined theme, period and policy context in strategic commissioning, bringing together quantitative and qualitative evidence to generate a more comprehensive and policy-relevant understanding.

Qualitative methods are particularly valuable for exploring decision-making processes, stakeholder perspectives, and service implementation, providing rich, context-specific insights that quantitative data alone cannot reveal (Renjith et al., 2021). On the other hand, quantitative methods are crucial for establishing cause-and-effect relationships and generating generalizable data (Verhoef & Casebeer, 1997). By combining these approaches, mixed-methods research enhances analytical depth, mitigates methodological limitations, and strengthens the validity of findings through triangulation, ensuring a rigorous and well-rounded evaluation of strategic commissioning in mental health services (Demkowicz et al., 2025).

### 2.1.1. Qualitative Approach

This study employed a qualitative methodology using the READ approach for document analysis and semi-structured stakeholder interviews.

#### 2.1.1.1. Document Analysis – The READ Approach

Document analysis is a systematic procedure for reviewing and evaluating documents, widely used in health policy research to provide contextual understanding, track policy changes over time, supplement other research methods, and corroborate findings from multiple sources (Bowen, 2009). Despite its significance, there is limited specific guidance on conducting rigorous document analysis in health policy research, necessitating structured approaches to ensure methodological rigor and reliability.

This study adopted the READ approach (Ready materials, Extract data, Analyse data, Distil findings) proposed by Dalglish et al. (2020), a step-by-step framework designed to facilitate systematic and comprehensive document analysis in qualitative policy research. The READ approach was chosen for its practicality in guiding researchers to maximize the analytical value of policy documents while maintaining methodological robustness. By applying this structured method, the study ensured consistency in data extraction, interpretation, and synthesis, enhancing the credibility of findings.

Document analysis can be employed as a standalone method to examine policy evolution, but it is particularly powerful when combined with other research techniques, such as interviews, observations, and quantitative analyses. Cross-validation through multiple methods (commonly referred to as triangulation) enhances the depth and reliability of research insights. As Bardach and Patashnik (2015) noted policy research relies on two fundamental sources of information: documents and people. Thus, integrating document analysis with stakeholder interviews allows researchers to explore emerging themes, clarify ambiguities, and identify additional sources of information. Alternating between document analysis and interviews strengthens the research process, as documents can inform interview questions, while interview findings can direct attention to relevant policy materials.

Furthermore, document analysis plays a crucial role in developing interprofessional interventions in primary healthcare settings, addressing contextual challenges, and supporting strategies for enhanced collaboration and service integration (Africa et al., 2022). By systematically reviewing policy documents, guidelines, and reports, researchers can gain valuable insights into healthcare governance, commissioning structures, and implementation strategies. This, in turn, ensures that research findings contribute meaningfully to policy development, strategic decision-making, and the continuous improvement of healthcare services.

The first step of the READ approach, *Ready Your Materials*, requires researchers to make key decisions regarding the scope of their document analysis. Dalglish et al. (2020) outlined three fundamental considerations for this phase: (1) defining the topic of investigation, (2) determining the dates of inclusion, and (3) identifying sources for document retrieval. These steps ensure that the analysis remains focused and methodologically rigorous. In this study, the topic of investigation is the commissioning landscape of ICBs located in Southeast and East England, specifically examining their commissioning activities and plans for mental health services, resource allocation, and financial planning. The timeframe for inclusion spans from 2022, marking the formal establishment of ICBs, to November 2024, when data collection for this research was completed. Relevant documents were identified through a combination of targeted searches on the official websites of the selected ICBs and broader searches using Google. The search strategy included key terms such as “strategic commissioning,” “priority-setting,” “mental health services,” “healthcare,” “integrated care,” “new models of care,” “local,” and “England.” In addition to official ICB publications, reports from independent UK-based organisations with a focus on health commissioning such as the King’s Fund were also reviewed to provide additional context and insight. Dalglish et al. (2020) emphasized the importance of consulting a diverse mix of documents, including grey literature (such as reports, evaluations, and white papers) and informal working documents (such as meeting notes, PowerPoint presentations, and memoranda). Accordingly, this study selected a collection of 42 documents categorized under implementation and working documents, ensuring a comprehensive and multi-faceted analysis of Southeast and East ICBs’ commissioning frameworks.

For the purpose of this analysis, a set of implementation and working documents were selected to provide insight into the operationalisation of mental health commissioning within the chosen ICBs. The implementation documents reviewed include the 3-Year Plan for Adult Mental Health Inpatient Services, ICB Annual Reports, the Integrated Care Strategy, and the Local Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing. In addition to these strategic documents, a range of working documents were also examined to capture the day-to-day governance, decision-making processes, and operational developments within the commissioning system. These

include Board Meeting Reports and Minutes, Memoranda, Board Committee Annual Reports, and PowerPoint Presentations. A full list of documents reviewed can be found in **Appendix I** at the end of this thesis.

The second step, *Extract Data*, involves systematically organizing and capturing relevant information from the selected documents. Dalglish et al. (2020) suggested multiple techniques for data extraction, recommending the use of structured tools such as Excel spreadsheets to track document details and analytical insights. Following this best practice, this study utilized an Excel-based framework, where each document was assigned a row and key categories of information (e.g., document title, author, publication date, and thematic relevance) were captured in separate columns. This structured approach facilitated a transparent analysis, aligning extracted data with the study's overarching research questions and the strategic commissioning cycle framework.

The analyzing data phase of the READ approach involves systematically interpreting extracted information to develop a comprehensive understanding of the commissioning landscape. In qualitative research, data collection and analysis are inherently iterative processes, with findings continuously shaping the interpretation and refinement of the dataset. A comprehensive understanding of the data, however, can only be fully developed once the extraction phase is complete. To systematically structure this analysis, established methodologies such as policy analysis (Buse et al., 2005), thematic content analysis, discourse analysis, framework analysis, and process tracing (Humble & Mozelius, 2022); (Vaismoradi & Snelgrove, 2019) can be applied. Health studies, including those of mental health, benefited widely from qualitative methods by various means (Harper & Thompson, 2011); (Bucyibaruta et al., 2022).

For this study, a combination of policy analysis and thematic content analysis was employed to evaluate the commissioning processes of ICBs located in Southeast and East England. Policy analysis was used to examine variations across governance structures, integration efforts, and provider relationships, providing insight into how commissioning decisions are structured and operationalized. Thematic content analysis was applied to identify recurring patterns, key priorities, and emerging challenges within the commissioning landscape. This dual approach ensured a structured and in-depth evaluation, capturing both the strategic and practical dimensions of Southeast and East ICB's commissioning frameworks.

The final stage of the READ approach, *Distil Findings*, involves synthesizing the extracted and analyzed data into meaningful conclusions. A document review reaches completion under one of three conditions: (1) completeness - whereby all relevant documents fitting the criteria have been obtained, (2) time constraints - whereby limitations prevent further document retrieval, or (3) saturation - whereby reviewing additional documents no longer yields new insights. Ideally, research should reach the third stage, ensuring a well-rounded understanding of the topic.

For this study, the document review was finalized based on completeness (1) and saturation (3). The dataset included a comprehensive selection of relevant policy documents, commissioning strategies, financial reports, and implementation frameworks, ensuring completeness in addressing the research objectives. Additionally, as analysis progressed, no significant new themes or insights emerged from further document review, indicating that data saturation had been reached. This ensured that the findings provide a robust and representative evaluation of the commissioning processes in both ICBs in question.

#### 2.1.1.2. Semi-structured Interviews

Semi-structured interviews serve as a valuable qualitative research tool in healthcare, offering both depth and flexibility in data collection through a series of questions (DeJonckheere & Vaughn, 2019). They allow researchers to explore participants' experiences and perspectives while maintaining a focus

on key themes (Adams et al., 2015).This approach strikes a balance between standardization and adaptability, enabling interviewers to delve deeper into relevant topics while allowing respondents the freedom to raise unanticipated insights (*ibid*).

Effective implementation of semi-structured interviews requires careful planning. This includes developing a well-structured interview guide to ensure consistency, establishing rapport with participants to encourage open dialogue, and addressing ethical considerations such as informed consent and confidentiality (DeJonckheere & Vaughn, 2019). When conducted skillfully, semi-structured interviews can yield rich qualitative data that might not emerge through rigidly structured methods, providing deeper insight into the effects of specific policies and practices (Adams et al., 2015).

#### 2.1.1.2.1. Data Collection

A semi-structured interview guide was prepared by the primary researcher in line with the research aims and based on themes emerged from the literature review and insights extracted from READ document analysis. The guide was developed to facilitate data collection, specifically targeting commissioners, VCSE representatives, ICB and Council executives. The guide was designed to explore their roles in healthcare commissioning, their opinions into current practices and forward plans. Crucially, the responses obtained from interviewees were systematically mapped onto the NHS England strategic commissioning cycle, allowing for an applied analysis of how the commissioning process functions in practice. This approach ensured that findings could be interpreted within the structured framework of strategic commissioning, highlighting both areas of alignment with the model and deviations due to local contextual factors. The interview guide is presented in **Appendix II**.

As the primary researcher, I conducted all interviews in English with commissioners, VCSE representatives, ICB and Council executives in April 2025. Interviews were audio-recorded with the participants' consent and conducted remotely via Microsoft Teams, utilizing the standard cameras and microphones of both the interviewer and interviewees on their respective personal laptops. Each participant was interviewed individually, fostering an environment conducive to in-depth and personalized discussions (Bearman, 2019). This approach minimized potential group dynamics or conformity biases, allowing participants to articulate their perspectives with greater authenticity. Individual interviews also provided an opportunity to explore sensitive or complex aspects of commissioning that participants might be hesitant to disclose in a group setting (Fox et al., 2007). The focused and private nature of these semi-structured interviews facilitated rich, nuanced responses, enhancing the validity and reliability of the data collected (Bearman, 2019).

#### 2.1.1.2.2. Sampling and Recruitment

A purposive-snowball sampling approach was employed to recruit interviewees from two ICBs located in East and Southeast England. Local leaders involved in commissioning processes were identified through an initial mapping exercise, ensuring that participants had relevant expertise into healthcare commissioning. Selection criteria focused on individuals with direct experience or specialized knowledge of local commissioning frameworks, decision-making processes, and service planning. Stakeholder roles and types were defined in advance to ensure balanced representation across all levels and degrees of seniority.

Following this selection process, 15 stakeholders were invited via email to participate in the study. The invitation included a participant information sheet detailing the research objectives, ethical considerations, and confidentiality assurances. Of those invited, 10 accepted and took part in a semi-structured interview, resulting in a response rate of 66%. From the interviewees, 6 were accountable officers or executive leads, 2 were public health consultants, 1 was chief medical officer and 1 was chief executive officer.

#### 2.1.1.2.3. Ethical Review

Ethical approval was obtained from the Central University Research Ethics Committee (Reference: 991351). Participants were provided with a written participant information sheet, which was verbally explained to all participants. Written consent was obtained from all participants.

#### 2.1.1.2.4. Data Analysis

All interview transcripts were imported into NVivo 15, a qualitative data analysis software commonly used for in-depth analysis of text-based data. The data were analysed using Braun and Clarke's (2006) thematic analysis framework, which offers a flexible yet systematic approach to identifying, analysing, and interpreting patterns within qualitative data. Guided by this framework, a hybrid approach combining inductive and deductive coding was adopted to allow for both data-driven insights and theoretically informed interpretation. First, deductive parent codes and child nodes were determined using the NHS commissioning cycle to provide a robust, theory-driven framework for analysis. The transcripts were then re-examined inductively to identify any emergent themes outside the initial framework, ensuring that unexpected patterns and stakeholder perspectives were fully captured. Through this inductive process, five previously unanticipated themes were identified, prompting the creation of two new parent nodes and three child nodes that extended the original framework and ensured a comprehensive representation of stakeholder perspectives. This was particularly effective in exploring participants' experiences in relation to the three phases of the NHS England strategic commissioning cycle. NVivo 15 supported a structured and transparent coding process, enabling efficient organisation and comparison of emerging themes. The software was selected due to its availability through a university license, the researcher's prior training and familiarity with it, and its suitability for managing large, complex qualitative datasets. At the end of each interview, participants were invited to indicate whether they would like to receive a copy of the findings once the analysis was complete.

### 2.1.2. Quantitative Approach

This study employed a quantitative methodology to assess the value for money of mental health services provided by VSCE organisations. Two specific mental health services were selected as case studies. The first was chosen due to its capacity to demonstrate the value generated by VCSEs by quantifying participant progress, measured through comparisons of initial and final Strengths and Difficulties Questionnaire (SDQ) scores relative to the per-session cost. The second service was selected for its ability to offer insight into the costs associated with alternative interventions, thereby contributing to an evaluation of the cost-effectiveness of VCSEs. Both services are described in greater detail in the sections that follow.

#### 2.1.2.1. Value for Money

In this study, Value for Money (VfM) was assessed through a combination of Cost-Benefit Analysis (CBA) and Return on Investment (ROI), both of which are established economic evaluation approaches. VfM is a vital concept in health economics, providing decision-makers with a structured means of comparing the costs and benefits of interventions to ensure that limited resources are allocated efficiently (Drummond et al., 2015). In the context of healthcare commissioning, VfM assessments help evaluate not only the affordability of interventions but also their ability to generate meaningful outcomes relative to their cost, supporting evidence-based policymaking and resource allocation (Brousselle et al., 2016). Recent studies applying VfM concepts to health and education settings include analyses of community-based mental health interventions (McDaid et al., 2019) and public health

prevention strategies (Masters et al., 2017), which highlight the growing role of VfM assessments in guiding service delivery and policy development.

#### 2.1.2.2. Cost-Benefit Analysis

CBA is a widely used economic evaluation method that assesses whether an intervention is worthwhile by comparing its costs and benefits, both expressed in monetary terms (Edlin et al., 2015). Unlike cost-effectiveness or cost-utility analyses, which measure outcomes in natural or utility-based units, CBA assigns a monetary value to both inputs and outcomes, allowing for cross-sectoral comparisons for instance, between health, education, and infrastructure spending (Marsh et al., 2012); (Edlin et al., 2015). This feature makes CBA particularly valuable in evaluating allocative efficiency and informing broader public investment decisions (Donaldson, 1998); (Johnson, 2012).

##### 2.1.2.2.1. Dataset

The dataset used in this study for CBA originates from the Children & Young People Supported Self Help Programme and was acquired from Oxfordshire Mind. The programme is a six-week guided service for young people aged 7-17 years old experiencing mild to moderate mental health difficulties and is based on the principles of Cognitive Behavioural Therapy (CBT). The dataset comprises 620 patients, with key variables captured include date of initial session, gender, source of referral, initial and final SDQ (Strengths and Difficulties Questionnaire) scores, number of sessions attended and pathways (e.g., anger, anxiety). This structure supports a quasi-experimental design, allowing analysis of within-patient changes in outcomes before and after exposure to the service. The data was initially collected for operational monitoring and reporting purposes by the program staff. While it was not originally designed for this research, the format and content were adapted for secondary analysis to enable a structured evaluation of cost-efficiency. The cost value used in the analysis was sourced from a separate document outlining the total cost of the service for the 2024/25 financial year, and for the purposes of consistency, this figure was assumed to apply uniformly across all years included in the evaluation.

##### 2.1.2.2.2. Data Adjustments

Some data adjustments were made to the original dataset to enhance the validity and interpretability of the analysis. Participants who completed an initial assessment but never attended a single class were excluded, as they would not have had the opportunity to derive benefit from the intervention and thus could not be meaningfully evaluated for change. Similarly, individuals who attended multiple sessions but were missing either a baseline or follow-up score were also excluded, as it would be impossible to assess improvement without both data points. This included cases where either the baseline or final score had not been collected during service delivery. Further exclusions were made for entries containing errors in the dataset, such as invalid cell values (e.g. “#VALUE!” or “#REF!”), which compromised the reliability of the data. These refinements were essential to generate a more robust and accurate picture of the intervention’s effectiveness and to avoid distortions that could arise from incomplete, erroneous, or unrepresentative cases.

##### 2.1.2.2.3. Data Analysis

The data analysis for CBA began with the presentation of descriptive statistics, including frequency counts, mean values, and measures of variability, as recommended by Cooper and Schindler (2014) and Kumar (2019). This initial descriptive phase provided an overview of the dataset, helping to identify trends in participation and general improvement pattern. To further explore this relationship, box plots were used to visualise the distribution of changes in SDQ scores relative to the number of sessions

attended. These visual tools offered preliminary insights into whether greater engagement was associated with improved outcomes.

Following this, the analysis calculated the mean VfM estimate, expressed as the ratio of average exam score improvement to the cost per participant. This measure allowed for a standardised comparison of efficiency across the sample. A 95% confidence interval was included around the mean VfM to assess the precision and reliability of the estimate, providing an indication of the extent to which observed differences could be attributed to sampling variability.

The core analytical component involved a linear regression analysis to examine the predictors of change in SDQ results. The dependent variable was the change between the initial and final SDQ scores. Independent variables included the baseline SDQ score, the number of sessions attended, gender, and the pathway for each participant. This model was designed to explore whether initial performance, engagement levels, and key contextual factors had a statistically significant effect on outcome improvement. By controlling for these variables, the analysis aimed to isolate the influence of each factor on performance change and offer insight into which characteristics were most strongly associated with measurable gains.

All descriptive and inferential statistical analyses were conducted using Microsoft Excel and Stata, enabling both efficient data handling and robust analytical output.

#### 2.1.2.3. Return on Investment

ROI is a widely used performance indicator originating from the business sector, employed to evaluate the efficiency of an investment by comparing the monetary return to its cost. Although traditionally associated with corporate finance, ROI has gained increasing attention in public health and healthcare settings due to growing pressure to optimize programme efficiency and outcomes (Turner et al., 2023). ROI analysis is now recognised as a valuable planning and evaluation tool that can be applied to a wide range of healthcare initiatives including clinical services, quality improvement interventions, and new technologies where both costs and benefits can be quantified (Thusini et al., 2022). In the healthcare context, ROI can encompass not only direct fiscal savings (e.g., reduced medical expenses), but also broader monetized benefits such as improved health outcomes. Its application has become more prominent in areas such as Medicaid policy and public health programming. However, ROI methodologies in health settings remain varied, and inconsistencies in how ROI is defined, measured, and reported can limit comparability across studies (Turner et al., 2023). Increasingly, ROI is being conceptualised more broadly as an indicator of value - incorporating both monetary and non-monetary benefits - thereby serving as a strategic tool for assessing value for money across health system investments.

##### 2.1.2.3.1. Dataset

The dataset used for ROI in this study originates from the Safe Haven programme and was acquired from Oxfordshire Mind. The programme is eight sessions length of crisis de-escalation or prevention support across 12 weeks for people who are experiencing a mental health crisis. The dataset comprises key variables such as attendance type, age at the start of the programme, source of referral and location. Notably, patients were also asked where they would have gone had the programme not been available - information that served as a proxy for counterfactual assumptions in the ROI analysis. While some patients appeared more than once in the dataset due to participating in multiple sessions, each session outcome was treated as a distinct observation for the purposes of outcome and cost-effectiveness evaluation. The data was originally collected for operational monitoring and internal reporting by programme staff. Although not initially intended for research purposes, it was adapted for secondary analysis to facilitate a structured evaluation of cost-efficiency and return on investment. The cost value

applied in the analysis was drawn from financial documents detailing the total programme cost for each financial year, providing the basis for year-specific cost-efficiency and return on investment calculations. The cost value applied in the analysis was drawn from financial documents detailing the total programme cost for each financial year, providing the basis for year-specific cost-efficiency and return on investment calculations.

##### 2.1.2.3.2. Data Adjustments

Some data adjustments were made to the original dataset to enhance the validity and interpretability of the analysis. Participants who left the question about alternative intervention type blank were excluded from the dataset, as it was not possible to construct a counterfactual scenario for cost comparison. Actions associated with non-attendance - potentially due to early withdrawal, ineligibility, scheduling conflicts, or lack of engagement - were also excluded, as these instances involved no exposure to the intervention and therefore could not yield meaningful outcome data. Since some participants were linked to multiple action entries, only the specific records where no attendance occurred were removed, rather than excluding the participant entirely. These exclusions were necessary to ensure that the dataset included only those with a defined comparator and verifiable participation, thereby preserving the internal validity of the return on investment analysis.

##### 2.1.2.3.3. Data Analysis

The data analysis involved several key steps to enable a structured and interpretable calculation of ROI. First, attendance type was converted into a binary indicator to clearly distinguish records where attendees participated in the sessions from those where they did not. This allowed for consistent categorisation of programme exposure. Next, the alternative intervention types (111, A&E, AMHT, Ambulance, Friends/Family, GP, None, and Samaritans) reported by participants had they not received help from Safe Haven were matched with corresponding cost estimates for each financial year, based on official benchmarks for provisions such as Personal Social Services Research Unit (PSSRU) and the National Center for Biotechnology Information (NCBI). These assigned costs were treated as "savings", representing the avoided public expenditure that would have occurred had the participant been placed in one of these alternative settings.

The ROI was calculated as the ratio of estimated savings to the intervention cost, following the formula: ROI = estimated savings ÷ intervention cost. This approach provided a consistent metric to evaluate cost-effectiveness across different patient groups and financial years, grounded in both participation data and reported counterfactual scenarios.

## 2.2. Overview of Framework – Strategic Commissioning Cycle

As outlined in the background section, this research conceptualizes strategic commissioning as a continuous, cyclical process, following the framework established by NHS England. This framework directly informed the study's methodological design, providing a structured basis for aligning data collection, analysis, and interpretation with the distinct phases of the commissioning cycle. This conceptualisation also reflects the dynamic nature of commissioning, where planning, procurement, and evaluation are interlinked and continuously inform one another. Adopting the NHS England framework provides a structured lens through which to assess how Integrated Care Boards translate strategic priorities into commissioned services and adapt over time. The commissioning cycle, illustrated in **Figure III**, consists of three key stages: (i) strategic planning, (ii) service procurement, and (iii) monitoring and evaluation. Within each stage, there are three distinct activities that must be undertaken to ensure effective commissioning (Langdon & Murphy, 2021).

### 2.2.1. Strategic Commissioning Cycle Stages

#### 2.2.1.1. Strategic Planning

The first stage of the commissioning cycle, strategic planning, centres on developing a detailed understanding of the population's health and social care needs. This involves assessing demand, identifying service gaps, and evaluating the potential impact of introducing or adjusting services on individuals, communities, and existing care systems. Commissioners seek to answer key questions such as who requires services, in what numbers, when and where these services are needed, and what outcomes might result from changes in provision. To inform these decisions, they draw on a wide range of data sources, including Joint Strategic Needs Assessments, population health management tools, Community Services Data Sets, the Mental Health Services Data Set, national datasets, and the Secondary Uses Service repository. Collaboration with providers and system partners further enriches this analysis by incorporating operational insight and future planning perspectives (Hughes, 2024). Together, these efforts guide the setting of commissioning priorities and support the effective allocation of resources to meet current and emerging population needs.

#### 2.2.1.2. Procuring Services

The next stage of commissioning, procuring services, focuses on translating strategic priorities into actionable service delivery. With a clear understanding of existing provision and identified gaps, commissioners must design and implement changes to improve services or address unmet needs, ultimately working towards the 'desired state.' Service provision may involve a diverse range of providers, including NHS services and VCSEs. Commissioners are expected to work collaboratively across the ICS, engaging with service users, families, and carers to ensure services are co-designed and aligned with system-wide priorities. The accountable ICB plays a crucial role in ensuring that commissioning professionals work in partnership to shape and procure services effectively. This may involve redesigning service models to enhance patient and carer experiences, redistributing capacity to optimize efficiency, or expanding provision to offer additional support alongside assessment outcomes. Once commissioning decisions are made, detailed service specifications should be developed in co-production with key stakeholders, including service users, carers, and clinicians, to ensure clarity on provider expectations. A critical final step in procurement is capacity planning and demand management. Commissioners must assess and plan for the necessary capacity across different provider sectors, ensuring that services can meet assessed demand and are delivered efficiently across the NHS and VCSEs.

#### 2.2.1.3. Monitoring and Evaluation

The final stage, monitoring and evaluation, ensures that services deliver on their intended objectives and continuously improve in response to evolving healthcare needs. Commissioners must establish robust evaluation frameworks that measure both outputs (the actions taken) and outcomes (the benefits achieved), using this insight to refine and enhance service provision. Key performance indicators (KPIs) are frequently used to track performance, often focusing on process efficiency (Hughes, 2024), but should be balanced with broader outcome measures to ensure that services are both effective and impactful. A well-structured approach to evaluation helps prevent unintended consequences, such as prioritizing operational targets at the expense of service quality or patient experience. A fundamental aspect of this evaluation is upholding patient choice, a core principle of the NHS Constitution (DHSC, 2012). Patients have the right to make informed decisions about their care, and commissioners must ensure that the services they commission provide accessible, transparent, and equitable options. This requires offering timely and relevant information to support decision-making and ensuring that patients can access a range of providers and treatment pathways that align with their needs. In addition to ensuring choice, managing provider performance is essential to maintaining service quality. Commissioners must routinely assess the effectiveness of providers by reviewing adherence to clinical guidelines, compliance with regulatory standards such as those set by the Care Quality Commission

(CQC), and overall service efficiency. Performance appraisals should be conducted holistically, considering financial sustainability, patient outcomes, and overall service value (*ibid*). Over-reliance on any single metric such as reducing wait times can risk compromising other key aspects of care, such as adherence to best practice guidelines or patient satisfaction. A balanced performance management framework ensures that services meet contractual obligations while maintaining high standards of care. Finally, seeking public and patient views is a vital element of the evaluation process, ensuring that services remain aligned with the needs and experiences of those they serve. Commissioners should implement structured feedback mechanisms, such as surveys, focus groups, and advisory panels, to capture patient and carer insights. Regular engagement with the public not only strengthens accountability but also fosters a more responsive and patient-centered healthcare system (Hughes, 2024).

**Figure III:** NHS Strategic Commissioning Cycle (NHSE, 2022a)

### 2.2.2. Commissioning Timelines and Contracting Cycles

The duration of the commissioning cycle varies significantly depending on the scale and urgency of the intervention. While small or time-sensitive changes may be implemented within one to two months, large-scale transformations often unfold over several years. Procurement processes, when required, introduce further complexity and can take upwards of a year, although the legal minimum is typically three months.

Traditionally, commissioning follows an annual cycle aligned with the financial year (April to March), structured into quarterly phases. However, there has been a shift toward multi-year contracting arrangements - often two years or more - to promote stability for providers and reduce administrative burden. While this approach offers greater continuity, it does not eliminate the need for periodic review. Elements such as activity levels, funding envelopes, and alignment with updated national guidance often require renegotiation at the end of the first year. Furthermore, commissioning is not always a linear process; contract amendments and mid-cycle adjustments may be necessary to respond to emerging priorities or policy shifts. As such, even within multi-year frameworks, ongoing evaluation remains essential to ensure contracts remain responsive and fit for purpose.

# 3. CHAPTER: RESULTS

The findings from the READ document analysis, semi-structured interviews, and quantitative analysis are presented in Chapter Three. The chapter begins with an overview of the selected Integrated Care Boards, followed by an assessment of their financial positions. It then explores their commissioning processes for third-party providers, with a particular emphasis on mental health services. Through the integration of document analysis and stakeholder insights, the commissioning approaches of the ICBs are systematically mapped onto the strategic commissioning cycle framework, enabling a structured evaluation of their current practices, challenges, and future priorities. Complementing this qualitative analysis, quantitative methods are employed to assess the value for money of third-party mental health service providers, adding a critical dimension to the evaluation of commissioning effectiveness.

## 3.1. Southeast ICB

### 3.1.1. Structure and Governance

The Southeast ICB is a statutory NHS body responsible for planning and delivering healthcare services across its geographic area. It was established as part of the NHS reforms under the Health and Care Act 2022, replacing CCGs with ICSs. The ICB is responsible for commissioning health services, improving population health, and integrating care across primary, secondary, and community services.

The governance structure of Southeast ICB includes a board comprising executive and non-executive members. The board meets publicly and consists of representatives from NHS Trusts, primary care providers, local authorities, and partner organizations. Key positions include the Acting Chair, Chief Executive Officer, Chief Finance Officer, Chief Medical Officer, and other executives responsible for finance, strategy, and governance. The board operates through various committees such as the Audit and Risk Committee, System Productivity Committee, and Population Health and Patient Experience Committee, ensuring financial accountability and strategic oversight.

### 3.1.2. Financial Overview

The financial position of Southeast ICB has been a subject of significant concern. Recent reports indicate that the ICB has consistently faced budgetary pressures, particularly in areas such as prescribing, continuing healthcare, and mental health placements. As of Month 6 in the 2024/25 financial year, the ICB reported a deficit of £40.6m, with a forecasted year-end deficit of £60m. A key driver of these financial challenges includes the cost of industrial action, contract overruns, and overspending on acute and community health services. Despite these financial pressures, the ICB continues to work towards achieving a balanced budget through system-wide efficiency measures and strategic investments in primary and community care.

The board has also identified mental health services as an area requiring additional financial oversight due to increasing demand for placements and community-based care. Spending on mental health services has seen notable pressures, with Section 117 aftercare placements experiencing rising costs across the ICB. At Month 6 of the 2024/25 financial year, the ICB reported a combined £2.1m overspend related to high-cost drugs and devices (HCDD) and Section 117 aftercare packages—indicative of ongoing strain in complex mental health commissioning. The board has acknowledged that managing mental health expenditures requires closer collaboration with local authorities to optimize resources. This includes reviewing care pathways, commissioning additional third-party providers, and ensuring cost-effective delivery models for mental health services.

### 3.1.3. Commissioning Third-Party Providers

Southeast ICB plays a critical role in commissioning third-party providers to supplement NHS services, ensuring that patient care is accessible and efficient. The commissioning process follows a structured approach, involving tendering, contract negotiations, and performance monitoring. The ICB utilizes both block contracts (fixed funding for a defined service over a specific period) and activity-based contracts (funding based on service usage) to manage provider relationships. Notably, the ICB is actively working to enhance partnerships with the VCSE sector. VCSE organisations are being increasingly integrated into the delivery model for Integrated Neighbourhood Teams, where they provide bespoke support tailored to local population needs. These efforts are aligned with the ICB's broader goal of shifting care into community settings, as part of the Primary Care Strategy which emphasizes coproduction and communication with third-party providers to ensure sustainability. To further support these goals, the ICB is introducing mechanisms to better monitor and evaluate the impact of VCSE contributions within primary care and community-based services. For example, the ICB is piloting structured outcome reporting frameworks that require VCSE partners to provide regular data on service reach, user satisfaction, and contributions to reducing health inequalities.

Commissioning for mental health services is a significant component of Southeast ICB's strategic plan. A considerable portion of funding is allocated to independent providers for inpatient and community-based mental health care, such as Priory Group, Cygnet Health Care, and Turning Point, who deliver specialist services including acute inpatient beds, rehabilitation, and community mental health support. Contracts for mental health services often include outcome-based payment mechanisms, where providers are reimbursed based on patient recovery rates and service effectiveness. The ICB has also implemented capitated payment models in certain areas, wherein providers receive a fixed per-person annual payment to cover all mental health services for that individual. This model is designed to incentivize preventative care and long-term patient management over reactive, acute interventions.

## 3.2. East ICB

### 3.2.1. Structure and Governance

The East ICB is a statutory organization established to oversee health and care services across the region. It was created as part of the national reforms to integrate health and social care, aiming to improve service coordination and patient outcomes. The East ICB functions as part of the broader Integrated Care System (ICS), which includes local authorities, NHS providers, voluntary organizations, and other stakeholders.

Governance of the East ICB is structured around key committees and partnerships. The Health and Wellbeing Board (HWB) and the Integrated Care Partnership (ICP) play crucial roles in shaping strategic priorities. The board is led by a Chief Executive Officer and an Independent Chair, with oversight from both NHS England and local government authorities. Decision-making within the East ICB is aligned with national priorities while incorporating local health needs assessments, as outlined in the Joint Forward Plan (JFP) and the Health and Wellbeing Integrated Care Strategy (HWICS).

### 3.2.2. Financial Overview

The financial management of East ICB is guided by sustainability goals and operational efficiency targets. The system has historically faced financial challenges, including a cumulative deficit, requiring careful budgetary planning. The financial plan is structured to support key areas such as primary care, hospital services, community care, and preventative health measures.

One of the major components of East ICB's financial strategy is the Better Care Fund (BCF), which integrates NHS and local government funding to improve social care, hospital discharge services, and community-based care. The BCF ensures that resources are pooled effectively to enhance patient outcomes and reduce unnecessary hospital admissions.

A significant portion of the East ICB budget is allocated to mental health services, reflecting the system's priority to improve mental well-being and early intervention measures. The funding strategy includes support for secondary mental health services, crisis intervention, and early prevention programs. Investment in third-sector mental health providers has been expanded to enhance community-based support. Additionally, there are dedicated funds to reduce mental health-related inequalities, particularly in employment and housing stability for those with severe mental illness.

### 3.2.3. Commissioning of Third-Party Providers

The East ICB operates a commissioning framework to engage third-party providers, ensuring a diverse and efficient health and social care ecosystem. Commissioning decisions are data-driven, based on the Joint Strategic Needs Assessment (JSNA) and population health metrics. Third-party providers include private healthcare firms, voluntary and community organizations, and social enterprises, contributing to service flexibility and patient choice.

Contracts are awarded through competitive procurement processes, with providers evaluated based on quality standards, cost-effectiveness, and patient outcomes. The primary payment mechanisms for third-party providers include:

- Block Contracts – Used for long-term service provision (e.g., specialist mental health care).
- Activity-Based Payments – Providers are paid based on services delivered (e.g., procedures and consultations).
- Capitated Budgets – Used for integrated care models, where providers receive a fixed amount per patient to cover a range of services.
- Outcome-Based Payments – Providers are rewarded based on improvements in patient health outcomes.

Specific contracting models for mental health services focus on integrated and personalized care. The East ICB collaborates with NHS Mental Health Trusts, voluntary sector partners, and private providers to ensure accessibility and continuity of care. Payment models for mental health services include bundled payments, which cover a range of services under a single contract, and risk-sharing agreements, where financial incentives are linked to patient recovery and reduced hospital admissions.

Key initiatives include:

- Expanding community-based mental health support to reduce inpatient admissions.
- Collaborations with local charities and housing associations to support mental health patients in secure accommodation.
- Digital mental health interventions, such as online therapy and crisis helplines, to improve accessibility.

## 3.3. Mapping Findings to the Strategic Commissioning Framework

This section presents the core findings of the study by systematically mapping the commissioning practices of the selected Integrated Care Boards (ICBs) onto the NHS strategic commissioning cycle framework. The framework's three components (strategic planning, service procurement, and monitoring and evaluation) serve as an organising structure to evaluate how each ICB approaches the

commissioning of third-party mental health services. Drawing on insights from the READ document analysis, semi-structured interviews, and quantitative evaluation, this analysis provides a comprehensive understanding of current practices, highlights key challenges, and identifies areas for future development within each phase of the commissioning cycle.

### 3.3.1. Understanding Strategic Commissioning: Implications for Commissioners

Before mapping current practices onto the NHS strategic commissioning cycle, it is essential to first clarify what strategic commissioning entails and how it informs the role, responsibilities, and decision-making processes of commissioners, as evidenced across the researched documents. Based on a thorough analysis of board minutes, strategic plans, financial reports, and engagement summaries from the chosen ICBs, strategic commissioning emerges as a sophisticated, outcomes-oriented approach to planning, funding, and evaluating services that respond to population health needs far beyond a mere procedural or contractual activity. Strategic commissioning requires commissioners to act as integrators and enablers working across NHS trusts, local authorities, voluntary organisations, and primary care providers to co-design and deliver care pathways that are preventative, equitable, and sustainable. This entails using robust data and population insights to guide long-term investment, navigating financial constraints through prioritisation and alignment, and embedding continuous learning through performance monitoring and stakeholder engagement. Within this framework, the focus is on prevention, reducing inequalities, and achieving measurable improvements such as increasing years lived in good health or supporting children's development through collaborative planning and delivery across NHS bodies, local authorities, and the voluntary sector.

Turning to the semi-structured interviews to explore what strategic commissioning means to those working within the system, a number of participants made a reference to NHS strategic commissioning cycle, but their response indicated only a surface-level understanding, with little to no insights into the specifics of implementations and impact. One participant drew attention to the gap between definition and practice nothing that while the concept is there in principle in reality "it doesn't really function". An interviewee went further, framing strategic commissioning as "complex", thereby reflecting the multifaceted nature of strategic commissioning and the challenges it poses for consistent implications. Within the specific setting of mental health, the concept was described as "fragmented" by one interviewee, underlying the perceived lack of coherence and coordination. Furthermore, the inability of some respondents to define the term suggests that, despite its strategic prominence, strategic commissioning remains abstract or inconsistently communicated within the system. Although policy documents portray it as a sophisticated, outcomes-oriented approach to planning, funding and evaluating services responsive to population health needs, its operationalisation often appears fragmented and transactional. This gap between aspirational policy framing and local implementation underscores the practical and conceptual challenges faced by commissioners.

How respondents approached this particular question often shaped the way they described the current activities and future plans regarding strategic commissioning. Those who were unable to articulate a clear understanding of strategic commissioning also tended to provide vague or ambiguous responses, often lacking specificity or practical detail. By contrast, participants who demonstrated confidence in their initial responses often engaged more critically with subsequent questions, citing current initiatives such as three-year strategic commissioning plan in support of healthcare utilisation model. When discussing forward plans, they emphasised the importance of maintaining a 5 to 10-year forward focus, strengthening the role of VCSEs in service provision, enhancing provider collaboration in mental health services, and improving the use of data to inform commissioning decisions.

### 3.3.2. Strategic Planning

#### 3.3.2.1. READ Document Analysis

In the strategic planning phase, the Southeast ICB documents demonstrated a clear intention to identify and respond to the health and social care needs of its population, particularly in mental health services. Mental health services are consistently framed as a high-priority area, particularly for individuals with severe and enduring conditions, those at risk of crisis, and populations experiencing health inequalities. The identification of mental health needs within the ICB is empirically grounded through the integration of population health analytics, system-level data such as that related to Section 117 aftercare and qualitative insights derived from engagement with service users and providers. Strategic planning documentation reveals that while tools such as the Mental Health Services Data Set, Community Services Data Sets, and Joint Strategic Needs Assessments (JSNAs) are routinely employed to assess need, there remain limitations in translating this data into precise estimates of service demand at the local or population subgroup level. Despite these limitations, the ICB utilises this intelligence to highlight critical gaps in service provision particularly around access to early intervention, community-based alternatives to inpatient care, and the rising burden on specialist placements. In doing so, strategic planning serves not only as a mechanism for understanding existing patterns of need but also as a foundation for shaping more responsive, equitable, and sustainable mental health services across the system.

Moreover, the ICB's strategic planning seeks to anticipate the impact of new or adjusted services on individuals and the broader care ecosystem. The development of joint capital and financial plans, for example, is explicitly linked to understanding the trade-offs of commissioning decisions balancing targeted investment in mental health transformation against wider system pressures. Collaborative planning with providers and local authorities' further grounds this process in operational reality, enabling commissioners to align future service models with workforce capabilities and infrastructure constraints. In doing so, strategic planning in the Southeast ICB aims to ensure that mental health services are not only aligned to current need but are positioned to adapt to evolving patterns of demand and complexity.

Similarly, documents of East ICB are ambitious and well-articulated: a data-driven, participatory, and outcomes-focused approach to understanding and responding to population health needs. The strategy documents present this phase as a starting point for system transformation where robust population intelligence, inclusive engagement, and collaborative leadership converge to shape coherent commissioning priorities, especially in mental health space.

Strategic plans consistently highlight the intention to use health assessment tools such as the JSNAs, population health management frameworks, and datasets specific to mental health and community services as the basis for determining commissioning priorities. Public engagement mechanisms like the *Let's Talk* campaign are also presented as integral to capturing community needs and preferences, while outcome metrics are positioned as guides for resource allocation. In principle, this framework is designed to promote equity, prevention, and measurable impact through evidence-informed decision-making.

However, unlike the Southeast ICB, where some degree of data application was evident in shaping investment choices and service gaps, the East ICB appears to struggle with operationalising its strategic priorities into concrete commissioning actions.

A close review of board minutes, financial reports, and strategic delivery documents reveals that the use of these tools often lacks follow-through. Although mental health frequently features as a declared priority, there is limited evidence that outputs from these assessment tools are systematically driving the selection and sequencing of commissioning actions. While the data infrastructure is sophisticated and

multi-layered, its practical application in shaping service configuration, investment logic, or workforce planning remains largely aspirational rather than operationalised.

This contrast highlights a key divergence in maturity levels between the two ICBs: while both articulate strong strategic intents, the Southeast ICB demonstrates a relatively stronger alignment between strategic plans and operational realities, whilst the East ICB's documentation remains more aspirational, particularly in linking population health data to commissioning priorities.

Commissioners aim to answer fundamental questions such as who requires mental health support, in what numbers, where and when services are needed, and how timely access might impact health outcomes. Yet, these questions are often addressed only in general terms or with static, system-level data. While ambitions such as reducing premature mortality in those with severe mental illness and improving housing and employment outcomes are clearly stated in the East ICB Outcomes Framework, there is little elaboration on how these priorities inform the commissioning of specific interventions or guide resource allocation. In practice, the language of upstream investment and early intervention is rarely mirrored in the structure or delivery of services. Rather, investment patterns tend to remain reactive, driven by acute system pressures and legacy funding arrangements, rather than by predictive modelling or future-oriented planning.

Although the Better Care Fund plans engage more directly with these questions particularly in the context of hospital discharge and community care, these efforts are often shaped by national mandates and budgetary constraints, limiting the degree of local responsiveness. As a result, even where needs are well-documented, the system response is often constrained by existing provision rather than dynamically matched to changing demand. The East ICB demonstrates a clear commitment to population health and a growing capacity to gather and analyse complex data, but the planning phase still falls short in analytical depth and in translating strategic insights into operational action. Without more precise modelling, clearer service-level planning, and an accountability framework for implementation, the transformative potential of this phase, particularly for mental health, remains unrealised.

In sum, while both ICBs show commitment to improving mental health through data-informed, participatory planning, the Southeast ICB appears to be further along in bridging the gap between strategic vision and implementation, whereas the East ICB remains more conceptual in its approach.

#### 3.3.2.2. Interviews

In exploring the first stage of the commissioning cycle, interview participants offered a range of perspectives on how needs are identified, prioritised, and subsequently translated into commissioning intentions. These reflections provide valuable insight into how strategic planning is enacted in practice, often revealing gaps between formal processes and the operational realities faced by commissioners. In line with the document analysis, almost all interviewees referenced the JSNA as a foundational tool for identifying population health needs and informing commissioning priorities. Typically led by local public health teams within councils, the JSNA process is undertaken in collaboration with ICBs and overseen by Health and Wellbeing Boards, ensuring that strategic planning reflects both clinical evidence and local public health intelligence. Two participants also mentioned the use of more specialised tools, such as Mental Health Needs Assessments, which are used to explore the prevalence, distribution, and complexity of mental health conditions within specific populations. These assessments supplement the JSNA by offering more focused analysis often identifying service gaps in areas like early intervention, crisis support, or access to psychological therapies and play a critical role in shaping targeted mental health commissioning strategies. While the JSNA is routinely cited as a foundational tool, its influence appears more symbolic than operational, functioning more to validate commissioning decisions than to actively shape them.

When asked about reliability of the data used to assess the population health needs, the lack of good quality data emerged as a consistent concern among participants, with several commissioners and system leads describing it as a fundamental barrier to effective strategic planning. An interviewee went further, referring to the issue of poor data quality as the “biggest obstacle”. Some interviewees highlighted the proliferation of datasets within the system, underlining concerns about their inconsistency and the tendency for them to present conflicting narratives about service need and performance. One interviewee explained this trend by noting that “from a mental health perspective, we have a lot of community providers across children’s and adults, and they’re not necessarily using the same systems to collate data”. The tension between data availability and data utility is particularly evident in mental health commissioning, where the volume of information often masks a lack of actionable insights.

When prompted to reflect on whether health assessment tools effectively inform priorities and commissioning decisions, participants offered mixed responses. Some interviewees indicated that commissioning decisions are made based on the health assessment tools, thereby prioritizing areas characterised by poverty, social exclusion, and health inequalities. These criteria are used to target resources toward populations with the greatest need, supporting the ICB’s broader commitment to reducing disparities in access, experience, and outcomes across the system. Representatives of VCSEs on the other hand questioned the utility of health assessment tools in deciding priorities. Moreover, the divergence in perspectives between system leaders and VCSE representatives highlights an important epistemic gap: what counts as evidence and how it is valued varies across organisational boundaries, impacting how priorities are set and whose voices shape them.

To sum up, there is a clearly articulated vision across strategic documents, reflecting a strong desire to move towards integrated, preventative, and outcomes-driven commissioning particularly in mental health. This is also echoed by most of the interviewees. However, the practical implementation often lags behind these ambitions due to persistent barriers such as inconsistent data quality, financial constraints, and the reactive nature of system pressures. This gap between strategic intent and operational execution reflects a broader pattern observed across both document analysis and interviews: planning structures are in place, but their translation into targeted actions remains uneven and, at times, superficial. While the strategic direction is well defined, operational capacity and real-world conditions continue to limit the full realisation of commissioning goals.

### 3.3.3. Service Procurement

#### 3.3.3.1. READ Document Analysis

In the service procurement phase, the Southeast ICB documents are marked by a combination of formalised structures, evolving collaborative practices, and persistent operational challenges, particularly in the context of mental health commissioning. The use of service specifications, often informed by local engagement and system intelligence, reflects a strong commitment to clarity and accountability. For instance, the Primary Care Strategy (May 2024) articulates plans to enhance community-based mental health provision through Integrated Neighbourhood Teams, with service models tailored to local need and co-designed with partners. Similarly, documents such as the July 2024 Joint Capital and Financial Plan show attempts to prioritise high-impact services and realign investment in ways that support transformation, particularly in mental health.

Contracting mechanisms play a central role in this phase, with the NHS Standard Contract serving as the principal legal and operational instrument. It ensures consistency and accountability by clearly defining payment terms, service standards, data-sharing obligations, and quality metrics. While Southeast ICB makes structured use of this contract to formalise service expectations and maintain oversight, the realities of implementation often reveal significant challenges. The rollout of community mental health services, for example, has necessitated close coordination with VCSE partners, substantial workforce

adaptation, and investments in supporting infrastructure each of which has experienced delays or faced resource limitations. Furthermore, although the procurement framework offers flexibility enabling commissioners to choose between formal competitive procurement and direct engagement with incumbent providers depending on the scale of change this adaptability also highlights underlying weaknesses in market responsiveness. Planning documents repeatedly acknowledge that provider capacity, especially within specialist mental health and voluntary sectors, is not always sufficient to meet assessed demand. This has led to implementation delays, constrained innovation, and an increasing reliance on overstretched incumbent services.

There is also a tension between the ICB's aspiration for co-produced, system-wide commissioning and the pace of change imposed by financial controls and national planning cycles. For example, although service redesigns in areas like Section 117 aftercare have aimed to offer tailored packages, the ability to innovate has been constrained by cost pressures and limited provider alternatives, raising concerns about equity and sustainability. Furthermore, while service specifications are increasingly detailed, some interview and document insights suggest that engagement with patients and carers in shaping these specifications remains inconsistent, limiting the full realisation of co-production ideals.

Capacity planning and demand management remain critical to this phase. As identified in the finance and strategy reports from July and November 2024, provider supply must be sufficient not only to meet forecasted demand but also to flexibly support shifts in care models. In the context of mental health, this has involved efforts to redistribute capacity away from inpatient settings towards community-based alternatives, as well as expanding partnerships with the voluntary sector to enhance reach and continuity of care. Despite these efforts, several documents note ongoing challenges in aligning commissioning ambition with market capacity, particularly given workforce shortages and financial constraints.

An examination of East ICB documents indicates that, in principle, the system is structured to effectively support the transition from strategic planning to implementation: local needs assessments inform priorities, and commissioners are tasked with designing services that are both targeted and responsive. Service specifications are meant to clearly define what will be delivered, to whom, and under what conditions, with collaborative input from service users, carers, and frontline providers. This intent is visible in the ICB's work on mental health transformation, hospital discharge pathways, and anticipatory care models, all of which are presented as priority areas in documents like the Better Care Fund plan and the Joint Forward Plan. However, in comparison to the Southeast ICB, the East ICB's procurement processes appear less formalised and transparent, creating ambiguity around how priorities are translated into contracted services.

The translation of these priorities into procured, operational services is uneven. While there are encouraging signs such as the expansion of mental health support teams in schools and efforts to enhance intermediate care these initiatives often proceed without publicly available service specifications or transparent procurement pathways. In cases where new services have been introduced, such as discharge to assess pathways or digital enablement pilots, it is not always clear whether these changes have emerged through strategic commissioning or as tactical responses to national directives and performance pressures. Furthermore, board minutes and strategic reports frequently highlight planned developments but provide little detail on the procurement decisions behind them, raising concerns about accountability, co-design depth, and value for money. This lack of transparency stands in contrast to the Southeast ICB, which, despite its own challenges, has made more explicit its procurement logic and criteria within strategic documentation.

Contracting practices within the ICB rely on the NHS standard contract to formalise service delivery, setting expectations for quality, reporting, and payment. While this provides a consistent legal and operational framework, it may not be sufficiently flexible for smaller or non-traditional providers, including many in the VCSE sector. This is particularly relevant in the mental health domain, where

VCSE organisations often play a key role in prevention, peer support, and community-based interventions. Despite repeated acknowledgements of their value, VCSE providers continue to face challenges in accessing stable, long-term contracts. Funding is often short-term, project-based, and administratively burdensome, making it difficult for these organisations to build capacity and contribute meaningfully to system-wide priorities. This issue appears more pronounced in the East ICB, where there are fewer structural enablers exist to facilitate the integration of VCSE providers into mainstream commissioning cycles.

Mental health commissioning remains a prominent feature of this phase, with clear references to redesigning service models around integrated, trauma-informed, and early intervention approaches. However, while strategic alignment is evident especially in response to national frameworks such as the Community Mental Health Framework, the procurement processes behind these changes are not always transparent or well-communicated. It is unclear, for example, how new providers are engaged, how decisions are made between extending existing contracts versus re-procuring services, or what mechanisms are in place to evaluate procurement outcomes. Additionally, while co-production is cited as a principle of commissioning, mental health service users and carers report limited opportunities to shape service design in practical terms. In comparison, the Southeast ICB has taken more visible steps to define and monitor the link between service design, co-production and procurement outputs, though implementation remains uneven.

The ICB also faces challenges in capacity planning and supply assurance. Although needs have been well-identified particularly in relation to ageing populations, mental health inequalities, and pressure on acute settings, there is limited evidence that service supply has been rebalanced accordingly. For example, while early intervention and community-based care are strategic priorities, investment remains skewed toward acute response, and workforce deployment continues to follow historical patterns. Commissioners are expected to forecast demand and commission sufficient provision across NHS, independent, and voluntary sectors, but capacity modelling tools and future-facing projections are largely absent from strategic documents. This mirrors similar concerns with the Southeast ICB, although that system demonstrates slightly more structured forecasting processes and has begun piloting demand-modelling tools in certain service lines.

In summary, while the ICB has a clear vision for procuring services in a collaborative, needs-led manner, the current reality is marked by gaps in transparency, implementation planning, equitable contracting, and dynamic capacity alignment, leaving much of the system's transformation potential still unrealised. Taken together, the comparative analysis reveals a common ambition across both ICBs to move toward more strategic, inclusive procurement but only the Southeast ICB provides early evidence of bridging the policy-practice divide.

#### 3.3.3.2. Interviews

Interview data relating to the second stage of the commissioning cycle, procuring services, participants offered a range of perspectives on how strategic priorities are translated into concrete service delivery. These reflections provide critical insight into the complexities and tensions of this phase, often exposing the disparity between procedural expectations and on-the-ground implementation.

When asked about how strategic priorities are set, most interviewees referenced a combination of national policy drivers, local priorities, and legal requirements alongside population health needs assessments. However, when prompted to reflect on whether these strategic priorities translate into actionable delivery, responses were more mixed. Some participants pointed to successful examples of service redesign, such as the implementation of a Healthcare Utilisation Model, commonly referred to as the 'New Care Model' or targeted investment in community mental health, as evidence that strategy can inform practice. Others, however, described a disconnect between planning and implementation, citing

difficulties in aligning ambition with operational capacity, especially in areas experiencing workforce shortages or persistent financial deficits. This divergence underscores a critical implementation gap: while policy frameworks emphasise integration and transformation, the systemic enablers such as workforce planning, stable funding, and provider readiness are not always in place to support delivery. Furthermore, where success was reported, it often relied on strong local leadership or bespoke arrangements rather than system-wide mechanisms, raising concerns about replicability and long-term sustainability.

In relation to co-designing commissioning decisions, most interviewees reported that they typically codesign commissioning services with other organisations and agreed on the value of coproduction. Even though mental health commissioning decisions are increasingly co-designed with NHS partners and VCSE organisations, some participants noted that these processes remain patchy and uneven across the system. While some areas within the ICBs in question benefit from strong, embedded co-design mechanisms, others lack the infrastructure or continuity of engagement to fully integrate service user and community perspectives into procurement decisions. This variability raises concerns around equity and consistency in how co-production is operationalised across different geographies. In practise, those with stronger institutional memory, relational capital, or access to commissioning networks may disproportionately benefit from co-production structures, whilst others remain peripheral to key decision-making processes.

As an example of the significant room for improvement in how co-design is embedded in the commissioning cycle, one participant remarked that "we don't do (co-design) as systematically and universally as I would like". This statement not only reflects a widespread aspiration for inclusivity but also signals a persistent structural shortfall in embedding co-design as a standard commissioning practice rather than an ad hoc or symbolic exercise.

### 3.3.4. Monitoring and Evaluation

#### 3.3.4.1. READ Document Analysis

The East ICB documents acknowledge the importance of the third phase of the commissioning cycle as a critical component of strategic commissioning. However, its implementation remains in development, with current practices not yet fully realising the potential of this phase. While service design documents such as the Joint Forward Plan, Better Care Fund Reports and the Outcomes Framework include intentions for evaluation, the extent to which these frameworks are rigorously applied and used to inform service adaptation varies considerably. At this stage, commissioners are expected to assess not only whether providers are delivering what was agreed safely and cost-effectively but also whether those services are achieving the intended outcomes for patients and carers, and whether improvements can be made. Yet, despite the formal presence of evaluation frameworks, their uneven application in the East ICB signals a gap between strategic aspiration and operational execution, weakening the ability of monitoring to function as a catalyst for system improvement rather than merely fulfilling compliance requirements.

There is some evidence of structured performance monitoring in East ICB, particularly for services commissioned through the Better Care Fund and those governed by NHS Standard Contracts. Commissioners routinely review activity reports, CQC ratings, and financial compliance, and there are established processes for escalating concerns related to safety or efficiency. Monitoring frameworks for services such as hospital discharge and intermediate care focus on metrics like timely delivery, safe transitions, and reducing readmissions. However, these evaluations often remain confined to compliance checks and basic activity data, offering a limited view of actual service effectiveness.

The level of scrutiny applied also varies significantly by service area. Acute and community care providers typically receive closer performance oversight, while smaller VCSE organisations particularly

those delivering mental health or preventative services are subject to less formal monitoring. Their contributions, though often critical to early intervention and community resilience, may be undervalued or under-reported in formal evaluations. Moreover, there is little public transparency around how value for money is assessed, raising questions about the consistency and fairness of performance management across provider types. Such inconsistency risks entrenching inequities in commissioning by systematically overlooking or under-measuring the impact of VCSE-led mental health interventions.

Critically, there is limited investigation into whether services are delivering meaningful outcomes, such as improved wellbeing, increased independence, or patient satisfaction thus constraining opportunities for real learning and service improvement. Moreover, the learning generated from monitoring is not always systematically fed back into earlier phases of the strategic commissioning cycle. While the ICB articulates ambitions to redesign services based on outcome data or scale effective models, concrete examples of this learning loop being fully enacted remain rare. One notable instance includes the refinements to discharge pathways under the Better Care Fund, where adjustments were made in response to capacity and performance pressures. Another partial example is the iteration of mental health support models in schools, which have been expanded following positive feedback and uptake data. However, these examples are exceptions rather than the norm, and the process of linking evaluation findings to strategic commissioning decisions often lacks clarity and consistency.

In many cases, services continue without modification despite evidence of underperformance often due to contractual inertia, limited provider flexibility, or the absence of real-time data that could support timely adjustments. The system is yet to show widespread examples of services being reshaped or decommissioned as a result of evaluative insight, highlighting a broader challenge in embedding learning into practice. This is compounded by the limited focus on whether services are delivering meaningful outcomes that align with population needs. Evaluations tend to emphasise throughput and operational efficiency rather than exploring whether interventions lead to improved wellbeing, greater independence, or satisfaction from service users. Without clear mechanisms to connect evaluation results to commissioning decisions, the opportunity to drive systemic improvement remains constrained, and accountability for poor or stagnant performance is weakened.

Mental health services again illustrate these limitations. Although the ICB has made strategic commitments to improve outcomes and tackle inequalities, there is minimal visibility into how service-level evaluations influence funding, contract terms, or model redesign. Interviews and reports indicate that outcome metrics are either too generic or inconsistently applied, which makes it difficult to draw conclusions about service effectiveness. This also hinders the ability to make targeted improvements or decisions about scaling, pausing, or ending services.

The Southeast ICB, much like its counterpart in the East, formally recognises the importance monitoring service delivery and feeding learning into future planning. Strategic documents including the Integrated Care Strategy, Place Partnership Updates, and service-specific implementation plans consistently underscore the need for robust evaluation mechanisms to ensure quality, safety, and cost-effectiveness. However, as with the East ICB, the operationalisation of these ambitions remains inconsistent, particularly in translating evaluation into strategic recalibration or service transformation. This suggests that in both ICBs evaluation is often treated as an endpoint rather than an engine of continuous improvement, gathered primarily for reporting purposes rather than to inform the redesign or refinement of services.

While mechanisms such as the NHS Standard Contract, performance dashboards, and quality reporting are in place, they often centre on compliance and activity metrics, providing only a partial view of service effectiveness. Evaluation data tends to be used reactively and variably across service areas, and the integration of these insights into planning cycles is still emerging. This is particularly evident in areas such as community and mental health services, where outcome-based monitoring is less developed

compared to acute care, and the feedback loop to strategy remains weak. This reflects an implicit prioritisation of acute care over preventative and community-based mental health services, undermining the strategic shift both ICBs claim to pursue.

Primary care strategy documents and system planning and transformation papers from across 2023 and 2024 reflect a growing emphasis on embedding evaluation processes into strategic planning, yet concrete examples of this feedback loop in action are limited. Monitoring practices are more established in high-priority areas like urgent and emergency care, elective recovery, and hospital discharge, where metrics on timeliness, throughput, and safety guide performance discussions. However, in mental health services particularly those delivered by VCSE providers monitoring is often less formalised, and outcome measurement frameworks are inconsistently applied. This creates blind spots in understanding whether services are achieving their intended impacts or represent good value for money. Until these blind spots are addressed, both ICBs will struggle to deliver equitable, evidence-informed commissioning and to justify resource allocation decisions transparently.

There are isolated instances where evaluative learning has informed service adaptation. For example, Southeast ICB's mental health support models in schools and refinements to Section 117 pathways demonstrate attempts to adjust services based on operational pressures and early feedback. Nonetheless, these cases remain the exception rather than the norm. Documents note that services often continue unchanged despite signs of underperformance, due to contractual inertia, limited provider flexibility, or the absence of timely, granular data. This evaluative inertia results in a system where underperforming services persist by default rather than being actively reconfigured by design, limiting both ICBs' ability to realise the transformative potential of strategic commissioning.

Crucially, the ICB still faces challenges in shifting from monitoring for assurance to monitoring for transformation. Evaluations tend to prioritise basic compliance and activity volumes rather than exploring service quality, patient experience, or long-term outcomes like improved wellbeing or increased independence. As a result, opportunities to decommission ineffective services or replicate successful models are constrained. Embedding a culture of continuous improvement, where learning genuinely informs future commissioning decisions, remains a work in progress across Southeast ICB's commissioning system. Ultimately, while the Southeast ICB demonstrates marginally greater progress than the East in piloting feedback loops, both remain distant from embedding evaluation as a core, cyclical driver of commissioning decisions, a prerequisite for achieving the "strategic" element of strategic commissioning.

#### 3.3.4.2. Interviews

Interview participants generally acknowledged that notable progress has been achieved in relation to monitoring and evaluation processes; however, they also reaffirmed the findings from the document analysis that there remains considerable room for improvement in ensuring that evaluation drives meaningful service adaptation and strategic learning. A few participants noted that performance is predominantly tracked based on output and throughput rather than outcomes, whilst VCSE representatives found monitoring and evaluation to be "weakness of the voluntary sector." This reflects a broader, system-wide issue in which the technical capacity for collecting data often outpaces the analytical capacity to translate it into actionable insights, particularly in the context of VCSE-led interventions where outcome metrics are inconsistently applied or poorly contextualised.

In terms of the current status being relatively fragmented in its application, one participant remarked that "we are not that confident about the outcome monitoring" in the context of mental health services, whilst an ICB representative stressed the need for improvement in key performance indicators by saying "I don't think we have a very mature approach to measuring outcomes". These acknowledgements suggest that while the language of outcome-based commissioning is now embedded in strategy, the

operational culture and technical frameworks required to support it remain underdeveloped. Notably, this pattern was evident across both East and Southeast ICBs, indicating that difficulties in embedding rigorous evaluation are not site-specific, but symptomatic of broader system immaturity.

Moreover, the limited capacity to benchmark performance across different provider types—particularly, especially between NHS trusts and VCSE organisations, raises concerns around whether current evaluation practices are equitable, scalable, or sufficiently aligned to inform commissioning reform.

#### 3.3.4.3. Demonstration of assessing Value for Money

Given the acknowledged difficulty in capturing outcomes and demonstrating value for money in VCSE-delivered mental health services, we conducted case-based exercises to explore how their contributions might be more systematically evaluated. This process sought to make visible forms of value that often go under-recognised in conventional commissioning frameworks.

##### 3.3.4.3.1. Children and Young People Supported Self Help Programme

The programme includes 620 participants, with ages ranging from 6 to 18 years and a mean age of 13 years. Participants sat at least one session during the intervention period, with many attending multiple sessions across different time points. On average, participants attended in 4 sessions, reflecting a moderate level of engagement with the programme and enabling variation in exposure to be analysed in relation to outcomes. The most frequently occurring area of difficulty was anxiety, suggesting a systematic challenge in this domain among the cohort. Additionally, path-level variation in performance highlights an opportunity to better target instructional strategies toward areas with the greatest improvement need, ensuring that intervention resources are aligned with the specific domains where participants struggle the most.

The average change in SDQ scores across all participants was -5.67 points, with a negative value indicating improvement, as lower scores represent better mood in the SDQ grading system. This overall downward shift in scores suggests that the intervention was associated with measurable performance gains.

To better understand the distribution of VfM across the intervention, both unweighted and weighted means were examined. The unweighted mean VfM was 0.133, while the weighted mean was lower at 0.012, indicating that participants who received fewer sessions tended to have higher VfM, while patients who received more classes, potentially requiring greater support, had lower VfM. It was also apparent that more of the money or effort was concentrated on those lower-return cases, which may reflect prioritisation of need over efficiency in practice.

The regression model examined the factors associated with change in SDQ scores as the dependent variable. The coefficient for initial SDQ score was –0.70, indicating that participants who began with higher (i.e., worse) scores tended to exhibit greater improvement. The coefficient for number of sessions attended was 4.12 and statistically significant, indicating that each additional session was associated with an average improvement of 4.12 points in SDQ scores, holding other factors constant. In contrast, the coefficients for age and pathway remained statistically insignificant, implying that variation in these variables' complexity did not independently predict score change when controlling for other factors. The constant term of –25.9 reflects the expected change in score for a participant with zero values on all predictors, though this has limited standalone interpretability. Overall, the model underscores the importance of both baseline SDQ score and session attendance in shaping outcomes. While the results highlight a clear association between higher baseline scores and greater improvement, this pattern may

partly reflect regression to the mean—a statistical tendency for extreme values to move closer to the average over time, independent of intervention.

As mentioned above, our analysis found an average VfM of 0.012, meaning that for every £1 spent, students improved by 0.135 points on average. This provides a useful metric for estimating the cost of achieving clinically meaningful improvement. Based on the benchmark offered by Wolpert et al. (2014), a score improvement of 2.86 points is considered clinically meaningful . Applying our estimated VfM of 0.012, this implies that approximately £283.3 would be required per student to achieve a meaningful gain of this magnitude.

To deepen the analysis, a box plot of SDQ score change by number of sessions attended was produced to assess how the distribution of improvement varied across levels of intervention exposure as shown in Figure IV. The results suggest that while the intervention had a generally positive effect, the variability in outcomes was greatest among participants who attended fewer sessions, as indicated by wider interquartile ranges (larger boxes) at lower class counts. This implies that some participants benefited substantially even with minimal exposure, while others saw little or no improvement—possibly reflecting heterogeneity in baseline motivation, prior knowledge, or external support.

Conversely, narrower boxes at higher numbers of sessions indicate more consistent, though potentially smaller, improvements among participants with greater exposure. This could suggest that higher session intensity leads to more predictable outcomes, possibly due to the structured nature of repeated intervention. However, the trend of median values approaching zero with increasing session count may also point to diminishing returns, where additional sessions produce smaller marginal gains. Together, these findings highlight the importance of not only dosage but also identifying which participants benefit most from early, lower-intensity engagement.

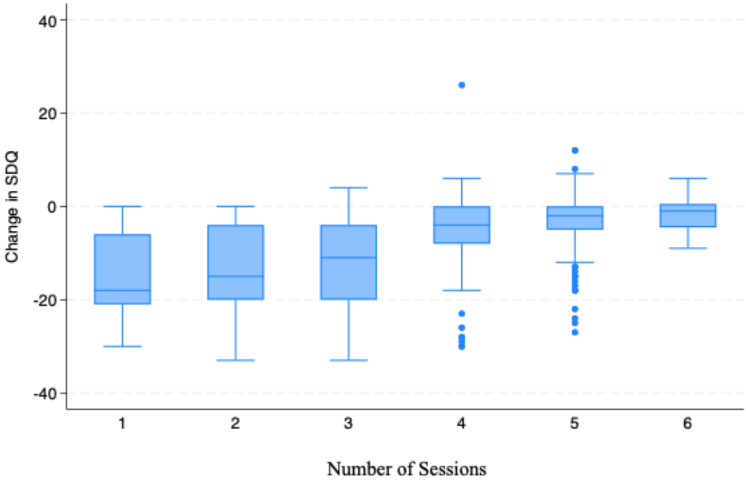


**Figure IV:** Variation in SDQ Score Improvement by Level of Attendance in Children and Young People Supported Self Help Programme

The line graph plotting mean VfM against number of sessions attended in **Figure V** shows a clear trend toward diminishing returns, as the mean VfM gradually approaches zero with increasing session count. This suggests that the cost-effectiveness of the intervention declines as more sessions are delivered, potentially reflecting a ceiling effect in participant outcomes or the targeting of more intensive support to participants with greater initial need but more limited responsiveness. Additionally, confidence intervals at lower class counts tend to be wider, indicating greater variability in VfM among participants who attended fewer sessions. In contrast, confidence intervals narrow at higher session counts,

suggesting that VfM becomes more stable and predictable with increased exposure, albeit less favourable on average.

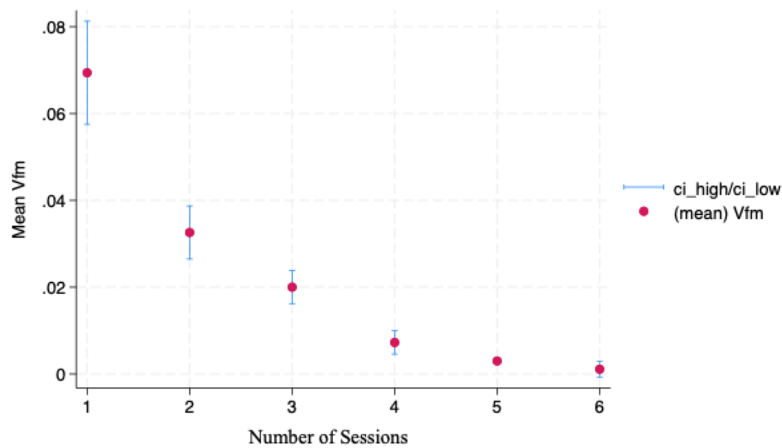


**Figure V:** Mean VfM by Number of Sessions Attended

Overall, the analysis indicates that the intervention yielded measurable improvements, with evidence of both effectiveness and variation in cost-efficiency across participants subgroups. While average VfM was positive, its decline with increasing session count suggests diminishing marginal returns, potentially reflecting that additional resources were directed toward participants with greater needs but lower responsiveness. The patterns observed in both the box plots and mean VfM trends underscore the importance of understanding not just whether an intervention works, but for whom, and at what cost. Confidence intervals around the VfM estimates further highlight that outcome variability narrows with more consistent exposure, yet efficiency may plateau. These findings reinforce the value of targeted, data-informed intervention design and suggest that future programme delivery could benefit from tailoring intensity to the profiles of participants most likely to respond cost-effectively.

#### 3.3.4.3.2. Safe Haven programme

There were 13,409 total actions taken under the Self Haven programme, with approximately 69% of participants joining the programme via Phone, reflecting the significant role of remote, low-tech, non-person platforms in enabling access to intervention. The use of phone-based participation highlights the programme's responsiveness to logistical and socioeconomic barriers that may prevent in-person attendance, such as travel constraints, caregiving responsibilities, or health-related concerns. This reliance on non-person formats underscores the value of flexible delivery models in broadening reach.

A ROI greater than 1 indicates that the alternative intervention option is more expensive than the programme, suggesting that Safe Haven delivers similar value at a lower cost. Conversely, a ROI less than 1 means that the programme is more costly than the alternative. This cost-based ROI approach enables a direct comparison of the financial burden associated with each intervention, helping to identify the most economical option for delivering mental health support. As shown in **Figure VI**, ROI varies across alternative intervention types. A&E, Ambulance and AMHT are more expensive than the programme. In contrast, options such as 111, Friends/Family, GP, None and Samaritans show ROI values below 1, suggesting that they are less costly than Safe Haven.

**Figure VI:** ROI Across Alternative Intervention Types

Support from Friends/Family appears to be among the least costly educational alternatives. This is expected, as these forms of support typically involve no direct monetary expenditure, making them seem highly cost-efficient from a budgetary standpoint. However, this interpretation overlooks key economic considerations. The analysis does not incorporate the opportunity costs associated with informal support such as the time, unpaid labour, or foregone income of those providing assistance. From an economic perspective, excluding these implicit costs can lead to an overestimation of cost-efficiency, potentially distorting comparisons between interventions. As such, while these alternatives may appear attractive on the surface, a more comprehensive valuation may yield a different understanding of their true resource demands.

In contrast, options such as A&E and Ambulance demonstrate ROI values significantly above 1, indicating that they are substantially above expensive than Safe Haven and other alternatives such as 111. This trend is largely attributable to the higher costs linked to A&E and ambulance services, which require trained personnel, specialised equipment, and in-person investigations, in contrast to remote triage and signposting model used by NHS 111.

The ROI comparison between Safe Haven and alternative intervention options remains consistent across the five financial years included in the analysis. This stability suggests that the relative cost-efficiency of the programme compared to its counterfactual alternatives has not fluctuated significantly, reinforcing the robustness of the observed economic advantage (or disadvantage). The trend is visually evident in **Figure VI**, where the ROI values for each alternative maintain a stable pattern across years, indicating that the cost-effectiveness hierarchy among options remains broadly unchanged, even as contextual factors may vary.

Across all financial years included in the analysis, the Return on Investment for the programme was estimated at 15%, indicating that for every £1 invested, an additional £0.15 in savings was generated. This positive ROI suggests that the programme provides favourable economic returns, offering a meaningful gain relative to its implementation cost. The sustained ROI across multiple years may reflect

a combination of factors, including stable delivery costs, consistent programme effectiveness, and the relatively higher cost of alternative intervention options.

While the ROI calculation provides useful insight into the programme's financial efficiency, it is important to recognise several limitations that may affect the accuracy of the estimate. The model does not capture indirect or non-monetised outcomes, which could lead to an underestimation of ROI. Conversely, the analysis also excludes potential hidden costs, such as variability in advisor quality, differences in patient engagement, or the opportunity cost of time and effort contributed by participants and caregivers, which could result in an overestimation. Additionally, the ROI does not adjust for contextual factors such as school-level differences or household socioeconomic conditions, which may influence both costs and outcomes. Taken together, these factors suggest that the reported ROI should be viewed as an approximate measure, and future research should aim to develop more comprehensive models that incorporate a broader range of variables.

###### 3.3.4.3.3. Interviews

The value of VCSEs was also reinforced during semi-structured interviews with commissioners, VCSE representatives, ICB and Council executives. One interviewee explained the value of VCSEs by stating "they have an awful lot of skills and abilities to deliver services in a really flexible and at pace approach", whilst another focused on the innovative and entrepreneurial nature of VCSEs, citing "They offer a single therapeutic session, which sometimes is enough to sort the issues out". Another interviewee highlighted the value of VCSE sector in their ability to build meaningful relationships within communities "that statuary bodies just can't achieve". Acknowledging the skills-based, entrepreneurial offerings and the community-driven nature of VCSEs, one interviewee remarked, "I would like to see the (VCSE) sector grow in our system and take more authority, more responsibility". Two interviewees also recognised the complementary role of VCSEs, emphasising their preventative role in addressing needs at an earlier stage, thereby reducing the pressure that would otherwise fall on the NHS later on. This framing recasts VCSEs not simply as peripheral actors, but as integral contributors to early intervention and long-term system sustainability, particularly in areas where statutory provision struggles to sustain relational continuity or cultural competence.

When asked about the commissioning of VCSEs, several interviewees referred to the NHS commissioning cycle, aligning their responses with the three key stages discussed earlier in this thesis. Following the identification of needs, national guidelines and local priorities are considered before initiating a competitive procurement process. This process was described as being open to bids, with the possibility of grant funding or subcontracting arrangements. The selection of VCSE provider over another was said to hinge primarily on their specialism, demonstrable expertise, and deep understanding of the local context. However, while these formal processes are designed to promote equity and transparency, several participants acknowledged that the competitive nature of commissioning may disadvantage smaller VCSE organisations, particularly those without dedicated bid-writing capacity or infrastructural sustainability.

Despite a shared recognition of the value of VCSEs and a desire for them to play a larger role within the system, interviewees also highlighted the reality of impending budget cuts. Several noted that subcontracted services are often the first to face reductions. This concern is compounded by the fact that the budget currently allocated to VCSEs that provide mental health services is already viewed as minimal i.e., significantly lower that what is allocated to statuary bodies raising doubts about their long-term sustainability within the commissioning landscape. This funding disparity prompts structural questions about how 'value' is defined and measured across provider types, and whether existing models of resource allocation adequately reflect the distinctive contributions VCSEs make to prevention and community resilience.

Another challenge faced by VCSE sector is the reliance on block contracts, which are awarded following a competitive procurement process for provider selection and include predefined KPIs against which services are assessed. While this approach is designed to ensure fairness and transparency, block contracts are often seen as rigid and less responsive to the nuanced, community-based work that VCSEs deliver. One interviewee highlighted this tension, noting that despite formal procedures, personal networks and relationships remain crucial in securing funding: “It actually comes down to individuals in key roles”. This observation underscores a broader tension between procedural legitimacy and informal power dynamics, suggesting that while the system aspires to fairness, access to funding remains shaped by interpersonal networks and organisational visibility rather than outcome evidence alone.

# 4. CHAPTER: DISCUSSION AND CONCLUSION

## 4.1. Review of Thesis Aim and Research Questions

This thesis set out to achieve two overarching aims: (i) to examine current commissioning processes for third-party mental health service providers by applying the NHS strategic commissioning cycle to two ICBs located in Southeast and East England, thereby generating insights into how services are planned, procured, and evaluated within these systems; and (ii) to assess VfM of these third-party providers, considering their cost-effectiveness, service quality, and overall contribution to the integrated care landscape.

To achieve these aims, the research was structured around five research questions, each addressed through a carefully designed combination of READ document analysis and primary qualitative and quantitative methods. The first research question, "*What is the current commissioning process for VCSE mental health service providers?*", was explored through the application of the NHS strategic commissioning cycle framework to the two selected ICBs. A comprehensive review of relevant documents provided insight into the processes, implementations, structures, and intended priorities underpinning commissioning within each system. To complement this, semi-structured interviews were conducted with key stakeholders from both ICBs, NHS Foundation Trusts and VCSE organisations, providing a detailed understanding of how these processes unfold in practice. These interviews were specifically designed to explore the factors that influence commissioners when selecting one VCSE provider over others, offering rich, context-specific insights into the complexities of provider selection that extend beyond what is visible in formal documentation. Findings revealed that while both ICBs articulate strong strategic intent and increasingly reference integrated, outcomes-focused commissioning, there remains a substantial implementation gap, particularly in translating population-level needs assessments into commissioned services and in embedding evaluation within future planning cycles.

The second research question, "*What are the perspectives of key ICB and VCSE stakeholders on the current commissioning process?*", was addressed through 10 semi-structured interviews with senior stakeholders across commissioning, provision, and voluntary sectors. These interviews offered critical insight into how commissioning is experienced on the ground. Interviewees frequently noted that despite rhetorical alignment around co-production, prevention, and parity of esteem for mental health, the operational environment remains constrained by legacy funding arrangements, limited data utility, and inconsistent infrastructure for integrating VCSE actors. Perspectives also diverged between system leaders and VCSE representatives, revealing epistemic tensions around what constitutes "evidence," how value is defined, and whose voices shape commissioning priorities.

The third research question, "*What factors influence commissioners in selecting one VCSE provider over others?*", emerged as particularly complex. While formal procurement processes especially NHS Standard Contracts and block contracts were widely acknowledged, interviews revealed that soft factors such as organisational visibility, relational capital, and historical partnerships often played a substantial role. Commissioners cited the importance of demonstrable local expertise, cultural competence, and service adaptability. However, VCSE representatives raised concerns that competitive procurement frameworks can disadvantage smaller providers lacking the bid-writing capacity or strategic networks required to secure funding.

To further unpack the complexities of the commissioning environment, both the document analysis and interviews were used to examine the fourth research question, "*What contractual models are used between ICBs and VCSE mental health providers?*". This question sought to illuminate the formal mechanisms through which relationships between commissioners and third-party providers are established, governed, and financially sustained. The predominant model across both ICBs remains the

NHS Standard Contract, often supplemented with block contracts that define KPIs and reporting obligations. While this formalisation supports accountability and standardisation, it also creates barriers for smaller, community-rooted providers who may struggle with rigid compliance requirements. A few participants critiqued the inflexibility of block contracts in capturing the relational, preventative, and often qualitative impact of VCSE-led interventions.

VfM of VCSE mental health service provision was assessed through two case examples using CBA and ROI. This approach enabled an evaluation of both the economic efficiency and outcome impact of these services relative to their costs. Such analyses are increasingly recognised as essential for informing evidence-based policymaking and resource allocation in integrated care systems.

The final question "*What is the value for money of VCSE mental health service providers?*" was addressed through CBA and ROI analysis of two representative case examples. This approach enabled an evaluation of both the economic efficiency and outcome impact of these services relative to their costs. Such analyses are increasingly recognised as essential for informing evidence-based policymaking and resource allocation in integrated care systems. These analyses demonstrated that VCSE-led mental health services particularly those delivering preventative and early intervention support can generate positive economic returns and measurable improvements in mental health outcomes, even when operating on relatively low budgets. However, these findings also underscored the methodological challenges of assessing VfM in this sector, especially given inconsistent outcome tracking and the limited availability of real-time data.

In sum, the thesis finds that while ICBs are making tangible progress toward more strategic, outcomes-driven commissioning, significant structural, operational, and epistemic barriers remain particularly in integrating VCSE providers as equal partners in mental health commissioning. Addressing these challenges requires not only reform in formal processes but also a shift in cultural norms, data practices, and definitions of value.

## 4.2. Principal Findings

There are three main findings in this thesis. The first is that, as evidenced across all reviewed policy documents, strategic plans, and operational frameworks, there is a consistently strong rhetoric and articulated ambition to realise the principles of strategic commissioning. These documents reflect a shared commitment across the system to move toward a more integrated, outcome-focused, and preventative model of care, underpinned by systematic planning and long-term investment. The discourse signals a paradigm shift from transactional service delivery to a more proactive and population-focused commissioning model. However, while the strategic intent is clearly established, the implementation remains in progress. The system, as observed, is very much on a developmental trajectory - what might be termed as ‘commissioning journey.’ Importantly, the analysis of ICBs located in Southeast and East England revealed that these systems are at different stages in this journey, with varying levels of maturity in aligning their commissioning practices to the strategic cycle.

The second key finding concerns the divergent understandings of strategic commissioning across representatives of different organisations, and how these variations shape the explanatory clarity with which actors describe current activities and articulate forward plans. Interpretations of what strategic commissioning entails - its scope, function, and processes - vary considerably, often reflecting each organisation's position within the system and their historical role in service delivery. This inconsistency affects how confidently and coherently stakeholders can link their actions to the broader commissioning cycle. Despite this variation, the potential of the new structural reform introduced by *the 2022 Health and Care Act* is widely acknowledged. The value of VCSEs and their community-led interventions are especially recognised for their innovation, flexibility, and complementary role in preventative mental health care. Yet, these services remain constrained by structural barriers such as fragmented funding

pathways, rigid procurement processes, and a continued reliance on informal networks to secure contracts. This limits their ability to be fully embedded within mainstream commissioning frameworks, despite their alignment with the strategic goals of integrated care.

The third key finding, derived from our CBA and ROI analysis, suggests that mental health services offered by the VCSEs have the potential to generate measurable VfM. Applying a clinically meaningful SDQ score change threshold, the analysis estimated that an investment of £283.3 per participant for Children and Young People Supported Self Help Programme would be required to achieve a gain of this magnitude. The results further revealed that, while the intervention demonstrated an overall positive impact, there was substantial variability in outcomes, particularly among participants who attended fewer sessions. As to the Safe Haven Programme, the study revealed that some alternative intervention options are more expensive than the programme, suggesting that the programme delivers comparable value at a lower cost. This finding is particularly valuable as it highlights the programme's potential to optimise resource use while maintaining service effectiveness, an essential consideration for commissioners operating within constrained public budgets. Moreover, when evaluated from an ROI perspective, Safe Haven Programme was associated with net fiscal savings, suggesting that in contexts where such alternatives are feasible and accessible, they could represent a viable substitute or supplement to conventional mental health services.

## 4.3. Recommendations

To overcome current inconsistencies and structural barriers in the commissioning of VCSE mental health providers, future commissioning frameworks should take a more strategic partnership-oriented approach. A key priority is the adoption of longer-term, outcome-focused contracts that move beyond short-term, transactional arrangements. Multi-year agreements would provide VCSE organisations with greater financial stability, support workforce retention, and enable longer-term service planning that aligns with system-wide priorities. In parallel, co-design should be embedded as standard practice, with VCSE providers meaningfully involved in the early stages of service design and procurement processes. This would ensure that commissioned services reflect both the lived experiences of communities and the expertise of third-sector organisations. Finally, commissioning frameworks should clearly define the role of VCSEs within ICB governance structures to avoid tokenistic engagement. Establishing formal mechanisms for VCSE representation in strategic decision-making forums would strengthen accountability, promote shared ownership of system objectives, and enable more consistent, system-wide partnership working.

Alongside improvements to commissioning frameworks, there is a pressing need to strengthen the way data is collected and evidence is generated from VCSE providers to support more transparent, consistent, and evidence-based decision-making. A persistent barrier to fully embedding VCSEs within mainstream commissioning has been the limited availability of robust, comparable data on service outcomes, quality, and impact. To address this, data collection requirements should be formalised within contracting agreements. All contracts with VCSE providers should include clear, proportionate obligations for outcome measurement and reporting, developed in collaboration with providers to ensure they are realistic and achievable, particularly for smaller organisations. Alongside this, policymakers and ICSs should work with VCSEs to establish standardised outcome frameworks for commissioned mental health services, including both clinical and social measures. Where possible, these should align with existing NHS frameworks to promote consistency and integration across the system. To support this, commissioners must also invest in building the capacity of VCSE organisations to collect, analyse, and report data. This could include targeted training, access to digital tools, or shared data platforms, ensuring that smaller providers are not excluded from participating due to resource constraints. Finally, it is essential that data generated through these processes feeds back into service design and system planning. By strengthening these feedback loops, commissioners can foster a culture of continuous learning and improvement, ensuring that both VCSE providers and the wider system are equipped to deliver more efficient, responsive, and high-quality mental health care. A summary set of

these recommendations is provided below.

Recommendations to overcome challenges in strategic commissioning of VCSE services

| | Challenge | Recommendation |
|---|---|---|
| 1. | Short-term funding cycles and grant-based commissioning contribute to service instability and difficulty in long-term planning, particularly for VCSEs. | Commission the Supported Self Help and Safe Haven programmes through multi-year NHS Standard Contracts or tailored grant agreements with defined review points, allowing providers the stability needed to retain staff, plan service delivery, and invest in service development. |
| 2. | Limited use of systematic economic evaluation in VCSE commissioning decisions | Use a validated outcome measure, potentially an NHS-mandated outcome measure where appropriate. Specifically:<br>• Use improvement in SDQ scores per cost (as shown in the Self Help Programme) as a metric for early intervention services.<br>• Use avoided A&E/crisis care attendance (from Safe Haven's ROI model) as a proxy for savings and system efficiency. |
| 3. | Disconnect between national outcome frameworks and locally assessed needs | Define outcome KPIs in contracts based on locally relevant metrics such as:<br>• Reduction in SDQ scores (emotional and behavioural difficulties) for CYP.<br>• Number of crisis presentations prevented or diverted by Safe Haven.<br>• Service reach into underserved or high-deprivation populations.<br>This could align service goals with ICS prevention and health equity agendas. |
| 4. | Inflexible or inappropriate payment structures (e.g., basic block contracts or one-off grants). | Implement a blended payment model that combines:<br>• A fixed base for operational sustainability<br>• A variable component tied to quality indicators or outcomes (e.g., engagement rates, improvements in wellbeing)<br>Such a model could provide financial predictability while still driving performance. |
| 5. | Fragmented data collection and reporting systems between statutory bodies and VCSEs. | Facilitate real-time data sharing through linked dashboards or interoperable tools that track:<br>• Attendance and completion rates<br>• Referral pathways<br>• Outcome progression (e.g., SDQ improvements, crisis episode avoidance).<br>This would support continuous monitoring for strategic commissioning. |

| | | |
|---|---|---|
| 6. | Many VCSEs lack infrastructure to meet complex procurement and reporting demands. | Alongside funding, commissioners could offer:<br>• Training on NHS procurement processes<br>• Support for impact measurement and evaluation<br>• Dedicated liaisons or support officers within ICBs<br>• Proportionate but effective procurement and contract governance processes that accommodate the size and infrastructure of most VCSE organisations.<br>This could help build long-term commissioning readiness. |

## 4.4. Strengths and Limitations

This study presents several key strengths that enhance its contribution to both academic literature and applied policy practice. Notably, it offers one of the first empirical examinations of the commissioning landscape following the implementation of *the 2022 Health and Care Act*, providing timely and policy-relevant insights into how the Act's provisions are unfolding in real-world contexts. By focusing on Integrated Care Boards (ICBs), a central feaure of the new system, it critically assesses the operationalisation of strategic commissioning under the Act, filling a gap in early-stage evaluations of ICS functionality. Thereby, the study offers an applied understanding of how national policy ambitions around integration, prevention, and system-wide accountability are translating into the commissioning of mental health services, an area long recognised as underfunded and complex to deliver.

Another major strength lies in the study's mixed-methods design. The combination of qualitative interviews with stakeholders and a quantitative analysis allows for a richer, multidimensional understanding of the strategic commissioning process. This approach not only captures the technical and financial dimensions of commissioning but also surfaces the lived experiences, perceptions, and strategic challenges faced by commissioners and providers. Through this design, the study contributes new insights into how formal frameworks, such as the NHS strategic commissioning cycle, interact with the practical realities of commissioning within ICSs.

In addition, the research delivers the most rigorous possible analysis of the VfM of two VCSE mental health services within the constraints of the available data and methodological approach. By applying established cost-benefit and ROI calculations, it generates empirical evidence on the cost-efficiency of third-party mental health provision, an area where systematic economic evaluation remains limited. These findings are particularly relevant in the current context, where fiscal pressures, growing demand, and the expanding role of VCSE providers require commissioners to make evidence-informed decisions regarding the design and funding of mental health services.

Taken together, these strengths position the study as both a meaningful academic contribution to emerging commissioning literature and a practical resource for supporting more transparent, economically grounded, and system-sensitive decision-making within England's integrated care landscape.

While the study provides valuable insights into the cost-efficiency of different mental health interventions, several limitations must be acknowledged. A key limitation of this research is that the interviews primarily capture the perspectives of commissioners and VCSE representatives within a limited geographical area, restricting the generalizability of the findings to the broader population of commissioners and VCSE representatives across England. It is also important to acknowledge that participants' stated views and intentions may not always align with their actual decision-making and actions in practice. Despite these constraints, this research offers valuable insights into the strategic commissioning process and may serve as a foundation for further in-depth studies with a larger and more diverse sample. Moreover, semi-structured interviews introduce potential methodological challenges, including susceptibility to interviewer bias due to the flexible and adaptive nature of the interview process (Adams et al., 2015). Semi-structured interviews also raise ethical considerations and power dynamics that may influence participant responses, further limiting the generalizability of findings (Belina, 2022). Nonetheless, their ability to provide rich, nuanced data remains a strength, contributing to a deeper understanding of commissioning practices within integrated care systems.

As to the CBA analysis, a key limitation of the dataset is the absence of detailed demographic and socioeconomic information, which constrains the ability to conduct subgroup analyses based on factors such as parental education, or socioeconomic status. For instance, it is not possible to

determine whether children and young people from disadvantaged backgrounds derived greater or lesser benefit from the service - an important consideration for equity-focused policy evaluation. Additionally, the dataset lacks broader contextual variables that could significantly influence outcomes, such as therapist quality, household income, or school-level resources. These omitted factors may confound the relationship between the intervention and patient performance.

While the ROI analysis provides valuable insights into the cost-efficiency of the intervention, several limitations should be acknowledged. First, the dataset lacked detailed demographic information such as socioeconomic status, ethnicity, or special needs, which limits the ability to explore equity implications or differential impacts across subgroups. Second, the use of self-reported alternative intervention types introduces a degree of subjectivity and potential recall bias, which may affect the accuracy of estimated savings. Finally, the ROI metric focuses exclusively on direct financial return and does not capture wider social or educational benefits, outcomes that may be essential to a more holistic understanding of programme impact.

## 4.5. Conclusion and Future Research

This thesis set out to investigate the commissioning processes for third-party mental health service providers within the framework of Integrated Care Systems (ICSs), using the strategic commissioning cycle to analyse practices in the Southeast and East Integrated Care Boards (ICBs). Through document analysis, interviews, and economic evaluation, the study has illuminated both the ambition and the complexity embedded in current commissioning structures.

The findings suggest that while strategic commissioning is strongly advocated in policy documents and echoed in stakeholder discourse, the system remains on a developmental trajectory. There is widespread acknowledgement of the need to move towards more integrated, outcomes-focused commissioning. However, the operationalisation of these goals is uneven, with organisations demonstrating differing levels of understanding and application of strategic commissioning principles. This inconsistency has direct implications for patients and service users: uneven implementation means that access to timely, community-based, and culturally responsive mental health support can vary significantly by geography, undermining national ambitions for equity and early intervention.

Particularly striking is the underdeveloped integration of third-party providers, notably those in the Voluntary, Community and Social Enterprise sector. Despite their recognised value in delivering flexible, innovative, and preventative interventions these organisations continue to face structural barriers including limited funding, short-term contracts, and lack of representation in strategic decision-making processes. The consequence for service users is that preventative or community-based mental health support—often designed to meet needs that statutory services cannot easily reach—remains fragmented and precariously funded, reducing its reliability and continuity for vulnerable populations. The economic analysis further supports their potential, showing that such services are not only cost-effective but also contribute to long-term system savings by addressing needs earlier and reducing pressure on mainstream provision.

Despite this acknowledged value, this study revealed persistent shortfalls in the integration and resourcing of VCSE providers. As evidenced through both document analysis and stakeholder interviews, these organisations continue to face structural barriers, including short-term funding arrangements, complex and resource-intensive bidding processes, and limited representation in strategic decision-making forums. The reliance on spot purchasing and grant-based funding models further exacerbates their financial precarity, inhibiting long-term service planning and organisational sustainability. These constraints reflect broader challenges within strategic commissioning, where the rhetoric of collaboration and integration is not always matched by the mechanisms and incentives required to support meaningful partnership with the VCSE sector.

Looking forward, strengthening the role of VCSEs will require a more consistent and strategic approach to their commissioning. This includes moving beyond short-term transactional arrangements towards longer-term, outcome-focused contracts that recognise the distinctive contribution of VCSE organisations to system-wide objectives. It also demands greater investment in building the capacity of both commissioners and VCSEs to engage effectively in co-design, ensuring that services are developed in ways that reflect local needs while supporting organisational sustainability. Such changes would directly improve patient and community outcomes by ensuring that preventative, culturally tailored mental health services are not only available but also stable and scalable. As this study has shown through its economic evaluation, VCSE-delivered mental health interventions can offer demonstrable value for money, reinforcing the case for their fuller integration into commissioning arrangements. Realising this potential will be essential if integrated care systems are to deliver on their commitments to prevention, equity, and system efficiency.

In conclusion, while this research finds clear evidence of progress in strategic commissioning, it also identifies critical gaps between policy aspiration and practice. The system is, in many ways, still "on the journey." Realising the full potential of integrated commissioning, particularly in the mental health space, will require a more consistent application of strategic frameworks, a genuine commitment to partnership with third-party providers, and the creation of sustainable commissioning mechanisms that support long-term planning and accountability. This study’s findings underscore that without such shifts, the benefits of strategic commissioning for service users—such as timely access, continuity of care, and culturally competent support—will remain unevenly realised.

This thesis contributes to ongoing debates about the future of health and care commissioning in England and offers a practical framework for evaluating third-party provision. By explicitly linking commissioning processes to patient outcomes and drawing on empirical research on system transformation, it strengthens the evidence base for how strategic commissioning can move from aspiration to impact. It is hoped that these insights will inform future policy, commissioning practice, and further research in the field.

Building on the findings of this study, future research could explore several important avenues. First, a comparative analysis across additional ICBs would provide deeper insight into the extent of variation in commissioning maturity and approaches to integrating third-party providers. Such comparative work is essential to identifying which systems have developed more effective, inclusive, and sustainable commissioning models, and understanding the contextual factors that contribute to these differences. In doing so, future research could directly assess how such variations in commissioning translate into differences in patient outcomes, equity, and service user experience. These insights would be of particular value to policymakers, commissioners, and system leaders seeking to share best practices, reduce unwarranted variation, and inform the development of targeted support or policy interventions aimed at strengthening commissioning capacity and the meaningful integration of the VCSE sector across regions. Longitudinal studies could also help assess how strategic commissioning practices evolve over time, particularly as ICSs mature and new accountability mechanisms are introduced. Further investigation into the specific outcomes of VCSE-delivered services both quantitative (e.g. cost savings, clinical outcomes) and qualitative (e.g. user experience, community engagement) would enhance the evidence base for their commissioning. Additionally, research examining the informal dynamics of commissioning, such as the role of relationships, trust, and networks in shaping access to contracts, could offer valuable perspectives often overlooked in formal evaluations. Finally, developing and testing applied commissioning tools or frameworks particularly for assessing value for money in low-cost, preventative services could support more consistent and evidence-based decision-making across the system. Such research would not only inform policy and practice but also contribute to the theoretical development of commissioning as a distinct field within health systems research.

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## Appendix I

### Reviewed ICB Documents

| Annual Report and Accounts |
| --- |
| System Delivery Plan |
| Joint Capital Resource Use Plan |
| Three Year Plan for Mental Health |
| The Integrated Care Strategy |
| Local Transformation Plan |
| Primary Care Strategy |
| Board Meeting Minutes |
| Strategic Commissioning Plan |
| Joint Forward Plan |
| ICB Meeting Papers |
| Mental Health Strategy |

## Appendix II

**SEMI-STRUCTURED INTERVIEW**

Opening statement: *First of all, thank you for your participation. We are conducting interviews in order to understand the current commissioning landscape, vision and next steps towards strategic commissioning of healthcare services, with a particular focus on mental health services. As (name of ICB/VSCE) transitions towards strategic commissioning, this research aims to conduct an exercise to assess the current position of making healthcare spending decisions, identify the necessary steps to reach the ideal commissioning stage, and establish a feedback loop with the NHS.*

*This interview will take approximately 45 minutes. You are free to stop or pause the interview at any point, and you are not obliged to answer all questions. The interview will be recorded but not shared with anyone else, and information will be treated confidentially.*

*Do you have any questions, or would you like any additional information? If it is okay with you, I am going to start the audio recording now.*

a. Date:
b. Interview Number:
c. Name:
d. Organization:
e. Start time: _________. Finish time: ________.

**1. GENERAL BACKGROUND**

1.1. Can you tell me a bit about your role? Which team are you part of? And, for how long have you been in the *(name of potential ICB/VSCE)*?

1.2. Are you involved in the commissioning process and if so, how?

1.3. How would you define strategic commissioning process?

1.4 In your organisation, what are the current activities and future plans regarding strategic commissioning?

2. STRATEGIC PLANNING

2.1 How does your organisation assess the health and social care needs of the population you cover and what are the next steps?

2.2 How reliable is the data you use to assess demand, identify gaps in service provision and evaluate the potential impact of new or adjusted services?

2.3 Does your organisation use health assessment tools to decide priorities? If not today, do you have any plans to use health assessment tools to decide priorities on the forward?

3. DESIGN AND PROCURE

3.1. How does your organisation set strategic priorities?

3.2. Would you say the population needs and strategic priorities translate into actionable service delivery?

3.3 Does your organisation co-design commissioning decisions? If so, how?

3.4. What is the process of capacity planning and demand management?

4. MONITOR AND EVALUATE

4.1 Does your organisation uphold patient choice, if so how? Does your organisation seek public and patient views?

4.2 How does your organisation track performance, do you measure both outputs and outcomes?

5. COMMISIONING MENTAL HEALTH SERVICES TO THIRD PARTY PROVIDERS (TPP)

5.1. What is the process of commissioning mental health services to TPP?

5.2. What factors influence commissioners to choose one TPP over other TPPs, local authorities, and/or NHS-Trusts?

5.3. How does your organisation evaluate the success of the third-party service providers? How do you assess their value of money?

5.4. What proportion of (name of the ICB) mental health budget is allocated to third-party providers? How is this percentage calculated?

5.5. What are the payment mechanisms in place between the ICB and third-party providers?

5.6. How are contracts structured for third-party providers of mental health services?

5.7. What are the incentives or penalties built into these contracts to ensure quality care and efficiency?

5.8. How does the quality of care provided by third-party mental health service providers compare to that provided by the NHS?

5.9. What is the importance of VCSEs in supplementing and substituting the NHS?

Closing statement: Ask for relevant documentation (based on information the participant has shared along the interview).

- *Beyond the issues that we have discussed here, do you have any further comments that you wish to add?*
- *Would you like to receive a copy of the recorded interview?*
- *Would you like to receive a copy of the transcribed interview?*
- *Would you like information on the outcomes of the research?*

*Many thanks for your time*