Extending What Works: Individual Placement and Support (IPS) in the Primary Care Context

Guidance for IPS Service Providers

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IPS GROW

Extending What Works: Individual Placement and Support (IPS) for people with severe mental health challenges in the context of community mental health transformation in England

Introduction

The community mental health transformation in England will mean that many people with severe mental health challenges will receive their support and treatment within primary care. This has major implications for IPS services which have traditionally been integrated within community mental health teams and early intervention in psychosis teams in secondary mental health services.

If IPS is to be available to everyone with severe mental health challenges who wishes to work, this means that IPS services must also be integrated into the extended multi-disciplinary primary healthcare teams. The purpose of this briefing paper is to explore the implications for IPS services of the transformation agenda and how they can be accessed not only by people using the specialist mental health services located within primary care, but also by people with severe mental health challenges who are using only the broader, general primary care services.

An inclusive vision

Everyone with severe mental health challenges should be encouraged to think about the possibility of gaining and/or maintaining a job. For those who want employment support they should have access to the best, evidence-based support to enable them to do so.

There should be 'no wrong door'. Wherever people living with severe mental health challenges seek and receive support – whether it be from secondary mental health services, primary care, social prescribers, social services, housing providers, voluntary and community sector organisations, Jobcentre Plus, Probation Services – they should have the opportunity to talk about their employment aspirations and to access IPS in a timely manner.

For example, someone with severe mental health problems may:

- Go to a practice nurse for their annual physical health check
- See a primary care pharmacist or GP for their regular medication review
- Have contact with a social prescriber
- Meet with a GP, psychiatrist, CPN or other health professional
- Go to an addiction service for help with drug or alcohol issues
- Speak with their social worker or supported housing provider
- Meet with a Job Coach at Jobcentre Plus
- Attend meetings with the Probation Service, and/or
- Go to a voluntary sector or community organisation

All of these are opportunities to talk about employment and the way in which it might benefit recovery and to refer people to an IPS service that can assist them in gaining and maintaining a job in line with their interests and preferences.

Alternatively, someone with severe mental health problems may:

- See a leaflet or poster about IPS employment support in a GP surgery, library, or community facility
- Speak to a friend or relative who has used an IPS service, and/or

- Look on the internet and research employment support available in their area

Moreover, there needs to be opportunities for people to approach IPS services and ask for employment support directly ('self-referral').

Community mental health transformation in England

The NHS Long Term Plan (2019) aims to break down the hierarchies, barriers and divisions that exist between mental and physical health, primary and secondary care, health and social care, statutory sector, and voluntary/community organisations. The aim is to shift towards an integrated, place-based system of health and social care characterised by connections, interdependencies and partnership working at all levels.

Community mental health services are at the heart of this plan and the '*Community Mental Health Framework for Adults and Older People'* sets out a model for developing an integrated framework of primary and community mental health services. The aim is to provide continuous care across primary and secondary services and to ensure treatment and support is available to those who do not meet existing thresholds for secondary care. This should avoid people losing care following discharge from secondary care services and improve access to evidence based and meaningful care to help people to get better and stay well, including access to employment support. The ambition is that all areas have access to high quality IPS services.

The NHS transformation agenda describes a fundamental shift towards an integrated, 'place based' system with a vision of health and social at neighbourhood, place, and system (Integrated Care System) level. The fundamental building blocks of Integrated Care Systems are the Primary Care Networks which serve a population of 30-50,000 and bring together all the GP Practices in their patch.

The core community mental health services will be brought together around these Primary Care Networks. Most people experiencing mental health challenges will be provided with the treatment and support they need within primary care, with support from the specialist community mental health services as needed.

"There is a perception that people with severe mental illnesses such as psychosis or bipolar disorder are supported primarily by specialist mental health services rather than primary care. This is often not the case – our discussions with local commissioners suggest that around 30–50 per cent of people with these conditions are supported exclusively by primary care without ongoing specialist input. This includes people who have previously been supported by specialist services but who have been 'stepped down' to primary care as their acute mental health needs have stabilised and they are responding well to medication." (Naylor et al, 2020, p9)

The new integrated structures are developing at different rates, and in different ways, across different areas of the country. However, the overarching aims are clear (see NHSE/NHS Collaborating Centre for Mental Health, 2019[1]) and employment support is critical to their attainment (see Table 1).

Table 1

Aims of Community Mental Health Services NHSE/NHS Collaborating Centre for Mental Health (2019)	**Importance of employment and IPS**
1. Promote mental and physical health and prevent ill health.	Appropriate employment improves mental and physical health and decreases the likelihood of relapse.
2. Treat mental health problems effectively through psychological and/or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm and use a collaborative approach that builds on strengths and is underpinned by a single, personalised, care and support plan that is available to all involved.	The benefits of appropriate employment are widely recognised and build on a person's skills and strengths – employment support is therefore central to support planning.
3. Improve quality of life, including support for individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities and create or fulfil hopes and aspirations in line with their individual wishes.	Most people with severe mental health problems want to work and appropriate employment improves quality of life: links people to their communities, promotes social networks, provides a positive identity, and gives people a reason for getting up in the morning.
4. Maximise continuity of care and ensure no 'cliff edge' of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions, and discharge to little or no support. Instead, move towards a flexible system that proactively responds to individual care needs.	In order to enable people with severe mental health challenges to gain and sustain employment, it is vital that IPS support continues to be available across discharge from secondary to primary care.
5. Work together across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and the social determinants of mental health.	Employment is a central social determinant of mental health – unemployment is associated with an increase in mental health problems and risk of suicide – and employment is an equalities issue: people with severe mental health problems are disadvantaged in the labour market as are people from Black and minority ethnic communities.

[1] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest level of complexity[2] and who experience marginalisation.	Employment promotes social inclusion and is therefore centrally important to those who are at risk of marginalisation and exclusion and IPS is effective with people who have complex needs who are most at risk of marginalisation.

IPS in the context of community mental health transformation: Ensuring access for everyone with mental health challenges

Community mental health transformation has important implications for the way in which IPS services have traditionally operated (see 'Mental Health Transformation Agenda Briefing for IPS Leaders' IPS Grow, 2020). Typically, IPS services have worked on the assumption that everyone with severe mental health challenges is supported within the range of community mental health teams in secondary mental health services. Therefore, IPS services are integrated within these teams. Only very few IPS services are integrated with primary care to allow access for people with severe mental health challenges in primary care.

However, this picture has been changing: many people living with severe mental health challenges whose condition is deemed to be 'stable' have been discharged from secondary services to primary care. When IPS service are restricted to secondary care then, too often, people with severe mental health challenges who are discharged from secondary services lose the employment support they need to gain and sustain employment. Additionally, those people who are not deemed to meet the 'threshold' for access to secondary care are denied access to IPS – the very 'cliff edges' that the community mental health transformation agenda seeks to eliminate.

If IPS services are to provide continuity of support that is flexible, proactive, and responsive to individual needs, as required of all services by the transformation framework, we must work across primary and secondary services.

The majority of mental health care is provided in primary care. 90% of people with mental health challenges receive treatment only within primary care. In 2022, there were 532,363 people on GP 'severe mental illness registers' (NHSE, 2022). Research shows that between 30 - 50% of people with 'severe mental illness' are only seen in the primary care setting (Reilly et al, 2012; Naylor et al, 2020). With increased efforts to reduce community mental health team caseloads and the development of the community mental health transformation agenda, the proportion of people with 'severe mental illness' seen only in primary care is likely to increase.

If the vision is to make IPS available to everyone with severe mental health challenges who may wish to work, and if we are to meet the NHS Long Term Plan access targets for people with 'severe

[2] The '*Community Mental Health Framework for Adults and Older People'* (2019) makes it clear that 'severe mental illness'/'complexity' cannot be determined by diagnosis alone (psychosis, bipolar disorder, personality disorder, eating disorder, severe depression) but must take into account other factors such as the nature, duration and severity of problems (including co-morbidities and neurodevelopmental disorders), co-occurring drug/alcohol use, availability and quality or personal and social supports and networks, services' ability to engage with and be accessible to people, problems associated with ageing, co-existing physical health problems and the effectiveness of current/past treatment.

mental illness' receiving IPS support, then it is equally critical that we work across primary and secondary mental health care.

As well as showing that 30 - 50% of people with 'severe mental illness' are seen only in primary care, the research conducted by Reilly et al (2012) showed that, of the 69% who were seen in secondary care, 61% had no more than 2 secondary care contacts in a year. Across the whole sample of people with 'severe mental illness' only 20% of contacts were with secondary mental health services and 80% were within primary care and patients in contact with secondary mental health services were more likely to consult a GP for a mental health reason compared to those seen only in primary care (46.9% vs 29.7%). This indicates the important role that primary care services have in the treatment and support of people with severe mental health challenges.

If IPS services are to integrate employment support with mental health treatment, then it is vital they are integrated with the primary care services who provide so much of the mental health support received by people with severe mental health challenges.

Bridging the divide: IPS services working across primary and secondary care

The purpose of this briefing paper is to explore how we can begin to create IPS services that are accessible to everyone with severe mental health challenges who wishes to work, whether they receive mental health treatment and support in primary or secondary services (or indeed both).

In order to identify concerns that need to be addressed, IPS Grow regional leads were asked to identify concerns raised with them by team/service managers and Employment Specialists across England. These fell broadly into six areas:

1. **The IPS team within primary care and the Employment Specialist role** (for example, what does the Employment Specialist role look like, what does being part of a primary care team mean, which meetings to attend, how do we define the teams/units, do we have separate primary care IPS teams, how do we align Employment Specialists and Primary Care Networks, who is the 'lead' for the person if there is no care co-ordinator, will Employment Specialists be very isolated, what happens if the person needs mental health or other support if there is no multi-disciplinary team support and, do we need a separate team leader for primary care).

2. **Referrals – who is eligible for IPS** (for example, how to define 'severely mentally ill' in a primary care context, contractual limitations – we are only contracted to take people from secondary mental health services, how would the referral pathways work, how to guard against 'inappropriate referrals', danger of 'cherry picking' supposedly 'easier' people, would we end up with mostly 'retention' cases at the expense of supporting people to get jobs).

3. **Governance and accountability, especially relating to health and safety and safeguarding** (what happens if something goes wrong, who is clinically responsible, how can someone get mental health support if they need it/if a crisis occurs, difficulties in communicating with clinical staff, the safety of workers and lone working).

4. **Systems** (for example, different approaches to transformation taken in different areas, different clinical information systems between primary and secondary care, how are records kept up to date, can we access primary care information systems, how do we enter data on MHSDS).

5. **IPS Fidelity and the transformation agenda** (how do we define teams/units from a fidelity perspective, there is a challenge to fidelity ratings in relation to integration, assertive engagement process and time in the community with IPS in primary care, translating fidelity items into a primary care context, impact on quality mark, co-location – how would that work).

6. **Resources – issues about capacity** (For example, will this 'open the flood gates' and will we become overwhelmed by the number of referrals).

These concerns were then taken to a group of IPS practitioners with experience in working across primary and secondary care who were asked to describe how they addressed them. We are grateful to this group (see Appendix 1) for their wisdom and expertise which form the basis of the remainder of this briefing paper. A separate consultation was conducted, led by Miles Rinaldi, relating to IPS fidelity assessment in a primary care context (see Appendix 2).

For the purpose of this briefing paper the term 'Primary Care Network team' is used hereafter to refer to all individuals (GPs, practice nurses, primary care pharmacist for example) and all teams within a primary care network which will include the new integrated mental health teams (sometimes known as 'Hubs' but also known by lots of different names).

Chapter 1: The IPS Team within the Primary Care context

1a) The role of the Employment Specialist

Instead of creating a separate Primary Care IPS Service working with Primary Care Network teams, the preferred model is to have a single IPS service spanning primary and secondary care. Just as with IPS services in secondary care, each Employment Specialist works with a different clinical team: some within primary care network teams, some within secondary community mental health teams.

Employment Specialists are no more isolated in Primary Care Network teams than they are in secondary care, as they work as part of the same IPS service as a vocational unit. In line with the mental health transformation agenda, this arrangement serves to break down barriers between primary and secondary care and facilitates continuity of support.

When someone receiving IPS leaves secondary care, they continue to receive support from the same IPS team, albeit from a different Employment Specialist – the one attached to the Primary Care Network team of which their GP is a member. The aim is to create a fully integrated IPS Service working across primary and secondary care that provides employment support to anyone with severe mental health challenges in a given population who wishes to work. It has been estimated that there should be one Employment Specialist for each Primary Care Network team serving a population of 30-50,000 (NHSE, 2023). However, where resources do not permit this, there are instances where one Employment Specialist might work across two Primary Care Networks.

The role of the Employment Specialist within a Primary Care Network team is not substantially different from that of their counterparts in secondary care community mental health teams except that they work with a different clinical team with a different set of structures. Although structure, organisation and roles within primary care networks vary from one place to another, the Employment Specialist attends Primary Care Network meetings and the key people within the Primary Care Network team with whom they need to work include the Clinical Director, Network Coordinator, managers of nursing (including mental health nursing), the local NHS Talking Therapies service in primary care team and social prescribing link workers.

Relationships with social prescribing link workers may be particularly important as their role is to focus on what matters to the person, to connect people with community opportunities and to offer a holistic approach to health and wellbeing. Therefore, their role in discussing vocational issues with clients and linking people with IPS services may be particularly important.

In relation to individual clients, the Employment Specialist works with anyone who is involved with that individual. As well as GPs this may include practice nurses, practice pharmacists, social prescribing link workers and other roles created under the ‘Additional Roles Reimbursement

Scheme'[3], all of whom may have a role in discussing vocational issues with clients and introducing people with severe mental health challenges to the IPS service.

1b) Integrating Employment Specialists into Primary Care Networks

It is important to ensure that the Primary Care Network team is aware of the role of the IPS service and whom it serves, the importance of work to health and well-being, and their own role in raising vocational issues with clients in the course of their work with them. As IPS is new in primary care, it is necessary to be proactive in contacting all relevant professionals, giving presentations and information about the IPS service. As in secondary care, providing information and forging relationships with a Primary Care Network team can be time consuming in the initial stages, but the benefits of investing this time and energy pay dividends in integrating IPS, ensuring that people can access the service and increasing attention paid to vocational issues across the system.

As in secondary care, it is important to ensure that Employment Specialists remain focused on employment issues and do not get drawn into trying to resolve other challenges that the person is facing. This means that it is important to understand what others in the Primary Care Network team can offer both clinically and in the way of social support, and other resources available in the local area. While clearly GPs, practice nurses and pharmacists will be central in providing clinical and medication support, social prescribers have a major role in addressing social determinants of health and are likely to be an important source of information about other resources available in the community.

Although the transformation agenda makes it clear that the boundaries between primary and secondary care must be broken down, it remains the case that some IPS services are limited by contractual requirements or service specifications that state they can only serve people using secondary care mental health services.

It is really important to check the actual content of these contracts and understand what is actually specified in them: it may have been the practice for IPS services to only to take people from secondary services, but experience suggests that this is not always specified in contracts and service specifications.

Where contracts/service specifications do limit the service to people in secondary mental health services, it is important to ensure that the IPS service is considered as part of transformation planning processes to ensure contracts are adjusted so that the service can:

a) Serve the substantial number of people with severe mental health challenges who receive treatment and support only within primary care, and
b) Continue to provide employment support to those discharged from secondary to primary care (or indeed those returning to secondary care from primary care because of an exacerbation in their mental health problems).

[3] In recognition of the need to better address the social determinants of health, the Additional Roles Reimbursement Scheme (ARRS) provides funding for 26,000 additional roles to create bespoke multi-disciplinary teams in primary care networks in line with the needs of their local population. This may include, for example, mental health practitioners, social prescribing link workers, dieticians, pharmacists, physiotherapists, occupational therapists, nurse associates and health and wellbeing coaches https://www.england.nhs.uk/gp/expanding-our-workforce/

Experience suggests that, in transformation planning, employment support may be overlooked. Therefore, it is important that the IPS service is proactive in engaging in discussions about transformation, its role, and referral pathways, within the new systems. This might be achieved by identifying, and making links with, the Mental Health Transformation Lead within the Integrated Care Board and the Transformation Lead within the local Mental Health NHS Trust.

Chapter 2: Referrals within Primary Care

2a) Defining SMI in a primary care context

IPS services for people with severe mental health challenges operating within primary care cannot hope to meet the employment needs of everyone with mental health challenges who is served by the Primary Care Network. For people with common ('mild to moderate') mental health challenges, as well as the universally available services provided by Job Centre Plus, additional support should be provided from the Employment Advisors within the NHS Talking Therapies service in primary care.

A useful starting point for eligibility for IPS services for people with severe mental health challenges could be those on the Primary Care Severe Mental Illness (SMI) Register who wish to work. However, this register is largely based on diagnosis whilst the '*Community Mental Health Framework for Adults and Older People'* (NHSE/National Collaborating Centre for Mental Health, 2019) makes it clear that complexity cannot be determined by diagnosis alone and must take into account other factors like the nature, duration and severity of problems (including co-morbidities and neurodevelopmental disorders), co-occurring drug/alcohol use, availability and quality of personal and social supports and networks, services' ability to engage with and be accessible to people, problems associated with ageing, co-existing physical health problems and the effectiveness of current/past treatment.

Therefore, there may be some people who do not appear on SMI registers who nevertheless have complex needs and could benefit from IPS support. The NHS England (2023) *'Individual Placement and Support for Severe Mental Illness (IPS for SMI): Guidance for Integrated Care Systems*' also indicates a broader group of people with complex needs than appears on the Primary Care Severe Mental Illness Register.

It is also the case that some people with common mental health problems may not be eligible for NHS Talking Therapies[4] employment support (for example, because of their suicidal ideation) despite the complexity of their problems. Therefore, some services are developing ongoing reviews with the NHS Talking Therapies employment support services to make sure people with complex needs do not 'fall through the net' and develop ways of extending definitions of 'complexity' to prevent this occurring.

Experience suggests that, at least initially, there may be confusion about who is eligible for support from the IPS service for people with severe mental health challenges.

- Sometimes people with common mental health challenges, not just those with severe mental health challenges, may be referred. In this context, relationships with the NHS Talking Therapies in primary care service Employment Advisors team is important. Sometimes the person may be redirected to this service, but the NHS Talking Therapies services have clearly defined criteria for acceptance, so it may be necessary to direct the person to other employment support services available in the local area.

[4] Formerly known as IAPT.

- Sometimes people are referred who do not want to work, but wish to engage in education, voluntary work or resolve difficulties with their social security benefits. Such people should be re-directed to social prescribing link workers or other agencies (like Citizens Advice) who can assist with such issues.

Some IPS services have found it useful to establish triage systems for referrals that both redirect such referrals to other services and resources and provide feedback to the referrer to inform their future referrals.

2b) Referral concerns

Opportunities for self-referral may be particularly important in a primary care setting where traditionally vocational aspirations may not be routinely discussed in consultations. Where someone self-refers, they are asked to provide the name of their GP and consent to the Employment Specialist contacting their GP who is then informed that the person has requested IPS support and asked to complete a brief referral form (see Appendix 3 for an example of a IPS primary care referral form).

There have also been concerns that, within primary care, referrals for job retention support may increase, thus decreasing the capacity of the IPS service to help people to gain jobs and maybe leading to a shift in focus away from those with the most complex needs. Services have typically addressed this possibility by specifying a maximum proportion of 'retention' cases at, say, 25% and managing this closely to achieve an appropriate balance.

Chapter 3: Governance and accountability

3a) Safeguarding clients

The mental health transformation agenda breaks down traditional divisions between primary and secondary care and between statutory, voluntary sector and community services. This necessarily involves determining new governance and accountability arrangements and the determination of such arrangements at a local level is a central part of the mental health transformation agenda in all areas.

It is therefore critical that IPS services align themselves with the new governance and accountability arrangements in their local area and agree arrangements as part of the community mental health transformation process. The best source of information and assistance for IPS services around this is, again, the Transformation Leads in the Integrated Care Board and local Mental Health NHS Trust.

As stated above, everyone using IPS services in primary care is asked to give the name of their GP and provide consent for the Employment Specialist to contact them. The GP is then informed that the person has requested IPS support and asked to complete a brief referral form which includes basic information about risk.

If an Employment Specialist is very worried about someone's mental health, then they can speak to their GP. If the situation is less critical the person can be asked/assisted to make an appointment with their GP. If someone has other support needs (for example, problems with housing or debt or loneliness) they can be referred to others in the Primary Care Team (for example, social prescribing link workers) or other agencies in the community (social prescribing link workers are often a good source of information about what is available). As in secondary care community mental health teams, it is important that Employment Specialists know, or know where to find out, what is available within the team, service, and local community.

There are differences in the management of risk between primary and secondary care services. Typically, primary care only assess risk in terms of suicide ideation and the risk of suicide (Royal College of General Practitioners, 2017).

Unless formal, legal, restrictions are in place (e.g. via the Multi-Agency Public Protection Panel (MAPPA), restrictions imposed by Section 41 of the Mental Health Act or the Sex Offenders Register or a person is assessed as lacking specific capacity under the Mental Capacity Act) people with severe mental health challenges receiving support in primary care are generally deemed low risk and it is safe for them to live and function in their local community.

If there are concerns around the local arrangements for the management of risk in primary care, the best source of information and assistance for IPS services are the Transformation Leads in the Integrated Care Board and local Mental Health NHS Trust.

3b) Safeguarding workers

In terms of arrangements for the safety of IPS workers in primary care, procedures are the same as those adopted in many community mental health teams and other agencies: for example, meeting people in the community, leaving a record of where you are going, when you will be back and reporting in when your appointment has finished.

The usual safeguarding responsibilities and procedures are the same across primary and secondary care but the respective leads for children and adult safeguarding will be different between services. The best source of information and assistance for IPS services around this is, again, the Transformation Leads in the Integrated Care Board and local Mental Health NHS Trust.

Chapter 4: Systems

4a) Different areas, different approaches

Although the '*Community Mental Health Framework for Adults and Older People'* (NHSE/National Collaborating Centre for Mental Health, 2019) has determined the direction of travel and what the community mental health transformation needs to achieve, it is not prescriptive about how this will be done. A variety of structures and arrangements are being developed in in different areas, and different areas are proceeding at different rates. It is therefore vital that IPS services understand the community mental health transformation process in their area and where/how they will be included in the new structures.

Again, it is relationships with the Mental Health Transformation Leads in the local Mental Health Trust and Integrated Care Board that can provide this information and ensure that the systems and structures developed are inclusive of IPS.

4b) Information systems in primary and secondary care

It remains the case that different information systems are used in primary and secondary care. This is a tricky area that affects all aspects of the community transformation agenda, and 'inter-operability' is something that regions are working on as there are often lots of different information systems in place across an Integrated Care Board. Clearly it is desirable that Employment Specialists working in primary care have access to the GP information systems. It may be possible to negotiate this as part of the community transformation agenda.

However, it is possible for an IPS service to operate without access to shared information systems, for example, via sending e-mails for inclusion in the person's notes and direct conversation with other primary care practitioners involved in the person's treatment and support.

It is important for IPS services to understand the local arrangements and emerging systems and policies for sharing of information within the community mental health transformation agenda. As the new local systems are developed it will be necessary for IPS services to update operational policies to reflect the new systems and ways of working.

Commissioning arrangements for IPS services may also change within community mental health transformation as part of longer-term planning. Some IPS services will be commissioned at a place-based level through an Integrated Care Board whilst others might be commissioned at an Integrated Care System (ICS) level in preparation for the operationalisation of Provider Collaboratives. It will be important for IPS services to understand any such changes and agree with respective commissioners what additional data needs to be collected from a primary care perspective. For example, this might relate to referral information, GP practice or Primary care network team.

4c) Record keeping in the primary care context

Irrespective of whether a referral is from primary care or secondary care it remains essential that all IPS services ensure that data flows into the Mental Health Services Data Set (MHSDS). The

MHSDS is the system accounting for IPS access targets (key performance indicator) therefore all IPS services should flow data to the MHSDS.

The adage, 'if it's not on the system, it doesn't exist' applies here – If IPS services are providing support to a person but have not entered the data onto the MHSDS then the work is not counted. Entering data in the MHSDS can be done independently or via a contracting NHS Trust. Support to flow data is available from NHS Digital[5] here and IPS data is reported in a dashboard[6] here.

Whilst the majority of IPS services already flow data into the MHSDS, the quality of this data is often very poor due to missing / invalid entries and ongoing challenges with capturing activity from non-NHS IPS services where data sharing agreements are still not in place to enable direct data entry on MHSDS. Improving the data quality is the responsibility of IPS services and there are a range of resources that can be used to improve the quality of IPS data, which include:

- Step-by-Step Guide[7]: from registration to successful submission of the MHSDS
- Mental Health Services Data Set (MHSDS) Data Quality Submission Summary[8] Tool
- Direct support from NHS Digital MHSDS team: mhsdsdq@nhsdigital.nhs.uk
- IPS Hub[9]: MHSDS dashboard, data quality workshops and data resources
- Mental Health Services Dataset[10] – Data Quality Dashboard

IPS Grow support includes[11]:

- Advice and guidance for IPS services and commissioners
- Development of tools and templates
- Sharing best practice and communities of practice
- Delivery of fidelity reviews
- Support for recruitment and training

[5] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submission-guidance
[6] https://future.nhs.uk/connect.ti/IPSWorkspace/view?objectId=16649264
[7] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submission-guidance
[8] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/validation-summary-generator
[9] https://future.nhs.uk/IPSWorkspace/view?objectId=16649264&16649264
[10] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/data-quality/mental-health-services-dataset---data-quality-dashboard
[11] https://future.nhs.uk/IPSWorkspace/view?objectId=16650960&16650960

Chapter 5: IPS Fidelity and the transformation agenda

5a) The fidelity scale in the primary care context

Both IPS Grow and IPS services that already integrate with Primary Care Network teams serving people with SMI have experienced uncertainty about how to score these services when conducting independent IPS fidelity reviews. In some instances, this has resulted in fidelity reviewers taking different approaches with these services. Typically, a decision has been made to either include or exclude the primary care IPS service from the overall fidelity review.

The decision to exclude is problematic in the context of community transformation as integrated primary and community mental health services are expected to be the norm in England. From an IPS perspective, excluding such services creates doubt as to whether IPS is being implemented as intended within these services. If the IPS service's employment outcomes are low in primary care, it becomes difficult to distinguish between the failure of IPS as an intervention from the failure to implement IPS in primary care.

Within the context of community transformation, it is therefore important to include IPS primary care services serving people with SMI within fidelity reviews. Where IPS fidelity reviews have included such services, it has sometimes resulted in lower scores on some fidelity items due to the context and ways of working in primary care not aligning with some of the criteria or anchor points in the IPS-25 scale.

As already described, community transformation sets a direction of travel for services which means that services, structures and working arrangements are being developed locally and therefore will be different from area to area. For IPS services to be able to adapt to working with primary care network teams in their local areas and operate in line with fidelity, there are three factors that need to be addressed:

1. IPS fidelity reviews and associated fidelity scores must not be detrimentally impacted where IPS services accept referrals for people with SMI from primary care network teams.

2. During fidelity reviews, IPS services need to be able to clearly describe how they work with primary care network teams and how this way of working relates to specific fidelity items. IPS services will need to explain the local service model to fidelity reviewers to ensure they understand how IPS is integrated into primary care network teams to ensure reliability and consistency in approach and scoring.

3. IPS Grow reviews all guidance for fidelity reviews to ensure fidelity reviewers understand and feel confident about how to score IPS primary care services for people with SMI.

A group of IPS Grow regional leads and IPS team/service managers across England looked at the IPS-25 fidelity scale to see whether any adaptations were needed to assess fidelity scale in a primary care context. Five items on the fidelity scale were identified as needing consideration; four items under 'Organisation' and one under 'Services' (see Table 2).

Following a discussion recognising that a Primary Care Network consists of a range of different professionals (GPs, practice nurses, primary care pharmacists, social prescribers for example) and services in primary care including the new integrated mental health teams (sometimes known as 'Hubs' but are also known by other names), a consensus was reached where the unit of measurement in a primary care context is a Primary Care Network. Identifying the unit of measurement is key in fidelity assessments as this shapes the context and parameters of what is being reviewed.

5b) Recommended changes to fidelity in the primary care context

Table 2

Fidelity item	IPS-25 fidelity scale	Recommended changes for working in primary care in England
Organisation		
Item 4	Integration of supported employment with mental health treatment through team assignment: Employment specialists are part of up to 2 mental health treatment teams from which at least 90% of the employment specialist's caseload is comprised.	A footnote be added to this item to reflect that a Primary Care Network team would make up 1 mental health treatment team.
Item 5	Integration of supported employment with mental health treatment through frequent team member contact: Employment specialists actively participate in weekly "client focused" meetings with the mental health treatment team, (not replaced by administrative meetings), that discuss individual clients and their employment goals with shared decision-making. Employment specialist's office is in close proximity to (or shared with) their mental health treatment team members. Documentation of mental health treatment and employment services is integrated in a single client record. Employment specialists help the team think about employment for people who haven't yet been referred to supported employment services.	A footnote be added to this item to reflect that a Primary Care Network team meetings (client-focused) may occur at different frequencies compared to secondary care. It is important for fidelity reviewers to assess whether the Employment Specialist is actively participating in the scheduled client focused Primary Care Network meetings.
Item 8	Role of employment supervisor: Supported employment unit is led by a supported employment team leader. Employment specialists' skills are developed and improved through outcome-based supervision. Five key roles of the employment supervisor: • One full-time equivalent (FTE) supervisor is responsible for no more than 10 employment specialists. The supervisor does not have other supervisory responsibilities. (Program leaders supervising fewer than ten employment specialists	A footnote be added to the third bullet point on this item to reflect a mental health treatment team is the equivalent of a Primary Care Network team. Therefore, supervisors communicate with the Primary Care Network team leaders (Clinical Director of the Primary care Network and or the Network

	may spend a percentage of time on other supervisory activities on a prorated basis. For example, an employment supervisor responsible for 4 employment specialists may be devoted to SE supervision half time.) • Supervisor conducts weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives. • Supervisor communicates with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work. Attends a meeting for each mental health treatment team on a quarterly basis. • Supervisor accompanies employment specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modelling giving feedback on skills, e.g., meeting employers for job development. • Supervisor reviews current client outcomes with employment specialists and sets goals to improve program performance at least quarterly.	Manager/Co-Ordinator). The supervisor attends a meeting of the Primary Care Network team on a quarterly basis.
Item 11	Executive team support for SE: Agency executive team members (e.g., CEO/Executive Director, Chief Operating Officer, QA Director, Chief Financial Officer, Clinical Director, Medical Director, Human Resource Director) assist with supported employment implementation and sustainability.	A footnote be added to this item to include the Clinical Director of the Primary care Network and the Network Manager/Co-Ordinator as part of the example list of executive team support roles.
Services		
Item 25	Assertive engagement and outreach by integrated treatment team: While participation is voluntary, support is not terminated based on missed appointments or fixed time limits. There is systematic documentation of outreach attempts. Engagement and outreach attempts are made by both mental health and employment team members. Multiple home/community visits are made. Families are contacted when applicable. Once it is clear that the client no longer wants to work or continue receiving the supported employment services, the team stops outreach.	This item was considered by the group. It was decided that although the six strategies for engagement and outreach are most likely disproportionate from a primary care perspective, the gold standard for IPS is that the six strategies should be used wherever possible. It was recognised that freedom of choice, shared decision-making and client individualisation are mandatory and standardised elements of the IPS fidelity scale, and this applies to all items.

Chapter 6: Resources

While there has been substantial new investment in IPS, investment has been less than expected in some areas and targets for access to IPS have not been reached. Even with limited resources, decisions have to be made about how these can best be used. It is unlikely to be possible to make significant progress in meeting the required IPS access targets if a significant proportion of people with severe mental health challenges – those receiving treatment and support in primary care – cannot access IPS.

As the mental health community transformation process proceeds, and divisions between primary and secondary care are eroded, it will make less and less sense to restrict access to IPS to those periods when someone requires clinical input from secondary care services. The 'cliff edge' of loss of IPS support when someone leaves secondary mental health clinical care would be reinforced, jeopardising employment prospects.

Therefore, IPS services need to make decisions about the use of resources to serve the employment support needs of people with severe mental health challenges wherever they are receiving their clinical treatment. It is only by doing this that we can hope to move towards the inclusive vision of everyone with severe mental health challenges having the opportunity to access the best evidence-based support to enable them to work.

One of the major fears expressed by IPS practitioners about extending IPS services to include people with severe long term mental health challenges in primary care is of 'opening the flood gates' and services becoming 'overwhelmed' by receiving more referrals than they can hope to handle. However, it should be noted that many, if not most IPS services need to expand access to achieve their long-term plan targets. It should also be noted that:

- While it is likely that, when a service is set up, there will be a 'surge' in referrals of people who have not hitherto had access to employment support, experience suggests that this is not necessarily unmanageable.
- Over time the number of referrals is likely to decrease as the 'back-log' of people wanting employment support is reduced.

Therefore, services should consider starting to work with a limited number of Primary Care Networks before rolling it out to others as resources allow. The creation of networks that bring together providers of all employment support services (e.g., voluntary sector providers, Employment Advisers in NHS Talking Therapy services, other statutory/voluntary sector employment support providers) can avoid waiting lists developing by ensuring that people referred can be directed to the most appropriate sort of support.

However, within this context and not necessarily related to expanding access to IPS in primary care, there are also questions to be asked about the **wise use of resources that we do have** and explore whether more people could receive IPS support with a given resource.

6a). How long should we work with someone to help them to get a job?

Burns et al (2007), in their European randomised controlled trial of IPS, noted that the vast majority of people who were successful in gaining employment did so within the first 9 months of receiving support. This led them to conduct a research trial (Burns et al, 2015) comparing the results offering job-seeking support for only 9 months (but offering the possibility of their being re-referred at a later date) with time unlimited IPS job-seeking support.

They found no significant difference in the number of people who gained employment between time limited job-seeking support and traditional IPS over an 18-month period, but the capacity of the IPS service was greatly increased. During the trial, 91 people were supported by the two Employment Specialists offering 9-month time limited job-seeking support as compared with 69 people supported by the two Employment Specialists offering traditional IPS. By reducing the duration of job-seeking support, the number of people served was increased and the number of job starts increased by 17%.

We would therefore recommend that, rather than imposing fixed limits, if a person has not been successful in gaining employment after 9 months the IPS service perform a personalised review with the individual to explore whether alternative opportunities might be more appropriate to their needs while leaving open the possibility of them returning to the IPS service at a future date. It should be noted that this was the approach taken in the successful trials of IPS in addictions services[12].

6b). How long do we need to routinely support someone once they have gained employment?

A key principle of IPS is time-unlimited support to sustain employment. However, there is clearly throughput: if there were no throughput then an Employment Specialist would ultimately have a caseload that consisted entirely of people receiving ongoing support in employment. The question arises about whether everyone requires continuous ongoing support. Burns et al (2015) suggested the possibility of limiting the duration of routine in-work support to 4 months (with the possibility of coming back for more help if necessary) but their study was not long enough to provide conclusive results.

Data from South West London (corroborated by other IPS services) was that a lot of people only appear to require ongoing support for the first 3-4 months after beginning a new job and those who need support thereafter drops dramatically with time. If caseload management has become somewhat ‘sluggish’, some people may continue to receive ongoing support in employment when they do not really need it, thus depriving others of the chance to benefit from the IPS service.

One IPS service found that actively exploring whether people required routine ongoing support and keeping a register of ‘inactive’ or ‘light touch’ clients who were settled and prospering in work was effective. The service kept in touch with these people (via phone), and they could return for extra help if problems arose, but capacity was released to take on new clients.

[12] It should be noted that this sort of time-limited job-seeking support was provided in the successful trial of IPS for people with addictions https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-021-05673-z

There will be some people who need routine ongoing support, so the possibility of offering this should remain open, but there are also many people who do not. We would therefore suggest a more active approach to 'caseload management' where, after 4 months of in-work support, a personalised review is conducted with the person to ascertain whether they need ongoing support, with the clear indication that they can return to the IPS service if they need further assistance.

Again, this was the approach adopted in the successful trials of IPS in addictions services[13]. It may also be helpful not simply to specify the number of people on Employment Specialists' caseloads, but also to specify the number of people an Employment Specialist is expected to support in a year (maybe 40 – 50 people). This encourages active management of caseloads to establish whether people really need continued Employment Specialist input.

It may also be possible to explore other sources of ongoing support. For example:

- It may be possible for another member of the primary or secondary care team to provide some ongoing employment support via their routine ongoing contact with the person – maybe a community psychiatric nurse, or a GP, a practice nurse – if they could access extra assistance from the IPS service if problems emerged. Alternatively, a relative or close friend, or an employer, may be able to provide some ongoing employment support for the person if they could call on the IPS service if there were difficulties.
- Use may also be made of the DWP 'Access to Work'[14] programme which provides resources for the adjustments that a disabled person needs to remain in work. Typically, this is used to fund aids and adaptations for people with physical or sensory impairments, but it can also be used by people with ongoing severe mental health challenges. For example, it could provide support to manage mental health at work or provide transport to work but, again, the possibility should be left open for the person to come back for additional assistance from the IPS service if needed.

Clearly some people will need routine ongoing support from the IPS service but for those who are settled in work, actively exploring alternative sources of ongoing support and/or offering the possibility of coming back to the IPS service if further help was needed may be effective in sustaining employment and free up resource to serve more people.

6c) Do caseloads really have to be restricted to 20?

In all of the original research on IPS the recommended caseload for an Employment Specialist was 25 in line with the original IPS-15 fidelity scale. It is only more recently that recommended caseload size was reduced to 20 in line with the revised IPS-25 fidelity scale. In an era of limited resources, the question might reasonably be asked if it is wise to return to the original caseload of 25: it was, after all, services with caseloads of 25 that demonstrated the effectiveness of IPS. This again, would greatly increase the capacity of an IPS Service to offer support to more people.

[13] It should be noted that this sort of time-limited job-seeking support was provided in the successful trial of IPS for people with addictions https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-021-05673-z
[14] https://www.gov.uk/access-to-work

6d) Could small group support add value to individual support?

A key premise of IPS is that individual support is offered, tailored to the person's needs, wishes and preferences. This is critically important. However, it is possible that, this might be complemented by providing additional support on a small group basis. The value of peer support has been widely recognised (see for example, Repper et al, 2013) and providing some small group support could have the added value of providing both peer and professional support within IPS services. Not everyone values working in groups, but some people gain a great deal from the ideas, support and comradeship of others who face similar challenges.

For example, could group introductory sessions be offered, as well as individual ones, to introduce people to the IPS service and what to expect? This would enable people to see whether they wanted the sort of support IPS can offer and afford them the opportunity to see that they were not alone and have an opportunity to meet others facing similar challenges.

Could some interview practice be conducted on a group basis? What about some CV writing and some job-search activities? What about issues relating to 'disclosure' – the sharing of personal information at work? Such small group activities would enable people to gain ideas and support from each other and enhance the support provided.

It should be noted that some Recovery Colleges have been offering a range of employment related courses, often co-produced and co-delivered by Employment Specialists and people who have used the IPS service. These include, for example, 'return to work', 'CV writing', 'keeping well at work' courses and workshops. It may be that, for some people, these opportunities would add value to the individual work conducted within the IPS service.

Conclusion

As traditional divisions between primary and secondary care, and between statutory, voluntary sector and community provision are eroded in the community mental health transformation programme, the face of mental health support for people with severe mental health challenges is changing. Many people facing such challenges will receive their treatment and support in a primary care setting, and where people do require the additional input of a secondary mental health team, this is likely to be for relatively short periods of time.

This means that IPS services must increasingly work across the traditional primary and secondary care divide – integrate with and work within both secondary mental health community teams and the new, enhanced, Primary Care Network teams – and work as part of a network of statutory, voluntary sector and community services.

In this briefing paper we have tried to draw together information and experiences to assist IPS services in this changing landscape, but for everyone in the mental health arena, this is a journey of discovery and we are learning all the time. An underpinning question that has been consistent through the development of this briefing paper has been whether IPS services are actively engaged in the thinking and discussions about their local community mental health transformation programmes.

IPS services having relationships with the Mental Health Transformation Leads in the local Mental Health Trust and the Integrated Care Board are key to successfully integrating and operationalising IPS in the new ways of working across primary and secondary care services. Hopefully the ideas we have shared here will provide a useful starting point, but it will be important that we continue to share our learning as the journey continues.

Further Reading

- Mental Health Transformation Agenda Briefing for IPS Leaders
- Individual Placement and Support (IPS) for Severe Mental Illness (SMI): Guidance for Integrated Care Systems
- IPS Infographic for Commissioners
- Partnership Agreement

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Appendix 1

Members of the Working Group who contributed to this briefing paper chaired by **Rachel Perkins**, (BA, MPhil (Clinical Psychology), PhD OBE, Senior Consultant, ImROC Chair, IPS London Non-Executive Director of The Recovery Focus Group and Health Employment Partnership)

IPS Grow

Gary Johnson – Director Of Health Employment Partnership Operations
Carolyn Storey – Operations Manager

External

Helen Ramkhelawon - NHS England
Robert Baxter- South West London and St George's Mental Health NHS Trust
Rash Patel - Central and North West London NHS Foundation Trust
Elaine Coe - Norfolk and Waveney Mind
Martin Dominy - Southdown

Appendix 2

People involved in the consultation around IPS Fidelity and Primary Care led by **Miles Rinaldi** (BA (Hons), DipPsych, Head of Recovery and Social Inclusion at South West London and St George's Mental Health NHS Trust)

IPS Grow

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Gary Johnson – Director Of Health Employment Partnership Operations
Carolyn Storey – Operations Manager
Jan Hadfield – Business Manager
Amelia Willett – Regional Manager South
Gareth Hayes – Regional Manager Midlands
Joanne Barber – Lead Midlands
Laura Baines – Lead North West
Adele Marshall – Lead Midlands
Georgia Saxelby – Lead North East and Yorkshire
Yasmin Begum – Lead North East and Yorkshire
Stewart Cornelius – Lead South East and London
Matthew Clarke – Lead Midlands
Julia Stapleton – Lead London
Joss Hardisty – Lead North West
Nosheen Zabir – Lead Yorkshire and North West

External

Helen Ramkhelawon - NHS England
Robert Baxter- South West London and St George's Mental Health NHS Trust
Rash Patel - Central and North West London NHS Foundation Trust
Elaine Coe - Norfolk and Waveney Mind
Martin Dominy - Southdown

Appendix 3:

Sample referral form from Norfolk and Waveney Mind IPS Service

Norfolk and Waveney Mind is a forward-thinking, community-based organisation which encourages and supports mental wellbeing.

Referral Source:
☐ Self-referral
☐ Community Mental Health Team (Please state clinical team):
☐ PCN (Please state):

Before starting this form, please confirm our eligibility criteria that the patient:
☐ Is aged 18+
☐ Has the right to work in the UK
☐ Has a mental health diagnosis or has been receiving professional support for their mental health for over 6 months *****Not applicable for referrals from CMHT

Please tick **either** A, B or C:
☐ A) Is unemployed
☐ B) Is currently employed
☐ C) Is currently on sick leave and would like support to return to work

Personal Details
To include: Name, address, date of birth, NHS ID, phone number, email address, gender and ethnicity
Please indicate their preferred method/s of contact: ☐ Text ☐ Telephone ☐ Letter ☐ Email
Do they have additional communication needs?

Referrer & Patient's GP & Surgery Details
To include: Referrer's name, job title and email address/phone number, name of patient's GP and surgery address.

Please attach the combined assessment or answer the questions below
What is their Clinical Diagnosis, if they have any? **Are there any risks from the past 12 months?** **Have they ever been involved with the criminal justice system? If so, are they involved with the Probation Service or MAPPA?** **Do they have regular contact with their Lead Care Professional/Mental Health Worker?**
Why do they want to work? (In their own words)

Have they already accessed Routes support before?

☐ Yes ☐ No

Please sign and date

Referred person Date:

Referrer Date:

Please also sign the below data protection form and return to:
Employment@norfolkandwaveneymind.org.uk

Data Protection: Referral Consent Form

Permission to store and process your data:

To help with your referral and any support you receive from Norfolk and Waveney Mind we will need to record your details. These will include personal and sensitive data. (Personal data is information that can be used to identify you, for example: your name, DOB, address etc. Sensitive data is information related, for example, to health, racial or ethnic origin)

To comply with The Data Protection Act 2018, we as data controllers must ask your permission to store and process your personal and sensitive data. Your data will be stored on a cloud based electronic database accessed by employees (data processors) of Norfolk and Waveney Mind. Paper copies of your data may also be stored securely and accessed by authorised employees of Norfolk and Waveney Mind. Your data will continue to be stored for 6 years from the date you leave our service and will then be deleted at the end of this period.

If we need to share your information, we will only do this if there is a **clear and legitimate purpose for sharing and we have your consent** or **there is a lawful reason to share your information.**

I give my consent for Norfolk and Waveney Mind to record and process personal data about myself.

Name			
Signature		**Date**	

I give my consent for Norfolk and Waveney Mind to record and process sensitive data about myself.

Name			
Signature		**Date**	