

POLICY

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Measuring what matters

Key indicators for the development of
evidence-based employment services

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Executive summary

In today's world that which is not measured is not done. If people with mental health problems are to get the high quality services they need to enable them to meet their employment aspirations, it is vital that commissioners and service providers routinely collect and publish information about progress against key indicators of success – that they measure what matters.

This paper puts forward a set of key performance indicators (KPIs) to assist local mental health and employment services to monitor employment outcomes and target development priorities for people in contact with specialist mental health services. The indicators were developed after consultation with a group of key stakeholders and tested, in collaboration with the NHS Confederation, across 17 sites with NHS and voluntary sector providers and local commissioners. As a result they have been revised and are presented here, along with the learning we have gained from the pilots.

We found:

- The indicators proved to be a practical means of obtaining reliable information on the performance of local employment services for people in contact with specialist mental health services.
- Local 'champions' were invaluable in facilitating adoption of the framework. At each site their commitment and enthusiasm was critical in determining successful implementation.
- It was difficult to involve local commissioners in the process of implementing the KPI framework. This seemed mainly due to shortages in capacity and competing priorities.
- Specialist employment support providers, particularly those from the third sector, were generally more accepting of the need to collect information relevant to their performance and welcomed the emphasis on quality and effectiveness.
- Participants highlighted the need for electronic data collection systems to help them to report on employment outcomes for people in contact with specialist mental health services.

- The pilot sites had made good progress in the implementation of Individual Placement and Support (IPS), which has been proven to be the most effective way of helping people with severe mental health problems to find and sustain paid employment. But there were deficits in the development of the NHS as an 'exemplar employer' of people with mental health problems and the establishment of evidence-based employment specialists in primary care.

We recommend:

For national policy makers and regulators

- The Department of Health, the Department for Work and Pensions and the Care Quality Commission should require local commissioners to prioritise the purchasing of evidence-based employment services and the monitoring of employment outcomes for people in contact with specialist mental health services.
- The Department of Health should pursue the implementation of electronic systems of data collection (e.g. Mental Health Minimum Dataset) to measure outcomes for Public Service Agreement (PSA) 16.
- Manual audits for PSA 16 should not be requested more frequently than once a year. In the interim, attempts should be made to retain the relevant data from the National Patient Survey.
- The Department of Health should clarify how PSA 16 for the NHS as an 'exemplar employer' will be routinely monitored.
- The Government should consider extending the period over which PSA 16 is applied by a further three years.

For local providers

- Providers should use the key performance indicators to monitor outcomes and set goals for service development.
- Providers should identify 'local champions' to develop their services and monitoring systems with the right skills and capacity, backed up by senior management support.
- Providers should ensure that local champions address the low expectations

regarding successful return to work for people in contact with specialist mental health services which are still held by many staff.

For local commissioners

- Local commissioners should use the key performance indicators to monitor outcomes and set goals for service development.
- Commissioners should include in their specifications of employment services an increase in employment opportunities for people with mental health problems in NHS organisations and other public sector agencies.
- Local commissioners should specify that specialist supported employment providers submit data regarding the quality and effectiveness of their services, together with evidence of independent corroboration, as part of their annual monitoring reports.
- If manual systems are used for data collection, local commissioners should consider the provision of additional support to help NHS trusts and employment providers to organise and oversee this process.
- Commissioners should ensure that there is increased availability of employment specialists in primary care, as part of the Improving Access to Psychological Therapies (IAPT) initiative.

We believe that the widespread use of the key performance indicators will offer service users and their families important information about the quality of employment support that is available to them locally. They provide the assurance that evidence-based supported employment services are commissioned and that their outcomes are monitored. This depends on local independent sector and NHS providers working together effectively to deliver them. Where these kinds of services are delivered, service users can expect that at least 50% of people in contact with specialist mental health services who express an interest in paid employment can be helped to achieve this goal. Although this still falls well below the levels in the general population, it is nevertheless an outcome well worth striving for.

Why employment matters

What we do during the day is at the centre of our lives. Work, in its broadest form, whether it is inside the home looking after children or elderly relatives, or outside in paid employment, gives us identity and helps give our lives structure and meaning. It is also often a key source of personal satisfaction, self-esteem, confidence, skills and social networks.

It is therefore not surprising that researchers tell us that work is generally ‘good for us’ (Waddell & Burton, 2006) and that unemployment is ‘bad’, both for our physical and our mental health. Since the original ‘Black report’ in 1980 (Townsend & Davidson, 1982) the serious negative health consequences of being forcibly excluded from the employment market – both in terms of physical status and mental wellbeing – have become more and more evident.

This is particularly true for people with severe and enduring mental health problems who are more likely to be sensitive to the stresses associated with unemployment and who face challenges in finding alternative routines and structures to their lives. Through the effects of repeated contact with mental health services – and the consequent stigma that this produces – they are also often cut off from a range of work opportunities and sources of social support.

Thus, it is not surprising that people with severe and enduring mental health problems have the lowest employment rate of any disabled group (Social Exclusion Report, 2004). Employers still tend to have very negative attitudes towards taking on people with a history of mental health problems (Manning & White, 1995) and, unfortunately, too many clinicians also have low expectations regarding the chances of people with severe mental health problems successfully returning to work (Marwaha, Balachandra & Johnson, 2009).

It is then disappointing to note that only half of those in contact with specialist mental health services report receiving much in the way of constructive help to deal with work and employment issues (Healthcare Commission, 2008) and there is a lack of routinely collected data on the quality and effectiveness of employment services.

Yet work remains a central theme in the successful recovery stories of people living with mental health problems (Shepherd, Boardman & Slade, 2008) and, despite the controversies and stresses surrounding return to work, it remains a central objective for most people with mental health problems – just as it does for everyone else.

We now have clear evidence about what works in terms of supporting people with severe and enduring mental health problems into sustainable, mainstream employment. Services that really do what works can achieve employment rates of over 50% among a group of people who are all too easily written off (Sainsbury Centre, 2009).

This paper sets out how service providers and commissioners can measure how well they are doing and what works to enable those who use them to achieve their aspirations.

Policy background

Mental health policy in England is in transition. Implementation of the National Service Framework (NSF) (DH, 1999) for working age adults ends in 2009 and consideration is currently being given to a new policy framework (DH, 2009).

Nonetheless, it is clear that government policy will continue to focus on enabling more people with mental health problems to get and keep paid employment. Dame Carol Black's review of health and work (Black, 2008) and the forthcoming mental health and employment strategy emphasise the Government's support for more help for people with mental health problems to gain and retain employment.

The Government's welfare reform agenda also emphasises the importance of getting more disabled people into employment. While there are legitimate concerns that too much emphasis is being placed on getting people off welfare benefits as a goal in itself, the risks of doing nothing to help disabled people to get work, especially during a recession, are greater still.

Probably the most important policy development to emerge recently in relation to employment for the most excluded group of people with mental health problems is the Public Service Agreement (PSA) targets for

2008-2011 (DCLG, 2007). These comprise a set of indicators, applied across government, to measure progress against key government spending priorities. They are set by the Treasury and revised every three years.

The current PSA indicators contain one target (NI 150) for: '*Adults in contact with secondary mental health services in employment*'. Local authorities and their partners are now expected to report annually on the numbers of people in contact with specialist mental health services who are in paid employment and the expectation is that these figures will show a steady increase.

The evidence on what works

There is a strong consensus that the Individual Placement and Support (IPS) model (Becker, Drake & Concord, 1994) is the most effective way to help people with severe and enduring mental health problems back into work and to maintain them in these positions. IPS is discussed in more detail in a separate briefing paper (Sainsbury Centre, 2009). The key principles of IPS are shown in Box 1.

Box 1: The key principles of Individual Placement and Support (IPS)

1. Competitive employment is the primary goal;
2. Everyone who wants it is eligible for employment support;
3. Job search is consistent with individual preferences;
4. Job search is rapid: within one month;
5. Employment specialists and clinical teams work closely together;
6. Support is time-unlimited and individualised to both the employer and the employee;
7. Specialist advice on welfare benefits is available to the person through the transition from unemployment into paid work.

(Adapted from Bond *et al.*, 2008)

The IPS approach has now been tested in a number of randomised controlled trials against traditional ('train-then-place') models across the globe. These studies have shown that employment rates for people who are helped to find and sustain open employment through IPS range from 40-60%, compared with 20-30% for traditional approaches (Sainsbury Centre, 2009). Those supported by IPS also work significantly more hours per month, have higher earnings and better job tenure.

The higher rates of employment resulting from IPS also have positive benefits in terms of improved confidence and wellbeing and reduced reliance on mental health services (Drake, 2008) although these effects may take longer to become evident.

IPS is no more expensive to implement than traditional methods of vocational rehabilitation and the costs of supporting an individual decrease over time the longer the person remains in employment. There is also emerging evidence from ten-year follow up studies of overall cost savings in terms of reduced mental health service use. Sainsbury Centre will be publishing a companion paper on the economic and financial case for IPS in the summer of 2009.

It is also important to note that the best results for employment placement can only be achieved if there is high 'fidelity' to the principles of IPS (Bond *et al.*, 1997; Burns *et al.*, 2007). This is the key reason for developing a set of indicators that measure the quality of the process of employment support, as well as its outcomes.

Commissioning guidance

Based on this kind of evidence, the Government produced guidance for local commissioners of vocational services (DWP, DH & CSIP, 2006). The five key elements are shown in Box 2.

This guidance forms a useful framework for local partners to begin to think about developing their services.

Box 2: Key elements for comprehensive local employment services

1. Clinical employment leads should be available within each specialist mental health team.
2. Employment specialists should deliver evidence-based vocational rehabilitation, e.g. Individual Placement and Support (IPS). These workers may be employed by the NHS or a local, independent sector, employment provider.
3. User employment schemes should be developed by local NHS trusts (NHS as an 'exemplar employer').
4. Sheltered work opportunities (social firms, cooperatives, etc.) should be made available.
5. Local 'Multi-Agency Forums', which reflect well-developed partnership arrangements between specialist and mainstream providers, with appropriate commissioner input, should oversee the development and implementation of strategies for local services.

(DWP, DH & CSIP, 2006)

Developing the indicators

Despite the strong steer towards setting up evidence-based supported employment services from both policy and research, there are very few places in the UK that can say with any authority that they are actually doing it or whether it seems to be working. We believe that, to make significant progress, commissioners and providers need to be able to measure performance and benchmark progress in a reliable way. They need a clear, easy to use, easy to collect, set of performance indicators which are self-evidently helpful.

Creating a set of indicators of this kind is important to at least five key groups of people and organisations:

1. **Local employment providers** – Are we providing high quality services and achieving outcomes?
2. **Local mental health services** – Are we contributing most effectively to these outcomes?
3. **Local commissioners** (health, social care and Department for Work and Pensions) – Are we commissioning the best quality services from providers?
4. **National regulators and policy makers** – Are local services delivering outcomes consistent with national priorities?
5. **Service users and their families** – Are we receiving the best possible services?

We set up a steering group which reflected the interests of the different stakeholder groups. Box 3 lists the members of this group.

Box 3: Steering group members

Commissioners

- Diane Woods (Surrey PCT)
- John Ellis (Cambridgeshire PCT)

Providers

- Jonathan Allan (Shropshire County Council)
- Don Boyle (Oxleas NHS Trust)
- Miles Rinaldi (South West London & St George's Mental Health NHS Trust)
- Andreas Ginkell and Gaynor Chisnall (Mental Health Providers Forum)

National organisations and regulators

- David Carew and Gurcharn Dhillon (Department for Work and Pensions)
- Nick Miller and Bernadette Oxley (Commission for Social Care Inspection)
- Anthony Deery and Nicola Vick (Healthcare Commission)
- David Morris and Simon Francis (Care Services Improvement Partnership)
- Geoff Shepherd, Helen Lockett and Jenni Bacon (Sainsbury Centre)

In addition, we met with representatives from the Department of Health and the Cabinet Office to keep them informed of developments and to ensure that the indicators were consistent with emerging policy – particularly the Public Service Agreement (PSA) targets.

The group met approximately monthly between May 2007 and February 2008 to develop the framework and the indicators. The process consisted of a series of lively, iterative discussions in which the overall conceptual framework was developed and then individual indicators were put forward. Each indicator had to have a clear 'provenance', i.e. be related to specific research evidence and/or current policy.

In order to motivate the people who would be collecting the data, we resolved that the indicators must also have a high 'face validity', i.e. appear to be potentially useful to those being asked to use them. Every attempt was also made to reduce any additional burden and, wherever possible, to use already existing data sets.

The indicator framework

The final framework has four sections:

- A. Local employment context:** background information describing the current (un)employment situation in the local community. It provides the context for setting local commissioning priorities and is best collected by local commissioners using existing data sources (mainly the annual Labour Force Survey).
- B. Client intake characteristics:** i.e. *who* the clients are. This allows commissioners (and providers) to assess whether the service has been 'cherry picking' suitable candidates. It also allows commissioners to ensure that certain target groups (young people, women and people from minority ethnic communities) are suitably represented. These indicators build on information which is usually already collected at referral by local providers.
- C. Service effectiveness and quality:** the *process* of care. This evaluates how effective the services are likely to be using criteria based on research evidence and guidance which represent 'best practice' (e.g. the IPS fidelity scale). This information can be

supplied by providers to commissioners as part of their annual contract reviews.

- D. Individual level outcomes:** the ‘outputs’.
 What are the outcomes in terms of placement in open employment and job retention? These can be collected by the specialist employment support providers and NHS mental health teams in the local community.

A technical report on the pilot study describing how the indicators were developed will be placed on the Sainsbury Centre website (www.scmh.org.uk).

Piloting

In collaboration with the NHS Confederation’s Mental Health Network, we recruited 17 pilot sites that were interested in using the framework to assess their current services, to identify development priorities, and/or to test the feasibility of the framework as a routine tool for gathering information about operations and outcomes.

The 17 sites were not a ‘representative’ sample of the whole country, but they did reflect a wide range of locations and settings, with four in cities (including two in London) and the remainder in mixed urban/rural environments. The sites are listed in Box 4.

Each site was sent the relevant documentation and invited to a day-long meeting in London to explain the project and to go through the framework in detail. The sites in Group A then received a personal visit from the project lead, if requested, plus intensive technical support by telephone throughout the project. Group B simply received the documentation, plus limited telephone support. There was a slight advantage for Group A in terms of how well the implementation subsequently went, but the differences were small.

We made it clear from the outset that we expected local commissioners and NHS and independent providers to work together to collect the necessary information. We reasoned that this kind of collaborative approach was most likely to be effective in the long run. It is consistent with the kind of ‘shared ambition with key partners’ envisaged in the documents on World Class Commissioning (Department of Health, 2007a; 2007b).

Box 4: Pilot sites

Group A: Introduction + site visits + intensive technical support by telephone

Camden & Islington
 City & East London
 Gloucester
 Leeds
 North Essex
 Northumberland, Tyne & Wear
 South Staffs & Shropshire
 Surrey Borders

Group B: Introduction + telephone support

Cheshire & Wirral
 Dorset
 Humber
 Kent & Medway
 Lancashire
 Nottinghamshire
 Somerset Partnership
 South Essex
 Sussex

Each local partner – commissioners, main employment service provider and NHS trust – rated the indicators in their section in terms of their ‘clarity’, ‘ease of data collection’ and ‘relevance’. Visits were made to each of the Group A sites to explore the local partners’ experiences of participating in the project using semi-structured interviews. Self-completion questionnaires were sent to the other nine sites which explored each partner’s experience of involvement in the project, covering the same topic areas included in the face-to-face interviews.

Participation in the pilot

Participation by NHS trusts

Eleven of the 17 original sites were able to show significant participation in the project and to deliver some or all of the data. This represents an overall response rate of 65%.

Six sites were not able to make significant progress. Four cited ‘competing organisational

pressures' as the main reason. These included the introduction of a new electronic data recording system, inadequate IT systems and amalgamation with social services.

A response rate of almost two-thirds is quite impressive given the host of conflicting priorities that NHS organisations face. But it is a matter for concern that at least a third of NHS trusts and local partners failed to make much progress, despite their initial enthusiasm. This has clear implications for any national programme of implementation.

Participation by commissioners

In general, the level of engagement of commissioners in the project was poor. This seemed to reflect their lack of capacity as much as any lack of motivation or expertise. Whatever the reason, this finding has significant implications for the development of effective partnership working and the necessary 'co-production' which is needed to underpin 'world class commissioning'.

Participation by employment service providers

The engagement of employment service providers, particularly those from the independent sector, was far more encouraging. They seemed much more accepting of the need to collect information relevant to their performance (presumably from their prior experience of contracting processes). Indeed, they often played a key leadership role encouraging and persuading their NHS colleagues to engage more actively with the project.

The importance of a local 'champion'

Local 'champions' were invaluable in facilitating adoption of the framework. At each site their commitment and enthusiasm was critical in determining successful implementation. They could come from any agency, but they needed to be capable of winning over the 'hearts and minds' of busy clinicians and key managers in order to get the framework established. They also needed to be able to spell out clearly the contribution of each person, at each level, in the different agencies involved. This required time (capacity) as well as enthusiasm and expertise.

The importance of local champions is, of course, a familiar observation in the organisational change literature (e.g. Iles & Sutherland, 2001) and our findings confirm the importance of these 'internal' change agents, in addition to the 'external' drivers provided by policy makers and regulators.

Benefits of participation

There was no doubt that those sites which invested most fully in the project gained the most benefits. Sites reported that the project helped give them a much clearer local picture of 'who' was currently doing 'what' with 'whom'. It also strengthened the focus on evidence-based practice (i.e. IPS) and enhanced the quality of the partnership working between agencies. Having to communicate over the details of the framework gave a structure and a common language to these discussions and it was this process that helped the agencies to work more effectively together.

Collecting the data

Most of the indicators were seen as clear, or reasonably clear, relatively easy to collect and highly relevant. Some suggestions for revisions and modifications were made and these have been incorporated into the final framework which we present in this paper.

Although many of the pilot sites were successful in implementing the framework, this should not disguise the challenges that they faced. One of the biggest concerns about the indicator framework was the time and effort it would take to collect the data. In one of the most successful sites the local commissioner invested additional funding into a part-time, fixed-term post to coordinate and oversee the data collection process. This was extremely helpful.

It proved very difficult to engage commissioners in the collection of information for Section A ('context') although the time actually required for this was relatively small (between 2-3 hours). It is perhaps a reflection of the pressures that many commissioners faced, that most preferred their local providers to do it for them.

One commissioner who did become involved said that, *"it was really easy ... it was also really interesting, I didn't know this website*

(NOMIS) before and there is lots of interesting information there". We hope that in future commissioners will be encouraged to prioritise this kind of activity. They need to make the time to collect this basic information about the local labour market in order to inform their commissioning decisions. Once commissioners become familiar with extracting data from the Annual Labour Force Survey (NOMIS) website then it should take no more than a few hours per year to collect and/or update.

Section B ('client intake') required only minimal adjustment to existing data collection systems. Most providers were collecting most of this information anyway. In the future it may mean some redesign of existing routine recording systems, but the extra work to collect the additional data is minimal.

Section C ('quality and effectiveness') could also be easily completed in 2-3 hours. Again, providers felt that these indicators were useful as they highlighted the importance of maintaining fidelity to evidence-based practice (IPS). They did not foresee problems in providing this information on an annual basis to their funders.

Section D ('outcomes') was more problematic. Most sites were successful in submitting reasonably complete data, but only after much effort. The additional time required was not actually huge (estimated at between 10-60 minutes once the systems had been set up) but, given all the other demands for information currently faced by NHS teams, the *perceived* burden of additional work appeared to be just too much.

Many of those who were successful in terms of data returns commented that they would not continue with the audits, "*unless they were asked to do so by commissioners*" and that they "*preferred to wait until there was an electronic system in place*".

In April 2008, PSA 16 was incorporated into the new Mental Health Minimum Dataset, which is mandatory for all NHS trusts, (see <http://www.isb.nhs.uk/docs/mental-health>). So, in the long run, this problem may be solved. However, the new system will inevitably take some time to 'bed in' and to start producing reliable data. In the interim alternatives such as manual audits will need to be used. Again, this highlights the limitations of information systems

in mental health services where they are rarely kept in a database format which can easily be interrogated.

If manual audits are undertaken, it must be recognised that they are onerous, and it is not practical to request them too frequently (e.g. probably not more than once a year). Local commissioners and providers would also be advised to consider investing a small amount of money in some dedicated staff time to oversee the collection of this information. In our experience, this would be money well spent.

Finally, we should also note that a proxy is available for PSA 16 through the National Patient Survey (Healthcare Commission, 2008). This collects the employment rate for those patients responding to the survey questionnaire. Although it is subject to some limitations (sampling, return rates, etc.), it is available for all trusts and is certainly a lot easier to access than manual audits. We believe that the data it produces are extremely valuable for this (and other) purposes and recommend that the Care Quality Commission continues to carry out the survey at least every two years. Without it, there would really be no alternative to manual audit.

What the data returns revealed

The primary purpose of the pilots was to test the performance of the framework, the reliability of individual items, and the general feasibility of data collection. However, the pilots also generated some interesting data describing the local employment services, characteristics of referrals, current practice and some information about outcomes.

Because of the opportunistic way in which the sample was constructed, and the relatively small size, it would be unwise to try to generalise from these findings to any larger populations (i.e. regional or national estimates). Nevertheless, the results give an indication of how local employment services are developing for groups of agencies in specific localities who have already demonstrated their commitment to this agenda.

Context

In most sites, two-fifths of incapacity benefit claimants were out of work because of 'mental health and behavioural disorders', while only

one-fifth of people of working age in contact with specialist mental health services were in paid employment. These are both in line with national figures.

Although most of the sites had made reasonably good progress regarding the elements specified in the commissioning guidance (see Box 2) relating to clinical employment leads in each team, employment specialists delivering an IPS approach and Multi-Agency Forums, few had established the local NHS as an 'exemplar employer'. Despite the Improving Access to Psychological Therapies (IAPT) initiative, most had also made little progress in establishing evidence-based, vocational rehabilitation services in primary care.

The NHS therefore needs to put its own house in order in relation to the employment of people with mental health problems (see Seebohm & Grove, 2006). It also needs to extend the careful attention that has been paid to the delivery of evidence-based psychological therapies to the delivery of evidence-based vocational services.

Referrals

Employment services in the pilot sites had an average of 17 referrals per month. Almost half were aged between 36 and 50. Just under half (47%) of new referrals had been employed (i.e. in paid work) in the last two years and 28% had been employed in the last six months. Only 10% had never worked. Three-quarters of new referrals had maintained continuous paid employment for more than a year in their lifetime and 18% were in work at the time they were referred. These data suggest that most of the referrals had reasonably good prospects in terms of successful placement in open employment.

While most users were receiving Incapacity Benefit and related benefits, almost a quarter were recorded without benefit information and 10% were not in receipt of benefits. This underlines the need for specialist benefits advice in these employment projects.

Quality and effectiveness

Most of the providers reported strong targeting on paid employment as their primary goal. Six out of ten reported that they usually made contact with employers based on client preferences and the same proportion reported contact with employers on average 1-2 months

after entry into the programme. For the remainder it was within 6 months.

All the sites reported providing access to specialist employment benefits and advice and for half this was an ongoing part of the service.

Almost all the providers reported high levels of integration between the employment service and the local NHS teams. Most of the sites also reported at least monthly, client-related contact with Jobcentre Plus and four sites reported at least quarterly formal meetings, often about the Pathways to Work scheme.

Most of the sites reported having undertaken a systematic quality audit in the last year, mostly using the IPS fidelity scale, and involving service users.

Outcomes

The number of people supported into paid employment was approximately five per site per month. Just under half (44%) gained part-time jobs in which they worked for fewer than 16 hours a week. One service user in ten was reported to have moved into education, training, unpaid voluntary work or retirement in the preceding quarter.

Given the design of the pilots, we cannot conclude anything meaningful from these data regarding the effectiveness of the local services: that would require prospective follow-up of specific cohorts. However, it is worth noting that services should be aiming to place at least a half of each cohort of referrals into paid employment within six months.

Only one in five referrals was reported to have a care plan which contained clear actions regarding open employment and only 4% were reported to have care plans with clear actions regarding job retention (although around 20% were employed).

There was also a specific difficulty in identifying an indicator that could be used to monitor the numbers of people being recruited by trusts who were prepared to disclose mental health problems. We hope that the new NHS Standard Application Form will be able to provide this information in the future, although it may require some redesign for use in an electronic format.

Conclusions

The indicators proved to be a practical means of obtaining reliable information on the performance of local employment services for people in contact with specialist mental health services. They can also help to identify key targets for improvement.

If all local providers and commissioners were to adopt the same set of indicators to describe their client groups this would help them both to be sure that services were targeted on the groups they wish to reach. A common data set can also help to foster joint working between agencies and support Local Strategic Partnerships and other common goals.

Similarly, the use of a small number of simple, clear, quality indicators, based on the best researched model of good practice available (IPS) can help providers and commissioners (and service users) to be assured that the local services available are of the highest possible quality and are most likely to deliver the key outcome (paid employment). This is an example of where a *process* measure does have value and it is worth remembering that the implementation of the National Service Framework, which has been so successful, was based almost entirely on ensuring that process measures for the new services were rigorously implemented.

One of the biggest difficulties encountered in the pilots was the level of engagement of commissioners. We are convinced that this was due largely to lack of capacity and to commissioners being generally overburdened with workload and competing priorities. Since most sites said that they were unlikely to continue with the data collection for outcomes unless they were, “*asked to do so by commissioners*”, this underlines the need for some clarity from the centre (i.e. Department of Health and the Care Quality Commission) regarding the relative priority to be given to the development of local employment services for people in contact with specialist mental health services. Given the centrality of this objective to a variety of current government policy objectives, this should surely be high.

The framework seemed to provide a common ‘language’ to facilitate communication between the different stakeholders and to increase

understanding and respect. To translate these improvements in ‘culture’ into action, sites clearly needed local ‘champions’ with the time, enthusiasm and expertise to make things happen. This needed to be backed up by senior management support.

But it was also evident that even well-motivated workers are unlikely to persist with the collection of outcome indicators if it depends on manual audit of caseloads. We are therefore pessimistic that the information required for PSA 16 (NI 150) will be reliably collected unless this can be completed electronically. Given the inevitable time for such systems to ‘bed in’ it seems reasonable to consider an extension of the current PSA target 16 (NI 150) for a further three year spending cycle, so that data are available which cover a meaningful length of time during which the target has been in place.

Recommendations

For national policy makers and regulators

- The Department of Health, the Department for Work and Pensions and the Care Quality Commission should require local commissioners to prioritise the purchasing of evidence-based employment services and the monitoring of employment outcomes for people in contact with specialist mental health services.
- The Department of Health should pursue the implementation of electronic systems of data collection (e.g. Mental Health Minimum Dataset) to measure outcomes for PSA 16.
- Manual audits for PSA 16 should not be requested more frequently than once a year. In the interim, attempts should be made to retain the relevant data from the National Patient Survey.
- The Department of Health should clarify how PSA 16 for the NHS as an ‘exemplar employer’ will be routinely monitored.
- The Government should consider extending the period over which PSA 16 is applied by a further three years.

For local providers

- Providers should use the key performance indicators to monitor outcomes and set goals for service development.
- Providers should identify 'local champions' to develop their services and monitoring systems with the right skills and capacity, backed up by senior management support.
- Providers should ensure that local champions address the low expectations regarding successful return to work for people in contact with specialist mental health services which are still held by many staff.

For local commissioners

- Local commissioners should use the key performance indicators to monitor outcomes and set goals for service development.
- Commissioners should include in their specifications of employment services an increase in employment opportunities for people with mental health problems in NHS organisations and other public sector agencies.
- Local commissioners should specify that specialist supported employment providers submit data regarding the quality and effectiveness of their services, together with evidence of independent corroboration, as part of their annual monitoring reports.
- If manual systems are used for data collection, local commissioners should consider the provision of additional support to help NHS trusts and employment providers to organise and oversee this process.
- Commissioners should ensure that there is increased availability of employment specialists based in primary care, as part of the Improving Access to Psychological Therapies (IAPT) initiative.

We believe that the widespread use of these indicators will offer service users and their families important assurances about the quality of employment support that is available to them locally. This depends on local independent sector and NHS providers working effectively together to deliver them.

Where these kinds of services are delivered, service users can expect that at least 50% of people in contact with specialist mental health services who express an interest in paid employment can be helped to achieve this goal. This seems an outcome that is well worth striving for.

Key Performance Indicators

The revised Key Performance Indicator Framework appears on pages 12-15. A word version of this can be downloaded from the Sainsbury Centre website www.scmh.org.uk.

Final Key Performance Indicator (KPI) Framework

(revised following pilots)

A. LOCAL EMPLOYMENT CONTEXT (for commissioners)

1. % of local population who are employed*
2. % of local population who are unemployed*
3. % of local population of working age who are economically inactive (not seeking work)*
4. % of local population whose qualifications are equivalent to NVQ Level 2 or above*
5. % of people with mental health problems in employment*
6. % of people with mental and behavioural disorders who are in current receipt of Incapacity Benefit / Severe Disablement Allowance (since October 2008, new claimants receive Employment Support Allowance)*
7. % of adults in contact with specialist mental health services who are in paid work**
8. % of adults in contact with specialist mental health services who report having received help with finding work**
9. % of adults in contact with specialist mental health services who would have liked to receive help in finding work, but didn't**
10. % of adults in contact with specialist mental health services who report being unable to work because of mental health problems**
11. Commissioners have ensured there is a comprehensive range of employment opportunities for people with mental health problems accessible across the community***
12. A local 'Multi-Agency Forum' has been established to address the work and employment needs of people with mental health problems in the locality***
13. There is onsite employment support available in primary care (employment specialists) in addition to psychological therapies. We suggest using the following to assess good practice:
 - Employment specialists in primary care provide at least 2 sessions a week 'onsite' in the practice
 - Employment specialists respond to GP referrals within 5 working days
 - Employment specialists have good joint working (i.e. regular face-to-face contact) with GPs
 - Employment specialists have good joint working (i.e. regular joint meetings) with specialist psychological therapists
 - Employment specialists (with the permission of the individual) have regular contact with employers and others in the service user's workplace
 - Employment specialists are able to provide benefits advice (either themselves or through local contacts)

* available from annual Labour Force Survey <https://www.nomisweb.co.uk/>

**available from National Patient Survey (2008)

<http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys/mentalhealthservices>

***as defined in Government guidance *Vocational Services for People with Severe Mental Health Problems: Commissioning guidance* (DH / CSIP / DWP, 2006)

B. CLIENT INTAKE CHARACTERISTICS (for providers, including independent sector)

These indicators will require simple modifications to existing systems for recording information about new referrals.

1. % Age (e.g. 16-35, 36-50, 51-65)
2. % Gender
3. % Ethnicity
4. % with educational level NVQ level 2 or above
5. % current employment status (as defined by Public Service Agreement, PSA 16)
6. % in contact with specialist mental health services at time of referral
7. % recency of any kind of paid employment (e.g. <than 6mths, 6mths-2yrs, 2-5yrs, >5yrs, never)
8. % who have maintained any paid employment for more than one year in lifetime
9. % in receipt of employment-related, long-term benefits (e.g. Incapacity Benefit / Employment Support Allowance)

C. SERVICE EFFECTIVENESS AND QUALITY (for providers, including independent sector)

We suggest using the following scales (where a score of '5 = Good' and '1 = Poor'). These items are all based on the Individual Placement and Support (IPS) fidelity scale (Bond, G.R., *et al.*, 1997, *Rehabilitation Counselling Bulletin*, 40, 265-284). These indicators could form part of an annual quality monitoring report to commissioners.

1. **Local specialist employment provider is targeted towards finding paid employment:**
 - 1 = Provider demonstrates weak interest in targeting open employment as the primary goal
 - 2 = Provider demonstrates some interest in targeting open employment as the primary goal, but no strong commitment
 - 3 = Provider demonstrates moderate interest in targeting open employment as the primary goal, but no strong or consistent commitment
 - 4 = Provider demonstrates reasonably strong interest in targeting open employment as the primary goal, but some variability or inconsistency
 - 5 = Provider demonstrates consistently strong interest in targeting open employment as the primary goal, at all stages of the process. Measurements of rates of competitive employment achieved are reported on at least a quarterly basis
2. **Local specialist employment provider is targeted towards finding paid employment consistent with user preference:**
 - 1 = Employment specialists seldom (<10%) make contact with employers based on client's preferences and strengths, rather than availability of positions in local job market
 - 2 = Employment specialists occasionally (<25%) make contact with employers based on client's preferences and strengths, rather than availability of positions in local job market

Continued overleaf

- 3 = Employment specialists make contact with employers based on client's preferences and strengths around 50% of the time, otherwise determined by availability of positions in local job market
- 4 = Employment specialists make contact with employers based on client's preferences and strengths around 75% of the time
- 5 = Employment specialists always make contact with employers based on client's preferences and strengths

3. Local specialist employment provider undertakes active job search within 4 weeks of first contact:

- 1 = First face-to-face contact with an employer about a competitive job is on average 9 months or more after programme entry
- 2 = First face-to-face contact with an employer about a competitive job is on average 5-9 months after programme entry
- 3 = First face-to-face contact with an employer about a competitive job is on average 2-5 months after programme entry
- 4 = First face-to-face contact with an employer about a competitive job is on average 1-2 months after programme entry
- 5 = First face-to-face contact with an employer about a competitive job is on average within 1 month after programme entry

4. Local provider provides up-to-date employment related benefits advice:

- 1 = Up-to-date employment related benefits advice is not available to most service users
- 2 = Employment specialist gives information about where to access employment related benefits advice.
- 3 = Employment specialist gives information about where to access employment related benefits advice and discusses individual needs with client
- 4 = Employment specialist gives information about where to access employment related benefits advice, discusses individual needs and arranges appointment with expert adviser prior to commencing employment
- 5 = Employment specialist gives information about where to access employment related benefits advice, discusses individual needs and arranges appointment with expert adviser prior to commencing employment. They also continually review client's benefit position and provide direct help where necessary with reporting to HM Revenue and Customs, housing agencies, etc.

5. Evidence of effective working relationships between local provider and local health and social care services:

- 1 = Employment specialists work independently from mental health treatment teams
- 2 = Employment specialists are attached to 3 or more mental health teams, OR are attached to teams from which less than 50% of their caseload is drawn
- 3 = Employment specialists are attached to 1-2 mental health teams from which 50-74% of their caseload is drawn. Employment specialists attend referral meetings and share decision-making
- 4 = Employment specialists are attached to 1-2 mental health teams from which almost all (80-90%) of their caseload is drawn. Employment specialists attend referral meetings, share decision-making, and contribute to same clinical records
- 5 = Employment specialists are attached to 1-2 mental health teams from which all of their caseload is drawn. Employment specialists attend referral meetings, share decision-making, contribute to same clinical records and are physically co-located

6. Evidence of effective working relationships between the local provider and local Jobcentre Plus offices, e.g. identified link worker, regular contact over individual clients, etc:

- 1 = Employment specialists and Jobcentre Plus (JCP) staff have client-related contacts (not face-to-face) less than quarterly to discuss shared clients and referrals, OR employment specialists have no contact with JCP staff

- 2 = Employment specialists and JCP staff have client-related contacts at least quarterly to discuss shared clients and referrals
- 3 = Employment specialists and JCP staff have client-related contacts monthly to discuss shared clients and referrals
- 4 = Employment specialists and JCP staff have planned meetings to review client-related contacts at least quarterly and contacts approximately fortnightly to discuss shared clients and referrals
- 5 = Employment specialists and JCP staff have planned meetings to review client-related contacts at least quarterly and weekly contacts to discuss shared clients and referrals

7. Evidence of effective use of audit by the local specialist employment provider to improve service effectiveness using recognised fidelity scale:

- 0 = No audit in last 12 months
- 1 = Audit carried out in last 12 months
- 2 = Clear action plan developed and key priorities identified
- 3 = Significant progress regarding at least one key development priority

8. Evidence of effective use of audit by the local specialist employment provider to improve service quality by seeking direct feedback from clients:

- 0 = No audit in last 12 months
- 1 = Audit carried out in last 12 months
- 2 = Clear action plan developed on basis of audit and key priorities identified
- 3 = Significant progress regarding at least one priority

D. INDIVIDUAL LEVEL OUTCOMES (for providers, NHS and independent sector)

This information will be collected in the new Mental Health Minimum Dataset, but until this becomes available these indicators will require manual audits of team caseloads. It is suggested that these are carried out annually.

1. Number of people with mental health problems known to be in contact with specialist mental health services placed in paid employment by specialist employment provider in last year (e.g. <5hrs/week, 5-16hrs/week, >16hrs/week)
2. % of people in contact with specialist mental health services who are currently employed (PSA 16)
3. % of people in contact with specialist mental health services who are currently unemployed, but actively seeking employment
4. % of people in contact with specialist mental health services moving into education or training (whole or part-time), unpaid voluntary work, or retirement in year
5. % of people in contact with specialist mental health services where care plan contains clear actions regarding placement in paid employment
6. % of people in contact with specialist mental health services and currently employed where care plan contains clear actions regarding job retention
7. % of new recruits to local mental health trust declaring 'mental health condition' on the confidential equal opportunities monitoring section of the new NHS Standard Application Form

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