LEARNING AND WORK INSTITUTE

HALVING THE GAP

Making the Work and Health Programme work for disabled people

July 2016

In January 2016, NIACE and the Centre for Economic and Social Inclusion merged to form Learning and Work Institute

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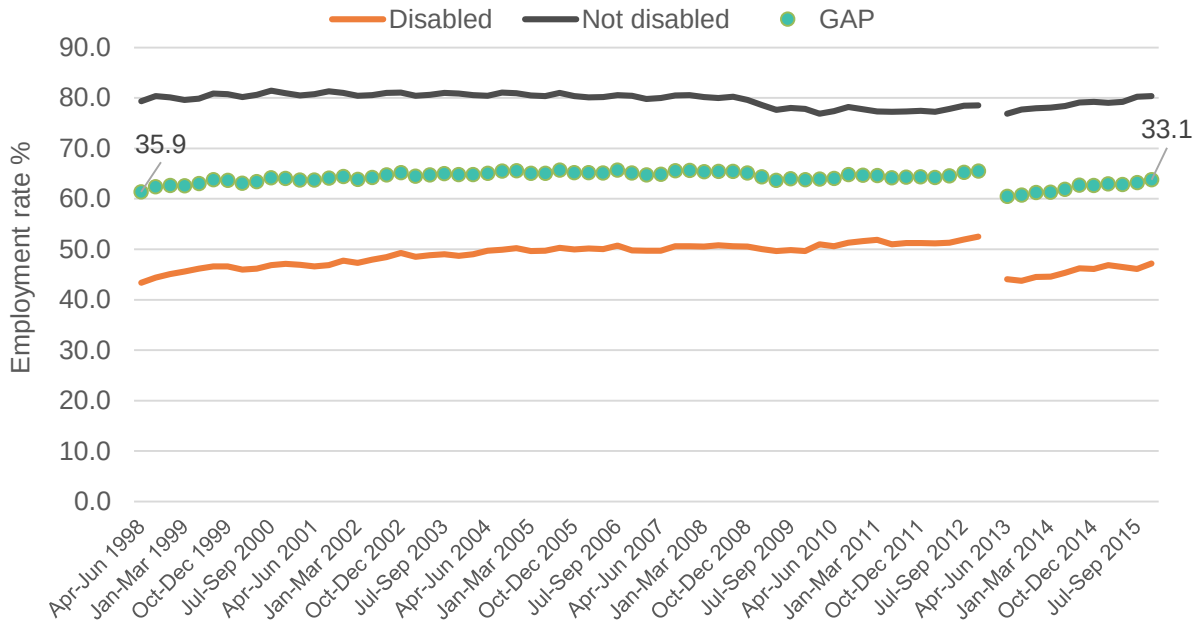
CONTEXT

THE CHALLENGE

6.9 million people in the UK aged 16-64 have a long-term health condition or disability. This is equivalent to around one in six of the 'working age' population. However, while 80% of those who are not disabled are in work, just 47% of disabled people are in employment.

This gap is unacceptably wide, and as Figure 1 sets out, it has remained stubbornly wide over the last two decades.

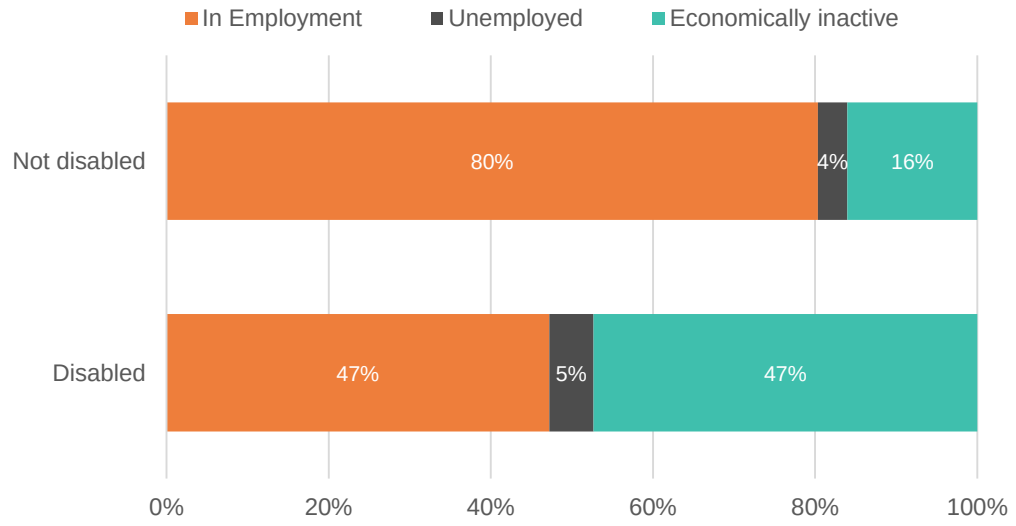
Figure 1 – Employment rates and the employment rate gap



Source: Labour Force Survey

Of the 3.6 million disabled people who are out of work, nearly half (47%) are neither looking for work nor available for work – this is three times the rate for those who are not disabled. Disabled people are half as likely to be actively looking for work as their peers who are not disabled.

Figure 2 Economic activity (% of working age), Oct-Dec 2015



Source: Labour Force Survey
Note: All people with a long-term health problem or disability in accordance with the core definition in the 2010 Equality Act.

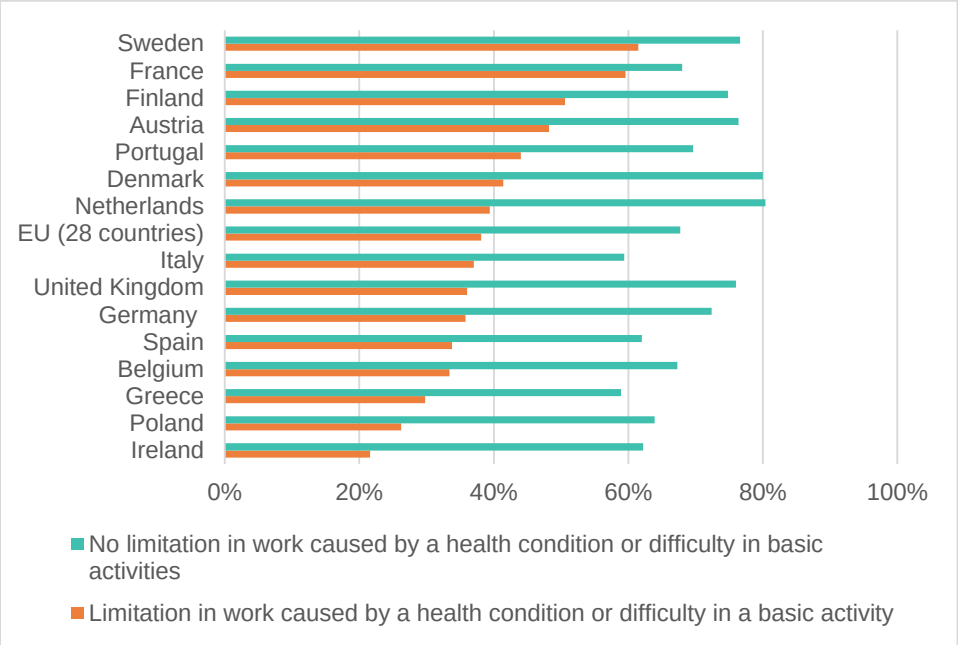
Disabled people are a diverse group with a range of capabilities and support needs. This includes some people with impairment-specific barriers as well as those with broader and common barriers such as time out of work, low skills, low confidence and lack of work-readiness. Many face multiple disadvantages. Employment rates are lowest for those with more significant impairments, for older disabled people and for those with mental health conditions.

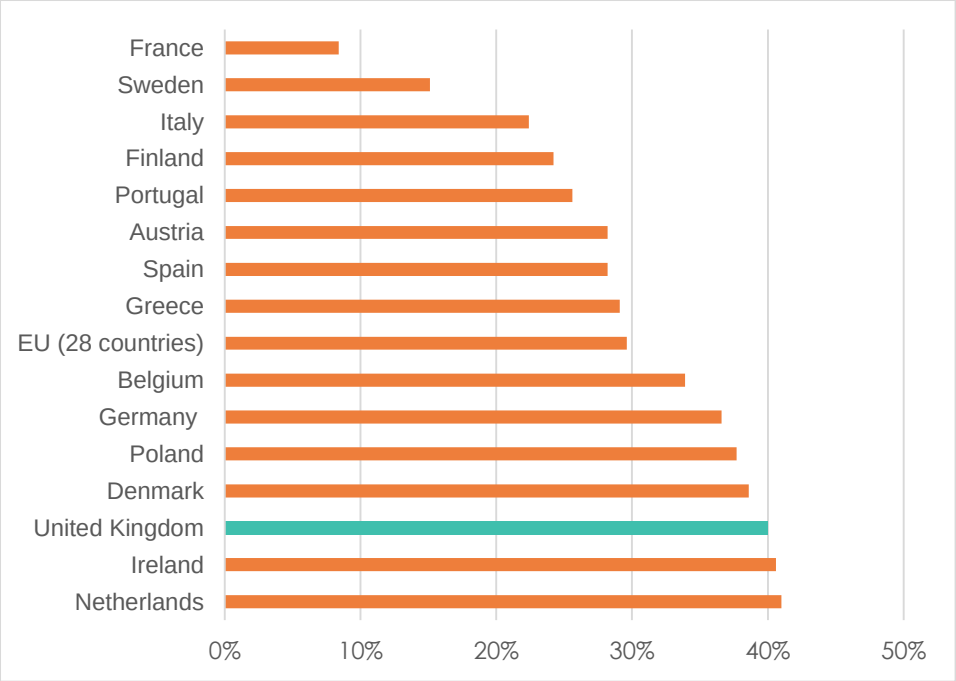
In their 2015 General Election Manifesto, the Conservative Party set out their aim of halving the gap in employment rates for disabled people in the coming Parliament. In practice, this means increasing the employment rate of disabled people from 46.4% in 2015 to 62.8% by 2020 – equivalent to **1.12 million more disabled people in work**. Since the General Election however, the gap has reduced by only 0.1 percentage points. At this rate of progress, it would take more than 200 years for the employment gap to halve.

The UK has now voted to leave the European Union. This brings some uncertainty over future policy. However, the scale and importance of the challenge to increase employment rates for disabled people have not changed.

It is clear that not everyone with a disability will be able to work, and the UK is not unique in facing the challenge of lower employment rates for disabled people. However comparative data from across the EU (see Figures 3a and b) suggests that more could be done.

Figure 3 a and b Employment rates (% of working age) and gaps, selected EU countries 2011





Source: EU Labour Force Survey[1]

We support the government's goal to halve the employment gap over the next four years. It is a huge challenge, and will require a transformation in attitudes to disability employment and support for disabled people.

[1] Data downloaded from Disability statistics – labour market access (http://ec.europa.eu/eurostat/statistics-explained/index.php/Disability_statistics_-_labour_market_access#Own_illness_or_disability:_major_reason_for_not_seeking_employment_by_disabled_people

This report is part of our Policy Solutions series. It is focused on how we can make the employment support system work better for disabled people and in particular how the Work and Health Programme can best be designed and implemented.

RESPONDING TO THE CHALLENGE

The government has announced its intention to publish a Green Paper in the autumn setting out new proposals on supporting disabled people and those with health conditions to get into and stay in work. Given the scale of the challenge, as described above, this paper needs to be ambitious and transformational.

There are currently four broad strands of activity supporting disabled people's employment.

1. Support for employers and disabled people in work

Through **Access to Work**, employers can access funding to pay for workplace adjustments to enable disabled people to stay in (or enter) work. This can include sign language interpretation, specialist equipment, or advice and support for managing a physical or mental health condition. Past research has identified a range of potential benefits from Access to Work including reduced sickness, improved attendance, retained employment and better health and well-being[2]. We have recently conducted a cost-benefit analysis of Access to Work for RNIB[3], and estimated that its overall benefits to society outweigh its costs by a factor of more than three to one.

The government also runs an awareness campaign, **Disability Confident** that seeks to promote good practice in the employment of disabled people. However, very few employers are currently signed up as 'partners' to the campaign, even from within the public sector[4] - with just nine Councils signed up; only one government department (the Department of Transport); three colleges; no universities; no police forces and one NHS Foundation.

In addition, the Equality Act places statutory responsibilities on employers not to discriminate against disabled people in their services and practices, and to make 'reasonable adjustments' to ensure that disabled people can access services.

2. Reducing exits from work

The new **Fit for Work Service** has now (in the last few months) fully rolled out, providing voluntary advice and support to employees, employers and GPs for

[2] Dewson, et al (2009) DWP Evaluation of Access to Work: Core Evaluation. Research Report No. 619

[3] Melville, D. Stevens, C, and Vaid, L. (2015) *Access to Work Cost Benefit Analysis, a report for RNIB*¸ Centre for Economic and Social Inclusion

[4] https://www.gov.uk/government/publications/disability-confident-partner-organisations

individuals who have been off work for at least four weeks. This is a new service, with its contract due to run until 2019.

Prior to the Fit for Work Service, support for those leaving or at risk of leaving work due to ill health has been limited – with **Statutory Sick Pay** providing a time-limited (for 28 weeks) minimum income paid by employers, which employers can choose to top up and/ or to supplement with rehabilitation services or other support. Access to Work can also play a role – with for example the Mental Health Advisory Service available to provide free and confidential advice to those off work or at risk of leaving work due to a mental health condition.

3. Support through the benefits system

After Statutory Sick Pay is exhausted (or for those not in work), financial support for disabled people and those with health conditions is also available through the benefits system.

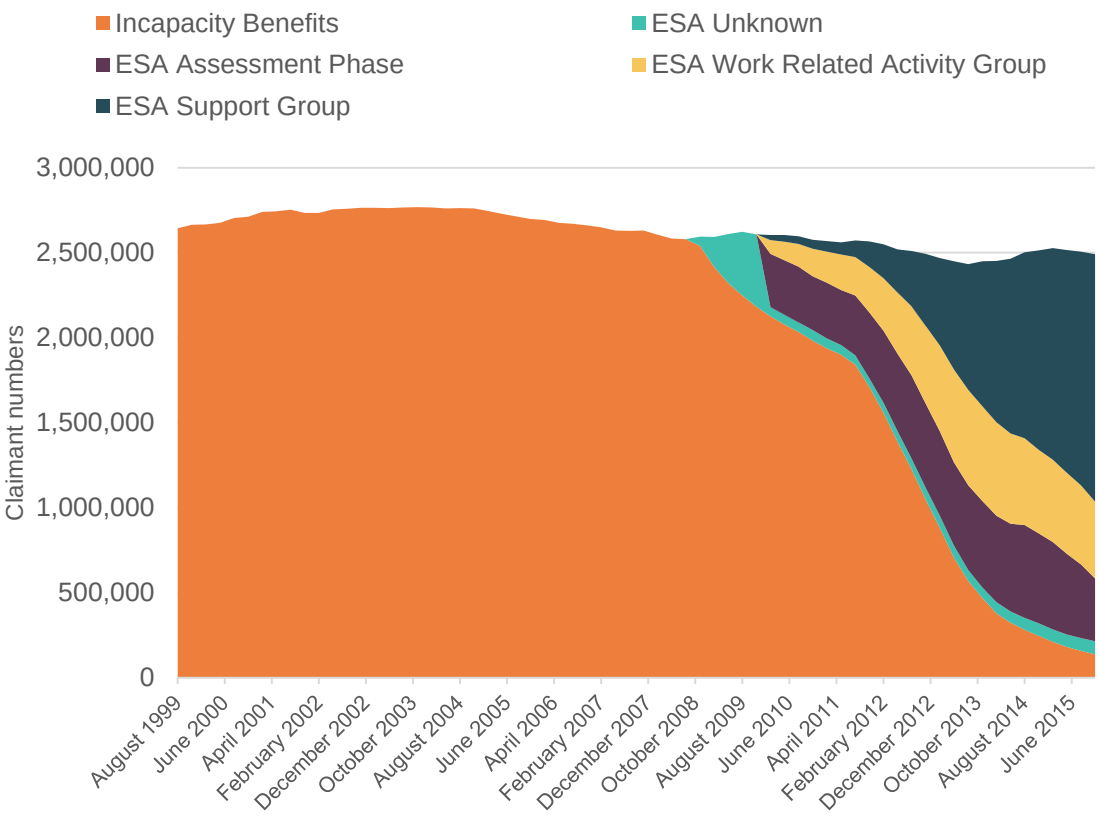
Through **Employment and Support Allowance** (ESA), individuals can receive financial support where their health condition or impairment means that they are not able to actively seek or take up employment. ESA claimants must undergo a 'Work Capability Assessment', after which they will either be found fit for work (i.e. not entitled to ESA), or found eligible for the Work Related Activity Group (WRAG) or the Support Group. WRAG claimants are required to undertake some work related activities, while those in the Support Group are not.

ESA was introduced in 2008, to replace a more complicated previous system of incapacity benefits, which had grown substantially through the 1980s and 1990s. However, as Figure 3 below shows, the numbers of people claiming ESA and incapacity benefits have barely changed since its introduction.

Overall, 2.49 million people claim ESA or incapacity benefits – down by 112,000 – or 4.3% - since May 2010. Over the same period, the number of people claiming other 'out-of-work' benefits (Jobseeker's Allowance or Income Support) fell by 1.05 million, or 45%. As a consequence, ESA claimants now make up two thirds of all of those claiming out of work benefits.

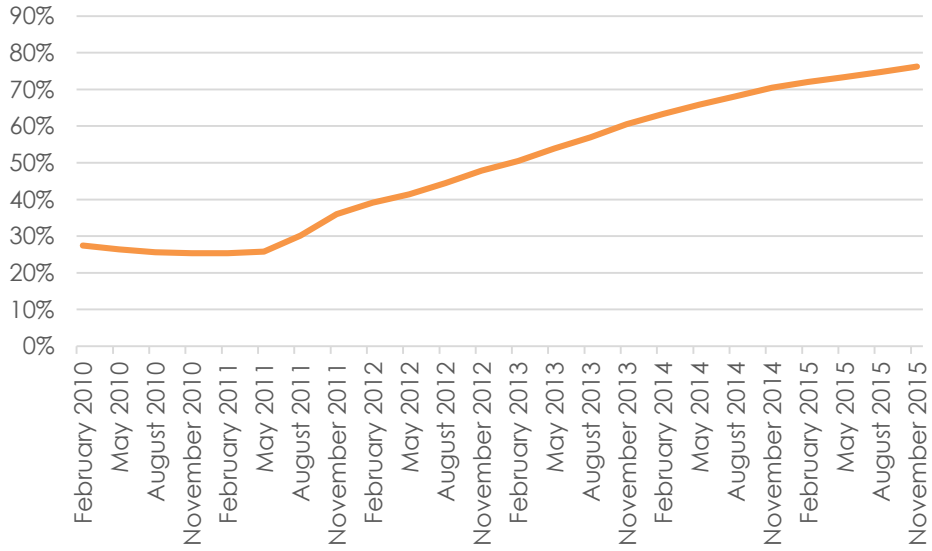
The proportion of new ESA claimants that enter the Support Group has also grown significantly over recent years. Just over three quarters of those who have completed their assessments are now placed in the Support Group, up from around 30% in 2010. This is shown in Figure 4 below.

Figure 4 – Incapacity benefits and Employment and Support Allowance caseloads – 1999 to present



Source: NOMIS and Learning and Work analysis

Figure 5 – Proportion of those completing Work Capability Assessments that are placed in the Support Group



Source: NOMIS and Learning and Work analysis

Unemployed individuals whose health condition or impairment does not prevent them actively seeking work or taking up employment can claim Jobseeker's Allowance (JSA). Statistics are not currently published on the overall number of JSA claimants with a disability, but are available for the Work Programme (which JSA claimants ordinarily join after 9 months' unemployment, or at 6 months for young people). There are currently 370,000[5] JSA claimants on the Work Programme with a disability, just over a quarter of the total.

4. Support to prepare for and get into work

Employment support for disabled people and those with health conditions is delivered primarily through Jobcentre Plus or through contracted-out employment programmes.

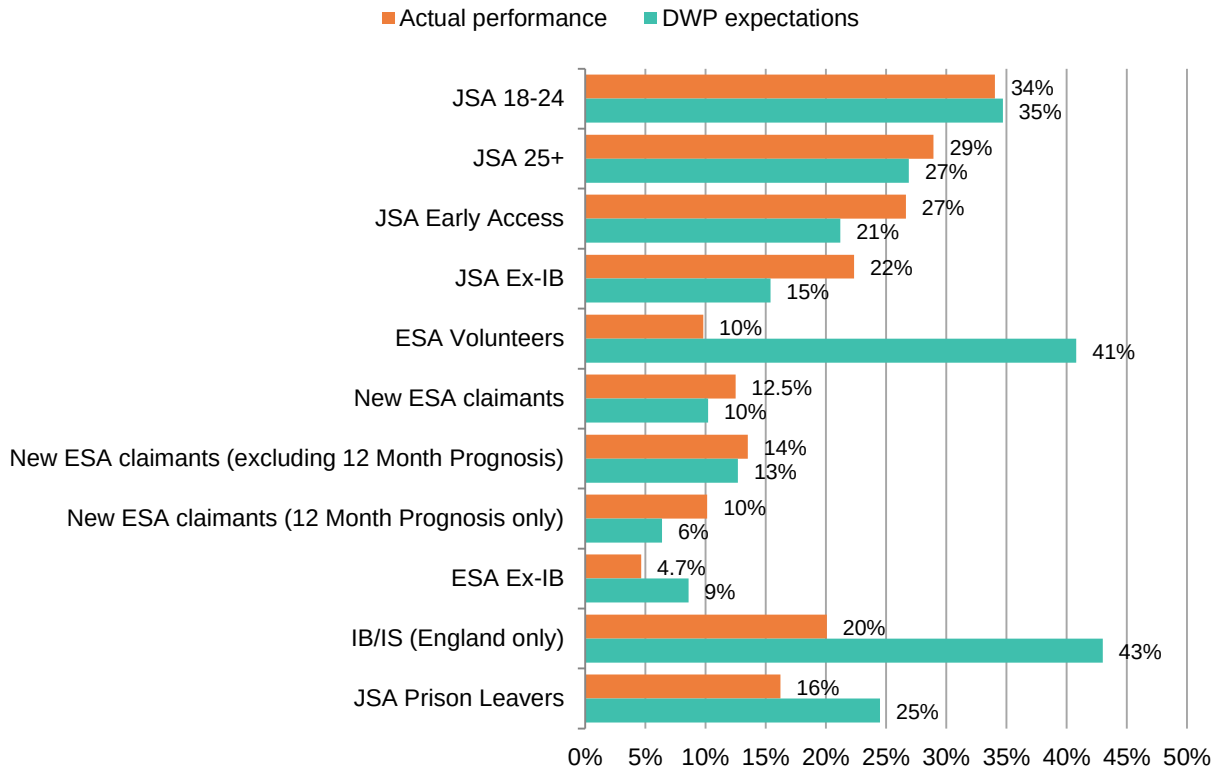
Through **Jobcentre Plus**, some ESA claimants within the WRAG are required to attend six-monthly interviews at Jobcentre Plus. Those with shorter prognoses (assessed as able to work sooner) are supported through the Work Programme (see below). Claimants in the ESA Support Group in practice receive no employment support at all.

Since their introduction in 2010/11, 742,000 disabled people have been supported through either the **Work Programme** or **Work Choice**. The vast majority of these, nearly nine out of ten (87%), are Work Programme participants. Overall, **one in five disabled people who entered either programme have gone on to secure employment** – a total of 155,000 people over six years. However, just one in eight participants that claim ESA or IB (12.4%) have gone on to achieve a job outcome.

The **Work Programme** is a large scale and predominantly mandatory programme, providing two years of adviser support to long-term JSA claimants and to ESA claimants deemed likely to be able to return to work within 12 months. As Figure 5 shows, performance is substantially lower for ESA than for JSA claimants, although it is now broadly in line with the government's (minimum) expectations.

[5] Data downloaded from https://sw.stat-xplore.dwp.gov.uk/webapi/jsf/tableView/tableView.xhtml on the 23rd of June 2016.

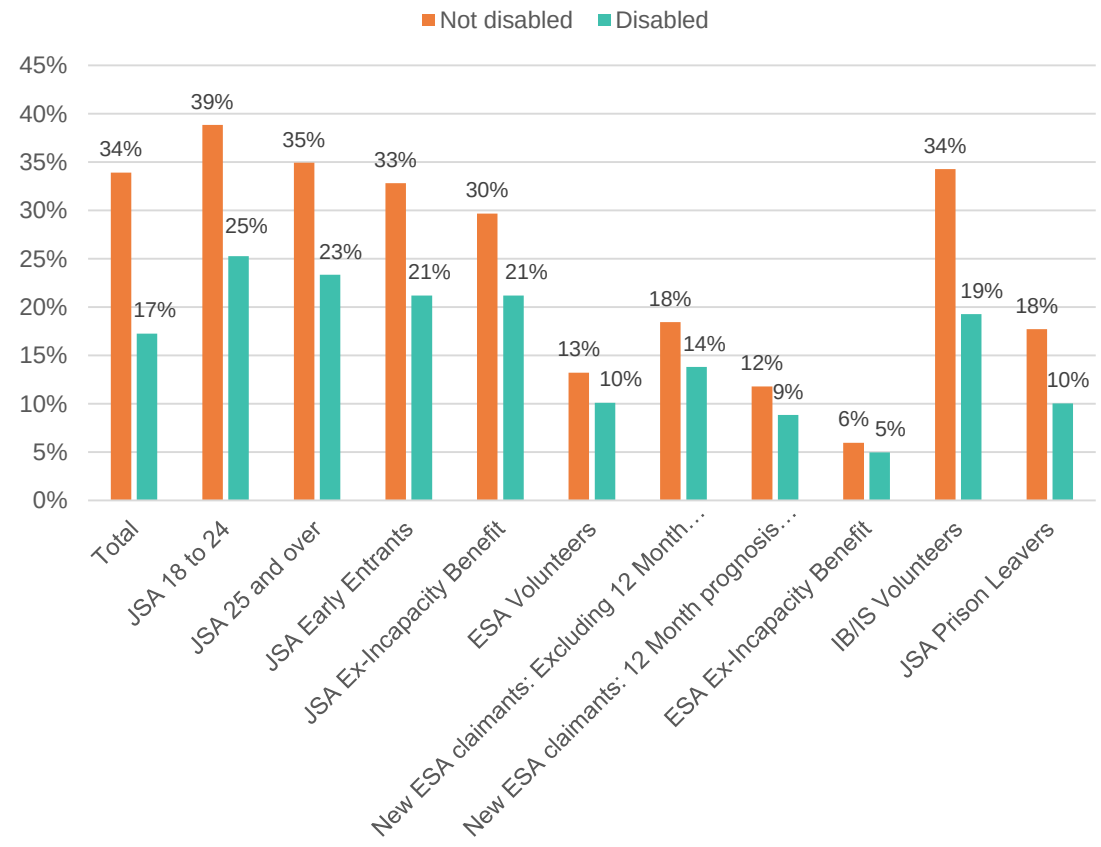
Figure 6 – Two-year job outcome measure benchmark compared to actual, by participant group (Jun-Dec 2014 referrals)



Source: DWP: Information, Governance and Security Directorate; Learning and Work calculations. Average weighted by monthly referral numbers.

The large majority of Work Programme participants are JSA rather than ESA claimants, with many of these also having a disability. In fact, over half (57%) of Work Programme participants with a disability are claiming JSA rather than ESA. It is striking though that within each participant group, disabled people fare worse than non-disabled people (see Figure 7). Overall, around one in six disabled people on the Work Programme secure employment, compared to one in three of those who do not report a disability.

Figure 7 – Job outcomes as a proportion of referrals by disability (Cumulative to Dec 2015)



Source: DWP WP Tab tool.

Work Choice is a far smaller programme, providing more specialist disability employment support to 94,000 disabled people over the last six years. The majority of these (54,000) were claimants of JSA, with just 16,000 claiming ESA or incapacity benefits. Work Choice is a voluntary programme, and to date 45% of participants have gone on to secure employment, although this includes supported employment - a smaller number (31%) have secured open employment.

Overall, through these two programmes, **we estimate that just one in ten disabled people who are out of work are currently receiving employment support, and just one in five of these will go on to secure employment**. Therefore, on current funding and performance, our employment programmes might increase the employment of disabled people by at most 2%.

The 2015 Spending Review announced that the Work Programme and Work Choice would be replaced with a new, single '**Work and Health Programme**'. This will have significantly less funding than the programmes that it replaces – £120 million per annum, around £400 million up to 2020/21. This is roughly equivalent to the current Work Choice budget.

In addition to this, Jobcentre Plus saw a significant increase in its funding, with the intention that in the future it will provide more intensive support to longer-term (12-24 month) JSA claimants (who would previously have joined the Work Programme) and to disabled claimants including those claiming ESA. In practice however, this support is still likely to be limited. On current plans, ESA WRAG claimants will receive, on average, 90 minutes of adviser support each year – so equivalent to one, half-hour interview every four months – while Support Group claimants will have no entitlement to support, although they will be able to volunteer to enter programmes.

PRIORITIES FOR ACTION

If the disability employment gap is to be halved, a lot rests on the successful design and implementation of the Work and Health Programme.

We consider that there are four key priorities for the programme – building on what we know has worked in the UK and internationally, the challenges currently faced and the opportunities presented through the Work and Health Programme, NHS commissioning and Devolution Deals.

1. **Aligning and increasing funding** through an AME/DEL agreement and supporting local joining up of funds such as European Social Fund (ESF) and its successors once the UK leaves the European Union (EU);

2. **Transforming how partners work together**, through a new framework for local outcome agreements with devolved authorities;

3. **Delivering the right support** by recognising the diverse needs of disabled people and the range of agencies able to support them, and taking a different approach to how employers are engaged;

4. **Making the market work**, by learning from the Work Programme, giving service users a voice and reforming 'payment by results'.

These are taken in turn below.

PRIORITY 1 – ALIGNING AND INCREASING FUNDING

Work and Health Programme funding

We estimate that spending on contracted-out employment support for disabled people is set to **fall by more than half** over this Parliament. Spending on the Work and Health Programme will be around £400 to £500 million in total[6], compared with our estimates of expenditure for supporting disabled people in Work Choice and the Work Programme of approximately £1.02 billion since 2010/11[7].

Disabled people claiming JSA who were previously supported through the Work Programme will in future receive additional support through Jobcentre Plus. However even excluding these claimants, funding of the Work and Health Programme will be around **one third lower** than the programmes that it replaces.

Lower funding means that fewer people will receive employment support. Overall, the number of disabled people receiving contracted-out employment support will be lower in this Parliament than in the last. On current funding, we estimate that the Work and Health Programme will be able to support between 100,000 and 400,000 disabled people, depending on the intensity of support delivered[8]. Taking the middle of this range (250,000), even if one third of these participants find work, then **the employment gap for disabled people would close by at most 85,000 over the course of this Parliament– less than 10% of the 1.1 million target needed to halve the disability employment gap[9]**.

These impacts could be increased if the programme is able to align with other funding. This includes the European Social Fund, which has allocated around £800 million to employment support, until the UK leaves the European Union. This is allocated through Local Enterprise Partnerships and is intended to support a wide range of disadvantaged people. Up to half of this funding has been committed already, so it is likely that up to £400 million could be available for alignment or matching until 2020, assuming that the UK government maintains the same levels of investment once the UK leaves the EU. The government should commit to maintaining investment at the same levels as planned under ESF and ensure that

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[6] Source: DWP Prior Information Notice

[7] Calculations set out in our written evidence to the Work and Pensions Committee, here: www.learningandwork.org.uk%2Fsites%2Fniace_en%2Ffiles%2Ffiles%2FDisability%2520inquiry%2520response%2520from%2520Learning%2520and%2520Work%2520FINAL(1).pdf

[8] We estimate unit costs of £4,800 per participant in Work Choice, and £1,200 in the Work Programme. Using the mid-point of the funding range for the Work and Health Programme (£450 million), this leads to estimates of 95,000 participants on a Work Choice basis, and 370,000 on a Work Programme basis

[9] In practice, the overall impact on employment will be lower than this maximum figure – as a proportion of those who find work would have done so without the support of the programme. Typically this figure is between 30 and 80% of programme participants.

local areas can direct this and align it with other programmes including the Work and Health Programme.

Further increasing funding – a new 'DEL/ AME agreement'

Importantly, funding in the new Work and Health Programme is **capped** – despite the obvious fiscal savings of supporting more people into work. This issue was first set out by David Freud in his 2007 report to government[10]. Subsequently, the Work Programme partially addressed this issue through a 'DEL/ AME agreement', where the Treasury agreed to fund high performance partially through the increased benefit savings that this would bring. This facility has, however, now been removed.

Based on the analysis in David Freud's review, there is a clear case for developing an 'invest to save' agreement for supporting ESA claimants. Using a single year benefit saving figure of £9,000, Freud's own and subsequent performance analysis would suggest that **between £900 and £1,000 could be available per participant** based on reasonable levels of performance (20% achieving employment) and reasonable assumptions on additionality (half of these would not have got a job without support).

OUR ASK

The government should reconsider its decision to cap funding for the Work and Health Programme at £500 million. In our view, this level of funding is far too low to make inroads into the disability employment gap.

The government should design a new 'AME/ DEL agreement' so as to free up new investment for the programme. If this cannot be delivered nationally, they should work with Devolution Deal areas to model this locally.

[10] Freud, D. (2007) *Reducing Dependency, Increasing Opportunity: Options for the future of welfare to work*, Report to Department for Work and Pensions

PRIORITY 2 – TRANSFORMING HOW PARTNERS WORK TOGETHER

Research by ourselves and others[11] has found that support for disabled people and those with health conditions is often patchy and fragmented, with little active co-ordination between services.

As set out above, mainstream employment programmes have been under-funded or rationed over recent years, with just one in ten disabled people able to access support. Within Jobcentre Plus, the large majority of ESA claimants receive no support at all, with a minority being seen by a work coach typically twice a year.

Meanwhile funding pressures within local government, combined with delays and significant reforms to European Social Fund (ESF) commissioning, has led to retrenchment in the provision of additional, targeted and discretionary local support for disabled people and those with impairments. Looking ahead, there is now uncertainty about what, if anything, will replace ESF funding once the UK leaves the EU.

Within health services, there are vanishingly few examples of co-ordination between health services and employment or welfare support, with those good practices that have existed coming under increasing pressure due to funding cuts (for example, the rare examples of co-located employment advisers within health services). Despite the inclusion of employment measures as indicators within the outcomes framework for the NHS[12], there also remain very few examples of NHS-commissioned employment and health support.

Where support does exist, this is often not co-ordinated or aligned across services – with NHS-funded provision targeted on the basis of clinical need (in practice, usually rationed to those in contact with secondary health services) and other support targeted according to the benefits that people claim or the wider services that they access. These differences also often mask a deeper mistrust between services – particularly over the role of benefit conditionality. This silo-based approach means that for those receiving support, wider services are not co-ordinated or aligned to meet their needs.

The Work and Health Programme will largely continue this silo-based approach. While local areas may be able to input into the specification of the programme, it will be commissioned and managed by DWP, with accountability for delivery to the Department. While local areas will have some limited input into the specification –

[11] See for example Purvis, A., Foster, S., Lanceley, L. and Wilson, T. (2014) *Fit for purpose Transforming Employment Support,* Centre for Economic and Social Inclusion; and Greig, R., Chapman, P., Eley, A., Watts, R., Love, B. and Bourlet, G (2014) *The Cost Effectiveness of Employment Support for People with Disabilities Final Detailed Research Report*, NDTi

[12] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/513157/NHSOF_at_a_glance.pdf

for example, to set out which local services exist and would need to be taken account of by bidders – there are clear risks that provision will not be aligned with local health or welfare support (as has often happened with the Department's 'Families with Multiple Problems' programme since 2012).

Notwithstanding this, there are specific examples where support is being aligned across services so as to better meet the needs of disabled people and those with health conditions.

In both **Greater Manchester** and **Central London**, local government is taking a lead on a new approach to co-ordinating and aligning support for people with health conditions who have been out of work for a long time.

In both cases, strategic boards have been established to oversee and co-ordinate the alignment of health, employment, welfare, skills and employer support. These boards provide a basis for agreeing objectives for how support should be delivered, agreeing clear accountabilities between partners, and monitoring how services are delivered and what outcomes are achieved.

Within this, new provision has been commissioned – 'Working Well' in Manchester and 'Working Capital' in London – to provide intensive, caseworker-led employment and health support to programme participants. While the detailed design of the two programmes is different, they are both aimed at supporting claimants of Employment and Support Allowance who have already received two years of Work Programme support without securing employment. In both cases, there is also a strong focus specifically on aligning support within local authorities across employment, health and wider services. This has included co-locating support within local authority and Jobcentre Plus premises, and engaging and aligning support with health services.

In addition, through the new Work and Health Innovation Fund, central government has committed over £100 million during this Parliament to testing and evaluating new approaches to delivering employment and health support for disabled people and those with health conditions. The unit is currently writing to the eleven areas that are negotiating 'Devolution Deals' with government, to invite them to develop proposals for health-led employment interventions. This is welcome, and could provide the basis for the testing of a more joined-up approach between employment services, health services and local government.

OUR ASK

The Work and Health Programme needs to exist as one part of a wider, shared effort locally to increase employment and employability for disabled people and those with health conditions. This should be based on:

- **Shared objectives** with clear outcome measures – set locally, but within a national framework

- **Clear accountabilities** between local partners to achieve these objectives – local authorities, health services, colleges and schools, Jobcentre Plus, contracted providers of employment support, and the voluntary and community sector
- **Clearly defined responsibilities** for delivering support
- **Effective oversight** – both at a political and strategic level, and between operational partners

As a start, the eleven 'Devolution Deal' areas should work with government to map out this approach and to then develop 'Local Labour Market Agreements' to deliver it.

For these areas, this should include joint commissioning of the Work and Health Programme – with the objectives and outcomes agreed with national government, but accountability for its delivery held locally through the Devolution Deal partnerships.

Devolution Deal areas should also be supported to align European Social Fund provision with the Work and Health Programme. Once the UK leaves the EU, the government should invest similar levels of investment in employment and learning support. This should be driven by cities and local areas, allowing effective co-investment and alignment.

In all other geographical areas, local partners should be encouraged and supported to develop governance arrangements that bring together employment, health and other local services so as to better co-ordinate support for disabled people. Where these arrangements are established, the Department should play a full role – allowing input into the oversight of both Jobcentre Plus and Work and Health Programme provision.

DWP, the NHS and local government should work together to develop a common framework for identifying, engaging, assessing and referring disabled people and those with health conditions. Service users are not well served by silo-based approaches to eligibility and needs assessment. A reformed framework should recognise that individuals access different and often multiple services, their journeys through support will be different, and needs may change. The Work and Health Programme should act as a test bed for trialling new ways of delivering integration.

PRIORITY 3 – DELIVERING THE RIGHT SUPPORT

We set out in our *Fit for Purpose* report in 2014[13] a range of recommendations for how employment support could be improved for those with health conditions and impairments. This project was supported by 26 organisations that deliver employment services and support to disabled people, and drew on reviews of 'what works' in the UK and internationally. In particular, we set out:

- **That disabled people are a diverse group**, and often have a range of capabilities and support needs – one size does not fit all
- **The key importance of effective and often specialist advisers** – with evidence that smaller caseloads, more personalised and frequent contact, and well-trained advisers all make a difference
- **That Supported Employment models work** – based around high-quality adviser support, vocational profiling, effective employer engagement, early and intensive support to then match and broker people into the right jobs, and ongoing wrap-around support once in work
- **The need for a different approach to employer engagement** – recognising the challenges around low awareness, the difficulties that some employers face in accessing support, and the barriers that recruitment practices can create
- **There is a range of learning from the UK and internationally** – in engaging the right groups, delivering the right interventions, and addressing particular impairments, conditions and needs

Drawing this together, we consider that this points to a higher degree of specification within the Work and Health Programme than existed in the Work Programme; an emphasis on using specialist and skilled advisers; and ensuring that caseload sizes are smaller than in other programmes. In the London Working Capital programme for example, caseload sizes are typically around 25 participants for each adviser.

There is also a clear case for making the Work and Health Programme voluntary. The Coalition government's disability and health employment strategy[14] set out a range of evidence on effective voluntary programmes, and both Working Capital and Working Well are based on voluntary engagement. This would also open up far greater opportunities for partnership with health services, by addressing concerns from clinicians around the appropriateness of mandating participation in services.

[13] Purvis, A. et al (2014) *Fit for Purpose: Transforming employment support for disabled people and those with health conditions*, Centre for Economic and Social Inclusion
[14] *The disability and health employment strategy: the discussion so far*, 2013, HM Government Cm8763

Given the need to widen access to employment support among disabled people and those with health conditions, a voluntary programme would need to be underpinned by a new strategy for widening engagement. This could involve increasing the frequency of work-focused interviews at Jobcentre Plus among ESA claimants in the WRAG group. However, there is currently little good evidence on the effectiveness of activation for people on sickness and disability related benefits. Testing how activation or other engagement strategies can increase the number of disabled people accessing support has to be a priority for the future. It is also important to consider how to provide effective support for and engagement with the support group.

Service standards, guarantees and delivery plans

In many cases, providers are given discretion regarding the nature and intensity of support that they offer, as long as they meet certain standards. These standards are set so as to ensure that participants remain engaged and are not 'parked' – which can in turn lead to people becoming more detached from work and further disadvantaged.

In the **Work Programme**, providers were required to set out their **'Minimum Service Standards'** for participants as part of their tenders. While providers all set these and had feedback mechanisms for monitoring them, the 'black box' nature of the programme meant that these varied widely between providers, making it difficult to compare service performance across providers. In practice, minimum standards were often relaxed by providers over time, and were formally discontinued earlier this year[15]. This 'light touch' approach to monitoring service quality likely contributed to the 'creaming' and 'parking' of service users that has been evident in research on the Work Programme.[16]In the **Australian 'jobactive' programme**, there is a common and high level **'Service Guarantee'** that sets out service expectations and responsibilities. Individual contracted providers are then required to display these Guarantees as well as their own **'Service Delivery Plans'**, which set out in more depth the services that users can expect to receive. In most cases, this includes commitments on the timeliness and frequency of support, as well as access to additional services. Service Guarantees have been a feature of Australian provision for over a decade, with varying degrees of prescription. The current approach attempts to strike a balance between the risks of 'parking' claimants on the one hand and creating unnecessary burdens on providers on the other.[17]

[15] The standards are available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510709/work-programme-provider-minimum-service-delivery.pdf

[16] See for example Carter E, Whitworth A 2015 *Creaming and Parking in Quasi-Marketised Welfare-to-Work Schemes: Designed Out Of or Designed In to the UK Work Programme?* Journal of Social Policy 44 (2); and Lane, P, Foster, R, Gardiner, L, Lanceley L, Purvis A 2013 *Work Programme Evaluation Procurement, supply chains and implementation of the commissioning model*, DWP Research Report 832

[17] An example Service Guarantee can be found here: https://www.employment.gov.au/your-service-guarantee-job-seeker-jobactive and an example Service Delivery Plan here:

Northern Ireland's Steps 2 Success programme also adopts a **Service Guarantee** model. In this case, the three contracted providers set out Guarantees for each client group, which must meet or exceed a baseline set by the Department. This specifies that all participants will have an initial assessment, action plan and then at least monthly face-to-face reviews. It also describes the sorts of additional support that should usually be available.[18] This model is specifically intended to address concerns around parking and to ensure that all participants are actively engaged.

A different approach to engaging with employers

Research points to a range of barriers for employers in recruiting and retaining disabled people. Our research for Shaw Trust[19] found that employers often had low awareness of the services that were available to them, were dependent on service providers to help them navigate support, and often had recruitment processes that were not accessible or less accessible for disabled people. However, employers often valued highly the support that they did receive, and in particular many pointed to the importance of financial support (mainly received through Access to Work).

This points to the importance of working with employers to understand the benefits of recruiting disabled people, exploring the use of targeted financial incentives and providing the right support to change recruitment practices and access services. Given the smaller and more fragmented nature of the Work and Health Programme, there is a need for greater coherence in how employer-facing support is delivered.

OUR ASK

The Work and Health Programme should be based on a caseworker-led approach, with specialist advisers working with small caseloads – typically no more than fifty participants per adviser, and ideally as low as twenty-five.

The programme should be underpinned by Service Guarantees that set out clear and transparent service standards for participants. This should specify what participants can expect in terms of their engagement, assessment, activation and support to prepare for work, as well as what will be expected of service users in return. Prospective providers should then be invited to set out how their own service offers will meet or exceed these benchmarks. This would enable more effective comparison of service standards across providers.

The sorts of additional support available to participants should be clearly based on the evidence of 'what works' and seek to align local provision. In particular, the evidence points to the effectiveness of Supported Employment

http://sarinarusso.com/media/1082/sarina_russo_job_access_service_delivery_plan_-_job_seekers_final.pdf

[18] See for example http://reedinpartnershipni.co.uk/files/serviceguarantee.pdf

[19] "Making Work a Real Choice", Shaw Trust, 2013

models, as well as specific interventions for different groups (such as group-based work, condition management and volunteering).

The programme should be voluntary by default. This would be substantively different to the Work Programme, and would require a greater focus on identifying those that may benefit, engaging them effectively and then delivering the right support. The government's new Work and Health Innovation Fund should play a key role in testing and evaluating new approaches to increasing engagement in employment-focused support which could include increasing the level of contact that the WRAG group have with Jobcentre Plus to discuss the support on offer.

Government should explore the scope for Jobcentre Plus, or a single provider, to provide specialist, employer-facing support, in particular for larger employers. The service would promote employer engagement with services, review recruitment practices and facilitate access to government support (including Access to Work). This single point of contact would then agree service level agreements with Work and Health providers, who could match and broker participants into work placements and jobs.

PRIORITY 4 – MAKING THE MARKET WORK

Commissioning the Work and Health Programme

The Work Programme was, at the time it was commissioned, the largest 'payment by results' programme in the world. Its commissioning was based on the principles set out in the 2007 Freud Review to government[20]: that larger scale programmes, with large contracts delivered by 'prime providers', would deliver better value than the services that they replaced. The gains would come from greater economies of scale, better management of performance by providers and the ability to use 'payment by results' contracts. This approach was reflected in the Labour Government's 2008 Commissioning Strategy[21], and the subsequent design of both Labour and Coalition employment programmes.

This model, however, was predicated on:

- The perceived benefits of the prime contractor model being realised; and
- These benefits being greater than any losses – for example due to services being less responsive to local circumstances or the introduction of managing agents leading to additional costs.

Our evaluation of the Work Programme[22] suggests that many of the gains of prime contracting have been realised – with services being delivered a lot more efficiently than in the past, costs reduced and performance broadly maintained. However, the benefits of 'payment by results' have been less clear cut – with our analysis[23] suggesting that a combination of factors has led to systemic under-funding of support for ESA claimants in particular. It is also unclear to what extent the gains have outweighed losses; the Work Programme has struggled in particular to join up services locally for disabled people and those with health conditions.

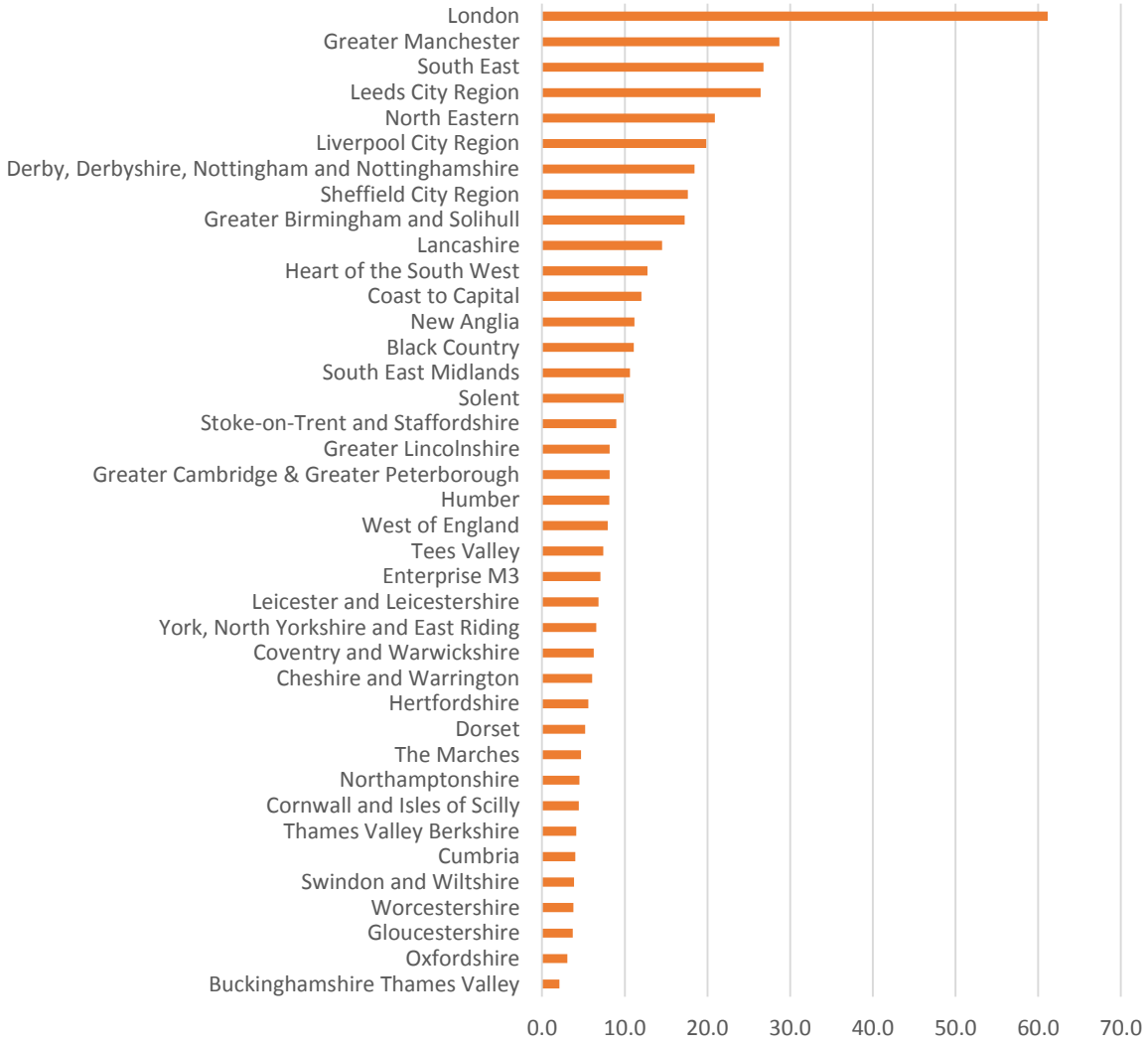
Given the funding and intended targeting of the Work and Health Programme, it is far from clear that a prime contractor model would be appropriate or desirable. As we set out in Priority 2, there would be clear benefits in jointly commissioning the programme within the eleven Devolution Deal areas – creating the opportunity to transform how support is aligned across health, employment and other services locally. It would follow from this that mirroring local commissioning boundaries – for

[20] Freud, D. (2007) *Reducing Dependency, Increasing Opportunity: Options for the future of welfare to work*, Report to Department for Work and Pensions
[21] *DWP Commissioning Strategy*, February 2008, Department for Work and Pensions, Cm7330
[22] Lane, P, Foster, R, Gardiner, L, Lanceley L, Purvis A 2013 *Work Programme Evaluation Procurement, supply chains and implementation of the commissioning model*, DWP Research Report 832
[23] Riley, T., Bivand, P. and Wilson, T. (2014) *Making the Work Programme work for ESA claimants*, Centre for Economic and Social Inclusion

example LEP boundaries – would increase the opportunity for services to join up, align and even pool funding.

However, the funding envelope for the programme would simply not support a prime contractor model with LEP commissioning. Figure 8 below sets out our assessment of what the indicative budgets for the Work and Health Programme would be (over its lifetime) if it were commissioned at LEP level. Beneath London (which we understand would itself be commissioned in four contracts), contract values range between £2.1 million and £28.7 million, with a median of £8.1 million. For the Work Programme, by contrast, the single smallest contract was **£40.4 million**.

Figure 8 – Indicative budgets for Work and Health Programme, if commissioned on LEP boundaries



Source: Learning and Work Institute analysis

Realistically, if the Department wishes to contract the Work and Health Programme using its preferred prime contractor model, this would lead to a relatively small number of contracts. This would mean contracts spanning multiple Local Authority

and LEP areas. Contracting on this geographical scale would make local input into commissioning, oversight of delivery and alignment of services very difficult and might lead to poorer value for money.

In addition, there are a number of other areas where the commissioning of the Work and Health Programme could learn from experiences in the programmes that it has replaced. This includes:

- **Having single providers in each area, rather than provider competition**– this would support partnership working, make outreach easier, and improve the economies of scale for what will be a relatively small programme locally
- **A more flexible and responsive approach both to volumes and funding** – the Work Programme suffered significantly from errors in estimates of participant volumes and performance which led to funding being around £1 billion lower than originally forecast – which has in turn led to fewer people receiving support and fewer finding work. A more open and flexible approach which involves more shared risk would be beneficial. This would include more transparency in how estimates are calculated and more responsiveness in correcting these errors
- **A different approach to management and oversight of provision** – based on collaboration, responsiveness and the place of the Work and Health Programme within local partnerships to raise employment of disabled people
- **Drawing on a wider provider base** – it is highly likely that a successful programme will need to draw on a wider range of organisations, including those in the voluntary and community sectors

Payment by results (PBR)

PBR has sharpened the focus on achieving employment outcomes across employment services, and has therefore likely driven some gains in employment for those who may have been closer to work. However, there is extensive evidence from PBR programmes that they can lead to those with more complex needs being 'parked' if they are not considered likely to achieve a job outcome, particularly if incentives and differential payments are not sufficient. This results in such participants becoming more disadvantaged and more detached from support. Of course, similar challenges can arise in other programmes too.

Our analysis of funding and performance for ESA groups found[24] that the early years of the Work Programme were characterised by a cycle of low performance, leading to low funding, leading to still lower performance – largely a consequence of

[24] Riley, T., Bivand, P. and Wilson, T. (2014) *Making the Work Programme work for ESA claimants*, Centre for Economic and Social Inclusion

mistakes in the design of the PBR model for these groups, combined with other issues in programme design and referral mechanisms from Jobcentre Plus.

PBR works where commissioners and providers know *what works* in terms of support and that the *cost* of support is at least met by the payments made. The evidence from the evaluation of the Work Programme is clear that differential pricing – that is, higher outcome payments for some groups than for others – did not lead to different service levels and did not improve services for those groups, at least partly because the costs of support for those with greatest need exceeded the payments available.[25]

In our view, well-designed PBR can play a role in driving marginal gains in performance, but there are risks attached to this for the commissioner as well as providers. A reformed approach to PBR should therefore:

- Simplify and reduce the number of 'payment groups'
- Reduce the proportion of funding paid on employment outcomes
- Explore more sophisticated approaches to incentivising high performance – such as the cohort-based 'accelerator model', where larger outcome payments are made as performance increases

Quality management and the voice of the service user

Employment programmes are almost unique among public services in the UK in having virtually no external assessment of the quality and value for money of the services being delivered. Ofsted previously played this role, but this was ended in 2011.

In virtually every other public service – education, adult skills, health, social care, local government services, police, criminal justice and so on – an independent inspectorate assesses the quality and value of the services being delivered. The only public services that do not have independent oversight of their quality and value for money are the tax system, the welfare system and employment services.

The absence of such oversight increases the risk that services focus on narrow key performance indicators rather than broader measures of service quality and value. In employment services, this is particularly concerning as we know that where individuals do not receive a quality service this can lead to them becoming more detached and more disadvantaged.

Related to this, employment services are also notable in not having any formal place for the voice of the service user – either in the design and oversight of support, its management (for example through satisfaction surveys) or in addressing problems

[25] DWP (2014) *Work Programme evaluation: operation of the commissioning model, finance and programme delivery*, DWP research report 893

(for example through an ombudsman). The absence of a service user voice is particularly perplexing given the increased focus on empowerment of disabled people in the provision of services. For example, the Coalition Government's Disability and Health Employment Strategy[26] emphasised the importance of programmes engaging and empowering service users – for example through co-design and oversight of services.

OUR ASK

The Work and Health Programme should be commissioned based on LEP boundaries. This will lead to contracts of between £2 million and £29 million. This will maximise the scope to align support with local provision and tailor support to local needs as well as being more attractive to, and viable for, a range of existing employment services providers.

Contracts should appoint one provider for each area (instead of within-area competition) – to maximise the scope for partnership working and collaboration.

The PBR element in the Work and Health Programme should be significantly lower than existed in the Work Programme, to minimise the risks of parking and of under-funding, and to create greater space for innovation and investment. Given the focus on testing and learning within this programme, it would be reasonable to make 20-30% of the contract value contingent on achieving employment outcomes. Combined with effective performance management, quality management and strong service guarantees, this would still ensure a strong focus within the programme on high performance and service delivery.

The Department should reintroduce quality management and oversight of employment support. This oversight should focus on the management, quality, delivery and value for money of services. In the first instance, it would likely be most appropriate for this to be delivered by Ofsted, but with a view to developing a more specialist independent inspectorate over time.

There should be a clear service user voice in the detailed design, implementation and oversight of the Work and Health Programme – drawing on disabled people's user-led organisations, as well as satisfaction surveys of programme participants.

[26] *The disability and health employment strategy: the discussion so far*, 2013, HM Government Cm8763