Briefing note for commissioners and procurement teams

Individual Placement and Support services

This document is intended as a resource for commissioners to use in the commissioning and procurement of Individual Placement and Support (IPS) services in their areas. It should be read in the context of relevant legislation, local and national procurement regulations, and other commissioning requirements.

This forms part of a suite of guidance documents, tools and templates developed by IPS Grow, a consortium that includes NHS England, the Work and Health Unit, the Centre for Mental Health, Social Finance, and a number of IPS Centres of Excellence, including Central North West London NHS Foundation Trust, South West London and St George's Mental Health NHS Trust, Northamptonshire Healthcare NHS Foundation Trust, and Southdown.

This Briefing Note provides supporting guidance on the following template documents:

- IPS Grow Model Service Specification: Mental Health and Employment Service (Individual Placement and Support)
- IPS Grow Finance Model Template
- IPS Grow Outcomes Target Calculator
- IPS Grow Method Statement Template

Last updated: June 2018

Commissioning and Procuring Individual Placement and Support Services

Briefing note

Introduction

Context

1. The note provides guidance to both NHS and Local Authority commissioners and procurement teams looking to develop Individual Placement and Support (IPS) services in their area. It has been developed by the IPS Grow consortium and forms part of a suite of materials created for commissioners and providers of IPS services.
2. This note should be read in conjunction with the IPS Grow Commissioning Guidance for Supported Employment services.
3. It is specifically designed to accompany the Model Service Specification and other procurement templates that have been developed for commissioners launching an open procurement process to select one or more IPS providers. However, it recognises that there are a range of ways of commissioning IPS services, not all of which will involve an open market procurement.

Purpose

1. The Model Service Specification has been designed for a typical high-fidelity Individual Placement and Support (IPS) service based in secondary mental health services.
2. NHS England has committed to doubling access to this type of IPS service, targeted at people with severe mental illness, by 2021.[1] IPS has also been endorsed by NICE as a recommended intervention for adults with psychosis and schizophrenia.[2]
3. 24 Randomised Control Trials have shown that IPS supports more people with severe mental illness to return to work than alternative models.[3] A 25-point fidelity scale has been developed to measure adherence to the IPS principles. Evidence suggests that there is a correlation between high scores on the fidelity scale and the achievement of employment outcomes.[4]
4. However, there are a number of factors to take into account when commissioning and procuring an IPS service that are not covered by the fidelity scale.
5. This note provides guidance to commissioners to enable them to make informed decisions on the different elements to include in their service specifications, contracts, and other service documentation.

---

[1] "The Five Year Forward View for Mental Health", NHS Engalnd (Feb 2016) – Recommendation 5
[2] https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-5-supported-employment-programmes
[3] https://ipsworks.org/index.php/evidence-for-ips/
[4] http://www.worksupport.com/documents/jvr_predictive_validity_individual_placement.pdf

6. It also provides guidance to procurement teams on considerations around procurement of IPS services.

Service design

Time-limited IPS

7. One of the principles of IPS is time-unlimited support for the person and their employer. Time-unlimited support, accompanied by the low caseloads required in IPS services, can cause operational challenges since it severely limits the number of people who can benefit from the service in any year.
8. A Randomised Control Trial, published in 2015, found that providing a time limit on IPS support did not materially affect long-term job outcomes achieved.[5] In that case, the service was limited to 9 months for those still unemployed or 4 months once an individual found work. This increased the capacity of the service significantly compared to traditional IPS.
9. Given the limited evidence for time-limited IPS, commissioners should decide for themselves whether to procure time-limited or time-unlimited IPS. If they opt for time-limited IPS, they would also need to determine the appropriate length of time for the intervention, both for individuals who remain unemployed and for those who enter work. They will also need to consider what support might be available for those who do not get a job within nine months – for example, sign-posting to alternative services.
10. It should also be noted that a key advantage of IPS is its ability to tailor support to individual needs. Deploying time-limited IPS should not prevent services from working with exceptional cases for a longer period if there is a clear case for doing so.

Eligibility

11. Another principle of IPS is “zero exclusion”, which means that everyone should be eliglble for the service as long as they wish to seek paid employment.
12. In practice, it is common for commissioners to place some basic restrictions on eligibility. For example, services are typically open to those:
    a Over the age of 18
    b Who are registered with a GP in [area]
13. Commissioners will need to make several further decisions about eligibility:
    a Diagnosis. NHS England funding is aimed at services providing support to people with a severe and enduring mental health issue. A number of trials and pilots are under way to determine whether IPS is effective for people with other diagnoses;
    b Care Programme Approach. The Adult Social Care Outcomes Framework (ASCOF) Indicator 1F measures the “proportion of adults in contact with

[5] IPS-LITE Trial: http://bjp.rcpsych.org/content/early/2015/06/09/bjp.bp.114.152082

secondary mental health services in paid employment". This indicator is also referenced in the NHS Outcomes Framework (indicator 2.5i) and in the Public Health Outcomes Framework (indicator 1.8). The definition of this indicator restricts the target cohort to people on the Care Programme Approach (CPA). However, it is not recommend that eligibility for an IPS service is restricted to people on CPA, since this unnecessarily prevents some people with a severe mental illness from accessing the service;

c Target mental health teams: Commissioners may wish to focus IPS services on a specific set of mental health teams, especially where there is insufficient resource to provide comprehensive coverage. Although IPS does not target any specific conditions or any particular part of the treatment pathway, some areas have prioritised early intervention teams and multi-speciality community mental health teams over complex care or crisis teams. This prioritisation is best conducted in conjunction with the Mental Health Trust to ensure joint ownership over the decision;

d Employment status. IPS is focused on people who are out of work, rather than those who are off sick or struggling in work. Many IPS services do work effectively on a preventative basis with clients who have not yet fallen out of work. Commissioners will need to determine to what extent they wish to fund job retention in addition to the core IPS service in their area, recognising that job retention does not form part of the core high-fidelity IPS model (see note on Job Retention below);

e Re-referrals. Commissioners will need to determine how to treat clients who exit the IPS service and wish to be re-referred to the service. In some cases, commissioners have set a minimum time period before re-referral is allowed;

f Discharge from mental health services. Commissioners will need to determine whether to restrict eligibility to people who are currently on the caseload of NHS secondary mental health services. In some cases, in particular where NHS mental health trusts are themselves the provider of IPS, the IPS service automatically discharges anyone who is discharged from the mental health service. It is recommended that IPS services are required to continue working with individuals, subject to need and potenital time limits on IPS support, even if they are discharged from mental health services.

Integration with the Mental Health Trust(s)

14. The fifth IPS principle is that IPS employment specialists are integrated into mental health clinical teams. This is critical to enable a steady flow of appropriate referrals; encourage positive conversations about employment between clinicians and service users; and enable the IPS specialist to focus on employment while the clinical staff focus on treatment.

15. However, integration can be very challenging to deliver in practice. It requires a shared commitment between commissioners, IPS providers, and the clinical staff and leadership of the relevant mental health trusts.

16. To facilitate this, commissioners can build in to their procurement process a number of useful tools and tactics. These include:

    a Encouraging providers to arrange for employment specialists to have honorary employment contracts with the mental health trust. This facilitates the use of IT equipment and other office facilities and builds buy-in from the trust for the service. An example honorary employment contract is provided as part of the IPS Grow materials available at www.ipsgrow.org.uk;

    b Encouraging providers to sign a Partnership Protocol with the commissioner and mental health trust, outlining each party's responsibilties with respect to successful implementation of the service. An example Partnership Protocol is provided as an annex to the model service specification. Ideally, commissioners would have engaged with the mental health trust beforehand to ensure the trust is satisfied with the contents of the protocol;

    c Providing detail on the mental health teams in the locality, including their active caseloads. This allows providers to plan well in advance for integration with the most appropriate teams. A template for this is provided as an annex to the model service specification;

    d Providing any guidance on which teams they believe IPS should be integrated into, although it would be helpful to retain some flexibility around this as discussions evolve with the trust.

17. Note that this section mainly applies to commissioners using an open procurement process, i.e., where the mental health trust is not the default provider of IPS services. However, even if the trust does employ IPS staff in-house, it is still vital for the trust's senior leadership to be engaged in the employment agenda and to support the integration of the service into clinical teams.

Fidelity assessments

18. To ensure that services are adhering to IPS principles, commissioners typically require that services are assessed against the internationally-validated 25-point fidelity scale.

19. There are a number of ways that fidelity can be assessed:

    a Self-assessment by the service itself

    b Peer assessment by a service that scores highly on independent IPS fidelity reviews

    c Assessment by a specially-trained IPS fidelity assessor. For example, the Centre for Mental Health runs a programme to assess the fidelity of IPS services. Services that score 100 or above ("Good") become part of their Centre of Excellence network

20. While all of these approaches are valid, it is recommended that services are required to undergo an independent assessment of their IPS fidelity 18 months after launching. They should be aiming to achieve a score of 100 or above by this point.

21. In the interim, it is recommended that services conduct a full self-evaluation every six months after launch to understand their strengths and areas for development.
22. Ensuring the ongoing fidelity of service delivery between reviews is best achieved by gathering operational management information linked to the fidelity criteria. Although commissioners should not necessarily mandate for this data to be collected, the best IPS services will typically aim to do so. These data items include:
    a Evidence of integration into the clinical team
    b Access to fidelity based employment supervision
    c Caseload size
    d % people supported to job seek within 4 weeks (target 75%)
    e Average no of days from initial assessment to first face to face employer contact.
    f New employment starts by time spent in IPS services from initial assessment to employment, i.e. less than 6 months, 6-12 months, and more than 12 months
    g Number of weekly face to face meetings with employers

Job retention

23. As described above, the core IPS model is focused on people who are out of work. However, many IPS services work effectively with people who are either in work and struggling or in work but off sick to prevent them from falling out of work. This is known as job retention to distinguish it from the in-work support provided to those who entered IPS out of work and were helped into employment by the service.
24. Commissioners should consider three elements around job retention in their service design:
    a Eligibility. Commissioners should decide what, if any, additional eligibility requirements should be put in place for those already in work. For example, commissioners might limit job retention cases to those who are off sick or, alternatively, allow anyone who who needs help at work to access support
    b Proportion of caseload. Given that job retention is outside of the fidelity model, commissioners are advised to limit the proportion of job retention cases within the IPS caseload. This can prevent the service being dominated by those in work, limiting access to those who are out of work. Commissioners may also advise that job retention is performed by a distinct job retention worker rather than the IPS employment specialists in order to maintain clarity of function
    c Outcomes. Defining a successful outcome for a job retention case is more complex than for a typical employment support case. This is because people in work are much more likely to have retained their job without support than people out of work are to find new work. A job retention outcome also has to be measured at a defined time from referral (e.g., after

three months and six months) whereas a new job start is measured at the point it is achieved. Commissioners will need to determine how they wish providers to report on job retention outcomes.

Staffing

25. Getting the right staff into IPS services can be a major challenge. IPS employment specailists need to have a positive, optimistic attitude and a belief that anyone can get into work. They need to be determined, persistent, and energetic. They need to be able to engage well with clinical teams, but also be persuasive with employers. IPS team leaders need to be fluent in the IPS model, able to manage and coach a sizeable team in a remote working environment, and must be credible in front of frontline clinicians and senior leaders in the trust and wider community.
26. For this reason, commissioners may choose to take a more prescriptive approach to the required staff banding, skill level, and recruitment processes that providers should use. The model service specification suggests that commissioners may want to recommend:
    a Band 5 (or equivalent outside the NHS) for IPS employment specialists, with appropriate London weighting
    b Band 6 (or equivalent outside the NHS) for IPS team leaders with appropriate London weighting
27. Comissioners may also choose to require IPS staff to be trained to an appropriate level in both the IPS model and other key service requirements (e.g., safeguarding, data systems, NHS trust induction).
28. Providers will also need to ensure that they put in place appropriate supervision arrangements for their staff. This includes direct supervision and coaching from an IPS team leader, but also clinical supervision from their host clinical teams.
29. In addition to the core IPS staff, it can be important for providers to make provision for admin or business support to help with data collection, IT system development, meeting planning, and payment calculations. Commissioners may choose to require providers to explain how these functions will be performed.
30. A wide range of resources to support the recruitment and training of IPS staff is available at the IPS Grow website, www.ipsgrow.org.uk. Commissioners may wish to recommend that providers use these materials to ensure consistency and deployment of best practice.

Management Information and Data Requirements

31. Best practice IPS services have had access to service user case notes via the mental health trust's standard case management system. This is facilitated for an external provider by having honorary employment contracts for their staff. In some cases, getting access to Trust systems has taken a considerable length of time (e.g., 2-3 months). Commissioners should be aware of this when considering the timescales for implementation and mobilisation.
32. Access to case notes not only supports closer integration between health treatment and employment support, but also allows IPS staff to ensure

completion of relevant Mental health Services Data Set (MHSDS) fields. These include:

c Referral to the IPS service. This records that the service user has been referred to, and is receiving, IPS. This is particularly important to support the measurement of NHS England's goal to double access to IPS nationally

d Employment status. This should be updated regularly to ensure it is accurate. It supports measurement of the ASCOF / NHS / Public Health England outcome around the proportion of people in contact with secondary mental health services in paid employment. It also enables clinical staff to have a better understanding of their service users.

e Hours worked

33. Aside from inputting into NHS case management systems, commissioners have not typically mandated a specific Management Information System for the operational delivery of IPS.

Key performance indicators and outcomes

34. A minimum data-set has been developed to reflect the key outcomes that IPS services should aim to achieve and should, therefore, report on. These have been included in the model service specification.

35. Commissioners will need to determine to what extent they require the provider to evidence job outcomes achieved. Suggested forms of evidence are provided in the model service specification.

36. An outcomes target calculator has been provided to give commissioners an approximate indication of what outcomes might be expected from a particular level of investment.

Payments and finances

Payment structure

37. Commissioners will need to determine what, if any, share of the contract value should be linked to outcomes (Payment-by-Results). A number of different payment structures have been tested, including 0%, 10%, 25%, 50%, and 100% outcomes-based contracts. There is no current evidence for what level of outcomes-based payments has the greatest impact on service delivery although some commissioners have had a negative experience with high levels of Payment-by-Results (above 50%).

38. If commissioners choose to link payment to outcomes, it is recommended that they use a simple set of outcome metrics. This could include the number of people supported to start work ("job starts") and the number of people sustaining their jobs for 13 weeks. It should be noted that linking payment to longer sustainment outcomes (e.g., 26 weeks or 52 weeks) may create data collection

challenges for providers, as some clients choose to disengage from services once they are settled in work.

39. A financial model template has been provided along with the model service specification.

Value Added Tax (VAT)

40. VAT should be expressly considered in the design of the financial element of the service specification and of the procurement approach as a whole.

41. This note cannot provide advice to commissioners on VAT treatment. However, commissioners should note:

    a The differences between Local Authorities, Combined Authorities, Clinical Commissioning Groups, and other public and private bodies in their ability to recover VAT charged on service provision

    b That VAT exemptions for different kinds of health and welfare services apply differently to public bodies, charitable providers, and private companies

42. Commissioners should seek advice if in doubt on the VAT implications of their procurement approach.

Procurement approach

Contracting models

43. IPS is currently delivered in the UK by a mixture of NHS, voluntary sector, and private sector providers. This creates a number of potential procurement and contracting options for procurement teams:

    a Open market procurement

    b Contract variation on an existing employment services contract

    c Negotiation with an NHS provider on re-allocation of funds within an existing block contract

44. The right approach will depend on the existing landscape of services locally and whether the commissioner is an NHS Clinical Commissioning Group (CCG) or Local Authority.

45. One key consideration is whether there are existing IPS services embedded into the Mental Health Trust outside of the local commissioner's boundaries. In these cases, commissioners and procurement teams may consider whether working with the existing provider is clearly the best option to extend IPS into their area.

46. In some areas, an NHS Trust may already be delivering an employment service within their mental health teams. In these cases, NHS commissioners may prefer to simply negotiate a change in their existing block contact to re-orient the service towards IPS, or to make IPS a core part of the care package. Other commissioners may prefer to test the wider market to achieve value-for-money.

47. Many IPS services are funded by a combination of CCGs, Local Authorities, and other funders (for example, Jobcentre Plus districts). In these cases, commissioners will need to determine the lead commissioner for the service. Note that the treatment of VAT may differ between CCGs and Local Authority commissioners, and between public and voluntary sector and private providers (see above).

Use of competitive dialogue

48. There has been a significant growth in the use of competitive dialogue in the procurement of IPS services. This has allowed commissioners to engage in discussions with potential providers around the viability of their staffing model (e.g., salary levels), the integration approach, and caseloads and outcomes.

Method statement

49. Commissioners will need to determine the quality/price split for their service. In some cases, commissioners have opted to use the "price" element to allow providers to bid for higher outcomes rather than a lower overall contract value. For example, instead of committing to deliver 100 job outcomes for the contract value, they could bid up to 120. Where there is a payment per job outcome, this automatically reduces such that the full contract value can only be earned if the higher job outcome target is achieved.

50. A model method statement has been provided along with the financial model template and model service specification. It includes suggested weightings on cost/quality and on different quality components. However, commissioners will need to make their own determination on the right set of questions and weighting for each component.

51. The model method statement does not include pre-qualification questions. Commissioners may choose to use this section to require providers to share case studies of other IPS services they are involved in delivering and/or other services that require integration with mental health teams or support people with health conditions into employment.

Co-production

52. There are a range of approaches to embed principles of co-production in pocurement. Examples include:

    a Engaging service users and people with lived experience in the development of the service specification

    b Involving people with lived experience in scoring bid questions, such as service delivery, and bidder presentations, as well as in score moderation