REPORT

Centre for Mental Health

Making Individual Placement and Support work

An evaluation of implementation and sustainability

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Contents

InHealth ASSOCIATES

An independent report by David Gilbert and Rachel Papworth of InHealth Associates – an independent patient-centred organisation providing evaluation and strategic advice in health and social care.

Foreword

Support with employment is an important part of recovery for many people living with a mental illness. Yet in many parts of the UK, effective help is not available where people live, and as a result too many people using mental health services don't have the option of evidence-based employment support.

For more than a decade, Centre for Mental Health has been working to change that, by helping more local areas to adopt the principles of Individual Placement and Support in their employment services for people with mental health problems. In that time, we have seen the number of IPS services grow, from very few ten years ago to many more today across England. But significant gaps remain and we are seeking to ensure that no one is left out because of their postcode.

The Making IPS Work programme was a unique opportunity to bring the benefits of IPS to mental health services in areas where they previously did not exist. With funding from the Department of Health, we were able to work with mental health services in six local areas to help them to adopt the principles of IPS and help more people into employment.

This report is an independent evaluation of the Making IPS Work programme, produced by InHealth Associates. It provides invaluable learning about the process of implementing IPS in mental health services at a crucial time in history.

In 2016, the *Five Year Forward View for Mental Health* set out the NHS's plans for improving mental health services nationwide. Included within it was a pledge to double the number of people accessing IPS. Our estimate is that about 10,000 people currently receive an IPS service each year in England. This welcome pledge will mean that many more people will get effective help with employment as part of their mental health support: it has the potential to change thousands of people's lives as well as addressing the postcode lottery in IPS provision across the country.

Centre for Mental Health supported the NHS Benchmarking Network to collect information on all supported employment available for people recovering from severe mental illness and to assess how much of this meets the criteria for an IPS service. We joined NHS England in presenting webinars and six regional workshops across England where the IPS approach was described and the opportunity to participate in the programme to double current provision by 2021 was discussed. Centre for Mental Health will be ready to provide the consultancy, staff training and implementation support which these new services will need, to establish themselves as effective, high quality employment services.

The lessons contained in this report, will, we hope, inform the delivery of the *Five Year Forward View* pledge, and ensure that the implementation will be as effective and transformative as it has the potential to be across England.

Jan Hutchinson, October 2017
Centre for Mental Health

Executive summary

For many people who use mental health services, having a job is an important part of recovery; yet few get the opportunity to look for paid work with the right support.

This is a report of an evaluation to explore the critical success factors for the implementation and sustainability of Individual Placement and Support (IPS), an evidence-based approach to supporting people using mental health services with employment.

It focuses on six sites where the expansion of IPS was funded by the Department of Health and supported by Centre for Mental Health through the Making IPS Work programme:

- Berkshire;
- Bradford;
- Lincolnshire;
- Luton & Bedfordshire;
- Northamptonshire;
- Wiltshire.

The benefits of IPS

In each area, the people interviewed for the project were overwhelmingly positive about IPS: in terms of its effectiveness in supporting people to get work; in terms of its wider benefits to people's confidence, skills, wellbeing and daily life; and in terms of the knock-on effects on staff morale and confidence within teams.

IPS services are staffed by Employment Specialists, working as members of clinical teams in mental health services. They were seen by the people interviewed for the evaluation as kind and professional: providing a 'person-centred' service, approachable, non-judgemental and able to build trusting and constructive relationships.

Implementation challenges and opportunities

Implementing IPS is a significant change requiring significant change management skills and time. It means changing the practices and roles of staff as well as bringing about a major culture change. But there was less resistance to the implementation of IPS from clinical staff than some expected.

Teams of employment specialists benefited from having people with a diverse range of professional backgrounds and specialisms (for example in benefits advice or employer engagement); but passion, commitment and person-centred values are as important as professional skills.

Learning and development are crucial for the creation of a growing IPS workforce: including not just formal training but opportunities to share learning with each other.

Clear management and supervision arrangements are vital for employment specialists to avoid confusion about accountability and priorities.

Relationships with mental health teams are crucial to ensure IPS services get timely referrals of people wanting help with work, and to raise the profile of employment within clinical teams.

Managing caseloads is important to ensure that employment specialists are able to offer a high-fidelity IPS service.

Partnership working can be difficult for IPS services, particularly with the Department for Work and Pensions (DWP); however some employment specialists developed good relationships with Jobcentre Plus staff. Partnership working with the voluntary sector is also key to success.

Organisational factors

Organisational factors that can help the adoption of IPS include:

- The presence of 'pioneers' within the organisation who have already used IPS;
- Values-driven leadership and a culture linked to wider notions of recovery;
- Strategic oversight and corporate support at every level;

- Visibility and high profile within the organisation;
- Good relationships with other employment service providers, particularly in the voluntary sector;
- Being able to withstand change, including in relation to staff turnover, restructuring, commissioning and national policy.

Sustainability

A major challenge for the implementation of IPS is to ensure it is sustained long-term. This is particularly challenging at present due to wider financial difficulties in the NHS, where IPS is a 'small fish in a big pond' for which it is not easy to protect funding.

Relationships between providers and commissioners varied between the different sites; where they worked well together it was easier to embed IPS within wider strategies and plans. In other areas, sustaining funding was extremely difficult and required considerable effort, for example seeking charitable funds to maintain services.

National leverage for IPS will be essential to make it a priority for commissioners to sustain funding nationwide beyond the *Five Year Forward View* implementation phase.

Recommendations

For the *Five Year Forward View* pledge of doubling IPS provision to be achieved and sustained, an Implementation Hub will be needed to support this process and ensure fidelity is maintained.

The report makes a series of recommendations to help organisations to expand the provision of IPS, building on the learning from the Making IPS Work project.

Centre for Mental Health implementation staff

Implementation Manager

The Implementation Manager is responsible for establishing the IPS service within a trust by developing the operational procedures and recruiting Employment Specialists. They oversee the quality and performance of the service, and provide training and supervision for the IPS team. They ensure sustainability of the service, prepare it to achieve 'Centre of Excellence' status within 18-24 months, and act as a champion for IPS supported employment within local mental health and social care services.

Team Leader

The Team Leader provides line management, training and supervision for Employment Specialists in the team. They seek out employers to secure employment opportunities and provide ongoing support to meet employee and employer needs. Team Leaders may hold a small caseload of job seekers, and they support the Implementation Manager to identify resources to secure ongoing sustainability of the service.

The benefits of IPS

Our focus was on how organisations implement and sustain IPS, not the model itself. However, attitudes towards the model influence implementation. And, on the whole, people were reassuringly positive about IPS – its purpose (the focus on paid employment), approach (dedicated Employment Specialists and their integration in mental health teams) and process (e.g. support provided to reach a client's goals).

Monitoring and performance management has been undertaken as part of the wider programme and did not form part of this evaluation. However, it's worth reporting that in conversations with clients and staff on implementation, we heard striking endorsement of the immense benefits of IPS – not just in helping people find jobs (universally seen as crucial in recovery) but also on people's confidence, skills, wellbeing and other aspects of daily life.

IPS represents a huge shift in thinking, an effective 'upskilling' for health professionals and an opportunity to raise expectations amongst clients. Many clients have been held back and institutionalised within mental health services. Where mental health services have had a focus beyond care and treatment, they have usually focused on getting service users into voluntary work. It has usually been the task of social care to support employment.

We heard striking stories of success from IPS teams and health professionals for people with particularly challenging circumstances (for example, a criminal record, literacy issues or having lived in deprived areas).

This positive view is shared by clients, Employment Specialists, health professionals, managers and senior leaders. This has had a knock on effect on staff, boosting morale and professional confidence within teams.

Employment Specialists are seen as kind and professional. The service they provide is person-centred, for example in supporting clients to seek employment suited to their needs and interests.

We heard many examples of Employment Specialists' 'humanity' – their approachability, non-judgemental nature, sensitivity to people disclosing their mental health status, being capable of developing trusting and constructive relationships with clients, providing strong support, encouragement, flexibility (e.g. having informal meetings in locations suited to clients), their ability to go 'the extra mile' and not seeming to be pressurised into 'ticking the boxes' for targets.

Where people's trust had been broken by their health experiences and/or experiences of the system, IPS went some way to repairing it.

Background

Why this report

This is a report of an evaluation to explore the critical success factors for implementation and sustainability of Individual Placement and Support (IPS). It focuses on six sites funded by the Department of Health and supported by Centre for Mental Health. These are:

- Berkshire;
- Bradford;
- Lincolnshire;
- Luton & Bedfordshire;
- Northamptonshire;
- Wiltshire.

The data was collected during six site visits, approximately six months apart, beginning at commencement of the projects in each site. Berkshire, Bradford and Lincolnshire were each supported by Centre for Mental Health for 18 months between February 2015 and August 2016 (wave one), and Luton & Bedfordshire, Northamptonshire and Wiltshire between October 2015 and April 2017 (wave two).

What we did

We interviewed a cross-section of stakeholders in each site, including:

- Employment Specialists;
- Team Leaders;
- Implementation Managers;
- Community Mental Health Team (CMHT) staff;
- CMHT managers and clinical leaders;
- Senior managers and leaders within the host organisation;
- Other internal stakeholders, such as user engagement leads;
- External stakeholders or partner agencies, such as commissioners (including CCGs and local authority representatives) and voluntary sector organisations;
- IPS clients.

Most interviews were one-to-one apart from a few group discussions (with service users and with teams of Employment Specialists). Most interviews were face-to-face although we conducted a small number of telephone interviews where we were unable to meet people on site. Discussions usually lasted between 30 minutes and one hour. Across the six sites, we conducted interviews with 300 people either individually or in groups (235 with members of staff and 65 with service users). This is broken down below:

Trust	**Visit 1**		**Visit 2**		**Visit 3**		
	Staff	**Service users**	**Staff**	**Service users**	**Staff**	**Service users**	
Berkshire	15	0	18	7	16	4	**49 staff 11 service users**
Lincolnshire	9	5	9	4	11	7	**22 staff 16 service users**
Bradford	12	0	17	3	13	3	**42 staff 6 service users**
Northamptonshire	9	2	13	6	11	6	**33 staff 14 service users**
Wiltshire	17	6	15	2	12	6	**44 staff 14 service users**
Luton & Bedfordshire	16	0	14	4	15	0	**45 staff 4 service users**

Overall, our aim was to investigate the following issues:

- Experiences and perceptions of stakeholders;
- What was working and/or in need of improving, in terms of implementation (and in later visits, around sustainability);
- Key challenges/issues;
- What helps/hinders success;
- Deeper exploration of particular critical moments on the IPS pathway (e.g. referral to IPS service, access to employment opportunities).

During our second and third visits, we refined our approach to enable elucidation of critical success factors at the following 'levels', which explored aspects of relationships between those involved in IPS implementation.

- **Service delivery level:** Exploring the relationships between Employment Specialists and clients helped us to identify which aspects of IPS were most valued and confirm (particularly from a user perspective) the value of IPS. It also revealed frontline attitudes towards IPS that might help or hinder implementation (about the overall model, particular elements of the model and about practical implementation issues and challenges).
- **Operational level:** Here, there were issues to explore about relationships between Employment Specialists and mental health professionals as individuals, or between the IPS team and CMHTs collectively (with regard to integration of Employment Specialists and referral processes for example). There were also issues around the IPS team itself and relationships between Employment Specialists within the team; and about IPS operational management and leadership issues.
- **Strategic level:** Here, we explored different aspects concerning senior and corporate support – how this work becomes embedded into everyday business practice. This highlighted the important internal relationships needed to get this right, and external partnerships (with funders, with other employment service providers, and employers).

At each of these levels, discussions spanned themes such as:

- Awareness/understanding/knowledge;
- Motivations/perceptions/attitudes/behaviours (including assumptions staff/users might make);
- Skills/expertise/capacity;
- Resources/practical support/time;
- System-wide factors, processes and culture.

During second and third visits, discussions across all three levels, but in particular at strategic level, also veered more towards sustainability issues.

It should be noted that, while we included service user/client perspectives, people's experiences of IPS was not the main focus of this study. It may be worthwhile to revisit this issue in more depth and with a more representative sample of clients. This might further elucidate critical success factors for implementation. However, these interviews highlighted what made for a good experience; it was reassuring to hear how much IPS is valued, and service user insights provided a unique perspective on what makes for good implementation.

Acknowledgements to participants

We thank all those we talked to during this project, whose expertise was palpable, and whose insights were invaluable; to everyone who made us feel so welcome. Particular thanks to the Implementation Managers and Team Leaders (and administrative staff) who planned the visits and overcame tricky logistical challenges! We were struck by the passion and commitment across all sites and all stakeholders. This bodes well for the future. It was an enjoyable and illuminating experience for us as evaluators. Thank you.

Part 1: IPS at the operational level

Firm foundations

Systems and processes

The different sites started from different points – both in terms of demographics and organisational contexts – but whatever the situation, developing firm foundations was the key.

Implementation Managers and/or Team Leaders had to develop systems and processes to enable IPS teams to operate, and have an eye on sustainability from the start.

Early tasks included recruitment and induction of Employment Specialists, awareness raising amongst mental health teams and service users, instigating policies and procedures for the new team, implementation of referral processes, ensuring IT systems were in place that 'talked to each other' (e.g. between CMHTs and IPS team so as to ensure shared record keeping; between different professional teams regarding referral processes) and setting up monitoring processes. It is also important that contractual arrangements are clear from the start (for example about who pays for Employment Specialists' office space, meeting rooms).

Some sites had elements of these in place, or put them in place swiftly. For example, with an Employment Specialist in post prior to the project, materials in one site had already been developed and data collection was easily modified. Where an Implementation Manager or Team Leader knew the territory, they built relationships that enabled the development of simple referral processes, early. Certainly it seemed that getting the Implementation Manager and Team Leader in place together early is crucial for establishment of roles, boundaries, relationships and system implementation.

Most sites reported a rush of hectic early activity, and this seemed to imply a need for excellent project management and prioritisation. In some sites, the rush of early referrals, while encouraging, threatened to overwhelm teams and derail the embedding of systems.

There were factors beyond team control in some sites that added to difficulties, with the main one being recruitment delays. This was a challenge and suggests that culture change requires attention to corporate teams as well as frontline clinical teams. We heard from several teams that this was an early sign of the need for good relationships with HR departments.

More widely, one team pointed out that the Key Performance Indicators (KPIs) for the project were not robust enough to monitor the projects. There were KPIs only for job outcomes, referrals and employer contacts and none related to fidelity. It was pointed out that targets could be reached without fidelity to the model. Perhaps the Centre could have required targets for fidelity (e.g. "you will have reached this level of fidelity by such and such a date").

Managing change

The implementation of IPS has required management of significant change. While some resistance to the IPS model came from clinicians (though less than envisaged by many Employment Specialists – and us), shifting to a pure IPS model led to significant, and perhaps underestimated challenges. Managing this change is about culture and relationships as much as it is about systems and processes.

There seem to be two critical areas of change management to be addressed:

- Transition to the IPS model means changing practice and delivery roles for any existing Employment Specialists;
- When early pioneers of IPS fail to secure the role they hoped for within the new setup, this needs careful and sensitive management.

Shifting to a different delivery model from that which existing Employment Specialists may be used to is not easy, whether they are shifting from being a 'generic' employment support worker or from a role within another model to

a 'pure' IPS role. Some staff who had worked in a more traditional employment service had trouble adjusting to, or struggled to see the benefits of, IPS (particularly when seeing some clients lose their previous level of support). Effective communication is critical and not always easy.

We heard some reports of former generic support workers not being informed adequately about the requirements of the role or not seeming to understand the need to work in particular ways, hit particular targets or provide the right documentation. One or two felt uncomfortable moving beyond their previous role (e.g. having to tackle employer engagement). Transitions are made harder if an Employment Specialist in the 'new' team does not have the requisite skillset – any wariness about IPS, and resistance to the new management team, is then exacerbated.

However, several formerly 'generic' Employment Specialists who changed roles came to value the IPS model. Those that came to work more closely with CMHTs in particular, seemed delighted that they were welcomed and could work in a more integrated fashion. This seemed to aid a sense of professional confidence that grew significantly over the period of the projects. We witnessed several former 'generic' support workers being supported well to take on new tasks and reporting that they felt able to take on more tasks over time (e.g. working within the community more than they had been; tackling benefits or financial issues with clients).

This widening scope for former generic support workers was aided significantly by teams developing inclusive partnerships with local agencies, such as those providing benefits advice, or by tapping into the wide-ranging expertise within the team (see also below).

The second issue concerning change management is when early champions of IPS perceive themselves or others as having been 'passed over' or under-valued in the shift to IPS. In some sites, this caused considerable tensions that became significant obstacles. The shift from a peripheral activity led by 'enthusiastic but lonely pioneers' to one that is formally embedded in systems can mean a shift in role for the pioneer(s) to a managerial position.

An organisation needs either to support the pioneer's transition or employ someone who already has those skills (see also 'What we did' on page 7-8). We often heard two sides of the story – either that 'pioneers' had been 'passed over', 'badly treated' or 'unsupported', or that the job (of Team Leader and/or Implementation Manager) had gone to the person who had been best qualified. In either case, the need for effective change management, good communication and leadership skills is paramount.

The right people

Team roles and capability

A diverse mix of backgrounds and capabilities seemed a solid foundation for good teams. Having team members with IPS experience was beneficial. There were mixed views expressed (particularly at the beginning) as to whether a mental health background was 'essential' but consensus that all Employment Specialists should undergo mental health training. In later visits, it seemed that IPS workers were picking up on care issues and feeding them back to mental health professionals, particularly when both sets of staff were accessing records.

For some Employment Specialists, the transition from inpatient work to community work or shift in hours was challenging. In one or two cases, we heard that redeploying someone from within an NHS trust, who didn't have the right skillset, was a mistake. There needs to be a clear approach to IPS implementation that stresses the primacy of the right skillset for the job.

However, the value of having people from different backgrounds was increasingly recognised as teams gelled, professional confidence grew, and sharing of learning between 'specialists' happened more often (e.g. on benefits advice, employer engagement, communication skills). Some teams experimented with additional roles (such as a clinical assistant on an apprenticeship, in Lincolnshire) and with different 'oversight'

models (i.e. having an Occupational Therapist supervise two Employment Specialists in Lincolnshire).

However, it is passion as much as professionalism that seems key. We were struck throughout by the palpable commitment, dedication and client-centred values displayed by all IPS team members, Implementation Managers and Team Leaders. We also witnessed a huge increase in personal and professional confidence amongst the teams as the project went on.

Learning and development

More could have been done around learning and development. People valued the training provided by the Centre (but some mentioned that it was expensive to send people to London and suggested that there could have been more sharing of learning). Some wanted the Centre to do more to celebrate success.

We heard several ideas to encourage learning and development. Some in wave two sites wanted to hear more from the wave one sites – how they tackled barriers to implementation and sustainability. Formal methods of peer support or other models of learning would have been welcome.

Some Team Leaders expressed a strong need to share their learning with each other. Employment Specialists working with particularly challenging groups (e.g. in Forensics) benefit from additional support and training. Managing relationships with clients' families was another challenge for some Employment Specialists. Families' expectations can be different to the expectations of clinicians and/or service users, and this can present challenges.

Overall, we got the sense of an emerging professionalism amongst Employment Specialists and a looming question about their career advancement – for many the choice seemed to be to go back to what they had been doing before, or find a job at an almost equivalent grade within the (very few) Employment Specialist type positions that are emerging. This begs a deeper question for the Centre and other IPS advocates: what can be done to support the development of an IPS workforce (including thinking through professional standards for training and regulation)?

Team leadership and management

Implementation Manager and Team Leader issues

This was a complex intervention within a volatile and uncertain environment and leaders (both Implementation Managers and Team Leaders) often demonstrated skillful, pragmatic leadership and management capability.

Where Implementation Manager and Team Leader roles were clearly defined, we saw huge success in setting up systems. In the early days, the Team Leader's focus needed to be internal – having to be in post early and getting IT and referral systems in place and aligning these with monitoring and performance requirements. Success for a Team Leader relies on management and supervision expertise alongside experience of managing a caseload.

There was also discussion on the appropriate background for Implementation Managers and Team Leaders. There seems no one-size-fits-all for an Implementation Manager role. Credibility can come from having an IPS background (albeit from another area) or from having worked within the trust (thus bringing local knowledge of systems or professional credibility).

A few people felt that the Team Leader role could have involved more strategic responsibility, particularly as the project developed – for example in developing organisation-wide awareness, in instituting reporting mechanisms to the board or other structures and/or being more of a service manager position.

We observed that, at times, the lack of clarity about the boundaries between Implementation Manager and Team Leader seemed to cause tensions – the Implementation Manager becoming involved in 'operational' matters and/or the Team Leader having to pick up a 'strategic role'.

Neither of these 'drifts' is wrong – and when relationships and communication are good, this can create synergies that help. But we sometimes saw, where relationships were not so good, confusion about who does what, with Team Leaders wanting a wider role, and/or Implementation Managers being sucked into managerial tasks. And both 'sides' desired better communication and transparency regarding decision-making.

Management and supervision

Employment Specialists were, on the whole, managed within CMHTs but supervised by Team Leaders. This has advantages and disadvantages – much depends on the quality of these relationships. One or two Employment Specialists felt pulled in different directions, particularly at the beginning, or did not know where decision-making authority lay – "I've had three people Big Brothering me", said one Employment Specialist.

This was particularly the case when there were parallel 'IPS-type' projects happening and people subject to different reporting lines. When core operational issues had been sorted (e.g. staff financial issues, such as reimbursement for travel, annual leave) things got easier in many cases.

Whatever the arrangements, Employment Specialists told us that having a good supervisor makes a big difference. Many Employment Specialists welcomed "having a foot in both camps" and receiving different sorts of support and advice. A few felt that the slight confusion over having "many masters" (as one Employment Specialist put it) was outweighed by the diversity of communication.

Who maintains oversight of the Employment Specialists became a sticking point during discussions around sustainability.

Critical delivery issues

Relationships with mental health teams

IPS services are small players in mental health teams and the services they provide. IPS staff have got their work cut out to raise awareness and it takes time to do this through the steady building of trusting relationships. Seeing successful outcomes is what tips the balance in many cases and reinforces a change in attitudes. One Team Leader reported that clinicians were initially resistant but, after a while, would come back to her saying "You're right! Service users DO want employment support".

Central to the IPS model is integration: that Employment Specialists are 'part' of the mental health team and IPS becomes a core offer to clients. This relies on other factors, including professional attitudes, clarity of roles, good working relationships, co-location of staff, and robust systems and processes (particularly for referrals).

Several IPS staff were pleasantly surprised by the welcome they received and the extent to which the approach was accepted by CMHT colleagues. We heard from mental health professionals that service users wanted more employment support and that this was a recognised gap in provision; also that IPS was a more meaningful offer than previous 'generic' employment support and that an Employment Specialist lifts the burden from busy care-coordinators, who haven't got the expertise or time to address employment.

The fact that mental health teams have changed over the years, that they have embraced non-medics, and been infused with social workers, OTs and psychologists means that the recovery model is well understood. There are still issues of medically dominated cultures, but they are less than they used to be, according to several people we talked to.

We did hear concerns about consistency of attitudes between CMHTs. Different CMHTs catered to different sorts of people, some with more severe mental health problems. There were a few examples of teams (for example in Forensics) where Employment Specialists (ES) reported professional 'resistance' to referrals. And one or two sites reported examples of traditional assumptions about clients' readiness for work (for example, from one or two CPNs) that all clients whose mental illness has lasted a number of years will never again be able to succeed in paid work.

We also heard about different sorts of contextual issues, such as cultural differences across CMHTs, that affected management of Employment Specialists. We also heard that CMHTs were operating in complex, changing environments themselves, with high staff turnover. This also affected how ESs worked with CMHTs.

The litmus test of professional attitudes is willingness to refer – to undertake earlier and more proactive identification of potential beneficiaries. In all sites, the results, in terms of referral rates, were stunning. Overall, it also seemed that quality of the referrals was good and service users understood the service to which they'd been referred, and were interested in finding employment (particularly by the time of our second and third visits to sites).

Several teams experienced an immediate "tsunami of referrals", with one Team Leader stating, during the second visit, that he had "never worked on a project that's reached this level of referrals so quickly".

During second visits, we heard that clinicians had become more likely to say people were ready for work. Some IPS staff across all sites felt that clinicians might assume that users have low aspirations, or the reverse – be too pushy.

Assessing motivation can be challenging, according to some professionals, particularly within people who've been in mental health services for a long time and may have become used to being passive. And some clinicians did express concerns about referring too early/ inappropriately. There were some interesting philosophical discussions – one was around the role of a mental health professional: was it to 'protect' or 'empower' clients?

The wider work is to inculcate a focus on employment in the CMHT. This also requires the CMHT to develop more holistic early assessments and there to be systems that record employment aspirations. In some cases, more preparation or education for managers around the IPS model and eligibility would have been helpful.

Among the service users we spoke to (mainly people who had benefited from IPS), only one felt that she had been referred when too ill. And during Employment Specialist interviews, staff seemed sensitive to client-side barriers: the difficulties of transferring from benefits; confidence and wellbeing issues; travel considerations etc.

It was clear that the practical benefits of having Employment Specialists working alongside mental health teams were huge. We heard this message time and time again. We heard numerous reports from all sites and stakeholders that being co-located and 'embedded' within teams makes a big difference. We also heard that, where an Employment Specialist was split across two sites, this can undermine the extent to which the service is in clinicians' minds. It helps if the Implementation Manager and Team Leader are visible and contactable easily by team members.

The importance of informal relationships cannot be over-estimated, particularly in a busy professional environment. We heard plenty of stories about clinicians stopping the Employment Specialist in the corridor to ask questions and seek advice, and of Employment Specialists being considered "part of the team". What were the factors behind this success? Team leaders invested early in raising awareness, developing systems and processes for referrals and building early credibility.

Managing capacity and workload

The very success of the model led (in Berkshire and Lincolnshire particularly) to immediate and ongoing pressures. Early influxes of referrals threatened to swamp workers before staff and systems were up and running. However, some sites, such as Northamptonshire, were more ready. This was because, when a new Employment Specialist post was created in the Early Intervention in Psychosis team, the Employment Specialist's supervisor compiled a list of people that Care Co-coordinators were considering referring, and triaged them. So, when the Employment Specialist started, he had a ready-to-go caseload of about 16 clients,

which was then reduced to five by applying IPS criteria. This early flow of referrals is an indicator of clinical and CMHT readiness for such a model.

Some sites, like Bradford, had a slower start – due to the focus on getting sustainable systems in place from the off, and to inadvertent delays in recruitment – but there, too, demand and capacity issues became a challenge. Geography made things harder as did staff shortages. Employment Specialists across several sites sometimes had to cover large rural areas (and in some cases within trusts, with limited transport reimbursement policies).

Traditional ways to cope with high demand include 'rationing' (e.g. waiting lists, adapting access thresholds). One variant is to move to 'IPS-Lite' (i.e. limit support with job seeking to six months per service user, and in-work support to 4 months). In a trial, this approach has been shown to achieve similar results to time-unlimited support.

The Berkshire, Lincolnshire and Northamptonshire teams adopted waiting lists. Some Employment Specialists felt this approach was acceptable, because staff and users are used to waiting lists, and because waiting gives people time to get used to the idea of paid employment and to be provided with further written information on the IPS service. Others argued that support needs to be available immediately, particularly for a client with mental health problems: long waits exacerbate anxiety. The few service users who talked about this did express frustration about waiting times.

In terms of access, Berkshire adopted a grading system to determine intensity of support needed – a sort of 'post-referral clinic'. Some Employment Specialists prioritised clients within their caseload. One Employment Specialist advocated discharging people who don't turn up for appointments. Another approach has been to 'bat back' inappropriate referrals – this requires a sensitivity to professional relationships and to be accompanied by raising awareness and understanding of criteria for referrals.

These strategies did seem to help. However, we did hear of caseloads beyond the ideal. This was exacerbated by some Employment Specialists taking on people who did not fit IPS criteria (i.e. job retention support or post-secondary care discharge). However, many Employment Specialists were keen not to blur the boundaries too much between 'pure' IPS and other aspects of support. We heard from some Employment Specialists that it might be a good idea to be flexible with regard to team roles – for example, for an Employment Specialist to concentrate on one geographical patch, but also to 'specialise' (i.e. so that the team could match Employment Specialists with people from different walks of life, or of different genders, cultures etc).

Several were worried about 'mission drift' and them becoming seen as generic support workers. This was a fear in some sites at the beginning, usually due to uncertainty about acceptance of ESs by CMHTs. The issue became raised again as discussions on sustainability meant questions of how ESs would be managed. Good leadership and engagement with the team is needed for honest conversations and to make difficult decisions about priorities and boundaries. Everyone we spoke to about this issue said that this was dependent on dedicated IPS management.

We also heard of Employment Specialists de-prioritising some IPS tasks (e.g. vocational assessment forms and employer engagement). It was not always clear to us, as evaluators, whether this was due to high demand or a reflection that some aspects of IPS are valued more than others. Some teams were wary of raising further awareness about the service in case it generated more demand than they could handle.

We also heard criticism about the "inflexibility" of the IPS model and it not being fit for purpose in a UK environment – some ESs said that targets for contact with employers seemed too onerous and could lead to a 'tick box' mentality. One mentioned that the 'American' model was not relevant in a UK job market, and that the fidelity rating process didn't allow for modern

practice (e.g. online recruitment processes). For those working with particularly challenging groups (e.g. in Forensics), submitting job applications within four weeks of beginning to support a service user is not easy.

One or two service users also questioned whether IPS suits everyone, for example those more highly qualified, or those with learning disabilities.

Some Employment Specialists felt under pressure with paperwork. There was particular criticism of the 'onerous' vocational assessment (and in Berkshire, this was amended). A few felt that IPS was too paperwork-heavy and risked distraction from a 'user-centred' process. Others stressed that a shift to a more efficient model means inevitable, but worthwhile, increases in administration.

As the IPS successes became more visible corporately, some Employment Specialists worried that reporting would become driven by corporate needs and that a more client-centred approach might be lost.

Partnership working

Working with the voluntary sector

IPS is one element in a spectrum of employment support. Good relationships between providers of these different elements is crucial so that users are offered a choice of how to get back on their feet – from voluntary work, through training to paid employment – and that there is a seamless transition from one offer (e.g. training) to another (e.g. work).

Relationships with the voluntary sector who, on the whole, support IPS, have not been easy. This is partly because IPS is different to the sort of service previously offered by community organisations. In some cases, due to economic constraints, or working to a different set of (local authority) targets, IPS can be seen as a threat rather than an opportunity to collaborate to reach more people and be more effective.

It takes sensitive leadership, time and commitment to develop partnerships. There were many good examples. Several teams built relationships with the voluntary sector over time. In some sites, partnerships with the voluntary sector were built into early commissioning intentions for models that were recovery based and so would allow voluntary and statutory sector to work together.

During later visits, it became clear that all sites were now thinking in terms of sustaining IPS as part of a spectrum of 'employment support' and were keen to make sure partnerships worked well between statutory and voluntary services (see part 3 on 'sustainability'). By visit two, the Lincolnshire team was working well with voluntary sector partners, as was the Bradford team, despite initial difficulties. By visit three, the trust in Bradford was discussing a more strategic and integrated approach between statutory and voluntary sector providers.

Working with the Department for Work and Pensions (DWP)

Dealing with the DWP and benefits agencies is a crucial component of the IPS service for clients. But IPS Teams, on the whole, found working with the DWP an uphill battle. The DWP and IPS may both support job-seeking, but IPS is about 'choice' and the DWP enforces benefit conditionality. The IPS model does not seem to be universally recognised by the DWP, nor are people with mental health issues catered for adequately by them, according to those we spoke to. It doesn't help when, as in Lincolnshire, the DWP has reduced capacity.

Some Employment Specialists have built good individual relationships with Jobcentre Plus staff. In Bradford, it has helped that one of the team has a background in benefits work and offers 'specialist' advice to the others. In Bedfordshire, a new team member with relevant experience has been invaluable. But bridging the two cultures at operational and strategic level has remained a challenge for several of the sites.

Employer engagement

Clients value employer engagement – from an "Employment Specialist's willingness to pick up the phone to an employer", through to raising

awareness of mental health issues and tackling stigma. However, there were challenges in embedding employer engagement.

The IPS emphasis on choice means it is hard to predict what type of employment will be desired. You don't want to disappoint an employer who's done their best to take service users on, but you don't want to drive clients to unsuitable employment just because of that employer-side effort.

Some Employment Specialists have found employer engagement tricky, particularly without prior experience. Some felt it "a sales role" alien to what attracted them to the job. There were also obvious practical problems, such as a dearth of employers in some areas. Employment Specialists found employer engagement easier over time as they gained experience. In each team, one or two had positive views, stressing the value of employer engagement, rather than its difficulties.

In Bradford, early work focused on major local employers. Employment Specialists reported that understanding local small scale opportunities required significant effort. In Berkshire, the team waited for the pattern of employment needs to emerge before developing a strategy. There were lots of innovative ideas, such as an employers' forum to support users, and work trials.

Strategic approaches to employer engagement are crucial to sustainability plans, particularly in the current financial climate. ESs were, on the whole, approaching employers in a 'piecemeal' fashion (i.e. when they had a user with a particular need). However, we also saw some Implementation Managers developing trusting relationships at senior level so as to foster a culture of employer acceptance towards users gaining employment and tackling stigma.

Part 2: IPS at the strategic level

Organisational readiness

On the whole, all six sites were 'ready' for the Centre project due to having in place the 'seeds' (some sort of employment work going on at service delivery level) and the 'soil' (a senior level commitment for the work). However, at both levels, this was of different types and to different extents in different sites.

In terms of prior employment work (the 'seeds'), this was in the form of more 'generic' employment support (in or outside the trust) or pioneers of IPS or more focused employment services, with links to mental health teams (perhaps in a specialist unit or with a CMHT), operating within the trust. For example, in Northampton, the Forensics team had had an IPS worker for four years in advance of the Centre project.

As the project moved on, we identified several organisational factors that contributed to successful implementation and sustainability. This is the strategic realm inhabited largely by the Implementation Manager.

These organisational factors are mutually dependent and explored in more detail in the remainder of this section.

Values-driven leadership

Several leaders said that the project was exciting and that it enabled a serious focus on employment support, after years of intermittent funding, fragmented vocational services and reliance on individual champions. Some told us that it was the innovative element that appealed, particularly where a trust prides itself on having a culture of innovation.

The early passion of pioneer Employment Specialists or IPS workers, prior to the Centre funded projects, should not be underestimated. We were struck by how hard these individuals had worked and their tireless enthusiasm for the cause, particularly during months and years of barrenness in terms of secure funding arrangements. Gaining access to wider, collective corporate support (as well as Centre funding) was sometimes dependent on an early enthusiast at middle or senior level.

There seemed a genuine passion amongst leaders for the work (sometimes arising from personal experience): "once you have that emotional connection, the penny drops and you see the need for a sustainable package that reduces reliance on services".

Many senior level interviewees disclosed personal experiences of having been affected by mental health problems, or of having family members or friends affected. We don't think this element of 'buy-in' should be neglected. It affects the wider corporate culture (see overleaf on 'making the connections').

Hard-wiring – corporate strategy, systems and processes

Strategic oversight and corporate support for IPS are critical success factors and were evident in all sites. Their presence, of course, was one reason why these sites were chosen in the first place.

The Implementation Manager needed to be well placed to align monitoring, reporting and performance management processes to mainstream programmes, executive teams and the board. This means making sure that senior leaders are aware of the work, value it, receive the right information at the right time and are able to link it to corporate priorities as well as the future of the health economy (again see overleaf on 'making the connections').

Often, inevitably, success depends on trusted and influential relationships. In some sites (e.g. Bradford), there were strategic champions at executive and board levels. However, IPS may be only a small part of a leader's brief and major change elsewhere may demand attention. Moreover, to what degree does the executive level lead for IPS have the 'ear' of the Chief Executive or Chair? These questions were beyond our knowing.

Senior leaders stressed the need for clear goals from the off, to enable early success and

motivation. However, the degree of senior level clarity and commitment seemed to vary across and within sites. At executive level, there needs to be clear accountability and influence. We saw this in some sites, where one person was the board level lead for IPS and/or employment and/or recovery work. Also, some sites were clearer than others as to how reports from the IPS team fed into senior team business agendas.

Many sites set up, or already had, relevant intermediate level steering groups for the work. These often had a broader focus than IPS, for example they might have been about 'recovery' more generally. Success relied on having the right people there – both enthusiasts and decision-makers. They certainly had the former, but there was mixed success with regard to the latter, with senior figures sometimes not turning up. There was always a danger of decoupling from decision making. The Implementation Manager and senior champions needed to have one eye on the money – internal programme budgeting processes, corporate planning cycles and the fluidity of funding arrangements. This was not an easy task given the intense nature of the setting-up phase.

The Implementation Manager was the key 'connector' upwards, but also needed to connect 'across' – to work closely with the Team Leader to link the work with CMHTs and clinical management teams. Where the Implementation Manager or Team Leader knew the organisation, this work was undertaken earlier.

Several IPS teams found early ways to raise the visibility of the work via public meetings, securing visits to the team from Chairs and senior managers, getting articles in the local media and winning trust team awards. The host trusts often ensured corporate visibility for the work through successful awareness raising sessions for board and executive teams. Getting Centre of Excellence status (e.g. in Bradford and Lincolnshire) was also seen as a great "marketing tool".

Corporate visibility and high profile is mostly a good thing. Employment Specialists were proud of this acknowledgement and rightly so: given that IPS was in its early days everywhere, the recognition of good work is important. But we did hear minority voices saying that resources needed to serve such events can distort day-to-day priorities and that awareness might not be matched by corporate action to ensure funding. We also heard worries about the impact of catching the corporate eye. Might a project become too bound to corporate needs which could add further burden and/or generate a 'tick box' mentality?

Making the connections – changing culture

As mentioned above, making IPS a corporate priority requires it to be valued and aligned to corporate goals. This is also about whether corporate culture is linked to wider notions of recovery: how does the executive team and board (and perhaps governing board in a Foundation Trust) balance the need to deliver on its traditional corporate mission with an emerging psychosocial model?

The traditional NHS trust business approach can include targets that are predominantly 'medical' or 'institutional' (e.g. readmissions), driven by commissioners (who may or may not yet value employment support or recovery models) or corporate risk and financial pressures (e.g. acute ward bed occupancy). In this respect, IPS is a small fish in a big pond.

CMHT culture has its roots in a powerful medical model that can affect a culture 'upwards' – to what extent is the trust still fuelled by biomedical models? How far is the medical or nursing director linked to power? Can the senior champion for the work influence old ways of working? On the whole, our remit precluded being able to investigate these deeper questions. But we were told a few times that traditional power brokers still hold sway.

Several stakeholders across all levels discussed the shift in mental health culture. In Bradford the executive champion was chosen partly because of his social care background and role. This meant promoting IPS as part of a trust-wide commitment to a more 'psychosocial' approach to care.

Many interviewees stressed that this shift towards psychosocial approaches had been going on for a decade. Many trusts had changed a great deal. This was evident through the advent of multidisciplinary CMHTs where identifying service users' employment potential was becoming routine. Some saw it as part of cultural transformation from a risk-averse biomedical model of mental health to a community-based psychosocial approach – "at last this stuff is being taken seriously," said one trust leader.

This wider move was also evidenced by large scale funding for recovery colleges and different commissioning approaches (e.g. ring-fenced recovery work, as in Bedfordshire). And we witnessed it directly through the tenor of conversations, particularly when people spoke of their passion for employment to be part of a holistic package of care. In many ways, IPS was a further evolution of a recovery approach.

How far did this appetite, for thinking differently about mental health, reach inwards? At the beginning, many stakeholders within the host trusts said employment within the host trust was crucial – it symbolised that the organisation modelled its own principles and values.

However, few IPS clients did get jobs in the host trust. This seemed a major disappointment for some IPS teams. The precise reasons for this are unclear, but there were significant challenges to getting the buy-in of HR departments and difficulties in shifting traditional recruitment practices.

The link between IPS, user/patient engagement and public engagement was sometimes unclear. At the beginning of our work, we heard a lot of passionate words from service user involvement leads and those from the voluntary sector about IPS in general, and the potential for linking with user involvement or the rise of peer support (i.e. co-delivery of services). In several cases, staff were hopeful that individuals involved in helping to improve services, 'lay representatives' on committees or peer support workers, might now get routes to employment. This did not seem to happen.

We were left to wonder whether there were deeper factors at work within staff and trust culture – was it that trusts were not able to practice what they preached?

Strategic partnerships

All sites stressed the need for good partnerships across the local area, to join up provision – particularly the need to develop good relationships with other employment service providers. This was a source of tension in one or two places where the voluntary sector may have perceived IPS as a threat; but it was also the source of good news – in some areas, better mapping of employment work was leading to clarity of roles for different providers, better alignment that allowed clients to access a spectrum of opportunities, and gaining access to wider funding sources.

As projects went on, senior leaders and Implementation Managers were developing more strategic approaches to employers, and some had begun to develop other strands of work related to employment work (such as providing advice to employers on combating stigma, and improving retention and wellbeing – such advice is encouraged as part of reaching exemplary IPS fidelity).

Given the national and local policy context, for example the advent of the *Five Year Forward View* and health and wellbeing strategies, it seems that key local statutory partners (such as public health teams) should be supportive of IPS. They need to be involved in strategic decisions about targets and outcomes.

As the spotlight turned swiftly to sustainability, trusts were keen to build strong links to commissioners. This was easier in some places than others. Where commissioners had bought into a recovery model or employment services, relationships seemed less strained.

In one site (Bedfordshire) where 'forever funding' had already been promised by the provider, commissioning arrangements for mental health meant local authorities and CCGs ring-fencing money for recovery services. This also allowed IPS champions, including the

Implementation Manager, to bring plans for IPS into the heart of an integrated approach to recovery. However, in other sites, the picture was more confused.

Our remit did not include talking to leaders in local authorities, public health or social care to provide a wider view on provision of employment services across local health economies.[1]

We also became aware that incentives for different parts of the commissioning and public health system may not yet align with outcomes from IPS. Each department may be working in their own silos. IPS provides whole system benefits, which may mean no one sees it as their responsibility. (These are our own interpretations, rather than based on stakeholder views).

Navigating the wider storms

Some things people could influence. Other things were out of IPS teams' (and even senior leaders') control. In between, there were complicated challenges that leaders had to navigate as best they could.

Senior leaders singled out demographic challenges (e.g. deprivation, rurality, transient populations), socio-economic factors (new business opportunities) and healthcare forces (resource constraints, NHS complexity and turbulence) as significant reasons for the need for IPS, but also as challenges.

Other contextual challenges evident in all sites to different degrees included high staff turnover or organisational change at all levels – from CMHT through to middle and senior management. In a few cases, organisational or IPS champions seemed side-lined and unable fully to influence plans for embedding the work and/or sustainability.

Organisational restructuring, staff changes and delays in initiatives (such as a day services review in Luton) had an impact on IPS. There was increasing uncertainty within teams that cast its shadow over people's commitment and confidence: it seemed in some sites that no sooner had implementation issues been sorted, than fears about the future surfaced.

The wider health and social care context had increasing impact as projects wore on. Not only were Implementation Managers aware of future resource constraints from the beginning, the visibility of these pressures became worse as time wore on. Evidence of impact and outcomes seemed not to be enough to win arguments about sustainability.

Despite this, Implementation Managers, Team Leaders and Employment Specialists continued their work with admirable passion and rigour. Their commitment to clients and high quality professionalism seemed to be the glue that kept the projects together.

[1] Public health teams moved across from primary care trusts a few years ago, shifting from NHS bases to local authorities; there are different sorts of relationships between public health teams and social care teams emerging across the country.

Part 3: Sustainability

From hope to uncertainty

In the early days at each site, staff were confident that the trust or commissioners would provide ongoing funding if benefits were demonstrated. However, evidence became only part of the battle with resource constraints beginning to bite harder.

As one director said, "Even if the project demonstrates great outcomes, there's no guarantee the trust will be able to prioritise it". The issues became complicated; each site tackled different challenges and had to take slightly different routes to tackle them, and it took huge amounts of effort.

Meanwhile, at operational level, emerging professional confidence, stepping up delivery of great outcomes and hope for the future became overshadowed by uncertainty. Where communication between operational and strategic levels had been muddy, they became distinctly opaque – especially when Implementation Managers were barred from being part of conversations between trusts and commissioners.

As evaluators, we ourselves became confused – sometimes we were faced with not getting answers as to who was responsible for making key funding decisions, or who held the budgets that would make IPS sustainable. Sometimes, we realised that this fog mirrored that of those we talked to.

Only after we sat down after all the visits could we see a story emerging. We could only discern this narrative by analysing where things seemed to have worked and where things did not.

With hindsight, the job for Implementation Managers, to secure 'forever funding' (as it became dubbed by project teams) was in two parts:

- To align three different levels of decision-making (corporate level within trusts, commissioning, CMHT/clinical management level);
- To frame and position IPS as integral to a wider strategic vision – usually that of a 'recovery' model.

In many ways, the latter – positioning IPS as part of recovery – was the key that opened the door to the others; however, some doors were more open than others to begin with (for example, the way 'commissioning for recovery' was undertaken in Bedfordshire allowed a more strategic approach from the start).

Below, we discuss these issues in more detail, then return to try to make sense of why some sites got further than others in terms of sustainability.

Corporate level – IPS lost in the maelstrom?

There were definite success stories. Northamptonshire secured the commitment of the trust's board to secure ongoing funding. As the project came to an end, two directors put a proposal to the board, to keep the existing team of five (three Employment Specialists, a Team Leader and someone in the Implementation Manager role) which was well received. The trust's aspiration is for a countywide service, covering Attention Deficit Hyperactivity Disorder (ADHD), Children and Adolescent Mental Health Services, and learning disabilities. At the same time, the commissioner for Adult Social Care and the commissioner for mental health services requested a meeting with the Implementation Manager to discuss how the service might be funded, including the Adult Social Care Commissioner considering how to provide employment support for people who are accessing social care services but not NHS services.

However, we also heard about warm words at corporate level not seeming to be matched in reality. Everyone was keen on IPS in principle, but in reality, in some sites it was not prioritised.

We heard different explanations for why this was the case. Perhaps IPS (as a small project) is

getting lost in the maelstrom of larger funding discussions. In the current climate, IPS is in the same boat as other services. They're all at risk and have to prove their worth against other priorities, and get senior leaders behind them.

Lack of mandatory/regulatory targets may also play into the lukewarm senior reception to sustainability or switching funding to IPS.

When it comes to return on investment and cost-effectiveness, the debate on impact and outcomes entered another realm. We heard that it's hard to "compare apples with pears" and demonstrate that one service will provide more value for money than another. The service investing in IPS may not be the one that benefits from the financial savings. And such savings are hard to track, monitor and quantify. The financial benefit isn't direct (unlike e.g. that of employing more clinical coders).

Others implied that there was a general lack of organisational clarity about decision making. Where communication and transparency was generally poor, then IPS conversations at strategic level may also have suffered, with key champions of the work marginalised.

Organisational turbulence was certainly another factor. There may have been political factors too, for example, suggestions to reduce number of beds or switch voluntary sector providers can galvanise objections from local communities and politicians.

All these things may have led to us hearing people within IPS teams (and some Team Leaders) claim that others (either mental health colleagues, commissioners, or senior leaders) were not doing as much as they could to support and expand the service. This is despite senior leaders portraying the project as inspirational and achieving significant outcomes.

The effect of this sort of uncertainty on staff should not be underestimated.

Getting mental health teams to fund IPS

At a minimum, sustainability means continuation of what was set up, in terms of continuing with Employment Specialist roles and the Team Leader, within a CMHT or specialist team. This was the aim in most sites from the beginning. Much depended on professional perceptions of the post holders – and in many cases (but not in all sites) this perception was positive. It felt to us that IPS Teams had done enough to persuade clinical and CMHT managers of their merits. But it wasn't ever going to be that simple.

Clinical team leaders and divisional managers' support was needed for two reasons – to influence corporate leaders to release funding for continuation, and/or to carve out money from their own budgets to allow for an Employment Specialist in their own team(s).

Influencing budget holders at this level was tricky and messy. It required understanding and networking with a wide variety of people across different teams, with different cultures and decision-making processes. Many Team Leaders and Implementation Managers had good relations with clinical and CMHT leaders. But for others, following up on well-meaning conversations has proved fruitless.

Without CMHT managers "fighting the corner", there was a risk of IPS being sacrificed for "higher priorities". In one site, the Implementation Manager's exit strategy included approaching specific governors to be IPS champions. But it was hard to see how awareness raising at this level (Governors in Foundation Trusts tend to be somewhat distanced from decision making) would lead to supportive executive decisions.

We heard from some team members that 18 months was insufficient to embed the culture change necessary, and that the Centre projects weren't large scale enough to change attitudes of practitioners, commissioners and service users. But the results were impressive and corporate awareness was on the rise around impact and outcome. We are not sure more time would have meant a significant difference to the nature and extent of the barriers we witnessed around sustainability.

Influencing CMHT managers to divert resources to create Employment Specialist roles was, if anything, even harder. Effectively, this

amounted to asking for an Employment Specialist to displace another role within the CMHT. We certainly did not hear of any CMHT managers with additional cash to spare! Thus, the 'risk' of funding Employment Specialists was passed down the corporate line. In some sites, there was talk about matched funding from corporate budgets if clinical leaders or CMHT managers could invest too.

Where CMHTs might have been sympathetic, finding dedicated additional supervision resources for a small number of workers was also problematic. Without this, the 'pure' nature of the IPS model was at risk. One site where sustained funding for Employment Specialists was found temporarily was confident that IPS oversight would be put in place, despite admitting that ongoing supervision would be less IPS intensive. Another said that the future would be IPS "at least to an extent". In a third, all Employment Specialists stressed the need for IPS fidelity to remain, whatever the management. But it was hard to see how this would happen.

Commissioning context

In one area (Bedfordshire), commissioners seemed to work well together across the local authority and health services. They also devised a mental health commissioning approach that meant funding for 'recovery' was ring-fenced. This was aided by there being a new mental health contract put out to tender that attracted a new provider. Working within this framework, it was possible for the Implementation Manager to bring IPS right into the middle of a recovery strategy, with the enthusiastic help of local commissioners and the trust. In this case, the door was open for IPS.

Other areas weren't so lucky. In the same site, but across the patch (Luton) there was no such joined-up approach. Even though the IPS team was part of the same trust as in Bedfordshire, many of the champions for the IPS work seemed effectively marginalised in conversations between the trust and local commissioners. This was at the same time as a major day service review, the outcomes of which were critical for the Employment Specialists' future (the trust wanted more money from the CCG for mental health day services, but was not telling the IPS Team whether there would be money brought across for IPS following the internal day service review). We heard phrases like 'brinkmanship' and 'lack of transparency' several times from various stakeholders.

In some cases, Implementation Managers and/or Team Leaders (in Luton, Berkshire, Northamptonshire for example) were told not to negotiate with commissioners due to the 'sensitivity' of discussions that were sometimes about more than IPS.

In some sites, for example Northamptonshire, commissioners seemed as committed to IPS as providers. Part of the reason for this is that, as some CCGs told us, they are required to deliver an IPS service to meet the NICE quality standard for Early Intervention in Psychosis (EIP) services. Outside EIP, NICE isn't specific about where IPS services should be located but it is specific about the number of people (i.e. the proportion of the population) who should be able to access IPS.

There is a wider question: though we heard much rhetoric about 'outcomes-based commissioning', we were left puzzled as to how this manifested itself for IPS. Though it is beyond the brief to explore this wider policy trend, we got the feeling that most commissioners are not doing true outcomes-based commissioning. If they were, it would favour IPS as the outcomes would be about recovery (to which IPS demonstrably contributes).

Better national recognition of IPS helps. We heard that employment support being featured in the *Five Year Forward View* means organisations bidding for Work Programme contracts could host IPS workers. And there have been some successes, e.g. two Employment Specialist posts have been created within Berkshire's EIP service. One or two people mentioned the NICE Early Intervention in Psychosis (EIP) standards. And, one person suggested that it was odd that Department of Health funding for IPS was framed as a 'pilot' rather than as a mandate. This person suggested central monies should

only have been made available on condition of sustainable funding.

But, on the whole, we did not hear much about national leverage for IPS. There is a question that remains also about how national bodies and central policy can help longer-term implementation. And the extent to which an organisation like the Centre needs to influence policy.

Perhaps this debate is part of a wider and recognised challenge in health care: how to implement evidence-based practice. It is difficult enough these days for innovative medical interventions to be funded. Is there something here also about the lack of relative value given to social or organisational interventions within a still medicalised health care service?

Some Implementation Managers were left isolated to find their way through the funding maze. They were inventive and tenacious – often to no avail. Some searched the commissioning strategies and strategic plans of public sector partners seeking mentions of mental health and wellbeing that might provide inroads to funding. This meant having to connect with different CCGs and local authorities for different pots for different Employment Specialists in different CMHTs.

Another route was via personalisation (Personal Health Budgets, managed by NHS trusts, and Personal Budgets, managed by Adult Social Care). Potentially, a service user could use their personal budget for Employment Specialist support. However, there are many complexities associated with this approach (time taken to award money; IPS being only one part of the budget so affecting possible prioritisation; budgets not being able to be spent on 'trust' services; it being too risky a venture for the voluntary sector).

Some took to external funding opportunities. One or two approached Employment and Disability Services (EADS), but found they wanted to work under restrictive conditions not conducive to IPS.

In Northamptonshire, the Implementation Manager and her trust managers were looking at various creative ways to create Employment Specialist posts (e.g. splitting them amongst differently located teams; upskilling lower band staff) but none of these seemed feasible. This was followed by protracted negotiations with different teams and the seeking of match funding from the trust, external 'innovation' funding' (e.g. for Employment Specialist support for people with ADHD) or money from the voluntary sector.

However, turning to charitable funds or other central or local sources would potentially create a patchwork of funding. This could create its own challenges. Timescales and reporting processes may not align and it carries a risk to sustainability as the NHS wouldn't control it.

Bringing it all together - IPS as part of a strategic approach

The key to securing further funding seemed to be to embed IPS within a wider strategic approach, and/or single employment service and/or recovery culture.

We heard of commissioners and providers trying to do this. Northamptonshire (see above) was one example. The Lincolnshire team explored the possibility of a service, accessible to anyone with mental health issues, to include volunteering, job retention, Recovery College and IPS. In Bradford, we heard about senior leaders and the voluntary sector working on proposals for a more integrated and strategic approach to employment services and recovery. This also implies taking IPS into new areas (e.g. forensics, ADHD, IAPT).

Let us now return to our narrative at the beginning of this section. If we are to assume that there were two elements needed for unlocking 'forever funding' – influencing and aligning decision-making (between commissioners, trust corporate levels and middle management) plus positioning IPS as part of recovery services, can we now further unpick what went right or wrong in each of the sites?

The answer is, yes, but only to a certain extent. There are clues here, but we would not wish this to be the final version of the truth.

- In Bedfordshire, all elements seemed aligned and allowed for the continuation of the IPS service.
- In Luton it seemed to us that marginalisation of key stakeholders, lack of transparency and poor commissioning arrangements prevented the same thing happening (despite IPS being provided by the same trust).
- In Wiltshire, having to negotiate with an external voluntary sector provider, over whom the Centre team had no authority, to ensure they adapted to providing IPS Employment Specialists, proved too challenging, despite commissioning enthusiasm.
- In Northamptonshire, a combination of other, primarily internal, factors meant that the project seemed to be up against it from the beginning (despite pre-project pioneering work). Despite this, they had done well to make up for problems.
- In Lincolnshire, confusion around decision-making left middle management (CMHT leaders) trying to find 'wiggle room' to sustain Employment Specialists within teams.
- In Bradford, there was hope emerging – significant senior management support was leading to innovative possibilities around recovery and matched funding.
- In Berkshire, the Implementation Manager seemed relatively isolated from strategic decision making, but nevertheless was able to find ways through.

Part 4: Critical success factors – a reflection

As we analysed and discussed our data, we came back again and again to three major issues that seemed to underpin or affect success.

The IPS shadow

There is a paradox at the heart of IPS when it comes to embedding it as part of an integrated strategy. This wasn't voiced explicitly, but is our interpretation of what we were beginning to see during discussions on sustainability.

The singular scope of IPS comes with a flip side. Many were vocal about the restricted nature of IPS. The three issues that came up time and time again were:

- The policy of 'discharging' clients from IPS at the same time as they leave secondary care was criticised. It risks fueling a revolving door syndrome as twin aspects of people's support fell away – for care and work support. Service users may also reach readiness for IPS support around the same time as they are ready to be discharged. It would seem ironic that a service designed to aid recovery can be withdrawn because a service user has started to recover. Some Implementation Managers negotiated this – the key point here is that if they are under the wing of a 'CMHT clinician' rather than their GP, then some CMHTs will consider this as still being in 'secondary' care and thus eligible for IPS. However, this is uncertain territory.
- Lack of focus on job retention and preventing people getting ill in the first place by supporting people at work. This is counter-productive: creating a situation where service users have to lose an existing job to qualify for IPS support to find a job. Some felt that an ideal service would include job retention support integrated with IPS.
- The need for more integrated support: ideally, IPS would integrate with other services supporting the spectrum of needs, such as training and voluntary work.

IPS can also risk skewing delivery of an integrated approach to employment support by being the shining example of success (and the caster of shade). In a way the success of IPS throws into relief other things, like the above, that are not happening. It is so good that gaps in other provision can look bad. Even if other good things are happening (e.g. good provision of training and support for voluntary work), the evidence-based nature of IPS, alongside a centrally funded programme, serves to illustrate the lack of outcomes data in other areas.

This all means that IPS is a disruptive innovation. It means also that change management approaches and a sensitivity to the commissioning environment need to be integral to implementation. We discuss these elements in the next sections.

Change management

The main surprise of this evaluation was that the barrier we expected to find was hardly a barrier at all.

Health professional and CMHT resistance to IPS was minimal across all six sites. We had expected to spend much time and thinking unpicking the levels of that resistance. Our proposal and topic guides were explicit that we would probe on issues, such as knowledge, awareness, attitudes and behaviours. We did do some of this in early visits, but we were struck by the appetite for the work, the explicitly stated need, the 'fertile' soil within many provider teams and CMHTs.

Of course, we interviewed mainly professional champions, early referrers and advocates. But we also talked to other stakeholders beyond the

CMHT and kept an eye on the data - the swift uptake of IPS and referral rates.

Instead our spotlight fell more on operational level issues rather than delivery – recruitment, role clarity, relationships, management responsibilities and accountabilities, and the like. It might be tempting in some cases, where things did not work so well, to point the finger. But we found one underlying factor underpinning operational difficulties – the challenge of effective change management.

Shifting to an IPS model is inherently both exciting and disruptive. Innovation usually is, and often needs to be. As always, there is a great deal to learn from the experience of managing change. And, as we have noted above, recognition of the IPS Paradox – that it is so good that it can cast shade on other aspects of services – creates its own tensions.

Getting buy-in from Employment Specialists who needed to change what they had been doing, and in many cases doing successfully, was always going to be a challenge, but we did find cases where this was done more or less sensitively: where, perhaps, impatience for delivery (within a short term pilot) meant inevitable struggle.

Managing change requires communication of the vision, business implementation skills, sensitivity, communication, influence and relationship qualities – in the end, successful IPS implementation and sustainability relies on building and maintaining relationships at many levels. For an Implementation Manager and Team Leader, this requires them also to model good relationships between each other.

Two key issues that led to difficulty were: employment of 'outsiders' to be Implementation Managers to the perceived chagrin of early champions; and teams of erstwhile generic Employment Specialists having to switch quickly (and sometimes without true consultation, or acknowledgement of the degree of change) to delivery of a pure IPS service. Neither of these things is 'good' or 'bad' in itself. It is all about the process – the recognition of these potentially disruptive forces and how they are handled. And they caused early and ongoing problems.

Commissioning

Our work has focused on implementation of IPS within a provider organisation. However, as the pilot sites moved on, it was clear that many of the challenges to sustainability were about the external context. And, in particular around commissioning.

To a certain extent, we as evaluators were left scratching our heads as to why 'forever funding' was so hard to secure. In these days of rhetoric about 'values-based' and 'outcomes-based' commissioning, it was something of a shock for some Implementation Managers to find it such a battle to enable senior level commitment.

Was it naïve to think that an initiative so obviously of benefit was going to make its own case? Could some Implementation Managers have done more? Or perhaps more importantly, done something differently? Certainly, there was no lack of effort.

We cannot find a simple answer to another question - why something so good should not be universally funded. This is a slippery question. But there are clues:

Structural change in some sites meant lack of continuity of some senior leaders (in commissioning particularly) and real difficulties in being able to influence people who were 'latecomers' to the IPS team's early enthusiasm.

The way commissioning was (is) done helped or hindered a shift to a recovery model – where commissioners had ring-fenced recovery-type approaches, this allowed the space for IPS to be grafted on to overarching strategies for local mental health that emphasised new ways to deliver services (see also above).

Early thought to sustainability is key (beyond setting up operational systems and processes). In particular, making sure that there were formal ways to get the right messages to the board – solid reporting, monitoring and accountability mechanisms.

We were also left with the impression that commissioners are risk averse to an intervention like IPS. At one level, this is shocking, given the success of IPS. On the other hand, it is hardly surprising if we take a broader socio-cultural look at health care. For example (a) the current NHS resource-deprived climate; (b) the continued bio-medical culture of the NHS; (c) the history of commissioners being risk-averse and sometimes less powerful than envisaged; (d) organisational challenges to implementation of evidence-based practice; (e) barriers to social innovation in health care; (f) the relative weakness of 'user-led' voices in health care (if we see IPS as something of value to the mental health service user movement); and (g) the difficulty in securing 'upstream' prevention initiatives, particularly after the restructure of primary care trusts.

If commissioners are to divert significant resources to IPS, there seem to be two main routes. The first is gathering pots of money within out-of-hospital services, such as day-services, befriending, advocacy etc. In turn, this will depend on how well they encourage and enable the voluntary sector to be part of the IPS mindset. If commissioners and provider organisations have already gone down this route, as in Bedfordshire, then this is possible.

The second route is to carve chunks out of mainstream services – and we have not seen any commissioners or providers willing to take that risk. So much still hinges on whether a locality has withstood pressures to pump more money into the acute sector.

Part 5: Recommendations

The *Five Year Forward View for Mental Health* is aiming for a doubling of access to IPS for users of secondary mental health services. NHS England is already encouraging commissioners to consider planning for new IPS services in areas where staff have no previous experience of IPS. As this continues at pace in 2017-19 there will be an increasing need for an implementation hub to support good fidelity.

With this in mind, the recommendations below are focused around key issues to be addressed – though mostly pertinent for local level players, they are also to be taken on board by those at national level. Within these sections, we have, where possible, differentiated between what a local organisation might do specifically and what an implementation hub might do. And we have offered some thoughts as to next steps to support the successful performance and sustainability of local IPS services.

Get the important systems in place early

- **Recruitment procedures should be rigorous**: Staff in roles being replaced by IPS roles should be assessed for suitability and offered redeployment/redundancy if they or their employer do not believe them to be suitable for the role. Staff transferring to IPS roles should be supported around that transition. There should be clear communication around expectations of the Employment Specialist role. Clarify contractual arrangements for staff who are to be based at an NHS site but not employed by the NHS before they are appointed (e.g. who pays for office space, access to NHS resources).
- **Management and supervision** arrangements should be made clear. Tackle early obstacles that may cause confusion, such as annual leave entitlements. Avoid a gap between start dates for the Implementation Manager and Team Leader. Clarify roles and communication channels between the 'operational' role of Implementation Manager and 'strategic' role of Team Leader.
- **Systems work**: Keep referral procedures as simple as possible. Background information on service users should be gathered from client management systems and during initial meetings. Manage expectations to avoid a 'tsunami' of referrals and give the IPS team time to get systems and processes in place. Provide clear options for demand management.

Focus on change management

- Recognise that many aspects of implementation rely on 'informal' approaches and building trusting relationships between key stakeholders.
- Implementation Managers and Team Leaders should provide influential, supportive and collaborative leadership (e.g. modelling good communication skills, developing the vision).
- Be clear on communication strategies at different levels of the organisation and who needs to say what to whom.

Create the climate

- Take an organisational development approach to implementation. Recognise the strategic element of implementation early.
- Identify additional IPS champions, allies, decision makers and budget holders.
- Ensure that commissioners, trust board, senior managers and IPS champions understand the scale of the change from any previous employment support approach to IPS, and the need to communicate this to e.g. external providers, staff and service users.
- Identify clear goals from the off, to enable early success and motivation.
- Ensure executive level accountability, responsibility and influence.
- Set up robust reporting, monitoring and performance management systems (including a relevant and influential intermediate level 'steering' group).

Put support in place

- Provide space and time for reflection and learning. Recognise that this is not easy but will be crucial.
- Create opportunities for ongoing sharing of learning between IPS teams across different sites.
- Investigate the development of 'professional' training for employment specialists and development of career progression opportunities.
- Make current and new learning opportunities for IPS teams more accessible and affordable.
- Provide leadership and change management support for Team Leaders and Implementation Managers if necessary.

Integrate IPS with other work

- Embed IPS within a wider strategic approach, single employment service or recovery culture.
- Link IPS work to user engagement work (e.g. peer support; learning from patients' experience; self-management support; patient and public engagement).
- Keep track and investigate people's experiences of the service.
- Keep a focus on employing users in the organisation – this requires more work to be done with HR departments and shifting the culture of the organisation (e.g. around stigma).

Engage external stakeholders properly

- Conduct a rigorous stakeholder mapping and communication plan.
- Work closely with the following key stakeholders:
  - **Department for Work and Pensions (DWP)**: When considering partnership working with DWP, be aware of the incompatibility of the DWP's benefit conditionality approach with the IPS model.
  - **Voluntary sector**: make early efforts to raise awareness of IPS in order to sell the message; work on ways to develop a spectrum of employment support that includes how clients can move from voluntary work and educational support to IPS.
  - **Employers**: Make the link as early as possible between IPS for individuals and a more corporate and strategic approach (awareness raising in the community; tackling stigma; support in the workplace). Make sure employment specialists are confident in their employer engagement roles.
  - **Commissioners**: Understand the commissioning context (e.g. who leads commissioning for mental health and employment support) and approaches that commissioners might use to enable dedicated IPS approaches – this is crucial for Implementation Managers to understand. In particular, understand how local authorities and CCGs work together and the roles of public health and social

care teams. Take into consideration current approaches to outcomes-based commissioning and to what degree other incentives in the system affect commissioners' attitudes to IPS (e.g. Sustainability and Transformation Partnerships (STPs), *Five Year Forward View*, regulation).

Reposition the IPS offer

- Consider flexing the IPS model to enable Employment Specialists to work alongside mental health clinicians, in whichever configuration they are organised, across secondary and primary care.
- Negotiate local targets (e.g. Key Performance Indicators based on aspects of IPS fidelity such as numbers of employers contacted).
- Consider flexibility around the IPS model (e.g. scope and fidelity scale) and local targets (e.g. KPIs around fidelity).
- Find a local resolution to the issue of discharge from secondary care ending eligibility for IPS support.
- Investigate perceptions around inclusion (i.e. some users and employment specialists may feel that IPS is not appropriate for more highly educated clients or people with learning disabilities).

Communication

- Take on board that professional resistance may be less of an issue than thought – be aware of professional attitudes and what is important to them (this is part of early work to better assess readiness).
- Communicate assertively – start from the premise that service users want employment support, and that getting it will contribute to recovery.

Research priorities

- Explore the commissioning landscape:
  - Changing structures and local systems (in particular around roles of the local authority and CCGs; public health and social care; role of STPs and rise of Accountable Care Organisations);
  - New provider models (e.g. GP Federations, lead provider models);
  - Outcome measures and incentives (NICE; outcome-based commissioning; personalisation).
- Explore client experiences of IPS: this may provide further support for the benefits of IPS and help address issues of inclusion and appropriateness of IPS for different client groups.

Learning and support

- Produce a learning and support package for employment specialists.
- Create a community of practice, hub or network for employment specialists to facilitate exchange of information, good practice and skills development.

Making Individual Placement and Support work

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