IPS GROW

Fidelity Scale Guidance IPS-PC

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To be used alongside adapted language IPS-PC fidelity scale + IPS fidelity manual + DWP grant guidance for IPS-PC

Why the guidance / intent for use

The IPS fidelity scale for primary care (IPS-PC) utilises the Centre for Mental Health UK adapted scale for mental health services (IPS-25).

The IPS-PC consists of the same items in the same order as the IPS-25, and the scoring is the same as for the IPS-25. Compared with the IPS-25, the IPS-PC has minor modifications throughout to make labels more precise, make ratings less ambiguous by offering contextual guidance on some items, and accommodate primary care setting issues, working with people with mild to moderate mental health and/or musculoskeletal conditions. In most respects the items are scored similarly to the IPS-25 as per the fidelity manual final-fidelity-manual-fourth-edition-112619_0.pdf (centreformentalhealth.org.uk)

NOTE 1: This is intended for IPS in primary care for adults who have a physical or mental health disability, and not applied into transformation in mental health primary care – see IPS Transformation COP - Recording - Individual Placement and Support (IPS) - FutureNHS Collaboration Platform (Please note, you'll need to be logged in to view these documents. If you're not a member, please contact support@ipsgrow.org.uk for access).

NOTE 2: This guidance is to sit alongside the IPS-PC adapted language scale. While we can't change the IPS scale, we realise some language adaptations provide support to make contextual application of the intent of the scale. This guidance document is to be used alongside the IPS-PC language adapted scale as a blueprint to implement IPS in the primary care context of your local area.

NOTE 3: This guidance doesn't replace the DWP grant guidance. Where relevant we have referenced sections of the DWP guidance which can be accessed here: we don't guarantee an exact reference for every item and providers are asked to ensure they have detailed understanding of the DWP guidance. Guidance: Individual Placement and Support in Primary Care - GOV.UK (www.gov.uk)

NOTE 4: Reference to the grant guidance is made in this document to help bridge some expectations from the DWP guidelines into IPS practice. For any queries on grant guidance or delivery expectations please refer to DWP and use Glasscubes to log your queries.

NOTE 5: The IPS-PC fidelity scale and guidance is aimed at supporting your IPS practice for unemployed participants/clients and is optional for your approach to managing job retention cases/in work participants.

See Glossary of terms on page 19

No	Fidelity item	Notes: we highlight some key things to notice and recommend to always cross reference with the fidelity manual for full delivery expectations
1	Caseload size See fidelity manual pg. 37-39	See DWP guidance for IPS-PC – section 43: "Employment Specialists (ES) are expected to work at any one time with a caseload of between 20-25 active cases". At time of a fidelity review, where employment specialist (ES) caseloads are between 20-25 clients, the fidelity report will confirm that this is in line with DWP requirements and would score 4.
2	Employment services staff See fidelity manual pg. 39-43	It is important to ensure that ESs remain focused on employment issues and do not get drawn into trying to resolve other challenges that the client/participant is facing. This means that it is important to understand what others in the primary and/or community health service team can offer both clinically and in the way of social support, and other resources available in the local area. While clearly GPs, practice nurses and pharmacists will be central in providing clinical and medication support, social prescribers, housing support, link workers, etc, have a major role in addressing social determinants of health and are likely to be an important source of information about other resources available in the community.

		Other key stakeholders within a primary care context include occupational therapist, advanced physiotherapist, community health services, health navigator, health and wellbeing coach, and community mental health practitioner. Sometimes people may be referred who do not want to work, but wish to engage in education, voluntary work or resolve difficulties with their social security benefits. These referrals should be re-directed to social prescribing link workers or other agencies (like Citizens Advice) who can assist with such issues.
3	Vocational generalists See fidelity manual pg. 43-45	To reduce dropout rates, it is important that the ES is the consistent contact and support for the client/participant throughout their IPS journey. This includes the first contact after a person is referred (intake), vocational profiling meetings (engagement and assessment), employer engagement (job placement), support on the job if required (job coaching), and in work support (follow-along support). NOTE: Referral to a specialist benefits incentive planner (found at ACAS or Job Centre) by the ES is acceptable and even recommended. Please note that having specialist IPS team roles focused solely on employer engagement in the team can impact the score of this item. This approach is not recommended due to the importance of individualised job development, and the relationship between the ES, participant/client and employer. There have been concerns that, within primary care, referrals for job retention support may increase, thus decreasing the capacity of the IPS service to help people to gain jobs and maybe leading to a shift in focus away from those with the most complex needs. Section 32 of the DWP guidance for IPS-PC states: "As a guide, around 75% of client/Participants should be Out-of-Work client/Participants and in need of support to attain employment

		and 25% In-Work client/Participants needing support to avoid falling out-of-work."
4	The fidelity scale says – "Integration of rehabilitation with mental health treatment through team assignment" See fidelity manual pg. 46-48 Which means for you – Integration of supported employment with primary and/or community health services through team assignment NHS England » Primary care NHS England » Expanding our workforce NHS England » What are community health services NHS England » Social prescribing	Integration with a treatment team is critical for the success of IPS. Supported employment cannot succeed for this client group in isolation from their treating/support health and or community services. ESs need to take a proactive approach to building relationships with clinical teams. ES should be integrated with up to 2 primary and/or community health services, and the majority of their caseload should be comprised of people referred from these teams. Self-referrals are counted as part of the ESs assigned team/s caseload, if they are receiving health services from 1 of the 2 teams the ES is integrated with (i.e. they would not be considered as a different referral source). For self-referrals, we advise that services consider: 1. how they ask for client/participant consent to check whether that person is receiving care (as services will run into bother if they start sharing data with a PCN/(or health/community service) where the patient doesn't want that or isn't part of that PCN or health/community service); and 2. whether they have found out about the service via that treatment team, as there may be instances where a patient identifying that they have found out via that route is sufficient. ESs should be part of the team of primary care professionals in the same way as, for example, practice nurses, primary care pharmacists, psychologists, physiotherapists, social prescribers etc.

		Providers may find that the best integration opportunities in a local area may not be immediately obvious or fall neatly in line with geographical parameters of a given team. LAs and providers will need to explore options within their patch and develop relationships within the health system to determine the most fruitful teams to integrate with. Tips: • **Integration with GPs may not be straightforward** due to limitations on space, and lack of joint working opportunities. • **Look for teams and/or services that most closely mirror taking an 'MDT approach',** for example physiotherapy teams, musculoskeletal (MSK) clinics, brain injury clinics, Talking Therapies, pain management clinics, occupational therapy teams, mental health neighbourhood teams etc. • **The key principle underlying this item is that IPS is integrated with health services** (as opposed to JCP or other non-health related provision), to ensure that employment support is embedded within the system/s from which recipients are receiving healthcare. • **Link in closely with IPS SMI teams** as they can support with access to MDT meetings where a discharge/step down offer can be made by IPS-PC for cases discussed and enable IPS-PC teams to link in with services where patients are referred and therefore enable a relationship to be built for direct referrals/integration. • **ESs should be physically based at least part of their time onsite** with the primary care team/health service setting that they are part of. This may vary from setting to setting but may include working from a treatment hub or from a practice or other clinic that allows the ESs and health staff to work in close proximity. This is important as office location can affect how frequently health professionals and ESs

		communicate, and frequent contact helps all parties to work as a team to assist people with their employment goals. See DWP guidance for IPS-PC – section 89: "Partnership working is considered essential to the success of the trial and therefore Grant Recipients will be expected to 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."
5	Integration of rehabilitation with mental health treatment though frequent team contact See fidelity manual pg. 49-56 Which means for you – Integration of supported employment with primary and/or community health services through frequent team member contact Multidisciplinary teams: Integrating care in places and neighbourhoods - SCIE	• Anchor 1 and 2: Although structure, organisation and roles within primary and/ or community health care settings vary from one place to another, the ES attends meetings and the key people within the primary and/or community health services with whom they need to work. For example, if the ES is integrated with a MSK clinic, they would attend multi-disciplinary team meeting with physiotherapists, osteopaths and psychologists present. If they are integrated with a mental health neighbourhood team, they would attend weekly meetings with a range of practitioners and specialists such as care navigators, social workers or occupational therapists etc. IPS services should select the most relevant meeting to attend that matches a participant/client focused weekly meeting. For example, a PCN might not hold a weekly meeting at PCN level but a high-referring practice where the ES is co-located might. Reviewers will assess whether it meets the anchor criteria but it's for the service to identify where the best fit is. • Anchor 3: Different case records systems are used in different areas. It may take time for the IPS team to gain access to clinical systems, and services may find honorary contracts and data sharing agreements can unblock barriers to system access. It is possible for an IPS service to operate

		without access to shared information systems, for example, via sending anonymised/encrypted e-mails for inclusion in the person's notes and direct conversation with other primary care practitioners involved in the person's treatment and support. To meet this anchor, ESs need to have access to the clinical system, with IPS progress notes and documentation uploaded alongside the persons health records. • **Anchor 4**: ESs should spend at least part of their working week co-located with the primary care team/health service setting. Ideally, this would be their clinical or office base, as opposed to their own organisation office. • **Anchor 5**: Replicable.
6	**Collaboration between employment specialists and JCP and other Government/DWP programmes and their contractors.** See fidelity manual pg. 56-58	Please consider reaching out to the other IPS teams in Drug & Alcohol services or SMI and conduct single monthly meetings with your local JobCentre, to avoid overloading local Job Centre staff. Reminder: The ES have stakeholder links and an understanding of how to utilise the Access to Work Scheme for service users/participants. Access to Work: get support if you have a disability or health condition: What Access to Work is - GOV.UK (www.gov.uk).
7	**Vocational unit** See fidelity manual pg. 58-61	A reminder to keep records of weekly team meetings / group supervision. Also ensure the team leader runs 1-1 supervision with their ES and keeps records of cases discussed and actions agreed.
8	**Role of employment supervisor** See fidelity manual pg. 61-67	The supervisor ideally engages with the largest referral teams to their ES from a primary and or community health service to support integrated working and promote IPS and employment as a key tool for recovery. They meet with these teams quarterly. The team leader offers field mentoring around job development and keeps records. See the manual for intensity of field

		mentoring need, based on ES employment outcomes and performance. Note: Relationships with social prescribing link workers may be particularly important as their role is to focus on what matters to the person, to connect people with community opportunities and to offer a holistic approach to health and wellbeing. Therefore, their role in discussing vocational issues with participant/clients and linking people with IPS services may be particularly important.
9	Zero exclusion criteria See fidelity manual pg. 67-71	Once the contract eligibility is met, people with a health condition/disability who express an interest in employment will be accepted regardless of job readiness factors, reported pain levels, limited travel outside of the home, social anxiety or other symptoms, substance abuse, history of violent behaviour, cognitive impairments, treatment non-adherence, and personal presentation. Note that participant/clients are helped into a new job if one ends and in IPS we always help clients look at lessons learnt from any paid work. This is sometimes referred to as "failing well – leaving a job well". Many clients may need to try more than one job to find their ideal job. NOTE: for this contract DWP guidance says a job outcome is only granted once per client. Reminder: There needs to be opportunities for people to approach IPS services and ask for employment support directly ('self-referral'). Hence please ensure posters are placed in primary and/or community health services waiting rooms, local libraries or community groups, information on the internet about local employment support all support this. Also the IPS service ensures that the team members of the primary and or community health service understand and promote self-referrals by their patients.

		NOTE: The DWP contract states that for job retention cases/ in work participant, those already in-work, must have been employed for at least 6 months before starting IPS-PC and be working a minimum of 7 hours per week. For those who are self-employed, in order to access the in-work element of IPS-PC they must be able to show they have operated a viable business for 6 months. See section 67 of DWP guidance for IPS-PC
10	Agency focus on competitive employment See fidelity manual pg.72-76 Which means for you – The primary and/or community health services focus on Competitive Employment	Local staff and managers of the primary and/or community health service demonstrate a commitment to promoting employment for people with health conditions/disabilities. This is defined fully in the anchors on the scale. This will take some time to achieve as given primary and/or community health services typically are not focused on employment and very focused on short term treatment and discharge. The IPS service providing information and forging relationships with primary and/or community health service can be time consuming in the initial stages, but the benefits of investing this time and energy pay dividends in integrating IPS, ensuring that people can access the service and increasing attention paid to vocational issues across the system. Evidence of this would include posters in clinical settings, minutes of steering group, primary and/or community health service newsletter articles or information on their webpage. Increase the ways recovery stories are shared- • Joint attendance with clients to health and or community care service meetings or training. • Participants/Clients to share employment related good news stories to other patients (Peer Support) • Attendance to Protected Learning Time events to share good practice to wider network

		• Links to IPS service webpages added to GP website • Make opportunities to contribute to publications or marketing to champion joint working with health services • Robust review of services and outcomes of the IPS service, shared on a quarterly basis with treatment lead (also supports item 8, anchor 3- Role of the Employment Supervisor) • Championing joint working within the trust in Local Implementation Groups, Primary Care Network meetings and community health meetings alongside clinical leads. Primary and or community health service intake includes questions about interest in employment • Regular case conferencing opportunities with clinical staff to emphasise the advantages of discussing employment at triage and support being incorporated into treatment plan and evidence regular reviews • Discuss with clinical service manager, how employment can be discussed at the beginning of someone's journey and throughout their journey • Share the possible advantages of working with an IPS services to support their objectives and elements of the primary and or community care contracts.
11	Executive team support for the IPS Service See fidelity manual pg.77-83	IPS services traditionally find it difficult to initially engage and connect with senior staff from the primary and or community health service. We have found this in systems supporting people with severe mental illness and drug and alcohol histories. It requires persistent and focused energy as top-down support is critical for maximising impact of the service. The executive team needs to be the health service linked to where the IPS service is mostly working with.

		Evidence of executive support would include membership and participation by senior primary and/or community health service staff in your IPS steering group meeting, IPS evaluation plan or report sent to senior executive meetings or persons, email communication with senior leaders and/or regional director. There is no one or absolute guidance here as this will look different according to teams within which your ESs are integrated with. Some different examples, e.g. if integrated with cluster of GPs – exec support would be the Primary Care Network (PCN) clinical director, if integrated in a MSK clinic – executive team would be the Trust executives. We suggest you aim to find the most senior person from the largest health team where referrals are coming from for your ES (see item 4 and 5). Ideally this role/person is able to influence and make changes within their health service and hence matches the intent of this item. In the first instance, try and find someone who is willing to champion IPS and employment as an extension of their care pathways.
12	Work incentives planning (financial / benefits) See fidelity manual pg.84-88	Need to have clear evidence on participant/client files that all participant/clients are offered advice on the impact on their overall financial situation of working (eg beyond just impact on benefits payments and explore all other income, financial responsibilities such as debt repayment and other commitments). . See page 85 of the manual – "Reviewers do not score higher than 2 when work incentives planning consists only of explaining the rules for entitlements." The IPS fidelity manual suggests that the rate of take up for benefits counselling is monitored to ensure participants/clients make an informed choice about whether to take up benefits counselling or not. Participant/clients need to be offered and

		have access to comprehensive, accurate information about how disability benefits and other government entitlements will be affected by a return to work.
13	Disclosure / Sharing Personal Information See fidelity manual pg. 89 - 93	This is a personal decision and participant/client led. Disclosure on what to share, when to share and with whom to share are decisions to be explored. Sharing of personal information may include health conditions (if relevant) criminal history etc. There needs to be documentation that disclosure or sharing personal information has been discussed on multiple occasions. Best practice would suggest a clear disclosure statement is crafted and agreed with the participant/client and on file. This is regularly reviewed and especially with any new approach to an employer. A link to ACAS guide on disability rights: The law on disability discrimination – Disability discrimination – Acas
14	Ongoing, work-based vocational assessment See fidelity manual pg. 93 – 96	Sources of information include the participant/client , and with their permission, clinicians, primary and community health/treatment team, social prescribers and clinical records, family members and previous employers. You need to find other sources of input. When most profiles do not include information from sources other than the client, such as family members, treatment team health, housing staff, etc., the score is affected. Need to see a vocational profile created over a few sessions and with input from a variety of stakeholders. A subsequent employment action plan with focus.
15	Rapid search for competitive job See fidelity manual pg. 97-100	Rapid contact with an employer is critical to show belief in the participant/client's ability to work and to avoid lengthy participation in vocational counselling, prevocational groups or work adjustment programs. Contact should be directed by the participant/client preference, and you may initially contact employers for the purposes of labour market

		investigation/employer specific information gathering; first contacts don't always have to be focussed on a job for the participant/client, though it may lead to a job. The service must track 2 key metrics, the first is the date of the initial appointment held between the IPS specialist and the participant/client, and the second is the date of the first face-to-face employer contact by the IPS specialist, participant/client, or both people together DWP IPS-PC Local Authority Guidance pg. 8 *"Place, Train and Maintain: An approach that Places people in work at the earliest opportunity, trains them to do the job in the way the Employer wants it done and provides ongoing support to maintain them in the job"*
16	Individualised job search See fidelity manual pg. 100 – 103	Ess should create an individualised job search plan for each participant/client based on joint exploration of their unique vocational preferences (i.e. what each person enjoys, their personal goals etc) and needs (including experience, ability, health etc.) rather than the job market using information from the vocational profile. Jobs that are readily available to all (i.e. via job boards) are less likely to suit the specific needs of clients, and employers may not be as receptive to considering reasonable adjustments than roles brokered or carved via IPS employer engagement activities. Remember- the vocational profile and individualised job search plan are live documents that need updating based on the participant/client journey; you may need to revisit these documents to record new jobs or fluctuating adjustments needed due to the client's health condition/disability when exploring job matches.
17	Job development – Frequent employer contact	ESs should keep an employer engagement log with clear columns recording the following information:

	See fidelity manual pg. 104 - 106	• date of contact • name of company contacted, • name of employee spoken to and their role (to determine whether they have hiring authority) • confirm they the hiring authority • type of contact, i.e. in-person, email, phone etc (see manual for full outline) • initials of the participant/client that the job development activity is being done on behalf of (or if it is speculative) • any information gathered/outcome of employer contact, whether it was an initial or relationship building contact The focus of employer contact for this item is job development; ESs must remember that a clear agreement needs to be in place regarding the participant/client's disclosure preferences before approaching employers on their behalf. Best practice suggests a written statement developed with the participant/client and reviewed regularly. Employer contacts are counted even when an employment specialist meets the same employer more than once in a week, and when the participant/client is present or not present. However, we do not count employer engagement when a participant/client meets an employer without an ES present. NOTE: we do not count job retention/in work support engagement with an employer as part of this item.
18	**Job development – Quality of employer contacts** See fidelity manual pg. 107 - 109	The aim of this item is to build and nurture relationships with employers for the benefit of participant/client and to create a local job market knowledge base. To evidence this (see point 17) the employer engagement log should feature columns to record dates of EE activity, in addition to noting the outcomes achieved and actions agreed as a result of the visit. ESs should record any

		face to face follow up visits planned and carried out with the same employer. ESs have vast opportunity to learn about varied roles within many sectors/industries, this curiosity and knowledge base informs better quality conversations during the vocational profiling phase.
19	Diversity of job types See fidelity manual pg. 109 - 111	ESs help clients to consider a wide range of jobs that are linked to their unique preferences, not directed solely by readily available jobs in the area or job board offerings.
20	Diversity of employers See fidelity manual pg.112 - 114	ESs help clients to consider a wide range of employers and to learn about the spectrum of jobs they offer in so doing. The employers suggested to a client should reflect their preferences as set out in their vocational profile and job search plan, and not be solely directed by an employer's prominence within local job markets or on job boards.
21	Competitive jobs See fidelity manual pg. 115 - 117	DWP guidance for IPS-PC – section 20/38 20.'Ensure all Participants work towards securing a minimum of 7 hours work per week, with as many as possible supported to work more than 16 hours per week for a minimum of 13 weeks duration.' 20.'Ensure all Participants work towards a Higher Threshold Job Outcome to work for a minimum of 7 hours per week for 26 weeks in a 32-week period' 38. 'IPS defines competitive employment as a job that any person can apply for regardless of their disability status. These jobs may be full or part time and can include self-employment. Workers in these positions should earn at least the minimum wage and receive similar wages and benefits as their co-workers. Volunteering, training, and work placements are not considered

		an employment outcome but may, in specific cases, be activities that help an individual secure paid competitive employment.'
22	**Individualised follow-along support** See fidelity manual pg. 118 - 121	Helping people succeed at jobs is as important as helping them find employment. Supports are individualised because different workers have different needs and preferences related to working a job. Reminder: The ESs have links and an understanding of how to utilise the Access to Work Scheme for service users/participants. Access to Work: get support if you have a disability or health condition: What Access to Work is - GOV.UK (www.gov.uk) The site provides examples of different types of support including enhanced supports by treatment team members or other relevant services (given currently primary and community health services probably won't have time to provide extensive support aside from some advice and guidance)
23	**Time-unlimited follow-along support** See fidelity manual pg. 122 - 124	There is some evidence that job loss is most likely to occur soon after a job start. Therefore, ES are encouraged to offer more supports to people who have just become employed. Note: Given commissioning of IPS in Primary Care (as is found with Drug and Alcohol IPS Services and many IPS services supporting people with severe mental illness contracts), the highest score available for this item is 4/5. See DWP Guidance - Funded Activities: item 26: *" ...as well as limiting the length of time that an Employment Specialist can support a Participant, to an expected maximum of 12 months for Out-of-Work Participants, or 4 months for In-Work Participants.".* Guidance: Individual Placement and Support in Primary Care - GOV.UK (www.gov.uk)

		Participant/Clients are transitioned to step down job supports from Access to Work arrangements or others in the primary care team following steady employment
24	**Community-based services** See fidelity manual pg. 124 - 126	ES carry out participant/client appointments in the community vs sitting in offices of your own organisation. This is because research suggest ES who carry out their job responsibilities away from their offices help more people with employment given the community is where employers are based. Examples of community locations could include libraries, schools and colleges, coffee shops. Clinical and/or health settings such as GPs do not count as community settings for this item. Community working includes meetings with DWP/JCP, attending job fairs, and undertaking employer engagement. Time spent travelling to different community locations are also included. Completing diaries in full for the whole day of work without gaps is recommended, including a location to show what and where each activity is taking place.
25	**Assertive engagement and outreach by integrated team** See fidelity manual pg. 127 - 129	The aim of this item is that a client/participant doesn't get closed because they missed one or 2 appointments. The journey into work is not always straight forward and easy and our job is to try and support, motivate and encourage people along that journey, even when they doubt themselves. Engagement and outreach attempts made through liaison with primary and or community treatment team, or a re-contact with the referrer, and coordinating joint meetings or drop in around existing treatment team meetings or where occurs undertake home/community visits. Dependant on the health team you are linked with this may or may not be possible. NOTE: Please cross reference IPS best practice and DWP guidance (item 158 in the DWP Guidance document Guidance:

		Individual Placement and Support in Primary Care - GOV.UK (www.gov.uk). For example- contact with Social Prescriber linked to GP practice to offer joint community appointment for next planned intervention with participant/client; or contact with the physiotherapist at the pain clinic to explore a joint meeting; or contact with the Talking Therapies counsellor. The term in the manual "integrated team members" means that you are not alone working with the participant/client, and you are ideally part of an integrated team between health/treatment and employment support; all working to help the client find paid work and find ways to overcome barriers to managing paid work.

Exemplary Score	115-125
Good Fidelity	100-114
Fair Fidelity	74-99
Not supported employment	73 and below

GLOSSARY

Term	Meaning
Client/participant	The person using the IPS service
Employment Specialist (ES)	The person delivering IPS and carrying a caseload of clients to support them into paid work
Employer engagement log (EE)	The excel spreadsheet that is the place where an ES can list their activity around engaging with employers. This includes frequency, confirmation they spoke with the hiring authority and follow up action.
Individual Placement and Support (IPS)	An evidenced based supported employment approach to helping people with disabilities or health conditions into work.
IPS fidelity manual	The instruction/ guide on how to confirm the quality of delivery of IPS against best practice.
IPS-PC scale	An easy reference of the IPS fidelity manual and the expression of the 8 principles into 25 delivery items that shows what are the main delivery points to do.
JobCentre Plus (JCP)	A government-funded employment agency and social security office that can be found in most cities, whose aim it is to help people of working age find employment in the UK.

Local Authority (LA)	An elected body that provides a range of services for a particular geographical area in the United Kingdom.
Multi-disciplinary team (MDT)	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient. The team members independently treat various issues a patient may have, focusing on the issues in which they specialise.
Musculoskeletal (MSK)	Musculoskeletal (muscles, joints and bones) People with musculoskeletal (MSK) conditions often experience aches, pains and a lack of mobility in their muscles and joints
Primary and/or community health service	IPS Employment Specialist is closely aligned with primary and community care and physical health care teams where appropriate, with Participants receiving employment advice alongside other healthcare support (item 37 of DWP grant guidance)
Serious mental illness (SMI)	Commonly refers to a diagnosis of psychotic disorders, bipolar disorder, major depression, anxiety, eating disorders and personality disorders
Protected Learning Time	Staff in primary care have some time each week assigned to learning
Transformation in mental health primary care	In some areas they are undertaking transformation in the way people with severe mental illness gain support. With transformation people who no longer need clinical case management will be stepped down to primary care and support from their GP and other service.

IPS Fidelity Scale for IPS-Primary Care

This Fidelity Scale is the Centre for Mental Health UK version, adapted by IPS Grow for IPS in primary and/or community health services (March 2024)

ipsgrow.org.uk