West Midlands Thrive Into Work: Individual Placement and Support Service

Service Specification | May 2017

Please note that this should be considered a draft document and is subject to change.

Table of Contents

1. Introduction

1.1. The West Midlands Combined Authority is working with NHS England, the Department of Work and Pensions (DWP), and the Department of Health (DH) to trial a new model of integrated health and employment support at scale. The aim is to test whether this model can deliver a transformational improvement in employment, health, and wellbeing outcomes for people who are out of work with a self-defined long term health condition or disability.

1.2. The trial will deploy employment specialists across primary and community NHS services in the region, focused on four geographic areas: Sandwell & West Birmingham, Birmingham and South Central, Dudley, and Wolverhampton. It will run from October 2017 to March 2020.

1.3. Over this time period, the trial aims to deliver services to 4,150 people who are out of work with a health condition across the four sites. The expected referrals and outcomes in each area are detailed in Section 20.

1.4. These employment specialists will apply the eight principles of the Individual Placement and Support (IPS) model, already well-evidenced internationally for people with severe mental illness, to provide a “place then train” supported employment service in parallel to the health treatment offered by NHS clinicians. Aside from working with trial participants, the employment specialists will also engage with clinicians to change the culture of the NHS to be much more focused on employment as a driver of health and wellbeing.

1.5. The contract is being procured in four lots of equal size, one for each geography. The service specification is identical in each area. As this service is being run as a trial, it will be critical that services in each area conform to the trial protocol. Please see Section 19 for more details on the lotting of the contract.

1.6. The programmed will be evaluated using a Randomised Control Trial (RCT), which means that all individuals referred into the service will be randomly allocated to either a treatment group or a control group. A national evaluator has been appointed to support the execution of this trial approach and collect data on individuals in both groups. The RCT methodology makes participant recruitment especially important, since the trial needs to work with enough people to get a statistically significant result.

1.7. The RCT element of the programme will run from October 2017 to March 2019. From April 2019 to March 2020, the programme will primarily support people who joined the service prior to April 2019, but some additional referrals might be accepted to optimise IPS specialist caseloads.

1.8. This programme is funded by NHS England, the Department of Work and Pensions (DWP), and the Department of Health (DH). It forms part of a national Innovation Programme to build the evidence for approaches that support people with health conditions and disabilities into paid employment.

1.9. This programme is a key element of the Thrive West Midlands action plan developed by the West Midlands Mental Health Commission in 2016, although the focus of this

trial will be broader than mental health. The action plan can be found at: https://westmidlandscombinedauthority.org.uk/media/1728/wmca-thrive-full-report.pdf

1.10. This programme is commissioned by the West Midlands Combined Authority, with procurement led by Wolverhampton CCG in conjunction with Arden & GEM Commissioning Support Unit (CSU). It is sponsored by Sarah Norman, CEO of Dudley Council, and governed by the Health and Wellbeing Board of the Combined Authority. Strategic leadership will be provided by Sean Russell, Director of Implementation.

2. Vision

2.1. Too many people with health issues and disabilities in the West Midlands are out of work. Unemployment among this group has significant social and economic costs for the region. The West Midlands is committed to tackling low rates of employment among people with health conditions and disabilities to enable them to:

i. recover more rapidly and effectively from their mental illness or build strategies to manage their health condition and barriers to work;

ii. build social connections and support networks;

iii. gain financial independence; and

iv. improve their general health and wellbeing.

2.2. The West Midlands Combined Authority has, therefore, established a partnership with NHS England, DH, and DWP to run a large-scale trial of a promising supported employment intervention, Individual Placement and Support (IPS).

3. National and local context

3.1. The NHS Five Year Forward View for Mental Health highlights that employment is vital to health and should be recognised as a health outcome. As supporting people to access employment will build on people's strengths and skills and enable people to realise their potential for recovery, this will also support the West Midlands Combined Authority ambition to harness economic growth and help to achieve the CCGs' goal to reduce health inequalities.

3.2. There are 2.8 million people in the West Midlands Combined Authority (WMCA) area, of which 1.8 million are of working age (18-64). In this group, there are around 125,000 people claiming out-of-work sickness benefits (ESA), of which 47% (59k) claim primarily for a mental health issue and 15% claim for a musculoskeletal issue. Around a quarter of ESA claimants are under 34, and a further 32% are aged 35-49.

3.3. Although unemployment is falling across the region, ESA claims have been rising for the past several years in each of the Local Authority areas (see figure 1 below).

3.4. Health data indicates 172,000 people (5% of the population) are registered as having anxiety or depression. Around one fifth of these individuals are referred to IAPT services, although this varies significantly across the WMCA. Around 58,000 people

have accessed secondary mental health services over the past year. However, only 30,000 of these have been identified on primary care mental health registers as having a severe MH issue.

3.5. Only around 8,300 people under age 70 are on the Care Programme Approach (CPA), a relatively small proportion of the total population with severe mental illness (SMI). For this group, for which data is most accurately recorded, just 6% are in paid employment. This is, however, consistent with the recorded proportion of people accessing secondary mental health services who are in work.

4. Individual Placement Support (IPS)

4.1. The IPS model has been identified by both DWP and NHS England as a promising intervention to support people who are out of work with a range of health conditions to gain paid employment. IPS is a replicable, evidence-based, supported employment programme that has been shown to deliver superior employment and health outcomes for people with severe and enduring mental health problems.

4.2. The IPS approach is based on eight key principles:

i. It aims to get people into competitive employment

ii. It is open to all those who want to work

iii. It tries to find jobs consistent with people's preferences

iv. It works quickly

v. It brings employment specialists into clinical teams

vi. Employment specialists develop relationships with employers based upon a person's work preferences

vii. It provides time unlimited, individualised support for the person and their employer

viii. Access to specialist benefits counselling is included.

4.3. IPS defines competitive employment as a job that any person can apply for regardless of disability status. These jobs may be full or part time. Workers in these positions should earn at least minimum wage, and receive similar wages and benefits as their co-workers.

4.4. This service will follow the principles of “IPS Lite”, which adapts principle vii to limit the length of time that an employment specialist will support a client to nine months or to four months after the client enters work. This has been shown to allow more people to use the service without impacting outcomes (Burns et al, 2015).[1]

4.5. IPS was originally developed to deliver an integrated, evidenced-based, mental health employment support service based within a Community Mental Health setting.

[1] http://bjp.rcpsych.org/content/early/2015/06/09/bjp.bp.114.152082

The employment specialist works in close collaboration with clinical staff and any individuals who express an interest in employment to achieve an employment outcome.

4.6. This programme of work will develop and expand the reach of IPS, testing its application in primary and community care. People with severe and enduring mental illness will still be eligible for support in this trial, but IPS specialists will not be based within secondary mental health teams.

4.7. This trial will be one of the largest trials of IPS conducted to date. Working at this scale is intended to help transform the local approach to work and health, embedding conversations about employment into health services across the region.

4.8. This is, therefore, a very exciting opportunity for a provider to be part of a truly innovative and globally significant pilot which may contribute to the roll-out of IPS more widely.

4.9. Further information on IPS within a Community Mental Health setting can be found at the Centre for Mental Health's website: http://www.centreformentalhealth.org.uk/individual-placement-and-support

5. Aims and objectives of the Thrive into Work programme

5.1. The goals of the trial are to:

i. Advance the goals of the WMCA to tackle high unemployment rates among people with a health condition or disability

ii. Develop a framework for effective, locally-driven employment support that can be sustained after the initial innovation funding has been depleted

iii. Build the evidence base for innovative employment interventions to facilitate the national roll-out of proven approaches

6. Evaluation

6.1. Evaluation will be fundamental to this trial, since a core objective for the programme is to build the evidence for IPS in primary and community care.

6.2. A national evaluator, a consortium led by the Institute for Employment Studies (IES), has been commissioned by NHS England, DWP, and DH to evaluate both this programme and a parallel programme in the Sheffield City Region. The evaluator will support providers to:

i. Develop tools to randomise trial participants into a treatment and control group;

ii. Collect data on participants randomised into the control group and some data on participants in the treatment group;

iii. Ensure that service delivery is consistent with the trial protocol.

6.3. Service provider(s) will be expected to collaborate with the national evaluator, including:

i. Participating in a process evaluation;

ii. Collecting data (full data collection and reporting requirements are set out in Section 16);

iii. Managers should champion the trial internally and promote the importance of the trial and associated requirements, for example, obtaining consent and randomising referrals, to their staff.

6.4. The evaluators will support the provider(s) by briefing employment specialists on the trial and requirements during mobilisation.

6.5. The evaluation is intended to answer three primary research questions:

i. Efficacy: Does the application of IPS principles enable more people to return to work, and improve their wellbeing, for individuals who present to primary and community care with a health condition and have been out of work for at least four weeks?

ii. Operational effectiveness: How can IPS be most effectively deployed under typical conditions in primary and community care settings, in particular to enable a sufficient number of appropriate referrals and effective engagement with clinical teams? Critically, this will test how the model could work at scale.

iii. Economic viability: How can IPS be deployed in primary and community care settings in a way that minimises cost per job outcome through effective and efficient management of staffing, caseloads, and other operational costs?

6.6. It is important to note that the service evaluation will be treated separately to the service KPIs with provider(s). Please see Section 17 for more detail.

7. Service description

7.1. The service will be an intensive, personalised supported employment service targeted at people with mental health or other health conditions, in the Sandwell and West Birmingham, Birmingham South and Central, Wolverhampton and Dudley regions.

7.2. The service will deploy teams of Employment Specialists to provide support in line with IPS principles These workers will be embedded in primary and community health settings and engage clinicians in viewing the service as an extension of their patient work and viewing employment as a health outcome.

7.3. Establishing co-location and co-working arrangements with primary and community health teams will be essential and the provider(s) will be expected to demonstrate how they will achieve this.

7.4. The service will maintain high fidelity to an adapted IPS model, providing time-limited support for people referred from primary care, community care, and self-referrals.

Active support will be time-limited to nine months for all users and four months for users who get a job.

7.5. The service will support people to achieve their employment aspirations with a focus on:

i. paid, competitive employment including self- employment;

ii. employment specialists embedded in primary and community care teams, with service users receiving employment advice alongside other medical support;

iii. rapid job search, followed by in-work support tailored to the individual needs of a person, making use of the resources available within the West Midlands.

7.6. The target cohort will be patients with a self-reported health condition which is limiting their ability to gain competitive employment.

7.7. The provider(s) should become part of the Centre for Mental Health's Centres of Excellence programme over the course of the contract. All related costs should be considered when allocating training budget, as the provider will be responsible for these costs.

7.8. In addition to above:

i. the service will complement existing and emerging provision in the borough including the Work and Health Programme, Jobcentre Plus, Access to Work, etc.; a partial list of existing employment services is provided in Appendix 2 [TBC].

ii. the service will be flexible and responsive to the changing needs of the current employment and welfare landscape; and

iii. providers will work together with stakeholders to identify learning/evidence from the project to inform the development of employment provision.

iv. Providers will report to a central programme team on pre-determined programme outcome measures, quality assurance performance and any issues around successfully operationalising the randomised control trial. The outcome measures are listed in Section 17.

7.9. Full eligibility criteria for people entering the programme are outlined in Section 10.

8. Staffing and caseloads

8.1. Recruiting effective IPS service managers, team leaders, and employment specialists will be a critical success factor for this programme.

8.2. The programme calls for the recruitment of a large number of high-quality staff. The provider(s) will need to demonstrate their ability to attract sufficient numbers of capable staff to the service, including through the pay and conditions they propose.

8.3. The provider(s) will be supported with recruitment from the central programme team, as outlined in Section 15. This does not negate the need for provider(s) to demonstrate ability to recruit, as outlined in 8.2.

8.4. As an adapted IPS service for primary and community care, it is anticipated that IPS specialists will work at any one time with between 25-30 active cases.

9. Referrals and care pathways

9.1. The service will demonstrate strong, timely, and seamless referral pathways.

9.2. The core target referral routes are as follows:

i. Primary care

ii. Community care (IAPT and pain clinics)

iii. Self-referral

9.3. Note: Re-referrals will be managed via central database of referrals (further details TBC).

9.4. Detail of the referral routes are outlined in Appendix 1.

9.5. The service will develop strong links and referral arrangements with community organisations and local partners such as GPs, CCGs and Local Authorities, Social Care, Community allied health services, Health Navigator services, educational institutions, volunteering organisations, and housing services, etc. [TBC]

9.6. The envisioned patient pathway is outlined in Appendix 8. This diagram outlines the process from the three main envisioned referral routes: primary care, community care, and self-referral.

9.7. Given the importance of the GP role, the project will be supported during the mobilisation period by a GP/Allied Health engagement lead within the central Thrive Into Work programme team.

9.8. The service will signpost and make onward referrals to a range of other opportunities into wider community services.

9.9. The provider(s) will be expected to undertake the initial engagement and consent process to be a part of the randomised control trial and then to apply the randomisation tool to determine whether the service user enters into the IPS intervention or is sign-posted to existing provision. [Note: Control group service TBD – may be given an employment support advice booklet]

9.10. As shown in Appendices 1 and 8, the care/referral pathway should include, but not be limited to:

i. treating clinician and patient discuss if a return to employment would be beneficial to recovery;

ii. patient decides whether to take part in the trial;

iii. patient meets with Employment Specialist who confirms eligibility and conducts the consent process and randomisation;

iv. if randomised into the IPS intervention, the service user meets IPS employment specialist at relevant location to discuss job aspirations and co-produce an employment plan;

v. after initial meetings, service user and the employment specialist rapidly begin to seek competitive paid jobs that match the user's individual aspirations;

vi. as part of conversations, the service user and specialist discuss and gain expert advice on the user's eligibility for benefits and how their income will be affected going back to work;

vii. as part of conversations, the service user and specialist discuss the value of sharing personal information (disclosure of condition), to a potential employer and agree on an approach

viii. between a third and a half of service users typically get a job, usually within two to six months;

ix. the IPS specialist continues to support the user for up to four months in the job with the chance for a service user to access in work support again if they require;

x. the IPS specialist ceases active support after nine months for individuals who do not get jobs. The user may remain in contact with the specialist, but will no longer count as part of the active caseload. Support may continue beyond nine months in exceptional cases;

xi. if the participant is randomised into the control group, the IPS employment specialist [provides the user with an employment advice handbook and sign-posts the user to existing local services].

9.11. Note that the referral pathway will change from April 2019, at which point the randomisation process will end and all eligible service users will access IPS employment support until the programme ends.

9.12. The service will provide the following with adherence to the IPS model:

i. assessment for intervention using the IPS model;

ii. specialist consultancy and advice to mental health teams/other clinical treatment teams, service users and carers;

iii. employment specialist staff should input into the treatment/discharge or clinical assessment and review process as appropriate;

iv. every service user to have a named employment specialist as the key point of contact throughout the job search process and continuing in-work support;

v. each service user will be supported to undertake a personal profiling of skills, strengths, past experiences, aspirations, education and training, support needs to develop a targeted vocational goal and plan;

vi. rapid job search for competitive employment with contacts made with potential employers within four weeks after programme entry.

10. Eligibility criteria

10.1. As a trial, services will need to conform strictly to a trial protocol that is approved by the national evaluator and has gained ethical approval from the Health Research Authority.

10.2. The trial protocol will include a set of inclusion and exclusion criteria for trial participants. These are provided in Figure 1 below. Provider(s) will need to ensure that all participants who are entered into the trial meet the inclusion criteria and do not meet the exclusion criteria. However, these criteria may change before trial launch based on feedback from the Health Research Authority or other parties. The final criteria will be provided, along with the final trial protocol, to provider(s) in advance of the launch.

Figure 1: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Registered with a GP practice in one of the following health geographies: 1. Wolverhampton 2. Dudley 3. South and Central Birmingham 4. Sandwell and West Birmingham	Not registered with a GP in one of the outlined areas.
18 years or older	Less than 18 years old
Have a self-defined long term health condition (LTC) or disability which precludes them from gaining work Include those poorly managing LTC e.g. diabetes	Exclude some conditions, e.g. moderate to severe learning disability, solely addiction issues or presenting with dementia. Exclude people who are not out of work with a health condition.
Out of work for 4+ weeks and have expressed an interest in finding paid employment	People who have been out of work for <4 weeks People in work but job in jeopardy, e.g. long-term sick leave. People who have a job offer
Not receiving state-funded employment support from a Local Authority or DWP-sponsored programme	Currently on a state-funded employment programme

11. Randomisation process

11.1. From October 2017 to March 2019, it is anticipated that services will recruit 5,300 trial participants in total. 50% of these (2,650) will be randomised into the control group and 50% (2,650) will be randomised into the treatment group and will go on to receive IPS. Note that recruiting 5,300 trial participants will likely require significantly more than 5,300 referrals from clinicians or self-referrers, given the drop-out rate between referral and engagement.

11.2. From March 2019 to March 2020, services are expected to work with 1,070 people, all of which will receive IPS employment support. This period of the programme is intended to allow provider(s) to continue to support clients recruited during the trial period. It will also provide learning on how to optimise IPS service delivery in a primary and community care setting without the additional requirements of running a randomised control trial.

11.3. The provider(s) will be responsible for meeting with all users referred into the trial, whether by clinicians or self-referral. During the initial meeting, an employment specialist (ES) will conduct the consent process required for participating in a randomised control trial.

11.4. Completed consent forms should be stored securely by the provider(s).

11.5. The ES will then use a web-based tool to check user eligibility, collect baseline data, and perform the randomisation. [TBC] This tool will be developed by the central programme team in conjunction with the national evaluator. It will be standardised across all four geographies. The tool will also provide a standard script for the ES to use in this part of the meeting.

11.6. Once the ES has pushed the randomisation button, the tool will inform them whether the user is in the treatment or control group. This determination is irreversible; the ES will not be able to re-run the tool.

11.7. If the patient is randomised into the intervention group, the ES will then arrange to provide the IPS service as usual.

11.8. If the patient is randomised into the control group, the ES will [provide an employment advice booklet and will sign-post the user to existing services].

11.9. If a service user withdraws consent at any point during the process, or during subsequent service delivery, the provider(s) must put in place a procedure for communicating this to the evaluators. The provider(s) will be given a dedicated contact from the evaluators.

11.10. The evaluators commissioned by the Work & Health Unit will provide a briefing to the provider(s) on how to conduct the consent process and randomisation. This will be integrated into the training of employment specialists.

12. Promotion of the service

12.1. The service provider must be prepared to work in partnership with the Thrive Into Work central programme team to actively promote the service and raise its profile across the locality. This will include:

i. ensuring easy access to information on the service, through online and print media;

ii. making information about the service accessible, in formats suitable for people with sensory impairment and/or languages other than English;

iii. working closely with community health and primary care teams to promote the service;

iv. making use of existing or new networks to promote the service across the health and employment systems.

12.2. The service provider will be assisted in this in the mobilisation period by the central programme team's GP or Allied Health engagement lead, who will lead on much of direct engagement with primary care practices and community health clinics. It will be expected that this is done in collaboration with provider(s) initially, with provider(s) taking on this function after the mobilisation period is complete.

13. Co-production with service users

13.1. The provider(s) will demonstrate, through outcomes, practices, policies, and procedures, a commitment to working with people with a variety of health conditions in the design, delivery, and evaluation of all services.

13.2. The principles of equality, diversity, accessibility, and reciprocity will be essential, when co-producing services with people. The provider(s) will ensure:

i. service users are represented and play an active role in consultation, service planning and delivery;

ii. model of co-production is adopted, whereby the service is planned and delivered in mutually beneficial ways that acknowledge and reward local 'lay' experience while continuing to value professional expertise;

iii. service users are regarded as an asset and encouraged to work alongside professionals as partners in the delivery of the service;

iv. the service is operated and provided in a person-centred way, which requires professionals and service managers to distance themselves from traditional roles as 'experts' and 'providers', into partnership models that work with 'individuals' and 'communities';

v. approaches that build on and/or strengthen social networks are adopted;

vi. service user networks (friends and families) are engaged; and

13.3. The provider(s) will look to develop client surveys, user advisory groups, or other means to get direct feedback from users on the service.

14. Partnerships and networks

14.1. Partnership working is considered essential to the success of this service and therefore the provider(s) will be expected to:

i. be committed to developing and maintaining strong partnerships with primary and community health services, including establishing co-location and co-working arrangements with a range of clinical teams;

ii. to work in a collaborative way and build partnerships with other community organisations to achieve service outcomes;

iii. be aware of and form working relationships with the existing West Midlands services to maximise the use of resources, share good practice, and develop new initiatives;

iv. work collaboratively with partners to target BMER communities and hard to reach groups within West Midlands, in particular, communities with high rates of English as an Additional Language (EAL);

v. work with community organisations to reduce stigma around disability and health conditions. They will ensure that services are designed and developed in a co-produced way and that the voice of the community is heard in developing the offer; and

vi. actively engage with employers in line with the IPS model.

14.2. The provider(s) will be expected to show evidence of existing networks in place and a commitment to forming new ones where applicable.

14.3. In practice, the providers will be supported by the networks formed by the central programme team and the wider Thrive West Midlands programme

15. Support for the provider(s)

15.1. Commissioning of this service is being led by Wolverhampton CCG and Arden & GEM CSU on behalf of the West Midlands Combined Authority, DWP, DH, and NHS England.

15.2. Service mobilisation and delivery will be supported by the Thrive Into Work central programme team, employed at Wolverhampton CCG. This team will is likely to comprise a programme manager, programme support officer, data analyst, and admin support. The central team will also have access to operational and clinical experts, evaluation expertise, and data-sharing and information governance expertise.

15.3. During the programme mobilisation phase, the programme is being supported by a project team including Vivienne Griffin, formerly of Wolverhampton Council, and Social Finance's Health & Employment Partnerships team. Social Finance is a non-profit organisation with experience of mobilising and supporting IPS services.

15.4. The central programme team aims to ensure the successful delivery of the Thrive Into Work trial. To this end, it will support provider(s) in the following ways:

i. Facilitating workshops with GPs and relevant other primary and community care pathways, supporting the ongoing engagement of GP and clinicians throughout the project;

ii. Wider stakeholder engagement to promote Thrive Into Work and wider Thrive West Midlands programmes;

iii. Liaising with national and international IPS experts to adapt fidelity guidelines for primary and community care;

iv. Liaising with the national evaluator, DWP, DH, and NHS England on issues related to national funding, the randomised control trial, and access to national support and expertise;

v. Centralised data analysis, dependent on timely and consistent reporting from provider(s) outlined in Section 16; and

vi. Operational support from national IPS and employment experts to help resolve issues in delivery.

15.5. The central team will aim to facilitate the recruitment of top-quality employment specialists alongside provider(s). The team will offer support for marketing the new roles as well as the subsequent recruitment, assessment, and initial training of IPS employment specialists, given the large number of specialists needed for this programme.

15.6. However, provider(s) should not assume any cost reduction from their side on recruitment or training of staff.

15.7. Although this support will be available free of charge, provider(s) who can demonstrate a track record and/or the willingness to perform these tasks going forward will be favoured.

16. Reporting

16.1. The provider(s) will be expected to have developed a detailed project plan and associated Gantt chart on the mobilisation of the new service, which will be agreed with commissioners.

16.2. The provider(s) will be expected to develop a yearly business plan which commences from April 2018, with key objectives, time frames, responsibilities and measures for success to ensure the ongoing viability of the research and service.

16.3. The provider(s) will be required to:

i. produce a monthly raw data export and a more formal detailed Quarterly Data Report;

ii. comply with a robust outcomes framework that will monitor outcomes and set goals for service development;

iii. submit complete, accurate, and timely monitoring returns to commissioners; and

iv. submit complete, accurate, and timely monitoring returns to the national evaluator.

16.4. Detailed requirements for outcomes reporting are provided in section 16.

16.5. Formal monitoring meetings will take place quarterly and will be attended by the Commissioning Manager and Contract Officer, a representative from the Thrive into Work programme team, the provider(s) and service user representatives.

16.6. The Provider(s) shall inform the CCG immediately if there is a change to the contract manager and if there is likely to be a substantive change to the service or any matter affecting any provision of the service during the term of the contract.

16.7. The central programme team project manager will be the first point of contact for the functioning of the contract and shall be responsible for the monitoring of the service and consultation with the provider(s).

16.8. The central programme team, based in Wolverhampton CCG, will be entitled to introduce, or change, any systems of contract monitoring and quality control giving reasonable prior notification to the provider(s).

16.9. The Quarterly Data Report must be sent within one month of the preceding quarter and at least one week prior to the contract monitoring meeting. As noted in the outcomes section of this specification, the report should be accompanied by appropriate evidence for each outcome reported.

16.10. Given the service is operating as a randomised control trial there will be an expectation for the service provider to liaise and work with the evaluator on a needs basis to ensure the research objectives are met.

17. Outcomes and KPIs

17.1. Throughout service delivery, data will be collected by the provider(s), the CSU, and evaluators.

17.2. This data will serve two purposes:

i. To be included in the analysis as part of the evaluation; and

ii. To report on operational KPIs.

17.3. The contract described in this specification will be monitored through reporting, as outlined in Section 15. This reporting will be informed by a set of data collected by the provider(s).

17.4. The provider(s) will also be expected to collect and report data to the evaluators to assist with their analysis. Figure 2 below outlines the data that will be collected, who will be responsible, and how it will be done.

17.5. The provider will be required to collect baseline data from all referrals who consent to take part in the trial during the initial consultation. This baseline data is outlined in Fig 16.x.

17.6. The provider will continue to collect data from service users as they receive the IPS intervention.

17.7. It is critical that data for the evaluation is collected in a consistent way across the trial, regardless of the number of providers. To this end, we are exploring:

i. Implementing a standardised IT system [e.g., web-based CRM] for the provider(s) to collect and store data, or

ii. Producing a specification for data collection which the provider(s) will be expected to work to.

17.8. The evaluator will be responsible for collecting data from services users randomised into the control group.

Figure 2 [Work in progress]

Name of metric	Who collects?	Data source
Job started and number of hours per week (i.e. under or over16hrs)	Provider	Copy of employment contract, letter or email from employer on letterhead or employer email address on file with case note record
Job outcome (6 weeks in work and could be in a number of different jobs) and number of hours per week (i.e. under or over16hrs)	Provider	Copy of pay slip on file with case note record
Job sustainment (6 months in work could be in a number of different jobs) and number of hours per week (i.e. under or over16hrs)	Provider	As above
Type of work and industries that users find work with	Provider	Service user survey (use Office of National Statistics classification)
Service User satisfaction with the service	Provider	End of program survey results

Name of Metric	Who collects?	Data source
Service user wellbeing	Provider	Warwick-Edinburgh Mental Wellbeing Scale (short version preferred) or similar
Service user health	Provider	SF36 or similar
Number of GP appointments	Evaluator	GP practice data
Change in use of community services (outpatient and inpatient)	Evaluator	Local NHS data

Number of prescriptions	Evaluator	GP practice data
Change in use of secondary care (A&E, elective, non-elective, and outpatient)	Evaluator	SUS data
Change in use of mental health services (inpatient and outpatient)	Evaluator	SUS data

17.9. A set of data will also be collected by providers to monitor the service's fidelity to IPS principles, which will include:

i. Number of overall referrals to the service and by source

ii. Time from referral to first contact

iii. Number of engagement to the service as defined by one meeting

iv. Vocational Assessment completed

v. Number of people supported to apply for a job within 4 weeks

vi. Number of people supported to gain a job start

vii. Number of job starts per service user

viii. Number of days from from initial assessment to first employment

ix. % of people who decide to discuss their diagnosis/condition with their employer

x. Methods used by service users to manage health and work

xi. Number of service users sustaining employment for a total of 6 weeks

xii. Number of service users sustaining employment for a total of 6 months

xiii. Hourly wage (or equivalent) of service users achieving a job outcome

xiv. Job role of service users achieving a job outcome

xv. Industry sector of service users gaining an employment outcome

xvi. Average length of in-work support

xvii. Number of people accessing mainstream education, mainstream work experience, mainstream volunteering work

17.10. The above data will be broken down using demographic data, including:

i. referral source;

ii. primary health condition;

iii. gender;

iv. GP practice;

v. job type;

vi. industry.

17.11. Supporting evidence will not be required as standard for the above outcomes, other than employment evidence. However, the service provider will be required to maintain appropriate data capture systems to ensure that these outcomes are recorded accurately and systematically of people still being supported to sustain employment from the previous 12 months.

17.12. This information will need to be reported quarterly to the central programme team. Supporting evidence will not be required as standard for the above outcomes, other than evidence of entry into and sustainment of employment.

17.13. However, the service provider will be required to maintain appropriate data capture systems to ensure that these outcomes are recorded accurately and systematically.

18. Timeline

18.1. The programme will be conducted in three phases.

18.2. Phase 1 - testing phase: As soon as provider(s) are selected, we intend to begin a brief test-and-learn phase to determine if the referral pathway assumptions, IT data exchange, reporting and case records system are ready for the commencement of the randomised control trial

18.3. Phase 2 - RCT phase: In October 2017 we plan to commence the randomised control trial element of the programme. This will last until March 2019.

18.4. Phase 3 - operational phase (no RCT): From March 2019 to March 2020, services are expected to work with 1,070 people, all of which will receive IPS employment support. This period of the programme is intended to allow provider(s) to continue to support clients recruited during the trial period. It will also provide learning on how to optimise IPS service delivery in a primary and community care setting without the additional requirements of running a randomised control trial.

19. Contract lots

19.1. [We are currently exploring the appropriate division of the contract into distinct lots, each representing a separate geographic area. The service model described above will be identical in each lot.]

19.2. [Option 1: Two lots:

i. Lot 1: Wolverhampton and Dudley

ii. Lot 2: Sandwell and West Birmingham and South Central Birmingham]

19.3. [Option 2: Four lots:

i. Lot 1: Wolverhampton

ii. Lot 2: Dudley

iii. Lot 3: Sandwell and West Birmingham

iv. Lot 4: South Central Birmingham]

19.4. Bidders may bid for any combination of lots either by themselves or in consortium with others.

20. Target outcomes [to be completed]

21. Finance [TBD]

21.1. The total contract value will be [£6.8m] over all lots over the full period of the programme.

21.2. 90% of the contract will be paid on a block, fee-for-service basis quarterly in arrears. 10% of the contract will be linked to outcomes [subject to market engagement].

21.3. The breakdown of the block payments by lot by year is detailed in the table below.

21.4. The outcomes payment will be capped at the values shown in the table below. The outcomes payment will be equal to £750 for every person on the service who enters paid employment, up to a maximum [to be detailed].

22. Policies and procedures

22.1. The service is expected to have the following policies in place:

i. Complaints (Appendix A)

ii. Risk management and serious incidents (Appendix B)

iii. Health and Safety

iv. Quality Assurance and Knowledge management

v. Business Planning

vi. Staff appraisal, supervision and training

vii. Staff grievance and disciplinary

viii. Recruitment

ix. Lone Working

x. Safeguarding vulnerable groups

xi. Confidentiality

xii. Service user consultation, involvement and empowerment

xiii. Information sharing

xiv. Data management

23. Workforce standards

23.1. The West Midland Combined Authority recognises the importance and value of good employment practices in delivering public services.

23.2. To safeguard good employment practice, the Authority has developed a set of minimum standards. The provider(s) will be required to demonstrate adherence to these standards through discussion and provision of information as part of the monitoring and review process. Details are provided in Appendix 5.

Appendix 1 – detail of referral routes

	Typical referees	How referee is prompted to refer	Criteria applied	Information available to referee	How referral process works	Who refer to
Primary care	GP, nurse	Patient indicates they are interested in working This may be preceded by a prompt to discuss employment (e.g. a pop-up on IT system)	Patient indicates interested in employment	Leaflet to give to patient Information sheet for primary care	Web-referral form (possibly integrated into IT system), shared with local IPS Provider via NHS.net email address	Local IPS provider who puts details on system
Community care	Physiotherapy, pain clinics, IAPT	As above	As above	Leaflet to give patient Information sheet for clinicians	As above	As above
Self-referral	N/A	Leaflet or website, word of mouth		Poster or leaflet, word of mouth	Patient calls local IPS provider, completes web-referral form, or emails local IPS provider -- all to book first consultation	As above

Appendix 2 – Existing service provision [TBC]

Appendix 3 – Complaints

The Provider(s) will provide service users with a copy of its complaints procedure at the commencement of the service. The complaints procedure should be available in the main local community languages and accessible formats where appropriate (e.g. easy read braille etc.).

Service users have the right to make a complaint directly to the Provider or to the Host Authority and this shall be made clear to Service Users.
The Host Authority has the right to investigate a complaint at any stage.

The Provider(s) will maintain a complaint register which records all complaints and their outcome. These will be made available upon request for monitoring purposes. The Provider(s) will inform the Host Authority of any serious complaint immediately.

Appendix 4 – Risk management and serious incidents

The service will have in place a risk management policy that includes:

i) Working with risk in a positive way to increase Service Users' independence; working jointly with other organisations, statutory and voluntary, to jointly manage individual risks; protecting staff (including where necessary minimum staffing requirements) and those using the service, from risk; lone working guidelines and procedures.

ii) The service ensures that an assessment of the potential risks to Service Users and staff associated with delivering the Service is undertaken, by a trained and qualified person, before staff commence work and a risk management plan put in place. This should be updated annually or more frequently if necessary.

iii) Where the service is concerned for the health, safety or comfort of other people as a consequence of a Service User's actions or behaviour, the service must discuss those concerns with the Service User.

iv) Where the Service User persists in continuing with their actions and the provider remains concerned for the well-being of the Service User or other people, the treating health practitioner must be informed immediately in order to identify how to address the risk.

v) The service shall record in writing any serious incident that occurs in the provision of the service and report the incident to the Host Authority within 24 hours of the incident occurring

Appendix 5 – Workforce Standards

Managing employees

Suppliers will have clear policies, processes and/or practices in place for dealing with employees in relation to performance, attendance, conduct and employee concerns.

Staff will be made aware of these processes and/or practices.

Suppliers will make staff aware at the earliest opportunity where their performance (including absence and conduct) fall below the standards required and provide the necessary support to bring about improvement.

Suppliers will induct staff into working on the contract so that they are aware both of the significance and importance of their individual contributions and also of their duties and obligations.

Training and skills

Staff will be provided with the appropriate IPS and other training, development and / or qualifications relevant to their role, including customer relations and health and safety training.

Staff will be supported to develop their skills and gain experience in line with any future roles that may be expected of them.

Suppliers will ensure that its managers are appropriately trained and developed to perform their role.

The service will ensure that staff are trained in the following areas:

- Awareness of the ethnic and cultural diversity of the service user group its implications for the delivery of the service and development of staff cultural competency;
- Management of complaints;
- Confidentiality, information sharing and data protection;
- Boundary setting;
- Advice and guidance;
- Health and Safety;
- Mental Health First Aid;
- Safeguarding adults and children

Health and safety

The supplier will have adequate policies and procedures in place to ensure the health and safety of its workforce and customers in keeping with all legal requirements.

Equality and diversity

The Equality and Diversity Vision of the West Midlands Combined Authority, is integral to the overall vision of improving the quality of life of everyone who lives and works in the West Midlands.

Equality and diversity is at the heart of the business; which values the diversity of all customers, staff, suppliers, partners and the people we work with. A clear commitment to treating everyone fairly and achieving equal outcomes for all.

The provider is expected to create a positive working environment where everyone is treated with dignity and respect and provide services and implement strategies that meet the diverse needs of people in the West Midlands.

https://westmidlandscombinedauthority.org.uk/media/1539/equalities_scheme2015.pdf

https://westmidlandscombinedauthority.org.uk/media/1541/wmca-equality-in-the-procurement-process-guide-2016.pdf

Employee Relations

Suppliers will have regard to good industrial relations practice on dispute resolution, including treating employees fairly and ensuring compliance with legislation

Suppliers will ensure that where there is a dispute, employees are aware of and have access to clear processes for dispute resolution;
Flexible Working

Suppliers will have a clear process for considering requests for flexible working;

Staff will be made aware of this process;

Suppliers will respond to requests for flexible working in a fair and timely manner;

Suppliers will ensure that contracts that don't guarantee or specify hours are only used where it is not reasonably practicable to offer contracts with fixed hours;

Suppliers will ensure that where these contracts are in place, staff are not prevented from carrying out work with other organisations.

Sustainablity Commitment

The West Midland Combined Authority environmental strategy has embedded social, economic and environmental considerations into the procurement process

The world is facing many environmental challenges including climate change, resource depletion and pollution. As a consequence, the Government has set targets to move the UK to a low carbon future and to reduce greenhouse gas emissions. We believe that we have a shared responsibility to support these global challenges, national aspirations and to help to create a sustainable future in our role as the region's Combined Authority.

Our environmental strategy is based on the concept of sustainable development and continual improvement. It sets out our objectives and approach to minimising the carbon impact of WMCA operations and our commitment to working with partners to facilitate sustainable public transport growth.

We are fully committed to action such sustainable travel by our staff, and supporting organisations across the region to implement Travel Plans.

https://westmidlandscombinedauthority.org.uk/about/environment/

Appendix 6 – Key Performance Indicators

The service provider will be expected to track, gain evidence and report upon key performance indicators in the quarterly report.

Key outcomes -Supporting evidence will be required as part of Quarterly Report

Outcome	Supporting Evidence Required
Number of people successfully engaged in the service Definition: Completion of three appointments with the user or when the provider has worked with the user to complete a vocational profile	- completed vocational profile; or - evidence of three completed appointments

Number of people referred into the IPS service who achieve a job start (<16 hours per week) Definition: Achieved 1st day in employment for a contract for under 16 hours per week	- evidence of job entry, typically employer-generated letter, 1st payslip. - as a backup, evidence will typically include a signed declaration from the client after 1 day at work
Number of people referred into the IPS service who achieve a job start (>16 hours per week) Definition: Achieved one day in employment for a contract for over 16 hours per week	- evidence of job entry, typically employer-- generated letter, 1st payslip - as a backup, evidence will typically include a signed declaration from the client after 1 day at work
Number of people referred into the IPS service who achieve 6-weeks in work, working, on average, <16 hours per week) Definition: Achieved when an engaged service user has commenced paid employment and has worked for six weeks (on average <16 hours per week)	- evidence of job entry, typically employer-generated evidence, such as a job offer letter and confirmation of employment totally 6 weeks (e.g., time-sheets or pay slips). - as a backup, evidence will typically also include a signed declaration from clients after 6 weeks in work.
Number of people referred into the IPS service who achieve 6-weeks in work, working, on average, >16 hours per week) Definition: Achieved when an engaged service user has commenced paid employment and has worked for six weeks (on average >16 hours per week)	- evidence of job entry and average hours exceeding 16 hours per week, typically employer-generated evidence, such as a job offer letter and confirmation of employment totalling 6 weeks (e.g., time-sheets or pay slips). - As a backup, evidence will typically also include a signed declaration from clients after 6 weeks in work.
Number of people referred into the IPS service who achieve a job sustainment outcome (working, on average, <16 hours per week) Definition: Achieved when an engaged service user who has achieved a job entry outcome is still in paid employment 26 weeks after job entry.	- evidence of job sustainment, typically employer-generated evidence, such as confirmation of employment at 26 weeks (e.g., signed letter, time-sheets or pay slips). - as a backup, it will typically also include a signed declaration from clients after 26 weeks in work with some additional qualitative evidence on the way that the IPS team has supported the client in work.

Number of people referred into the IPS service who achieve a job sustainment outcome (working, on average, >16 hours per week) Definition: Achieved when an engaged service user who has achieved a job entry outcome is still in paid employment 26 weeks after job entry and where they worked for an average of more than 16 hours per week over the previous four weeks.	- evidence of job sustainment at an average of more than 16 hours per week for the previous four weeks, typically employer-generated evidence such as confirmation of employment at 26 weeks (e.g., signed letter, time-sheets, or pay slips). - as a backup, it will typically also include a signed declaration from clients after 26 weeks in work with some additional qualitative evidence on the way that the IPS team has supported the client in work.

Operational outcome metrics – to be included in the Quarterly Report:

The provider will be expected to capture key demographic data on referrers and the service users and fidelity data to the IPS model. This data and analysis will form part of the detailed Quarterly report expected from providers.

Demographic data

Demographic data of will be used to determine patterns for service users who successfully engage, who achieve job entry outcomes, (showing a distinction for self-employed), and who achieve job sustainment outcomes.

Referrer/Service User demographics

i) Date referred
ii) Source of referral (i.e., GP, IAPT, Job Centre Plus, self-referrals etc.).
iii) Health condition/Disability type
iv) Consent
v) Region
vi) First name
vii) Surname
viii) DOB
ix) Email
x) Phone
xi) Gender
xii) Ethnicity

xiii) Religion and belief

xiv) Sexual orientation

xv) Education

xvi) Time since last worked (<6 months, 6 months–1 year, 1–2 years, 2–5 years, >5 years)

xvii) Type of benefits received

Appendix 7 – Adapted IPS fidelity guidelines

The table below outlines preliminary guidelines on what IPS fidelity in Primary Care and Community Care settings might look like. This is work in progress, and is being refined with guidance from leading IPS academics.

Staffing
1. Caseload size, mix and profile: Employment specialists have individual employment caseloads. The maximum open caseload for any full-time employment specialist is 25-30 service users for the first year of operation and could rise to 30-35 cases as the service matures and develops. We expect a person to receive support for up to 9 months to gain a job and up to 3 months support in that job; with the possibility to re-access more in work support should they or their employer require it (see Burns et al 2015). We expect a full time employment specialist to manage 45-50 cases a year in the first year and around 100 per year by the second year.
2. Employment services staff: Employment specialists provide only employment services versus focus on condition management. Employment support is focused on guidance in managing barriers to employment which could include debt issues, transport issues, childcare issues, working with family members and their perceptions etc.
3. Vocational generalists: Each employment specialist carries out all phases of the employment support, including intake, engagement, assessment, job placement, job coaching, and follow-along supports as necessary. Support may be face to face, telephone, in groups and via text or email as appropriate. Peer support is promoted; formal and informal ways to provide new service users with encouragement from service users who are job seeking or gained work. In this trial each employment specialist carries out the randomisation process and baseline data collection.
Organisation
1.Integration of supported employment and primary care treatment through team assignment Employment Specialists should be part of the team of primary care professionals in the same way as, for example practice nurses, pharmacists, psychologists, physiotherapists etc. Employment specialists are part of up to 2 primary health care practice/clusters/health centres from which the majority of the employment specialist's

caseload is comprised. Employment specialists are physically based at least part of their time in the practice/health centre.
2. Integration of rehabilitation with primary health treatment through frequent team member contact: Employment specialists actively participate in practice team meetings and liaise with other staff who are involved in the service users care. Employment specialists are based within the practices/health centres and use the primary care notes for documentation of health treatment and employment services. Employment specialists advise the primary health care team in relationship to employment on a formal or informal basis.
3.Collaboration between ES and JCP and other Government/DWP programmes: Employment specialists liaise with other welfare to work programmes on an individual and service basis in relation to mandatory activities and requirements.
4. Vocational unit: At least 2 full-time employment specialists and a team leader comprise the employment unit. They have weekly client-based group supervision following the supported employment model in which strategies are identified and job leads are shared. They provide coverage for each other's caseload when needed.
5. Role of employment supervisor: The employment unit is led by an Employment Team Leader. Employment specialists' skills are developed and improved through outcome-based weekly team supervision and individual 4 weekly supervisions. We expect a maximum ratio of 1 team leader to 10 employment specialist. The Employment Team Leader is also responsible for maintaining the relationships with the primary care teams and ensure there is a monthly tracking of referrals and action taken with any variance. Formal quarterly review meetings are undertaken with senior primary care staff and minutes kept of action and progress. The Employment Team Leader constantly looks for ways to improve outcomes. Targets are reviewed regularly and improvements made.
6. Zero exclusion criteria: All those randomised into the Programme and express an interest in employment will be accepted regardless of job readiness factors, substance abuse, symptoms, history of violent behaviour, cognitive impairments, treatment nonadherence, and personal presentation. Employment specialists offer to help with another job when one has ended, regardless of the reason that the job ended or number of jobs held. We are assuming time limited in work support of up to 3 months, however a service user can ask for further in work support as the need arises. Service users in this trial are only screened out if they have worked in the last 4 weeks.
7. Agency focus on competitive employment: The focus of the service is helping people gain competitive employment. Local Commissioners and Managers of the primary care service demonstrate a commitment to promoting employment for people with health conditions/disabilities.
Services

1.Employment benefits planning: All service users are offered assistance in obtaining comprehensive, individualised work incentives planning before starting a new job and assistance accessing employment benefits planning thereafter when making decisions about changes in work hours and pay. Employment benefits planning includes the impact on all sources of income and fringe benefits (Personal independence payments, travel concession, Working Tax Credits, Universal Credit etc.) and all costs associated with commencing or changing employment. Service users are provided information and assistance about reporting earnings to any other programme that needs to know the new income details (e.g. Housing, Council Tax, HMRC etc.). The use of the Access to Work scheme needs to be considered to provide support and adjustments in work.
2. Sharing personal information: Employment specialists provide service users with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a health condition/disability.
3. Ongoing work-based assessment: Initial vocational assessment is a "living document" and updated over time with information from work experiences in competitive jobs. The resulting vocational profile form includes information about preferences, experiences, skills, current adjustment, strengths, personal contacts, etc., and is updated with each new job experience. Aims at problem solving using environmental assessments and consideration of reasonable adjustments. Sources of information include the service user, and with their permission, clinicians and clinical records, family members and previous employers.
4. Rapid job search for competitive jobs: Initial employment assessment and first job application/face-to-face employer contact by the service user or the employment specialist about a competitive job, occurs within 30 days (one month) after programme entry.
5. Individualised job search: Employment specialists make employer contacts aimed at making a good job match based on service user preferences (relating to what each person enjoys and their personal goals) and needs (including experience, ability, symptomatology, health etc.) rather than those jobs that are most immediately available. An individualised job search plan is developed and updated with information from the vocational assessment/profile form and new job/educational experiences.
6. Job development—Frequent employer contact. Each employment specialist has designated time each week for employment engagement and employer contacts per week on behalf of service users looking for work. Employment specialists within a team share information about employment opportunities in the area and use a weekly tracking form to document employer contacts.
7. Job development—Quality of employer contact: Employment specialists build relationships with employers to learn the needs of the employer, convey what the Programme offers to the employer and as appropriate describe service user strengths that are a good match for the employer.

8. Diversity of job types: Employment specialists assist service users in obtaining different types of jobs.
9. Diversity of employers: Employment specialists assist service users in obtaining jobs with different employers.
10. Competitive jobs: Employment specialists provide competitive job options that could range from seasonal work, time limited contract work, apprenticeships through to permanent status. Competitive jobs pay at least minimum wage, are jobs that anyone can apply for and are not set aside for people with health conditions/disabilities.
11. Individualised follow-along supports: Service users receive different types of support for working a job that are based on the job, their preferences, work history, needs, etc. Supports are provided by the Employment Specialist, others involved in their treatment/support as appropriate, family, friends, and co-workers (i.e., natural supports). Employment specialist also provides employer support (e.g., educational information, job accommodations) at the service users request. Employment specialist offers help with career development, i.e., assistance with education, a more desirable job, or more preferred job duties.
12. Time limited follow-along supports: Employment specialists have face-to-face contact within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for the next 2 months up 3 months in work support in total from the Employment Specialist. After 3 months, the person or their employer can re-access support as necessary. Service users continue to receive support from others in the primary care team and elsewhere who provide their health and social care. Employment specialists contact service users within 3 days of learning about the job problems/loss.
13. Community-based services: Primary care settings are community based services and hence employment services such as engagement, job finding and follow-along supports could occur in these or other community locations based on service user choice and room availability. The initial engagement meeting to undertake the randomised control trial process is likely to occur in a primary care or community care setting.
14. Assertive engagement and outreach by integrated treatment team: Service termination is not based on missed appointments or fixed time limits. Systematic documentation of outreach attempts is required. Engagement and outreach attempts made by liaison with primary care clinician and facilitating joint meetings or home/community visits. Connect with family, when applicable. Once it is clear that the service user no longer wants to work or continue with the Programme, the team stops outreach.

A set of KPI data will be collected by providers to monitor the service's fidelity to IPS principles which will include:

1. Number of overall referrals to the service and by source

2. Time from referral to first contact
3. Number of engagement to the service as defined by one meeting
4. Vocational Assessment completed
5. Number of people supported to apply for a job within 4 weeks
6. Number of people supported to gain a job start
7. Number of job starts per service user
8. Number of days from from initial assessment to first employment
9. % of people who decide to discuss their diagnosis/condition with their employer
10. Methods used by service users to manage health and work
11. Number of service users sustaining employment for a total of 6 weeks
12. Number of service users sustaining employment for a total of 6 months
13. Hourly wage (or equivalent) of service users achieving a job outcome
14. Job role of service users achieving a job outcome
15. Industry sector of service users gaining an employment outcome
16. Average length of in-work support
17. Number of people accessing mainstream education, mainstream work experience, mainstream volunteering work

Appendix 8 – patient pathway