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Employment & Support Allowance: Evaluation of pilots to support Work-Related Activity Group customers with an 18 to 24 month re-referral period

Research Report

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A report of research carried out by Learning & Work Institute and NatCen Social Research on behalf of the Department for Work and Pensions

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Value of this research

These research findings produce new evidence to inform policy about what works to help Employment and Support Allowance (ESA) and Universal Credit claimants with complex health conditions to improve their prognoses, enabling them to move closer to work and to fulfil their potential.

Trustworthiness

This report is part of the DWP research report series and as such adheres to the Government Social Research publication protocol and the Government Social Research Code for Products. The report has been assured by professionally badged Government Social Researchers in DWP and its production has been supported by other professionally badged analysts from the relevant government analytical services including the Government Statistical Service.

Quality

Collection, analysis and reporting of findings in this research report have been carried out by approved independent research contractors, the Learning & Work Institute and NatCen Social Research, commissioned by DWP through a competitive tender process. DWP analysts have worked closely with the contractor throughout the project to assure the quality and ethics of all research methods, tools and analysis used in the production of this report. This includes adherence to relevant published guidance such as The Magenta Book on evaluation and GSR professional guidance on ethics.

Executive summary

This report presents findings from the evaluation of pilots to support ESA (Employment and Support Allowance) WRAG (Work-Related Activity Group) customers with an 18 to 24 month re-referral or 'prognosis' period. The pilots aimed to test the effectiveness of enhanced support to these customers, delivered over the course of two years. Three distinct models were piloted:

- the Jobcentre Plus (JCP) model
- the Work Programme (WP) model and
- the Healthcare Provider (HCP) model.

An internal DWP impact assessment estimates the impacts of the pilots on employment and benefit outcomes, while this report explores the delivery of support, participants' experiences of this, softer outcomes from the pilots and participants' perceptions of pilot impacts.

Findings suggest that the Jobcentre Plus pilot had a small impact on employment outcomes measured in the survey, and also had an impact on soft outcomes such as feelings about leaving ESA and starting work. The HCP pilot also appeared to have a positive effect on these soft outcomes, while the WP pilot did not have an impact on the outcomes observed in the survey.

There were five key ingredients which, combined, led to effective provision for this claimant group:

Personally tailored approach – with staff who could work flexibly with participants, tailor support individually and work according to each participant's support needs.

Flexibility in the mode of delivery – delivery of support in flexible formats that took account of participants' needs, such as physical mobility barriers, low confidence and social anxiety.

Intensity and duration of support – engaging with participants frequently to provide participants with a regular routine that emulated aspects of the work environment.

Staff capabilities – including well-trained and knowledgeable staff; adequate staffing levels; access to specialist staff and services; and peer support to share good practice.

Partnership working – in order to provide, or broker access to, a broad and holistic package of support.

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Glossary of terms

Disability Employment Adviser – specialist Jobcentre Plus staff who provide support and advice to customers with a health condition or disability.

Employment and Support Allowance (ESA) – a type of unemployment benefit offering financial support to people who are out of work due to long-term illness or disability.

ESA Work-Related Activity Group (WRAG) – people claiming ESA are placed into two groups depending on the extent to which their illness or disability affects their ability to work. The work-related activity group are required to have regular interviews with an adviser and undertake work-related activities.

ESA WRAG 18-24 month Prognosis Group – Once a claimant has been found to be eligible for ESA they will be allocated a prognosis or re-referral date where their entitlement to benefit will be reconsidered. The prognosis group was used to determine whether claimants were eligible for the Work Programme. This pilot extended mandatory referrals to the Work Programme for participants in the 18-24 month Prognosis Group.

Jobcentre Plus Work Coach – frontline DWP staff based in job centres who support claimants into work by challenging, motivating, providing personalised advice and using knowledge of local labour markets.

Jobseeker's Allowance (JSA) – a type of unemployment benefit paid to people who are out of work and actively seeking work.

Personalisation Pathfinder – a trial scheme offering tailored support to those with a disability or health condition who are unemployed.

Work Capability Assessment (WCA) – a requirement of every ESA claim, this assessment measures the extent to which illness or disability affects one's ability to work.

Work Choice – a specialist disability employment programme delivered by a range of provider organisations, offering work entry support and up to two years in-work support for people with disabilities.

Work Programme (WP) – an employment support programme delivered by a range of providers with the aim of helping long-term unemployed JSA and ESA claimants find employment.

Work Psychologist – professional staff who help people who are disabled, disadvantaged or those with health conditions to find and sustain work or training opportunities, by providing one-to-one employment assessments for individuals and supporting advisers in their work with claimants.

Abbreviations

DEA	Disability Employment Adviser
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
GP	General Practitioner
HCP	Healthcare Professional
IB	Incapacity Benefit
JCP	Jobcentre Plus
JSA	Jobseeker’s Allowance
LMS	Labour Market System
PG7	Payment Group 7
PRAP	Provider Referral and Payment System
RCT	Randomised Controlled Trial
UC	Universal Credit
WCA	Work Capability Assessment
WP	Work Programme
WRAG	Work-Related Activity Group

1 Summary

1.1 About the pilots

There are almost one in three working age people in the UK with a long-term health condition that puts their participation in work at risk and 4.6 million disabled people or people with long-term health conditions out of work.[1] The Government is committed to improving employment rates for disabled people and is currently analysing the results of its consultation on the Work, Health and Disability Green Paper, published in October 2016, which asked what it would take to transform the employment prospects of people with disabilities and long-term health conditions. Findings from this evaluation will help the Department for Work and Pensions (DWP) and other Government Departments to understand how to enable Employment and Support Allowance (ESA) claimants with complex health conditions to improve their prognoses, to move closer to work and to fulfil their potential.

The pilots were launched in 2013, following the Government's 2013 Disability and Health Employment Strategy, when DWP were asked to test alternative, innovative approaches to providing increased support to the ESA Work-Related Activity Group (WRAG) claimants who had an 18-24 month re-referral or 'prognosis' period. These claimants may have limited capability for work and complex health conditions. Currently they are mandated to 'the Jobcentre Offer' and receive an average of 88 minutes of Jobcentre Plus work coach time per year. Referral to the Work Programme (WP) is voluntary and to date limited numbers have opted in to it (relative to other mandatory referral groups).

The pilots aimed to test the effectiveness of enhanced support, delivered over the course of two years, to ESA WRAG customers with an 18-24 month prognosis period.[2] Three distinct models were piloted:

- the Jobcentre Plus (JCP) model
- the Work Programme (WP) model, and
- the Healthcare Provider (HCP) model.

The pilots were implemented using a Randomised Control Trial (RCT) design that allowed DWP to test the effectiveness of the three approaches in moving this group closer to or into work, compared to the current offer of JCP support. An internal DWP impact assessment, published alongside this report, estimates the impacts of the pilots on employment and benefit outcomes, while this report explores the delivery of support, participants' experiences of this, softer outcomes from the pilots and participants' perceptions of pilot impacts.

[1] DWP and DoH (2016) Improving Lives: The Work, Health and Disability Green Paper https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564038/work-and-health-green-paper-improving-lives.pdf

[2] ESA 18-24 WRAG customers are ESA claimants whose health condition will be reviewed at the 18-24 month point when they will undergo a repeat work capability assessment.

The pilot models comprised:

Jobcentre Plus (JCP) pilot: The JCP-led model involved extra work coach time for pilot participants (530 minutes per year), combined with improved support for work coaches, such as additional case conferencing and access to Work Psychologists where appropriate. The extra time with participants was intended to provide more intensive support to encourage them towards work. Attendance at appointments and completion of agreed work-related activity was mandatory for pilot participants.

Work Programme (WP) pilot: Participants in the WP pilot were referred to their local WP provider for two years of support. The nature of this support was not defined by DWP as WP providers operate under a 'black box' model. WP pilot providers were funded via the standard WP payment model. As with the JCP pilot, attendance at appointments and completion of agreed work-related activity was mandatory for all participants on the pilot.

Healthcare Provider (HCP) pilot: a provider from the private sector was contracted to deliver this pilot, comprising a series of appointments delivered by healthcare professionals, with the aim of supporting participants in the management of their health condition or disability and assisting them towards (a return to) work. The provider was contracted to provide three face-to-face appointments within the first 26 weeks of referral, followed by a further two face-to-face interviews after 12 and 18 months. Additional appointments were at the provider's discretion. Attendance at all appointments was mandatory for pilot participants, although activity between appointments was voluntary.

1.2 Evaluation design and methods

The evaluation of the pilots was carried out using a two-wave survey of participants, supplemented by two waves of in-depth interviews, to explore the views and experiences of pilot participants and staff involved in pilot delivery.

The evaluation aims were:

1. To explore what the pilots delivered and claimants' experiences of this.
2. To support the DWP impact assessment (focused on employment and benefit receipt), with an exploration of softer impacts, including attitudes and work-related activity, and participants' perceptions of pilot impacts.
3. To provide understanding about why the pilots did or did not have an impact on employment and benefit receipt.
4. To deliver lessons on the design and delivery of support for this claimant group to inform future provision.

Randomisation

DWP was responsible for the random allocation of ESA claimants to pilot and control groups across the three pilots, and this took place prior to the commissioning of the evaluation. JCP staff were then responsible for ensuring that claimants assigned to the control group received the standard 'Jobcentre Offer' and did not receive the extra support offered as part of the pilots.

Quantitative survey of ESA WRAG participants

A two-wave telephone survey was undertaken of both pilot participants and their control groups across the three pilots.

- The first wave was undertaken between October and November 2015, when most respondents were 15-24 months into the 24-month package of support. In total, 2,575 individuals took part in the Wave 1 survey.
- The second wave was undertaken between August and October 2016, when most respondents had completed the 24-month package of support. In total, 1,540 individuals completed the Wave 2 survey.

Qualitative interviews with pilot participants

Qualitative interviews were also carried out with participants across the three pilots in two waves. Control group respondents were not included in the qualitative research.

Across both waves, pilot participants took part in in-depth interviews (face-to-face or by telephone), which lasted up to an hour. At Wave 1 (September - November 2015), 24 interviews were undertaken with participants in each pilot (72 in total). At Wave 2 (July - December 2016), 62 interviews were undertaken with pilot participants – a mixture of longitudinal and new interviews.

Qualitative interviews with provider staff

Staff involved in the management and delivery of the three pilots were also interviewed for the evaluation, again in two waves of fieldwork. Both individual and small group interviews were carried out by telephone, lasting between 30 and 90 minutes. Wave 1 interviews took place between September and December 2015 and Wave 2 interviews took place between June and October 2016.

DWP baseline survey

The report also draws on data from a baseline survey conducted by DWP before the pilots began. This was administered to people who were eligible for the pilots, either during their first mandatory interview or during their ESA New Joiner's Work Focused Interview, between May and August 2014. This was completed by a total of 1,304 individuals, and collected information on individual characteristics, attitudes towards work and work-focused activity. This baseline data was collected only from a restricted group of eligible claimants, not all of whom took part in the subsequent Wave 1 survey for the evaluation.

Limitations

The following limitations of the methodology should be borne in mind when reading the evaluation findings.

Each of the three pilots was delivered in a different geographic area, and each had its own control group. As a consequence, differences in results across the pilots could be due to differences in business as usual support (i.e. the Jobcentre Offer) received by the control group; differences in the characteristics of the local population in each area; or to features of the local labour markets. This limits the extent to which robust conclusions can be drawn about the comparative effectiveness of the three pilots.

Care should therefore be taken in drawing comparisons between the outcomes for the three pilot groups, especially without considering how they compare to their respective control groups.

It should also be noted that the sample sizes for the WP pilot are smaller than for the other two pilots and so confidence intervals are wider, which means that any differences between the intervention and control group would have to be greater to be able to be detected as statistically significant.

1.3 Pilot participants

The majority of participants in the three pilots were white, aged 45 or above, had low levels of education, no dependent children aged under 16, and rented their accommodation. Respondents were evenly split between male and female.

Most respondents had been in paid employment at some point in the past (91 per cent on the WP pilot, 89 per cent on the HCP pilot, and 88 per cent on the JCP pilot) and the majority were in receipt of multiple benefits at the time of the Wave 1 survey, including Housing or Council Tax Benefit and Disability Living Allowance as well as ESA.

There were some differences in respondent characteristics across the three pilots. For example, HCP pilot participants comprised a more ethnically diverse group than either WP or JCP pilot participants, which is likely to reflect the different geographical areas in which the pilots were located – the HCP pilot was based in the Midlands, while the WP pilot was based in the North East of England and the JCP pilot in Southern England.

Health conditions

The severity of participants' health conditions and disabilities, and the extent to which their lives were affected varied widely. Some participants could manage daily life independently and work a small number of hours, while others had more limited mobility, were on strong medication or had regular hospital stays, and some had unstable conditions with fluctuating effects.

Around a third of pilot participants had moved from the ESA WRAG to the Support Group by the time of the Wave 2 survey (28 per cent on the JCP pilot and WP pilot and 30 per cent on the HCP pilot), which suggests that either participants' conditions worsened over time or that there were inaccuracies in the assessment process which placed them in the ESA WRAG group initially.

Barriers to work

Participants' health issues were cited as a key barrier to work, along with a lack of confidence, and anxiety and pessimism about returning to work. Staff felt that participants' mindsets about work, linked to their perceived limitations, was also a key barrier, particularly for longer-term claimants. Participants who had spent a long time away from the labour market often had outdated skills and experience, while other barriers faced by some participants included caring responsibilities, drug and alcohol abuse issues, offending histories, financial disincentives, problem debt, and lack of knowledge about the support available to help prepare for or enter work.

Feelings about work

Data collected for the baseline survey found that at the outset of the pilot, around two-thirds of respondents felt that their health condition or disability currently ruled out the possibility of work. Around a half of respondents reported that they did not know when they would be able to work and around one in six felt that they would never be able to do so. The majority said that they were not currently undertaking any work-related activities.

Differences between the three pilot groups

While the treatment and control group for each pilot was broadly similar, participants across the three pilots had some differences in terms of work-related characteristics. Those in scope of the WP pilot were more likely to say that the presence of their health condition or disability ruled out the possibility of work at that time and were less likely to be undertaking work-related activity, while those in scope of the JCP pilot were more likely to be undertaking such activity. Those in the JCP pilot also tended to have higher qualifications than those in the other two pilots.

1.4 Pilot delivery and outcomes

In the following section, the nature of pilot support and the outcomes achieved a re presented for each pilot in turn.

1.4.1 Jobcentre Plus pilot

Organisation of the pilot

The JCP pilot operated in four JCP districts in Southern England and deployed existing JCP work coaches, the majority of whom had prior experience of working with ESA customers. However, during the pilot, a new JCP staffing model was introduced, which moved away from specialist staff and towards the use of more generalist staff with mixed caseloads. This raised concerns about the use of less experienced staff for this pilot.

The training needs of JCP pilot staff were assessed at a district level and any gaps addressed through on-the-job and localised provision. In Wave 1 interviews, JCP pilot staff reported that they felt well-supported in their delivery, due to case conferencing and line management, and by Work Psychologists. However, during later stages of the pilot, staff reported a notable decline in this type of support, which was regarded as a challenge to effective delivery.

Pilot staff were not managed against any specific job outcome targets for this group of participants, either as an office or at an individual level. Instead, a range of other performance management tools were used. Both staff and managers felt that this approach was appropriate for the pilot, where job outcomes were perceived to be unlikely within the pilot timeframe.

Pilot delivery

The JCP pilot offered a maximum 530 minutes of contact time per year for pilot participants. It was anticipated that participants would be supported by the same JCP work coach over a two year period, although this was not always possible due to high staff turnover and operational changes.

Support was delivered primarily through face-to-face meetings at JCP offices. Telephone appointments were organised if a face-to-face appointment was not possible, for example due to ill health. Around two-thirds (65 per cent) of participants had face-to-face appointments only, while 29 per cent had a mix of face-to-face and telephone. Just seven per cent of participants had appointments only by telephone without any face-to-face meetings.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Just over three-fifths of respondents (62 per cent) reported that they had never missed an appointment. Where participants failed to attend, staff reported that this was usually because of their health condition or disability.

Support model

JCP staff delivering the pilot had flexibility to offer support that met individual needs and priorities, and in a sequence that worked for the individual. To support this, a baseline tool for assessing participants' needs had been developed specifically for the pilot, but this was not always used by work coaches, who often preferred to assess needs instead through an open-ended discussion with the participant.

Staff used action plans to document participants' goals and planned activities, and to monitor progress over time. It was important that goals and activities were achievable for participants, to prevent disengagement from the pilot.

Support delivered was a combination of employment-related, health-related and soft skills support. Employment-related support included a wide range of activity from Better Off Calculations and CV building to permitted work and voluntary work. Of these, support to look for and apply to jobs was most commonly received by participants – and in significantly higher numbers in the pilot group than in the control group (32 per cent and 31 per cent of pilot participants received support to look for or apply to jobs respectively, compared to 21 per cent and 18 per cent in the control group). Around a fifth of participants received training and a similar number were supported with voluntary work – again significantly more than in the control group. Pilot staff reported that voluntary and permitted work were effective ways of encouraging participants to start to consider work as an option for them.

Participants were also referred or signposted to health-related support, either to their GP or to self-help groups, pain management groups or mental health services. Almost a third of participants (31 per cent) reported that they had received support to help them manage their health condition in relation to work, significantly more than in the control group (23 per cent). Soft skills support, such as confidence building, was received less frequently (by 13 per cent of participants), but was still more common among those in the pilot group than the controls.

Once participants entered work, in-work support was limited, with staff reporting only being able to offer light touch support or referring participants to Work Choice.[3]

A wide range of external partners were used to provide participants with support during the pilot, although staff also reported gaps in provision, which varied according to the landscape of provision in the local area.

Outcomes

Employment and related outcomes

There was a small but significant difference between the proportion of JCP pilot participants in paid work at the time of the survey compared to the control group (eight per cent, compared to four per cent). **This suggests that JCP pilot support had a small impact on participants' employment status.** However, there was no significant difference between pilot and control groups in the number of job applications made, or in participants' views on whether they would find paid work in the future and the timeframe for this.

Participants who were in paid work were in both full-time and part-time roles across a range of sectors and occupations. Just over half (56 per cent) of those in work (including paid, unpaid or voluntary work) reported that working had had a positive effect on their health. There was no evidence that pilot support affected this.

Soft outcomes

The JCP pilot also appeared to have a positive impact on participant motivation to leave ESA and to find work. Just over a third (37 per cent) of pilot participants reported increased motivation to come off ESA as a result of the support received, compared with 28 per cent in the control group (nine point difference). A similar proportion (38 per cent) said they were more motivated to find work as a result of support received, compared with 27 per cent in the control group (11 point difference). It should be noted, however, that over half of participants reported that the support received had no effect on their motivation to leave ESA or to find work (58 per cent and 54 per cent respectively).

The JCP pilot also appeared to positively influence participants' feelings about how ready they were for work. Almost two-thirds (63 per cent) of the pilot group reported that they felt unable to work due to their health condition at the time of the survey, compared to 71 per cent in the control group, and 16 per cent felt they could return to work 'right now', compared to 11 per cent in the control group.

Perceived outcomes

While a majority of participants reported that they felt unable to work due to their health condition at the time of the survey, around two-fifths (42 per cent) felt that the pilot support had helped a lot or a little with overcoming some of their barriers to work. A similar proportion (39 per cent) said that the pilot had helped them to manage their health condition or disability, and around a third of participants (34 per cent) said that

[3] Work Choice is DWP's specialist disability employment programme. Provider organisations offer pre-work and up to two years in-work support.

the pilot support had helped them to move towards work. (These questions were not asked of the control group so cannot be compared with the perceived effects of 'business as usual' support.)

1.4.2 Work Programme pilot

Organisation of the pilot

The WP pilot operated in two Contract Package Areas in the North East of England, delivered by four prime providers and a host of subcontractors. Services were delivered by the providers' existing employment advisers, some of whom had experience of the ESA customer group and some of whom did not.

The extent to which delivery staff received pilot-specific training varied across the provider organisations. One prime provider sourced specialist training for staff delivering the pilot, but other providers generally did not. Support from specialists, such as occupational health staff, was also variable across the providers, but where this was available it was regarded by staff as helpful.

WP providers were not contract managed against any specific job outcome targets for this pilot group but were instead incentivised by the standard WP payment model. While providers reported that this model did not affect delivery of support on the pilot, they expressed concern that the Payment by Results (PbR) funding model, based on payments for job outcomes, was not sustainable for supporting this participant group in the longer term because of the limited job outcomes that could be achieved within two years. Some also suggested an outcome payment model linked to the achievement of intermediate or soft outcomes, rather than purely job outcomes, might be appropriate.

The qualitative research also suggested some ways in which the payment model *had* affected pilot support delivery. For example, performance targets for ESA claimants in payment group 6 (PG6)[4] appeared to drive enhanced service delivery (e.g. occupational health support) for this group, which was not available to pilot participants.

Pilot delivery

The WP pilot operated under a 'black box' model, which meant that pilot delivery was not prescribed. However, interviews across different WP providers suggested that pilot delivery largely mirrored the support provided to all ESA customers on the WP.

Pilot support was delivered through a combination of face-to-face and telephone meetings. Face-to-face meetings were preferred by staff as they believed these built better rapport and encouraged programme engagement. Around half of participants (48 per cent) had only face-to-face appointments, while another two-fifths (40 per cent) had a mix of face-to-face and telephone appointments. Just 11 per cent had telephone meetings only, with no face-to-face contact.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Around three-fifths of participants (62 per cent) said they had never missed an appointment.

[4] Full details of the Work Programme payment groups can be found at: http://www.dwp.gov.uk/docs/wp-pg-chapter-2.pdf

Support model

As with the JCP pilot, staff had flexibility to offer support that met individuals' needs and priorities, in a sequence tailored for them. Staff used a variety of diagnostic tools and questionnaires to assess participant needs and used action plans to record support options and to monitor participants' progress.

A mixture of soft skill, employment-related and health-related support was deployed. Support with job applications and CV writing was by far the most common form of work-related support received – reported by over two-fifths (44 per cent) of WP pilot participants (this figure is considerably higher than the control group level of 13 per cent). WP pilot participants were also more likely than the control group to receive support with soft skills development, such as confidence building and attending group sessions (received by 16 and 15 per cent of participants respectively). Support with soft skills was generally considered by WP staff as a key starting point on the pilot, with confidence and motivation courses seen as particularly useful for this participant group.

WP providers also referred participants to externally-provided health-related support, and around a fifth of participants said that they had received and taken up support to manage their health condition in relation to work.

In-work support was also available to participants on the pilot, in line with what was available to other Work Programme participants. Staff reported that they could offer either intensive or light touch in-work support, depending on the needs of the participant.

Outcomes

Analysis of outcomes measured in the survey suggests that the WP pilot did *not* have an impact either on employment and job search activity or on soft outcomes (e.g. motivation to leave ESA and to find work, or readiness to work).

The vast majority of participants on the WP pilot (82 per cent) reported that they were currently unable to work as a result of their health condition or disability. Around a third (31 per cent) felt that the pilot had helped them overcome some of their barriers to work, while a smaller number (25 per cent) felt that the pilot had helped them with their health condition. Just 18 per cent felt that the pilot had helped them move closer to work.

1.4.3 Healthcare Provider pilot

Organisation of the pilot

The HCP pilot operated across five JCP districts in Central England and was delivered by a single provider who recruited healthcare professionals (primarily occupational therapists) to deliver the pilot. A few, but not all, of these staff had prior experience of working with ESA claimants and/or delivering employment and training support.

A key challenge for this pilot was securing and maintaining adequate levels of appropriately trained and experienced staff to deliver the support. Managers reported that the full complement of staff was not in place until 6-7 months into pilot delivery. Healthcare professionals already in the organisation (who were supporting WP delivery) were asked to undertake pilot delivery in the early months to ensure delivery was not unduly affected.

HCP pilot staff reported receiving a comprehensive programme of training for the pilot and a good level of support in pilot delivery – through processes such as case conferencing, peer observation and group supervision.

As with the other two pilots, neither the organisation nor individual staff were performance managed against job outcome targets, which was felt to be appropriate for this pilot. It was also felt that the support needs of the pilot group, and their perceived distance from the labour market, necessitated a funding model which included a significant element of service or attachment fee to sustain delivery. However, the HCP provider also indicated that, if there had been a payment-by-results funding model based on job outcomes (rather than a service fee model which paid the provider on delivery of appointments), this would have led them to alter the pilot design – potentially including additional employability provision.

Pilot delivery

The structure of support in this pilot was specified in provider guidance and reflected in its funding model. It comprised five appointments in total: three taking place in the first six months of the pilot, with the fourth taking place after 12 months and the final appointment after 18 months. Additional support outside of this appointment structure was at the provider's discretion. It was also specified that support should be delivered by healthcare professionals.

As with the other pilots, face-to-face meetings were the preferred and predominant mode of support delivery, with 71 per cent of participants receiving only face-to-face support, and 21 per cent experiencing both face-to-face and telephone appointments. Just eight per cent had telephone support only with no face-to-face meetings.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Three-quarters (77 per cent) of pilot respondents reported that they had not missed any of their appointments.

Support model

The content of support delivered during the pilot was not specified in guidance and staff reported that they had the flexibility to offer support that met individuals' needs and priorities. Pilot staff used a tool developed for the pilot, which enabled an open-ended discussion about the participant's health conditions, treatment history, support networks and employment history. Health professionals also relied on their clinical experience in making client assessments. Action plans were used to set goals and monitor progress.

In contrast to the other two pilots, support delivered was primarily focused on health and soft skills, rather than employment-focused. Over a third of participants received support to help them manage their health or disability – either in general or in relation to work (37 per cent and 35 per cent respectively), much higher levels than in the control group (19 per cent and 22 per cent). Over a quarter (28 per cent) also received support focused on exercise, compared to just 7 per cent in the control group. Fewer participants took up support relating to pain management, physiotherapy and confidence building, but this was still received at higher levels than among the control group.

In contrast, work-focused support was rarely delivered, with no more than 10 per cent of participants taking up any form of work-related support. This was at a lower level than for the control group who were receiving business as usual support from JCP.

Outcomes

The HCP pilot appears to have made no difference to employment outcomes or job search activity among participants, but did appear to have an impact on some of the soft outcome measures. Around a third (34 per cent) of pilot participants said that the pilot had increased their motivation to leave ESA, compared to 26 per cent in the control group, and a smaller proportion than in the control group said that the support had *decreased* their motivation to enter work (5 per cent compared to 15 per cent).

As with the WP pilot, a large majority of participants on the pilot (80 per cent) felt that their health condition or disability left them unable to work currently. However over half (54 per cent) felt that the pilot had helped with their health condition and two-fifths (41 per cent) said that it had helped with overcoming some of their barriers to work. Only around a fifth of participants (21 per cent) felt that the pilot had helped them move closer to work. This is unsurprising given the pilot's focus on health rather than employment support.

1.5 Achieving pilot outcomes

Participants' journeys towards outcomes on the pilot were influenced by a range of factors, including personal circumstances such as their prior work experience and motivation as well as the quality of pilot support, and their use of other forms of support e.g. health specialists. The state of participants' health was also pivotal to the progress they made.

Overall, there were **three key elements** of support that facilitated the achievement of soft outcomes (such as improvements in confidence, motivation and wellbeing). These were:

- **One-to-one adviser support –** Staff and participants believed it was most effective when participants were supported by one adviser continuously, whom they saw with enough frequency, and when advisers had the skills and ability to build a trusting relationship with the participants, to challenge mindsets and, where able, to provide holistic support that addressed a range of barriers, e.g. money, housing and health needs, as well as employment-related support.
- **Support aimed at developing confidence, motivation and work-related attitudes –** Staff emphasised the importance of having a package of either in-house or externally-delivered support to develop participants' soft skills, including courses aimed at improving confidence and motivation, addressing barriers, and changing the way participants' thought about work-related activity.
- **Health-focused provision –** While the JCP and WP pilots were not focused on health provision to the same extent as the HCP pilot, all pilot staff emphasised the importance of referring or signposting participants to health-related support (such as occupational health and work psychologists) to support progress towards soft outcomes.

For the achievement of **work-related** and **sustained work outcomes,** staff and participants also identified the following elements of support as important:

- **Skills development –** Across all three pilots, referrals and signposting to training courses (from basic skills to specialist vocational courses) were used to build participants' confidence and soft skills, as well as to develop job-specific skills.
- **Permitted work and voluntary work –** Both permitted and voluntary work allowed participants to regain confidence in their skills and develop new ones, while experimenting with different roles and sectors without fear of losing benefits.
- **Employability support –** The JCP and WP pilots used employability support extensively, especially by engaging participants in discussions of their existing skills and experience, in order to develop their CV and consider their job goals. Participants reported gaining confidence in their work abilities via these discussions.
- **In-work support –** Across the pilots there was no specific provision for in-work support and pilot participants who entered work reported receiving a lack of transitional support to help them adjust to being in employment.

Key ingredients for effective support

Overall, the findings suggest there were five key ingredients which, combined, led to effective provision for this claimant group:

- **Personally tailored approach –** with staff who could work flexibly with participants, tailor support individually, and work according to each participant's support needs.
- **Flexibility in the mode of delivery –** delivery of support in flexible formats that took account of participants' needs, such as physical mobility barriers, low confidence and social anxiety.
- **Intensity and duration of support –** engaging with participants frequently to provide them with a regular routine that emulated aspects of the work environment.
- **Staff capabilities –** including a range of features, such as well-trained and knowledgeable staff; adequate staffing levels to ensure caseloads were manageable; access to more specialist staff and services; and peer support which facilitated the sharing of good practice.
- **Partnership working –** in order to provide, or broker access to, a broad and holistic package of support that participants would not have had the motivation to seek out for themselves, or would have struggled to find.

1.6 Conclusions

Across all of the pilots, staff reported that the participant group had complex support needs and that it was inappropriate for some of them to be on the programme due to the severity of their conditions. Staff also suggested that the severity of their conditions and/or their perceived distance from the labour market meant that work and work-related outcomes were difficult to achieve within the two-year duration of the pilot.

Likewise, the participant survey found that only a minority of pilot participants had made job applications and very few (between two and eight per cent) had entered paid employment during the lifetime of the pilot. The majority of survey respondents across all three pilots reported that their health condition or disability currently prevented them from working and fewer than one in five on the JCP pilot and one in ten on the WP and HCP pilots felt that their health was such that they could return to work 'right now'. The majority were, however, positive about the pilot support overall, with over 80 per cent reporting a 'good' or 'very good' experience, and substantial minorities reported that the support had helped them to overcome barriers or helped with their health condition.

Overall, the JCP pilot appeared to have a small impact on employment outcomes, albeit not on work-related activity, and also to have an impact on soft outcomes, such as feelings about leaving ESA and starting work. The HCP pilot also appeared to have an effect on some of these soft outcomes.

The key features of effective delivery of support to this group were:

- A focus on participants' health-related needs and utilisation of specialist services as appropriate, whilst maintaining an employment-related focus.
- Delivery of flexible and personalised support to take account of diverse needs.
- The development and maintenance of positive and consistent one-to-one adviser-participant relationships.
- Use of advisers with appropriate levels of skills, experience and support for this participant group.
- Access to specialist health support for adviser staff, with external partnerships playing a key role in this.

In-work support was a weak element across all three pilots. Participants and providers also articulated a need for improvements to information in a number of areas, such as at the point of referral.

The relative priority that organisations placed upon the delivery of the pilot appeared to be an important factor in determining successful implementation. Within the WP and HCP pilots, this was at least partly driven by contractual requirements (such as the achievement of funded outputs, outcomes or other performance targets). It is important, therefore, to consider the potential impact of these factors during the design and implementation of interventions.

2 Introduction

This report presents findings from the evaluation of the Employment and Support Allowance (ESA) Work Related Activity Group (WRAG) 18-24 month prognosis pilots. The pilots aimed to test the effectiveness of three models of support, which were designed to support pilot participants towards work and were delivered by Jobcentre Plus, Work Programme providers and healthcare professionals.

DWP commissioned the Learning and Work Institute and NatCen Social Research to carry out this evaluation. The findings are based on a two-wave quantitative survey with pilot participants, and on qualitative interviews with participants and those staff involved in the management and delivery of the pilots.

This chapter describes the policy context for the pilots, the evaluation aims, the research methods used in the evaluation, and the structure of the report.

2.1 Policy context

Almost one in three working-age people in the UK have a long-term health condition that puts their participation in work at risk, and 4.6 million disabled people or people with long-term health conditions are out of work.[5] The Government is committed to improving employment rates for disabled people and in 2015 made a manifesto commitment to halving the disability employment gap (the gap between employment rates for disabled and non-disabled people) which currently stands at 32 per cent.

Following the Government's 2013 Disability and Health Employment Strategy, the Minister for Employment, the Chief Secretary to the Treasury and the Prime Minister's Office asked DWP to test alternative, innovative approaches to providing increased support to ESA WRAG claimants with an 18-24 month prognosis.

Currently this group is mandated to the Jobcentre Offer and receives an average of 88 minutes of Jobcentre Plus work coach time per year. Referral to the Work Programme is voluntary and to date limited numbers have opted in to it (relative to other mandatory referral groups).

[5] DWP and DoH (2016) Improving Lives: The Work, Health and Disability Green Paper https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564038/work-and-health-green-paper-improving-lives.pdf

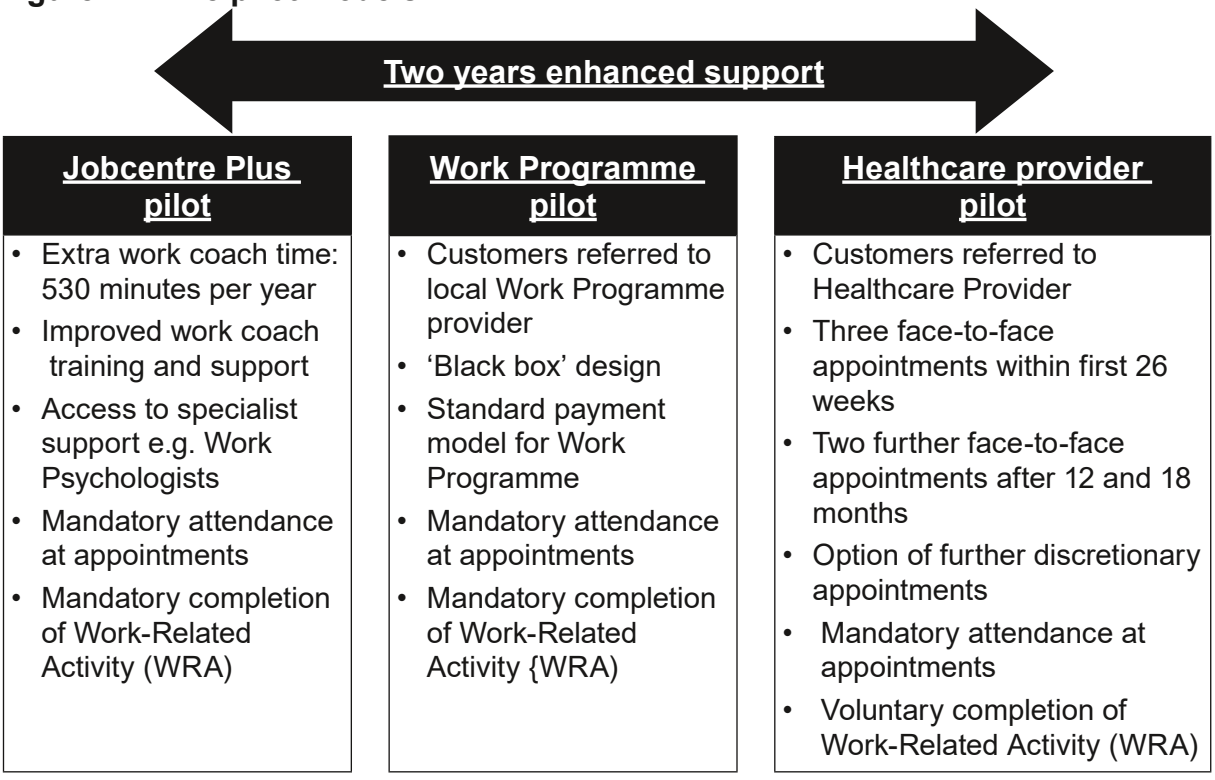
ESA WRAG claimants may have limited capability for work and complex health conditions. In some cases, they may have multiple conditions that affect their capacity for work. These may be physical issues that make walking, sitting or standing difficult; mental health conditions; learning disabilities; or behavioural issues. Some claimants may have drug or alcohol issues and other secondary conditions, such as depression.

The Government is currently analysing the results of its consultation on what it would take to transform the employment prospects of people with disabilities and long-term health conditions – published as the Work, Health and Disability Green Paper in October 2016. Key issues under consideration include how to build the skills and capabilities of Jobcentre Plus work coaches so that they can support a diverse group of claimants with complex needs, and how to ensure that health and employment service providers can deliver a more tailored and integrated service. Findings from this evaluation will help DWP and other Government Departments to understand how to enable ESA claimants with complex health conditions to improve their prognoses, to move closer to work and to fulfil their potential.

2.2 About the pilots

The ESA WRAG 18-24 month prognosis pilots were launched in 2013 and aimed to test the effectiveness of enhanced support delivered over the course of two years to ESA WRAG claimants with an 18-24 month prognosis period.[6] Three distinct models were piloted: the JCP (Jobcentre Plus) model, the WP (Work Programme) model and the HCP (Healthcare Provider) model. The three pilot variants are summarised in Figure 2.1 and described in detail below.

Figure 2.1: The pilot models



[6] ESA WRAG 18-24 claimants are ESA claimants whose health condition will be reviewed at the 18-24 month point and at which time will undergo a repeat work capability assessment.

Jobcentre Plus (JCP) pilot: The JCP-led model involves extra work coach time spent with pilot ESA participants (530 minutes per year) combined with improved support for work coaches, such as additional case conferencing and access to Work Psychologists where appropriate. The extra time with participants is intended to provide more intensive support to encourage them towards work. Attendance at appointments and completion of agreed work-related activity is mandatory for pilot participants.

Work Programme (WP) pilot: Participants in the WP pilot are referred to their local WP provider for two years of support. The nature of this support has not been defined by DWP as the WP providers operate under a 'black box' model. The WP pilot provider is incentivised by the standard WP payment model. Attendance at appointments and completion of agreed work-related activity is mandatory for all participants on the pilot.

Healthcare Provider (HCP) pilot: A provider from the private sector was contracted to conduct a series of appointments with pilot participants delivered by a healthcare professional, with the aim of supporting participants in the management of their health condition or disability and assisting them towards (a return to) work. The provider is contracted to provide an initial appointment (of 60 minutes duration) followed by at least two further face-to-face appointments (of at least 45 minutes duration) within the first 26 weeks from the point of referral. This is followed by a further two face-to-face interviews after 12 and 18 months (of at least 45 minutes duration). Additional appointments are at the provider's discretion. Attendance at all appointments is mandatory for pilot participants although activity between appointments is voluntary.

2.3 Evaluation design and methods

Using a Randomised Control Trial (RCT) design, DWP aimed to test the effectiveness of the three approaches outlined above, in moving the ESA WRAG 18-24 month prognosis group closer to or into work, compared to current JCP support. An internal impact assessment was undertaken by DWP to estimate the economic and wider social benefits associated with moving this claimant group closer to the labour market.

This evaluation aims to:

- Explore what the pilots delivered and claimants' experiences of this;
- Support DWP's assessment of pilot impacts on employment and benefit receipt, with an exploration of perceived impacts on proximity to work, including attitudes and work-related activity;
- Provide understanding about why the pilots did or did not have an impact;
- Deliver lessons on the design and delivery of support for this claimant group, to inform future provision.

Randomisation

DWP established three separate RCTs, each with a pilot and control arm. Claimants were randomly allocated to the pilot and control groups based on the value of the last three digits of their National Insurance Number. DWP staff entered the number into an Excel tool, which then allocated the individual to a pilot or a control group. The assumption underpinning this method was that the value of the last three digits does

not correlate with claimant characteristics or the likelihood of a positive outcome. JCP staff were then responsible for ensuring that claimants assigned to the control group received the standard support work coach and did not receive any additional support offered as part of any of the three pilots.

2.4 Fieldwork and samples

The evaluation was carried out using a two-wave quantitative survey of participants and qualitative in-depth interviews to explore the views and experiences of pilot participants and staff involved in the delivery of each pilot.

2.4.1 Quantitative survey of ESA WRAG participants

A two-wave quantitative telephone survey was undertaken with ESA WRAG pilot participants.

- The first wave took place between October and November 2015, when most respondents were 15-24 months into the 24-month package of support. In total, 2,575 individuals took part in the Wave 1 survey. It had originally been intended that the Wave 1 survey would be a baseline measure but, as the study began after pilot delivery began, this was not possible.
- The second wave was undertaken between August and October 2016, when most respondents had completed the 24-month package of support and had received at least two months of post-pilot support. In total, 1,540 individuals completed the Wave 2 survey.

This section provides a brief summary of the methodology at both waves of the survey, including the sample and the questionnaire design.

Sample

The sample issued at Wave 1 included ESA WRAG claimants recruited to the three pilots[7] between November 2013 and December 2014, a total of 10,529 individuals.

The sample issued at Wave 2 included 2,367 respondents who had completed the Wave 1 survey and had agreed to be re-contacted.

Both waves included individuals from each of the three pilot and control groups, as shown in Appendix Table A.1.

Questionnaire

At Wave 1, the questionnaire took just over 30 minutes to complete, on average. Questions were routed according to whether participants were in one of the pilot or control groups.

The questionnaire was divided into five sections, as follows:

[7] From the original sampling frame, the following cases were removed: cases without at least one telephone number, cases that had been already selected for the piloting of the questionnaire, and cases where there was evidence that the claimant made a payment to one of the providers. We were advised by DWP to exclude these cases because this payment could signify contamination (e.g. people with a control group marker being referred to pilot provision).

1. Details of the support received under the pilot (either HCP, WP or JCP):
    a. Nature of the support provided, including frequency of contact, length of each session and type of advice and support received
    b. Reasons for any non-attendance at meetings/ appointments
    c. Views on the most helpful aspects of support and what could be improved
2. Overview of support provided to the control group
3. Attitudes to work and work-related activities:
    d. Changes in motivation to come off ESA and reasons for this
    e. Whether support has helped to overcome barriers to work
    f. Changes in motivation to find work and reasons for this
    g. Whether support has helped respondents to get closer to finding work and why
    h. Feelings about work
4. Current activity at interview:
    i. Current benefit and employment status
    j. For those not in work, barriers to finding work and when they think they may find work
5. Background socio-demographic and wellbeing information.

The Wave 2 questionnaire, which took 20 minutes on average to complete, was routed depending on:

- Whether participants were still within the 24-month period of support/ had completed within the last month; or
- Whether they had completed the pilot at least two months earlier.

There were four sections in the Wave 2 survey:

1. Details of post-pilot support received from JCP - asked of those who had completed the 24-month package of support and who had received at least two months of post-pilot support. This included questions on frequency of contact, length of each session and type of advice and support received.
2. Attitudes to work and work-related activities – asked of those still on the pilot or only recently completed, including:
    a. Changes in motivation to come off ESA and reasons for this
    b. Whether support has helped to overcome barriers to work
    c. Changes in motivation to find work and reasons for this
    d. Whether support has helped respondents to get closer to finding work and why
    e. Feelings about work
3. Current activity at interview – asked of all participants, including:
    f. Current benefit and employment status

g. For those not in work, barriers to finding work and when they think they may find work

4. Background socio-demographic and wellbeing information - asked of all participants.[8]

At both waves, a draft of the questionnaire was piloted prior to the main survey and findings were used to revise the questionnaire for the main survey. At Wave 1, the main changes were the removal of questions to reduce the questionnaire length, some additional questions for claimants in the control group, and simplification of questions about referrals to other providers. At Wave 2, the post-pilot changes were limited as the overall structure was seen to work well and question coverage was good.

Fieldwork and response rates

At Wave 1, a letter was sent to everyone in the sample prior to the start of fieldwork. It explained the nature of the research and gave recipients the opportunity to opt out. 2,382 individuals (23 per cent of the sample) opted out in this way. This is higher than in most comparable surveys, and possibly reflects the severity of health conditions among the respondent group.[9] At the end of the opt-out period, sample members who had not opted out were issued for calling. To maximise the response rate, all cases in the sample were called up to 20 times on different days of the week and at different times of day, until the telephone was answered, or it became clear that the number was no longer valid. A further 5,465 individuals (53 per cent of the original sample) either could not be contacted or did not complete the interview when contacted by telephone. In total, 2,575 individuals took part in the Wave 1 survey. This comprises 24 per cent of the original sample 29 per cent of those with valid contact details, and 44 per cent of those who were contacted by an interviewer.

At Wave 2, all those that had completed the Wave 1 survey and had agreed to be re-contacted (n = 2,367) were sent an advance letter to remind them of the research and to inform them that they would be contacted shortly about taking part in a follow-up interview. Recipients could email/ phone in to opt out at this point if they wished. In total, 1,540 individuals completed the Wave 2 survey, which is 65 per cent of the original Wave 2 sample, 66 per cent of those with valid contact details, and 86 per cent of those who were contacted by an interviewer.

Tables A.2 and A.3 in the Appendix provide details of response rates for each of the pilot and control groups at both waves.

At both waves, respondents completing the survey were given the opportunity to skip any questions they did not wish to answer. However, most respondents answered all questions. ‘Don’t know’ was taken as a valid response to questions, but these responses have not been included in tables.

Weighting

Prior to analysis, the final Wave 1 data was weighted to adjust for differential levels of opt-out and non-response among different sample groups. Distributions in the final weighted data set matched those of the population of 10,529 cases eligible for issue

[8] Questions on static socio-demographic characteristics were excluded at Wave 2.

[9] By comparison, 16 per cent of those sampled for the survey element of the Evaluation of Support for the Very Long-Term Unemployed Trailblazer in 2012 opted out in this way.

on the following measures: pilot/ control group for each pilot, gender and age groups (interlocked[10]), health status, and whether at the mid- or end-stage of the 24-month package of support (mid-stage: 15-19 months in; end-stage: 20-24 months). It should be noted that as population data was not available on employment status or recent employment history, this could not be factored into the weight that was computed.

The final Wave 2 data was also weighted to adjust for differential response. As well as the measures considered for the Wave 1 weight, the Wave 2 weight took into account survey responses at Wave 1. Further detail on weighting is available in Appendix A.

Analysis

This report mainly presents descriptive statistics from the two telephone surveys. Where questions were asked of both the pilot and control participants, the two groups are compared for each pilot. The three pilots are compared in terms of which appeared to be more successful in achieving outcomes compared with standard JCP support.

The report presents either Wave 1 only data, Wave 2 only data, or a combination of Wave 1 and Wave 2 data. At Wave 1, around half (55 per cent) of respondents were at the pilot end-stage (i.e. between 20 and 24 months into the 24-month package of support) when interviewed, and the remainder were at a mid-stage (between 15 and 19 months in to the pilot). Respondents that were at the mid-stage at Wave 1 were re-asked the same questions about pilot support at Wave 2 to obtain a response in relation to the full 24-month package of support. At Wave 2, 24 per cent of respondents were end-stage or had completed the pilot less than two months ago, while 76 per cent had completed the pilot and received at least two months of post-pilot support.

The bases of the tables in this report include all respondents who were asked a particular question (at Wave 1, Wave 2, or Wave 1/ Wave 2) excluding any who did not know, or did not give an answer. Full figures are provided in the tables in Appendix D, while commentary and charts are provided in the chapter text. Where differences are reported within the text, these are statistically significant at the five per cent level unless otherwise stated.

In addition to descriptive analysis, a small number of variables were used to examine change in responses over time from Wave 1 to Wave 2. The small sample sizes of participants responding to these questions in both waves of the survey means the findings from this analysis are tentative. This analysis has been included in Appendix B.

Baseline data

Chapter 3 of this report refers to baseline data. These data are from a short survey with people who were eligible for the pilots, which took place prior to the start of the pilots, between May and August 2014.

The baseline survey was conducted by JCP staff during ESA New Joiner's Work-Focused Interviews or during the first mandatory interview for repeat claimants. All of those who were eligible to be recruited to the pilots were invited to take part in the survey. It was completed by a total of 1,304 individuals.

[10] Age group within gender was used for the weighting.

The data were intended to be used as a baseline, so that changes in participant 'soft outcomes', such as attitudes to work and work-related activities, could be measured over time for participants in each of the pilots. However the baseline data were collected only from a restricted group of eligible claimants, not all of whom took part in the subsequent survey for the evaluation. Therefore, the baseline data have only been used in this report to assess change across the cohort as a whole, rather than at an individual level.

2.4.2 Qualitative interviews with pilot participants and provider staff

Qualitative interviews were carried out over two waves with both staff and participants across all three pilots. Control group respondents were not included in the qualitative research.

Pilot participants

In-depth interviews (face-to-face or by telephone), lasting up to an hour, were undertaken with participants in each pilot in two waves of fieldwork.

Wave 1

At Wave 1, (September - November 2015), 24 interviews were undertaken with participants in each pilot (72 in total). The sample for each pilot included variation on gender, age group, health condition, recent work history and district. A full breakdown of characteristics is shown in Figure 2.2, below.

Using topic guides developed in collaboration with DWP (see Appendix C), the interviews captured participants' experiences of the support, their views on the support and its impact on bringing them closer to work, as well as their suggestions for how the support could be improved.

Figure 2.2 Achieved participant sample for Wave 1 qualitative interviews

Sample characteristic	Achieved JCP pilot	Achieved WP pilot	Achieved HCP pilot	Total per pilot
Gender				
Male	**12**	**13**	**12**	**24**
Female	**12**	**11**	**12**	
Age				
18-29	**3**	**5**	**7**	
30-49	**11**	**11**	**7**	**24**
50+	**10**	**8**	**10**	
Health condition[11]				
Mental	**6**	**5**	**8**	
Physical	**9**	**6**	**8**	**24**
Both	**9**	**13**	**8**	
Evidence of work in last 4 years[12]				
Yes	**7**	**5**	**4**	**24**
No	**17**	**19**	**20**	
District *(District Number)*[13]				
District	*1:* **6**	*21:* **6**	*11:* **3**	
District	*2:* **6**	*22:* **10**	*12:* **5**	
District	*3:* **5**	*23:* **8**	*13:* **4**	
District	*4:* **7**	*n/a*	*14:* **8**	
District	*n/a*	*n/a*	*15:* **4**	**24**

[11] This is the heath condition which has been recorded by Jobcentre Plus advisers on LMS (Labour Market System).

[12] This is drawn from P45 data which does not pick up all employment history.

[13] See Appendix Table A.8 for District Key.

Wave 2

At Wave 2, (July – December 2016), 62 interviews were undertaken with pilot participants. Eighteen of these interviews were longitudinal, undertaken with participants previously interviewed at Wave 1, and the remaining 44 interviews were with new respondents who had completed the Wave 2 survey.

For both the longitudinal and new interviews, the primary selection criteria was whether the participant had moved forward in some way since starting on the pilot. This could include an improvement in their health, a perceived movement towards work, engagement in work-related activity or taking up paid work. The variables that were used to select survey participants, and the achieved sample numbers for each outcome, are shown in Figure 2.3, below.

Figure 2.3 Primary sampling variables and achieved sample for Wave 2 qualitative interviews*

Pilot outcome	Survey variable	Achieved interviews*
In paid work / has worked / soon to start work	**DEmp** "What are you doing at the moment?" = 1 (in paid work as an employee) or 2 (working as self-employed) **DEmpStill** "Did you start a job since the last interview that you no longer have?" = 1 (yes) **DStJob** "Do you have a job that you are about to start in the future?" = 1 (yes)	**15**
Applied for jobs / attended interviews / attended course	**CSrch** "Have you applied for paid jobs?" = 1 (yes) **CInt** "Have you attended interviews?" = 1 (yes) **DEmp** "What are you doing at the moment?" = 4 (in education or training)	**13**
Helped manage health / helped overcome barriers	**CBHIP** "Has the support helped you to overcome barriers to work?" = 1 (helped a lot) or 2 (helped a little) **CHlpHealth** "Has the support helped you to manage your health condition?" = 1 (helped a lot) or 2 (helped a little)	**4**
Helped move towards work / increased motivation to leave ESA / changed views about work	**CSoft1** "Has the support increased or decreased your motivation to leave ESA?" = 1 (increased a lot) or 2 (increased a little) **CHlpWork** "Has the support helped you to move towards work?" = 1 (helped a lot) or 2 (helped a little) **CWExp** "Has the support had an impact on how you think about work?" = 1 (yes) and **CWECh** = 1 (changed more positively)	**12**
Total no. of interviews		**44**

*This only includes the 44 participants sampled from the survey.

These sampling criteria were used because the intention of the second wave of qualitative research was to explore in more detail what had helped participants move forward. Other sampling criteria included gender, age group, health condition, recent work history and district (as in Wave 1).

Interview numbers across the three pilots were uneven at Wave 2, due to variability across the pilots in those fitting the sample criteria and consenting to be re-contacted. Thirty-four participants from the JCP pilot were interviewed, 13 from the WP pilot, and 15 from the HCP pilot. Sample characteristics for each pilot are shown in Figure 2.4.

Topic guides for the Wave 2 interviews again captured participants' experiences and views of the pilot support and probed in greater detail (than at Wave 1) on how and why the support had helped them to make progress. Topic guides for the longitudinal interviews also asked about changes since the previous interview in participant circumstances, experiences of support and its perceived impact, as well as longer term outcomes and changes since completing the pilot.

Figure 2.4 Achieved participant sample for Wave 2 qualitative interviews

Sample characteristic	Achieved JCP pilot	Achieved WP pilot	Achieved HCP pilot	Total
Gender				
Male	18	7	6	
Female	16	6	9	
Total	**34**	**13**	**15**	**62**
Age				
18-29	4	0	3	
30-49	15	5	9	
50+	14	8	3	
Total	**34**	**13**	**15**	**62**
Health condition[14]				
Mental	8	4	2	
Physical	11	1	2	
Both	15	8	11	
Total	**34**	**13**	**15**	**62**
Current employment status				
In paid work	11	3	2	
In unpaid work/volunteering	3	2	1	
Not in paid work	18	8	12	
Other	2			
Total	**34**	**13**	**15**	**62**
District *(District Number)*				
District	1: 8	21: 4	11: 2	
District	2: 5	22: 7	12: 3	
District	3: 12	23: 2	13: 1	
District	4: 9	n/a	14: 4	
District	n/a	n/a	15: 5	
Total	**34**	**13**	**15**	**62**

[14] This is the heath condition which has been recorded by Jobcentre Plus advisers on LMS (Labour Market System).

Interviews with staff

Staff involved in the management and delivery of the three pilots were also interviewed for the evaluation, again in two waves. Decisions about the number and roles of staff, as well as interview coverage, were informed by a set of initial scoping interviews with strategic personnel for each pilot. In each of the three pilots, staff interviewed included:

- **Frontline staff** working directly with participants to deliver the pilot (work coaches, employment advisers or health advisers);
- **Team Leaders, Business and Operational Managers** responsible for managing advisers and overseeing delivery of the pilot; and
- **Strategic Leads**, responsible for coordinating the pilot within their district or contract package area (CPA).
- In the case of the HCP pilot only, a small number of **contact centre staff**, responsible for booking participant appointments, were also interviewed.

Both individual and small group interviews were carried out by telephone, lasting between 30 and 90 minutes. At Wave 2, a face-to-face group discussion was also conducted with advisers and managers in two of the Work Programme supply chains. Figures 2.5-2.7 below show the achieved staff sample for each pilot.

JCP pilot

A total of 34 JCP staff took part in interviews at each wave. At Wave 1, individual interviews were conducted with work coaches and District leads, while three-way telephone interviews were undertaken with managers, each of whom represented a different 'cluster' of JCP offices. At Wave 2, three-way interviews were undertaken with both managers and work coaches.

Figure 2.5 JCP pilot staff achieved sample

Role	District 1	District 2	District 3	District 4	Totals
Wave 1					
District leads	1	1	1	1	**4**
Managers	3	3	3	3	**12**
Work coaches	4	6	4	4	**18**
Total	**8**	**10**	**8**	**8**	**34**
Wave 2					
Managers	3	1	2	2	**8**
Work coaches	6	9	5	6	**26**
Total	**9**	**10**	**7**	**8**	**34**

WP pilot

A total of 39 WP pilot staff took part in interviews for the evaluation, 26 at Wave 1 and 13 at Wave 2. This covered all four prime providers involved in delivering the pilot and a selection of subcontractors. The subcontractors were selected based on their share of pilot referrals and differences in delivery practice, as identified in the scoping interviews.

At Wave 1, some managers were interviewed in pairs, but most interviews were conducted individually by telephone. At Wave 2, managers were interviewed individually and advisers were interviewed in groups of three. Wave 2 interviews were also supplemented with staff group discussions in two of the WP pilot supply chains. In total, two Supply Chain Managers and 15 advisers took part in the group discussions.

Figure 2.6 WP pilot staff achieved sample by Prime Provider/ Sub-Contractor

Role	Prime Provider	Sub-Contractor	Total
Wave 1			
Advisers	4	12	**16**
Managers	2	4	**6**
Strategic leads	4	0	**4**
Total	**10**	**16**	**26**
Wave 2			
Advisers	3	3	**6**
Managers	1	3	**4**
Strategic leads	3	0	**3**
Total	**7**	**6**	**13**
Supply chain group discussions			**2**

HCP pilot

A total of 17 HCP pilot staff took part in interviews, 11 at Wave 1 and six at Wave 2. At Wave 1, this comprised individual interviews with health advisers, pilot managers and contact centre staff. At Wave 2, health advisers were interviewed in a group and the manager individually. In addition, two DWP contract management staff with responsibility for this pilot were interviewed. All were conducted by telephone.

Figure 2.7 HCP pilot staff achieved sample

Role	Total
Wave 1	
Health advisers	**7**
Managers	**2**
Contact centre staff	**2**
Total	**11**
Wave 2	
Health advisers	**3**
Managers	**1**
DWP contract managers	**2**
Total	**6**

Distinct topic guides were developed for use in interviews with different staff roles:

- Interviews with district/ strategic leads captured reasons for the design of the support model, details about what was delivered and by whom, how pilot participants were responding to the support, and implementation challenges.
- Interviews with Business and Operational Managers explored experiences of resourcing and implementing the support model, operational challenges and participant outcomes.
- Interviews with frontline and contact centre staff captured detailed experiences of supporting the participant group, participant outcomes and operational experiences.

At Wave 2, topic guides asked about any changes in the support model and pilot delivery over time, and probed in greater detail about which elements of provision were most successful in moving participants forward. All three topic guides probed on lessons learnt and suggestions for future delivery.

Interpreting qualitative findings

The qualitative research provided in-depth insight into the range of experiences, views and recommendations among pilot delivery staff and participants. The reporting of the qualitative findings deliberately avoids assigning numerical values to experiences and views expressed, since the sample is not statistically representative. Rather, purposive sampling was used to identify the range and diversity of experience and views, and questioning methods sought to explore issues in depth within individual contexts.

Verbatim quotations and case illustrations are used to illuminate the findings. They are labelled to indicate gender, age group, pilot model and wave e.g. ‘Woman, 50+, JCP pilot, Wave 1’. Further information is not given in order to protect the anonymity of research participants. Quotes and case studies are drawn from across the sample.

2.5 Limitations

This report provides a descriptive analysis of differences in participation and outcomes between the intervention and control group for each of the three pilots. As the randomisation process used in the RCT has not been fully verified by the evaluation team, any differences in outcomes between the pilot and control groups reported here should be interpreted only as *indicative of impact*.

The evaluation team assessed the baseline equivalence of the pilot and control groups on a small number of available observable characteristics. These included gender, age and mental and physical health status. This analysis did not identify any imbalances between the pilot and control groups in the measured participant characteristics. However, we cannot fully rule out that some imbalances between the pilot and control groups might exist given the limited baseline characteristics available. Ideally, a wider range of baseline characteristics would have been considered and any differences accounted for in the analysis.

In addition, it was beyond the scope of this study to assess the extent to which frontline staff honoured the allocation of claimants to pilot and control groups and maintained trial conditions. Similarly, quantitative analysis of the internal consistency of the participant data, to verify the assumption that NI numbers (used for randomisation) do not correlate

with claimant characteristics, was beyond the scope of the study. As a consequence, robust evidence of impact can only be provided by DWP's full impact analysis, published alongside this report.

In addition, care should be taken in drawing comparisons across the three pilots. The pilots were delivered in different geographic areas and each had its own control group. Therefore, variations in results between the pilots could be due to the characteristics of the local population, features of the local labour markets or to differences in standard JCP support. Indeed, as Chapter 4 outlines, the demographic characteristics of participants varied across the three pilots. Therefore this study can provide an indication of the effectiveness of each pilot for its participants, but robust conclusions about the comparative effectiveness of the three pilots cannot be drawn.

It should also be noted that the sample sizes for the WP pilot are smaller than the other two pilots and so confidence intervals are wider – any differences between the intervention and control group have to be greater to be detected as statistically significant.

Finally, although the dataset was weighted to account for differential levels of response among different subgroups of the sample, employment status was not taken into account as population level employment data was unavailable. As a consequence, there is a risk that those who have moved off ESA into employment are under-represented in the sample.

2.6 Report outline

The report presents findings from both waves of the evaluation. The findings are presented in the following chapters:

Chapter 3 discusses the organisation of the pilots, including staff resourcing and training, performance management, and perceived operational challenges.

Chapter 4 provides a description of participant characteristics (including their socio-demographic profile, work histories and barriers to work), drawing on baseline and survey data plus qualitative findings. It compares the characteristics of pilot and control groups for each pilot, as well as participants across the three pilots.

Chapter 5 presents a detailed description of the support delivered in each of the three pilots, drawing on qualitative material from staff and pilot participants, and then compares support received by pilot and control group participants for each pilot in turn.

Chapter 6 reports pilot outcomes using survey data, comparing work-related outcomes, health-related outcomes and other soft outcomes, across the three pilots and their control groups. It also examines the perceived impact of the pilots on participants.

Chapter 7 contributes to explaining the findings reported in Chapter 5, by i) exploring the range of participant outcomes in more detail, drawing on qualitative data, and ii) drawing together the evidence gathered from staff and participants on the effectiveness of different elements of pilot support and approaches to delivery.

Finally, **Chapter 8** presents conclusions from the evaluation evidence, including the effectiveness of the three pilots in achieving perceived outcomes, and the lessons for future delivery of support to this pilot group and other ESA claimants.

3 Organisation of the pilots

This chapter discusses the organisation and implementation of the three pilots, drawing primarily on qualitative interviews with provider staff at two different points, towards the middle and latter stages of the two year pilot (reported below as Waves 1 and 2). It describes how the organisations approached the implementation of the pilots, including staff resourcing and training; the approach to performance management in each pilot and, where appropriate, the pilot funding model; and provider views on the challenges associated with implementation and operation.

3.1 Jobcentre Plus pilot

The 'enhanced' Jobcentre Plus (JCP) pilot comprised of 530 minutes of work coach support per year, coupled with improved work coach training and support such as additional case conferencing and access to Work Psychologists where appropriate. The purpose of the extra time with participants was to provide more intensive and personalised support to encourage them towards work. It was intended that the support would be delivered face-to-face wherever possible and by the same work coach throughout the two-year pilot. Attendance at appointments and completion of agreed work-related activity was mandatory. The support was more work-focused than health-focused and work coaches could draw on external provision to help develop participants' employability. Control group participants in contrast were entitled to 88 minutes of contact time with work coaches per year. This section describes the way in which the JCP pilot was organised across participating districts to deliver this support model.

3.1.1 Pilot districts

The JCP pilot operated in four JCP districts in Southern England:

- Avon, Severn and Thames;
- Devon, Cornwall and Somerset;
- Surrey, Sussex and Berkshire; and
- Swindon, Wiltshire and South-West Hampshire.

There were initially five participating districts[15], but this was changed to four during year one of the pilot, following a reconfiguration of JCP districts.

[15] Greater Wessex; Thames Valley; Devon, Cornwall and Somerset; Surrey and Sussex; and Gloucestershire and West of England.

3.1.2 Pilot

The JCP pilot staff included work coaches who worked directly with participants assigned to the pilot, and Work Service Managers who managed and supported work coaches and were responsible for organising staff resources.

The qualities that were considered to be important for work coaches involved in the pilot included having a good understanding of health conditions and disabilities, knowledge of the local labour market and links with local skills providers and employers. Good listening, coaching and people skills were also viewed as important, in addition to patience, resilience and empathy.

It was originally intended that the pilot would be staffed by work coaches with prior experience of working with ESA claimants, but staff reductions in some districts meant that work coaches without this background were also involved. As a result, the work coaches delivering the pilot ranged from those with considerable experience of working with ESA claimants to those with little or no experience. Concerns were raised by some strategic and operational managers about this. They felt that mainstream advisers, without prior experience of working with ESA claimants, lacked the expertise needed to support pilot participants.

Organisation and size of caseloads

Operational managers reported that separate work coaches were assigned to work with the control and treatment groups for the pilot. This was to ensure that the two support models were distinct, and to make it easier to compare the enhanced model with the standard offer. Whilst, in general, work coaches[16] interviewed as part of the evaluation only saw participants in the treatment group, some mixing of control and treatment caseloads was also evident. While the reasons for this were unclear, work coaches with mixed caseloads said that participants in the two groups were treated differently, with those in the pilot group being seen more regularly.

The size of work coaches' caseloads depended on the hours of work (full-time work coaches having larger caseloads), the size of the office, and the number of non-pilot claimants on the caseload. At the start of the pilots, work coaches specialised in ESA and some were also disability employment advisers (DEA). The claimants on their caseloads reflected this. They comprised pilot and non-pilot ESA claimants and sometimes participants of other pilots such as the Personalisation Pathfinder. Some work coaches reported that working on more than one pilot could be difficult, but they did not perceive any negative impacts for pilot participants.

A new work coach delivery model was subsequently introduced[17], in which work coaches moved from being specialists to generalists with mixed caseloads. The claimant groups they worked with expanded to include JSA, Income Support and Universal Credit claimants. In some instances, work coaches reported that they had maintained the role of DEA, alongside the new generalist role. This affected the time work coaches could spend with pilot customers if their caseloads subsequently

[16] Some of whom worked in different clusters to operational managers.

[17] Jobcentre Plus introduced a new 'work coach Delivery Model' in 2016 which ended the practice of specialist disability, lone parent and young people advisers. This has led to mixed caseloads in which work coaches support claimants on different benefits, with a range of needs and conditionality requirements.

grew or if their time was taken up by learning to support new claimant types. The operational challenges associated with the move to mixed caseloads are discussed further in section 3.1.5.

Work coaches generally perceived the need for smaller caseloads to allow more time with pilot participants. Perceptions of the manageability of caseloads varied though, with some work coaches feeling that 30 participants was too high while others felt a caseload of 70 was manageable. Those with larger, but reportedly manageable, caseloads appeared to have less frequent appointments, particularly with participants perceived not to want the support or who were not showing signs of progression. This indicates that these participants may not have received the full 530 minutes of work coach contact time per year.

As may be expected, the size of pilot caseloads reduced over time. Claimants had either

- migrated to the ESA Support Group or other benefits including JSA;
- entered paid employment;
- ceased claiming benefits without moving into work;
- moved into full-time care; and/or
- were now deceased.

Caseloads had also decreased in size as a result of pilot participants being re-distributed among work coaches to even out unbalanced workloads.

Towards the end of the support, when pilot caseloads had shrunk considerably, some work coaches were taken off the pilot and their caseloads were transferred to remaining pilot work coaches. Changing work coach was not generally considered by staff to disadvantage pilot participants, and some managers suggested that moving to a new Coach at this later stage of the pilots could be beneficial and could help refresh the approach taken to supporting participants.

3.1.3 Staff training and support

A pre-pilot launch was held for work coaches delivering the pilot. Other training support was limited as it was intended that the pilot would be delivered by work coaches who had experience in working with this participant group. The launch included a training day and a follow-up session which explained the pilot aims and elements of the support model. These sessions also aimed to provide a networking opportunity to encourage knowledge-sharing and peer support between work coaches.

In individual districts, work coaches' training needs were reviewed, and any skills gaps identified were addressed through on-the-job and localised training provision. This meant that some work coaches received no additional training, while others shadowed colleagues or were trained in specific areas, such as drugs and alcohol dependency, mental health conditions and motivational (or 'solutions-focused') interviewing. The latter was felt to be a particularly useful technique for working with pilot participants.

Generally, the more experienced work coaches felt less need for additional training because they already considered themselves to be equipped to work with the participant group. They also tended to express greater levels of confidence about delivering the pilot. Work coaches with less experience of the participant group did not feel as prepared for the pilot:

> '*I'd not worked with ESA customers before, so that was new to me [laughs] and it's just like, "Oh no, I don't know what to do!"'*
>
> (Work coach, JCP pilot, Wave 1)

These less experienced work coaches valued additional training where it was offered. However, operational managers felt that, in retrospect, they could have benefitted from further training, particularly in relation to managing difficult conversations and challenging negative perceptions. In addition, some work coaches (including those who were more experienced) identified a need for more training around mental health conditions, which were felt to be widespread among the participant group.

Once the pilot had started, work coaches and managers took part in more intensive case conferencing, both within and across districts, sometimes attended or led by Work Psychologists. The case conferences involved discussion of individual claimants, with a view to sharing experiences and ideas about moving them forward. In some districts, local providers such as mental health organisations also attended to promote awareness of their services. Overall, work coaches viewed case conferencing as a useful way of identifying new approaches to working with participants.

In addition to case conferencing, some work coaches received additional advice and support from line managers, which was highly valued. Work coaches could also seek advice from Work Psychologists and Occupational Health advisers. (Further information about the use of Work Psychologists can be found in Chapter 5.)

Overall, JCP pilot work coaches reported that they felt well-supported in the earlier phases of delivery, and received good advice on supporting the participant group from managers, peers and specialists:

> *'There's been a lot of support from everywhere, really. To help us if we come - you know, get stuck on a case and not sure how to move it forwards.'*
>
> (Work coach, JCP pilot, Wave 1)

In the last six months of the pilot, however, case conferencing had either stopped or become less frequent in three out of four districts. Work coaches were disappointed by this because case conferencing was considered a useful forum to share ideas and knowledge. In the district where monthly case conferencing continued, work coaches were appreciative of this but noted that there had been no management attendance for the last six months:

> '*We're very lucky in our district that we continued to have our monthly meetings with the other pilot advisers, which is really beneficial.*'
>
> (Work coach, JCP pilot, Wave 2)

Work coaches across pilot districts reported receiving very little support from management in the second year of the pilot, particularly compared to the first. Wider organisational changes, such as to the line management structure and the move to

mixed caseloads were reported to mark the perceived waning of such support. Work coaches who were now supported by managers without a specialism in health and disability also felt less effectively supported:

> *'At the time it was launched we had a dedicated ESA team with a manager that was just responsible for ESA. And she was very supportive and fully on board... As time moved on, we've all been moved into separate teams so we don't have a dedicated ESA team now. Everybody does a little bit of ESA, everybody does a little bit of JSA, everybody does a little bit of IS. So your manager doesn't have... that expertise. [..] Having the dedicated team made things easier than now, where... my manager doesn't really understand it all because she's got a million and one other things going on as well.'*
>
> (Work coach, JCP pilot, Wave 2)

3.1.4 Performance management

Staff reported that no performance targets had been set for the pilot, apart from targets around the amount of time spent with participants, which was monitored on an ongoing basis. Although there were no specific targets for claimant off-flows or work outcomes[18], district leads explained that Management Information on these measures was collated centrally and shared on a monthly basis.

Generally, work coaches did not appear to have any pilot-specific performance targets, although during Wave 1 of the research it was reported that in one district they were incentivised to achieve work outcomes using a points-based system, in which more points were awarded for job outcomes in the pilot group. A manager reported that this system was effective with points used to inform discussions with line managers about work coaches' performance. In addition, managers monitored work coaches' performance by reviewing claimants' distance travelled and satisfaction rates.

Work coaches were clear that due to the participant group's long prognosis period, the pilot primarily aimed to progress participants towards work but not necessarily to achieve job outcomes. They were therefore appreciative of the lack of formal work outcome targets and an understanding approach developed among managers if participants were slow to progress. There were, however, reports of increased pressure from senior managers to achieve work outcomes as the pilot went on. This was not seen as appropriate by staff, particularly for participants with more severe health conditions.

3.1.5 Operational challenges

Overall, the delivery of the JCP pilot was felt to have gone smoothly, although a range of operational challenges were described by staff.

Changes in staff resourcing in the participating districts presented challenges to the delivery of the pilots. Early in the pilots, staff reductions and uneven referral volumes resulted in unmanageable caseloads, so work coaches struggled to see participants

[18] There is an existing off-flow target for ESA customers at 65 weeks, however many of the pilot group participants had already gone beyond this point and so were generally seen by staff as a separate group.

regularly. As discussed in section 3.1.3, less-experienced work coaches were then enlisted, but were felt both by managers and themselves to have unmet training needs, particularly around managing claimants with negative mind-sets and/or mental health conditions. This led some non-specialist work coaches to question whether their support was in fact detrimental to claimants' mental health:

> *'because I'm not trained, am I actually saying the right thing or am I saying things that are detrimental to their health?'*
>
> (Work coach, JCP pilot, Wave 2)

Bringing new staff onto the pilot was also thought to disrupt the work coach-participant relationship, which took considerable time to establish.

In one district, after high levels of staff turnover (possibly related to the reconfiguration of JCP districts), caseloads were redistributed among other work coaches on the pilot. However, work coaches raised concerns that in one area pilot customers were not reassigned to a different work coach, and that these customers were lost from the pilot.

As mentioned earlier, a new work coach delivery model was implemented during the pilot. Specialist teams such as Health and Disability adviser teams were disbanded, and work coaches moved to generalised caseloads, although this was not the case in all offices.

In some JCP offices, one approach to reorganising pilot caseloads in response to the new work coach delivery model was to redistribute pilot participants from pilot-specific work coaches to all work coaches in the office. Claimants were not necessarily believed to have been impacted negatively by this transfer if adequate handovers were given and the frequency of appointments was retained. It was even suggested that pilot participants sometimes benefited from such changes. This contrasts with views reported in Wave 1 interviews, where disruption to the work coach-participant relationship resulting from the arrival of new staff was viewed as potentially negative.

Work coaches were less positive about the effect on pilot customers where they struggled to spend as much time with participants due to the demands of a mixed caseload. This included those who retained their pilot caseloads and those who did not. The amount of time these work coaches could spend on the pilot shrank because their caseloads were larger, or because their time was taken up learning about supporting new claimant groups. One work coach reported that the support offered to pilot participants tailed off in the last six months of the pilot because they no longer had the time to offer the same intensity of support, except to those they felt had more chance of progressing into work.

Managers also reported that work coaches' time and priorities were affected by supporting new customer groups. One work coach for example reported being in Universal Credit full service training for four weeks followed by annual leave and therefore having a 6-8 week gap in seeing pilot claimants:

> *'This client group were previously very much our priority, there was very much a keen focus on them in terms of our time and the investment we could put into them and the focus that we gave them. Which perhaps now... they perhaps don't get because we're supporting the many other customer groups at the same time.'*
>
> (Operational Manager, JCP pilot, Wave 2)

A further challenge, described by staff across pilot districts, was a decrease in organisational focus on the pilot, which was, to some extent, also attributed to staff turnover. Some staff also felt that the lengthy timescale of the pilot, the challenging nature of the participant group, and the need to address other organisational priorities may have contributed to this perceived loss of focus; in some cases, pilot staff received managerial instruction to prioritise other areas of work.

There were attempts to address these organisational challenges part way through the pilots. For example, the importance of the pilot was reinforced to operational managers, uneven caseloads were redistributed, and pilot 're-launch' events were held for new staff. Work coaches, however, reported a further deterioration in the profile of the pilot in its last six months. They attributed this to the decline in case conferencing and managerial support, as well as the deprioritisation of appointment frequency.

It is important to note that a major challenge reported by staff was the reduction over time in the delivery of elements which they regarded as strengths of the JCP pilot model. This included delivery by specialist ESA or health and disability advisers with effective support from specialist managers; regular case conferencing with pilot work coaches, managers and Work Psychologists; manageable caseloads, and; a strong organisational focus on the importance of the pilot.

Another key challenge identified by staff was the availability of external support relevant to the participant group. Work coaches emphasised the need for good-quality external provision tailored to the needs of the group, both in terms of its substantive focus (e.g. on confidence-building or on specific health conditions, particularly mental health) and in terms of its format. Some staff reported that tailored provision was not widely available, and where it was, difficulties were reported, including long waiting lists and funding difficulties. Later on in the pilot, some staff reported reduced access to in-house Work Psychologist support due to a former Work Psychologist leaving and not being fully replaced. Access to this form of support for these staff members went from weekly to six-weekly.

A final key challenge was the nature of the participant group, which staff attributed to a combination of some or all of the following factors:

- the severity of participant health conditions;
- fluctuating health conditions and the effect of medical interventions, such as operations;
- participants' age (i.e. being close to retirement age);
- negative attitudes towards work;
- low confidence and self-belief about their ability to work; and
- long-term worklessness and distance from the labour market.

A recurring theme raised by work coaches was the inappropriateness of some claimants for pilot support due to the severity of their conditions. Work coaches perceived many of the factors above to be barriers to meeting the requirements of the support model, such as seeing pilot participants for 530 minutes per year, or setting Work-Related Activity. Some were also of the view that due to these factors, it was unlikely that some participants would enter work, either during the pilot period or in the future.

3.2 Work Programme pilot

The Work Programme was an integrated welfare-to-work programme, implemented across Great Britain in June 2011. It was commissioned by DWP using a prime provider approach, whereby the Department contracted for service delivery with single provider organisations. Two different models of delivery practice developed among prime providers. The first comprised a managing-agent prime, that provided no direct services, but sub-contracted delivery through a supply chain of subcontractors. The second combined direct delivery, of varying levels, with subcontracting within a supply chain.

Further, the Work Programme combined a minimum specification, or 'black box', approach to service delivery with a 'payment by results' (PbR) model. Thus, contracted providers were paid for job outcomes and were free to design their own support provision, with minimal intervention from the Department.

Various categories or 'payment groups'[19] of claimants were referred to the Work Programme by Jobcentre Plus, and for some claimant groups this referral was mandatory. This included ESA WRAG claimants in the 3-12 month Prognosis Group. This pilot extended mandatory referrals to participants in the 18-24 month Prognosis Group[20] within pilot areas.

3.2.1 Pilot districts and providers

For delivery of the Work Programme, England, Wales and Scotland were divided into 18 contract package areas (CPAs), with two or three Work Programme providers contracted within each of these CPAs[21]. The Work Programme pilot ran in two CPAs, which covered three of the five Jobcentre Plus Districts of the North East England Group. These Districts were:

- Durham and Tees Valley (CPA 5)
- Northumberland, Tyne and Wear (CPA 5)
- North East Yorkshire and the Humber (CPA 18)

The contracting arrangements for the delivery of the Work Programme pilot were relatively complex, involving four prime providers and their supply chains of subcontractors, which encompassed around a further 25 organisations. Some of these subcontractors had contracts with more than one prime provider for delivery of this pilot. In addition to this, the organisational make-up of supply chains and the proportion of support delivered by prime providers, and their subcontractors, varied over the lifetime of the pilot.

Three prime providers were initially involved in the pilot, one covering Durham and Tees Valley, and Northumberland, Tyne and Wear, and the other two covering North East Yorkshire and the Humber. Two of these providers utilised the delivery prime

[19] Full details the payment groups can be found in: http://www.dwp.gov.uk/docs/wp-pg-chapter-2.pdf

[20] Prior to the pilot, this group could volunteer to join the Work Programme, although once they joined their participation then became mandatory.

[21] For a list of prime providers and a map of CPAs, see: https://www.gov.uk/government/publications/work-programme-contract-package-area-and-prime-providers

approach, carrying out some direct delivery of support alongside a supply chain of subcontractors. The third was a managing agent prime so all of their pilot delivery was via their supply chain.

These delivery arrangements were altered from March 2015, when an additional prime provider took over one of the Work Programme contracts in North East Yorkshire and the Humber from the original prime provider. All existing pilot participants who were not yet in work were transferred to the new provider at this point, although any in-work participants remained with the outgoing provider. The new provider was also a managing agent prime and did not carry out any direct service delivery themselves, only via their supply chain.

The complexity of these contracting arrangements, together with the black box nature of the Work Programme contract, meant that it was not possible to identify a single picture of delivery of this pilot. Instead, the evaluation reports on the range of approaches described by providers with the largest share of pilot referrals (see Chapter 2 for more detail on the sampling approach).

3.2.2 Pilot

Pilot providers generally reported that they dealt with pilot participants in a similar way to their other Work Programme participants. Their advisers had mixed caseloads of participants from across the range of Work Programme payment groups. Some providers reported this approach was helpful to ensure advisers worked effectively, since it was suggested that a caseload consisting largely of pilot participants, many of whom may have been facing significant barriers to work, could negatively affect adviser morale and performance.

A range of caseload sizes was reported in the Wave 1 staff interviews, from around 70 up to 150 participants (both pilot and non-pilot) per adviser, although most providers reported that caseloads later reduced as referral numbers declined. During both waves of research, the proportion of pilot participants within caseloads also varied considerably. One adviser reported a caseload of 130, of which around half were pilot participants, while others reported a much lower proportion of pilot participants at around ten per cent of overall caseload.

One prime provider involved in the early stages of the pilot reported a different approach consisting of a new support model which included specialist adviser staff recruited specifically to work with pilot participants. They reported that they aimed to keep caseloads relatively low, initially aiming for around 40, although this did increase towards the end of their Work Programme contract, as staff sought employment opportunities elsewhere. This provider felt that relatively low caseloads were important to ensure that advisers had sufficient time to deliver the level of personalised support they felt was required by pilot participants:

> *'The idea was always that we were going to have a maximum of 40 customers per Employability Support Mentor and… they crept up closer to the 60 mark and that was detrimental… the lower you can get the better, because you can spend more time with them.'*
>
> (Team Leader, WP Pilot,)

Whilst the use of specialist adviser staff dedicated to the pilot was unique to this provider, some other providers also noted the benefit of having access to specialist staff. This included the use of subcontractors who specialised in health and disability employment support, whose frontline staff had in-house access to specialist support, such as occupational health professionals. One provider also indicated that they had some specialist ESA Advisers (who work across all of the ESA payment groups), and another reported they were considering the introduction of this role. Another provider reported that they had introduced a specialist healthcare practitioner role, although this was not specifically linked to their involvement in the pilot, and their funding for this role ended shortly before the end of the pilot. The use of this more specialist staffing is discussed further in Chapter 5.

3.2.3 Staff training and support

As noted above, only one provider reported the recruitment of staff specifically for the pilot. These staff reported receiving a range of training, including a course run by the Centre for Mental Health on motivational interviewing. This appeared to be well-received by staff, who regarded it as useful for their work with participants:

> *'it was a really, really good resource and not simply for people with mental health. I think a lot of people who we come across within the pilot, although their main medical issue may not have been mental health, a lot of them become quite isolated, quite low self-esteem, depression and things'.*
>
> (Team Leader, WP Pilot, Wave 1)

Staff from this provider also commented that they felt well-prepared for the pilot, and mentioned other training such as *'mental health first aid*'. This course supported advisers in identifying the 'episodes' of ill-health that participants with mental health conditions may experience, the potential causes of these, and where to direct participants for further support.

Staff at other providers referred to a range of training or briefing sessions that were designed to support their work with pilot participants. Whilst these did not appear to be as comprehensive as the training reported above, they were well received by staff. Some provider staff, however, reported that they had received little or no training related to the pilot or to supporting this group of participants:

> *'We weren't very prepared really. It was just, "Here are some customers on your caseload and this is what we're going to do to improve their circumstances", basically.'*
>
> (Adviser, WP Pilot, Wave 1)

Some of these staff felt they would have benefited from additional support or training. In particular, some suggested that training on health conditions and their impact on individuals would assist with their role. Others however stressed the employment focus of their role and felt there was limited need for health-related training.

In addition to training, a number of provider staff mentioned the benefits of peer support between staff when working on the pilot, for example the sharing of information on relevant agencies to signpost participants to. This type of support was reported across offices within the same provider, and also between providers within a supply chain. As discussed above, some prime providers stressed the importance of

using subcontractors who specialised in health and disability employment support and drew on the experience of staff in these organisations to support pilot delivery across their supply chain.

3.2.4 Funding model

As discussed above, providers are paid for Work Programme delivery via a PbR model, with payments linked to job outcomes. The Work Programme payment model also includes a differential payment structure through which providers are paid at different rates for outcomes achieved by different target groups, with outcomes for 'harder-to-help' groups paid at higher rates than those for groups deemed closer to the labour market. This incentive structure aimed to discourage providers from concentrating effort and resources on those participants for whom they can achieve an employment outcome most quickly or cheaply.

There was, however, evidence from the Work Programme Evaluation (DWP, 2014) that differential pricing has had little impact in driving provider behaviour in how they divided participants and prioritised support. Some providers also suggested that the costs of support for participants with the greatest needs exceeded the payments available in some cases.

These themes were generally reiterated by the providers involved in this pilot. Despite this, providers generally reported that the funding model had no impact on the support delivered to pilot participants, rather, that support was delivered on the basis of their assessment of participant needs. One subcontractor provider did, however, suggest that the financial model may have had some impact on their delivery of support. They reported that, at times, they focused on Work Programme participants who were most likely to enter work in order to secure some income from job outcome payments:

> '*When you've got a mix of PG* [payment] *groups within a caseload as we all have here, as I said, you tend to fish where the fish are, if we hadn't done that then we wouldn't have been earning any income to keep us going, so to speak, so it's a kind of a needs must, it's not that we ignored these people or parked them or left them.'*
>
> (Operations manager, WP Pilot, Wave 2)

During the Wave 1 fieldwork, providers also emphasised the high level of needs within this participant group, and their distance from the labour market, which they suggested would mean few were likely to enter work. Therefore, despite the relatively high level of payment for job outcomes for this group, it was suggested by some that applying the current Work Programme funding model to this participant group would result in an overall financial loss. During Wave 2 staff interviews, pilot providers generally reported that this initial view had been borne out by the low numbers of sustained job outcomes they had been able to achieve with the pilot participants:

> *'we don't receive anything extra for any claimants on these pilots and we receive no upfront finances for them. Everything comes out of the provider's budget, and if these claimants go into work and they don't stay there for 13 weeks we don't get paid whatsoever. As you can see, out of 1,162 claimants we've actually only placed 82 into work but we're still covering the cost for all of the rest of the claimants.'*
>
> (Senior manager, WP Pilot, Wave 2)

In addition to concerns about the funding model, the prime provider who had developed the new support model also reported high pilot implementation costs associated, for example, with staffing and/or the development of new tools (to support the assessment and tracking of participant progress). They indicated that a strategic decision had been made to accept the loss in order to develop their service and reported that some pilot-specific tools were now being used across their wider provision.

It was also suggested by some provider staff that the sustainability of supporting pilot participants via the Work Programme funding model was particularly problematic for subcontractors, whose payments were subject to the deduction of a management fee by their prime provider. Some providers suggested that an initial 'attachment fee' or interim payments linked to the delivery of minimum levels of service might be appropriate. This would be closer to the current funding model for the DWP specialist disability employment programme, Work Choice.[22] Other providers suggested that payments linked to the achievement of soft outcomes would be more achievable and appropriate for work on this pilot. They indicated that with funding on this basis, they would be able to offer specialist staff and smaller caseloads to facilitate more intensive work with participants, as offered in other areas of their provision.

Whilst most providers questioned the sustainability of the funding model, and their ability to offer appropriate levels of support to move pilot participants into work, one provider involved in a Wave 1 interview felt that, within the context of their overall Work Programme funding, it was sustainable across the programme as a whole.

3.2.5 Performance management

Providers indicated that they did not use specific outcome-related performance targets for the pilot at either an organisational or individual adviser level. Generally, where targets were reported, they were linked instead to job outcomes across all ESA participant groups.

One prime provider did report that they had been asked by DWP to propose indicative job outcomes for the pilot. They used their broader ESA work programme performance to inform this and set a *'very nominal'* three to five per cent job outcome target. However, they also reported that overall, they felt DWP were more interested in the 'distance travelled' towards employment than job outcomes for this pilot.

Provider contracts with DWP for the delivery of the pilot were not managed against specific job outcome targets, and this issue did not appear to play a significant role in driving provider delivery of pilot support. There was, however, some indication that a focus on achieving targets set for other Work Programme participants, specifically ESA claimants in payment group 6 (PG6)[23], may have prioritised enhanced delivery for this group, which was not available to pilot participants. During a group discussion with provider staff in one pilot area, some advisers expressed frustration at not being

22 Work Choice is DWP's specialist disability employment programme. Provider organisations offer pre-work and up to two years in-work support. This includes one-to-one contact with an adviser who can help navigate access to additional in-work support such as through Access to Work. See: https://www.gov.uk/work-choice/overview

23 Full details of the Work Programme payment groups can be found at: http://www.dwp.gov.uk/docs/wp-pg-chapter-2.pdf

able to refer pilot participants to the occupational health support their prime provider had funded for PG6 participants. They felt this support would have been beneficial to a number of pilot participants:

> *'We have a customer at the moment and we've literally done everything with him that we can and I really wanted to refer him to occ. health and then I found out that we can't because he's a PG7* [pilot participant]*… I feel that the occupational health service would be so beneficial.'*
>
> (Adviser, WP Pilot, Wave 2)

The prime provider reported that this additional specialist support was linked to a need to improve their job outcome performance for the PG6 group, so had been commissioned specifically for this group.

3.2.6 Operational challenges

As the Work Programme pilot was delivered by a diverse range of organisations, it is impossible to offer a unified picture of operational challenges across this pilot, as some of the issues reported relate specifically to individual organisations. For example, some providers described a challenge of delivering the pilot with generalist employment advisers who had limited experience of working with participants facing significant health-related barriers to work. Some of these staff articulated a need for more specialist support to work with this participant group. Other providers, however, reported the use of specialist support staff and subcontractors within their supply chain to address this. The prime provider whose Work Programme contract was ended during the pilot also reported a range of challenges associated with the ending of their contract, for example, operational difficulties associated with staff moving on from the organisation and a resulting increase in caseloads for the remaining staff.

One challenge reported more consistently across providers was around the pilot funding model. As discussed above, a number of providers indicated that this was a key operational challenge. Despite this, providers usually reported that the funding model had not had an impact on how the pilot was delivered, rather support to participants was delivered in line with an assessment of their needs. There was, however, some indication that this may not always have happened in practice, and overall providers felt that this approach to funding would not be sustainable if the pilot were to be rolled out.

Other specific operational challenges reported by providers included issues around eligibility, referral and mandation. Some providers felt that the mandatory referral to the pilot was potentially problematic and could pose a barrier to positive participant engagement:

> *'I think also as soon as you use the term "mandatory," it puts a barrier there. So I think that there is probably, you know, there needs to be something where it's not mandatory.'*
>
> (Adviser, WP pilot, Wave 1)

Some staff also indicated doubts that some participants, such as those with a terminal diagnosis[24], were suitable for the pilot as it was highly unlikely that they could move into work. One provider also suggested that Jobcentre Plus staff appeared to have come to similar conclusions about some of those they referred, and had on occasion indicated this within their referral information:

> *'when you get a customer referred to you and the information on the PRAP file says that this customer will never go into work… Why on earth have they come to us?'*
>
> (Adviser, WP pilot, Wave 1)

Provider staff also raised the issue of the timing of referrals, which they felt should be related more closely to a claimant's personal circumstances, because it was felt that some participants were not at a stage where they could successfully engage with, and benefit from, the pilot. Some also suggested that requiring participants to join the pilot before they were at an appropriate point could have negative consequences on their overall journey towards work:

> *'it's just gauging the timing of when someone would be able to fulfil that course, because it would be pointless to put somebody on something who was not going to be able to do it and then it will put them back as well, probably, with confidence.'*
>
> (Adviser, WP pilot, Wave 1)

3.3 Healthcare Provider pilot

The focus of the support provided in the Healthcare Provider (HCP) pilot was health-related and comprised a minimum of five appointments for pilot participants with healthcare professionals. These took place over a 24-month period, and required the first three appointments to take place within the first six months of a participant entering the pilot, with the fourth appointment at around 12 months and the final one at around 18 months.

3.3.1 Pilot districts and providers

The HCP pilot was contracted by DWP to be delivered by a single provider across the five Jobcentre Plus districts in the Central England Group. These districts comprise:

- Lincolnshire, Nottinghamshire and Rutland;
- Leicestershire and Northamptonshire;
- Derbyshire;
- Black Country; and
- Staffordshire and Shropshire.

24 JCP guidance stated that claimants with a terminal diagnosis should not be referred to the pilot.

A provider was selected through a competitive tender process. This provider is a large provider of employability programmes, skills training and health-related support in the UK and delivers the Work Programme as a prime provider in a number of CPAs, including across part of the area covered by the Central England Group. The HCP pilot was delivered exclusively by this single provider with no supply chain involved.

3.3.2 Pilot

The Department's specification for the HCP Pilot required that meetings with pilot participants were to be delivered by healthcare professionals, which were defined as registered occupational therapists, registered occupational health nurses or registered medical practitioners with occupational health experience.

The provider opted to recruit new staff to deliver the pilot. In addition to their professional expertise, as required in the specification, the key criteria for selection was reported by the provider to be an ability to gain rapport, engage and motivate participants. Recruiting these staff, however, was reported to be one of the key implementation challenges, and managers reported that it took considerably longer than anticipated (four to six months in total) to reach their full complement of staff. This and other operational challenges are considered in section 3.3.6 below.

The full staff complement included eight health advisers delivering the HCP pilot. By profession, they were primarily occupational therapists, but also included one nurse. Several had specialisms in mental health and/or learning disabilities, with prior experience in both NHS and community settings. A few advisers had prior experience of working with ESA claimants and/or delivering employment and training support. Pilot managers felt that the use of health professionals was a key benefit of the HCP pilot because of the trust that this generated with participants, while health advisers described making use of their listening and therapeutic skills in client interactions and having good knowledge of health and social services for signposting clients.

The advisory team was organised geographically to cover 26 different delivery locations across the five JCP districts. Some advisers worked remotely from a range of different locations, while others worked from the provider's offices. Working remotely presented some logistical challenges, and some advisers also spoke of the challenge of back-to-back appointments with limited time to complete paperwork or other tasks in-between appointments. Managers and advisers reported, however, that additional time was allotted for building relationships with partner organisations in their local areas, to aid the signposting of participants to sources of help and support.

3.3.3 Staff training and support

The healthcare professionals recruited to deliver the HCP pilot reported receiving a thorough programme of training and support both prior to starting pilot delivery and subsequently. This focused primarily on managing health conditions, and ways of engaging and supporting ESA claimants, rather than on employability support. Most advisers spoke positively about this training and support, stating that it helped them to feel adequately prepared for their role.

After the training, new advisers shadowed existing advisers until they were competent in their role. In addition, there was an ongoing programme of peer learning through observation, with advisers encouraged to observe staff who had a different specialism to theirs. Support and guidance was also delivered through bi-monthly caseload conferencing with a Senior Health Adviser, and regular group supervision sessions with the pilot Team Leader. Finally, the provider also reported the use of telephone-based forums within the organisation for further support and professional development, such as an ESA Forum and an Occupational Therapist Forum.

Pilot staff were generally happy with the range of training received and some commented positively on the responsiveness of the organisation to requests for additional training.

The initial shadowing of experienced advisers, regular sharing of experiences within the team, and being able to draw on the support of the team manager and a clinical supervisor, were highlighted as key assets:

> *'So I was very much eased in, not a kind of, "There you go …", which was really, really good, it was excellent actually, I think that helped and they did that really well.'*
>
> (Adviser, HCP Pilot, Wave 1)
>
> '*I learnt so much from shadowing, you know, and that's what gave you the confidence... because it was a completely different area of practice for us*'
>
> (Adviser, HCP Pilot, Wave 2)

Some staff, however, identified areas in which they felt additional support would have been helpful. This included:

- training on common health conditions experienced by pilot participants (e.g. how to help people manage with common physical conditions like arthritis)
- information and training on DWP benefits, and local sources of support and provision for participants.

Some health advisers also felt that the pilot could have been better integrated with the provider's wider activity (such as its Work Programme provision), thus enabling it to draw more effectively on the organisation's wider expertise and resources.

3.3.4 Funding model

The funding model for the HCP pilot is based on a service fee model rather than Payment by Results (PbR). The provider received funding on delivery of the first three appointments (out of the required five in total) with pilot participants. There were no payments for employment (or other) outcomes for pilot participants.

Pilot managers reported that if the pilot had been funded through a PbR model, with payments for employment outcomes, then the pilot support would have been designed differently, with a greater emphasis on employability support alongside the health-focused support delivered by the health advisers. Pilot managers felt that while an outcome-based payment model could have been helpful, the balance of payments should still be weighted towards attachments, rather than job outcomes, as they felt that the nature of the client group was such that many participants would not enter work within the timeframe of the pilot.

3.3.5 Performance management

Pilot performance was monitored through monthly meetings with DWP contract and performance managers. The provider reported on Key Performance Indicators (KPIs), such as the number of clients seen each month, the number seen within ten days of referral and the number of face-to-face appointments. Good news stories regarding soft outcomes and 'distance travelled' were also discussed.

There was no monitoring of employment outcomes in performance-management meetings, which reflected an understanding among both provider and DWP contract managers that the pilot primarily aimed to move participants closer to work, through better management of their health, rather than to achieve work entries. The provider did, however, establish internal mechanisms for monitoring a range of outcomes from the pilot, including employment-related outcomes (voluntary work, permitted work and full-time work) and soft outcomes (perceived health and wellbeing and readiness for work).

Reflecting the steer from DWP, the provider did not set any targets for employment outcomes from pilot staff. Both managers and advisers expressed a view that employment targets for health advisers would have been detrimental to the delivery of the pilot:

> *'they are very much health advisers through and through, and if work isn't the right thing for that person at that particular time they wouldn't push it. And if we were to face them with a job start target or something like that it would have affected them on a personal level and professionally, they wouldn't have liked that. I think actually we have got more out of them doing it this way than actually targeting them.'*
>
> (Manager, HCP pilot, Wave 1)

Instead, advisers were performance-managed through KPIs, which were monitored on a monthly basis. These included the number of appointments and Fail to Attends; re-arranging appointments and processing DMA actions; timely completion of paperwork, managing relationships with and making referrals to external health and employment services; and participant take-up of work-related activity (such as work placements and voluntary work). Some advisers felt that the targets for work-related activity were inappropriate. However, in general, staff were happy with the performance management arrangements on the pilot.

3.3.6 Operational challenges

The main operational challenges reported for the HCP pilot were in relation to staffing. Pilot managers reported that at the outset it was difficult to attract health professionals to the pilot, partly because the provider was unable to compete with the remuneration packages offered in the NHS, and partly because the positions offered were on a temporary basis due to the pilot timeframe. There were also delays in completing necessary paperwork such as DBS checks. This resulted in the provider having insufficient health advisers in place to cover all the early referrals to the pilot. However, they were able to manage this by using healthcare professionals already in the organisation (who were supporting Work Programme delivery) to undertake pilot delivery in the early months until a sufficient number of health advisers were in post.

The second key challenge related to the large geographical area of the pilot. With no indication of the profile of referrals in advance, and a very large area to cover, staffing the pilot was a logistical challenge. This made it difficult to achieve the ten-day timeframe between a referral and an initial appointment as specified in DWP guidance.[25] Similarly, as the pilot wound down at the end of the delivery phase and staffing on the pilot was reduced, it became increasingly difficult to provide face-to-face appointments for all remaining participants, and so there was more reliance on telephone support.

The large geographical area of the pilot, including areas where the provider had no existing provision, also brought additional challenges, such as securing adequate premises for delivery and establishing remote working procedures. In addition to the challenges for advisers in covering such a large geographical area, participants reported that the distance between delivery sites in rural locations also presented access difficulties. Some HCP pilot staff cited the necessity of keeping up-to-date with changing provision across this large geographical area, which was often diverse across local authority and CCG boundaries, as another key challenge.

3.4 Summary

The three pilots faced a number of organisational challenges, some of which were specific to individual organisations, and some of which were more generic and related to the nature of the participant group.

Staff resource

Some of the pilot sites reported issues related to securing and maintaining adequate levels of appropriately-trained and experienced staff. This was a particular challenge for the HCP pilot, where managers reported that the full complement of staff was not in place until six to seven months into pilot delivery. It was also viewed as a challenge in the JCP pilot. During Wave 1 fieldwork, staff reductions in some districts meant that work coaches without prior ESA claimant experience were brought into the pilot. The use of less experienced staff and higher caseloads than initially planned was a concern for some managers, as was the question of establishing effective working relationships with participants, as this was disrupted where there was staff turnover. In the later stages of the pilot, however, some staff suggested that moving participants to new work coaches could be beneficial by potentially offering a fresh approach to support. During the pilot, a new JCP staffing model which moved away from specialist to more generalist staff, with mixed caseloads, was reported. Again, concerns about the use of less-specialised staff for this pilot were raised, in particular where this was accompanied by a reduction in other features like case conferencing.

Staff training

Staff described a need for access to appropriate training, support and resources to meet the needs of the participant group. The extent to which pilot staff received this varied across and within the pilots.

[25] Managers reported that this requirement was later relaxed by DWP to 15 days.

- HCP pilot staff appeared to receive the most consistent and comprehensive programme of training for the pilot, and reported a good level of support in delivery, through processes such as case conferencing, peer observation and group supervision. The training focused primarily on health-related rather than employment-related support, reflecting the focus of this pilot.
- For JCP pilot staff, training needs were assessed at district level and any gaps addressed through on-the-job and localised provision. Work coaches generally felt that the training was adequate, although some less experienced staff articulated a need for further training. In Wave 1 interviews, JCP pilot staff reported that they generally felt well-supported, again through case conferencing, line management and by Work Psychologists. However, during the later stages of the pilot, staff reported a notable decline in this type of support, which was regarded as a challenge to effective delivery.
- The extent to which Work Programme delivery staff received pilot-specific training varied across provider organisations. Some reported that they had received little or no training related to the pilot and felt unprepared because of this. One prime provider sourced specialist training for staff delivering the pilot, but other providers generally did not. The extent of support from specialists, such as occupational health staff, was also variable across providers, although where this was available it was regarded as helpful.

Across the three pilots, some staff had received training in motivational interviewing, which was found to be useful. Most commonly, staff desired more training on specific health conditions (particularly mental health conditions), their management and effect on individuals.

Caseload characteristics

Staff across the three pilots also reported a range of challenges associated with the participant group, which were linked to a range of factors, including the severity of their health conditions. For example, staff across the pilots reported that participants were often worried and reluctant to engage when they were first mandated to the pilot, for fear of being 'forced' into something that they did not feel ready for. Moreover, some staff from each pilot felt that it was unlikely that some participants would enter work, either during the pilot period or beyond that. Some of these staff also suggested that some participants were not suitable for referral for the pilot. This included participants with a terminal diagnosis[26] or those close to retirement. Some JCP pilot staff also reported that it was difficult to source external provision that was appropriate for the needs of this customer group.

Targets

In general, the pilots were not managed against any specific job outcome targets, either at an organisational or at the individual staff level. Instead, a range of other performance indicators were generally used. Both staff and managers generally felt that this approach was appropriate for the pilot. However, one of the districts in the JCP pilot did report using an incentive scheme with a points-based system, in which more points were awarded for job outcomes in the pilot group.

[26] JCP guidance stated that claimants with a terminal diagnosis should not be referred to the pilot.

Funding model

The funding models for the WP and HCP pilots raised some issues for providers. Most WP pilot providers felt that the PbR funding model, due to it being based solely on job outcome payments, would not be sustainable for supporting the pilot group in the longer term. Despite this, providers stated that this did not affect their delivery of support on the pilot. There was, however, some evidence that this was not always the case in practice. HCP providers indicated that use of a PbR (job outcome) rather than service fee model would have resulted in a different pilot design, with additional employability provision. However, they also felt that the support needs of the pilot group, and their perceived distance from the labour market would require a funding model which included some element of service or attachment fee to sustain delivery. The WP pilot providers also raised concerns about the need for attachment or service fees with this participant group. Some also suggested an outcome payment model that was linked to the achievement of soft, rather than purely job outcomes, might be appropriate.

4 Pilot participants

This chapter provides key contextual information on the participants in each of the three pilots. It includes an analysis of baseline data collected by DWP before the start of the pilots, as well as a description of the demographic profile of respondents within each pilot, drawing on survey data. It also explores participant barriers to work in greater detail,* drawing on findings from the qualitative research with staff and pilot participants.

4.1 Profile of pilot participants

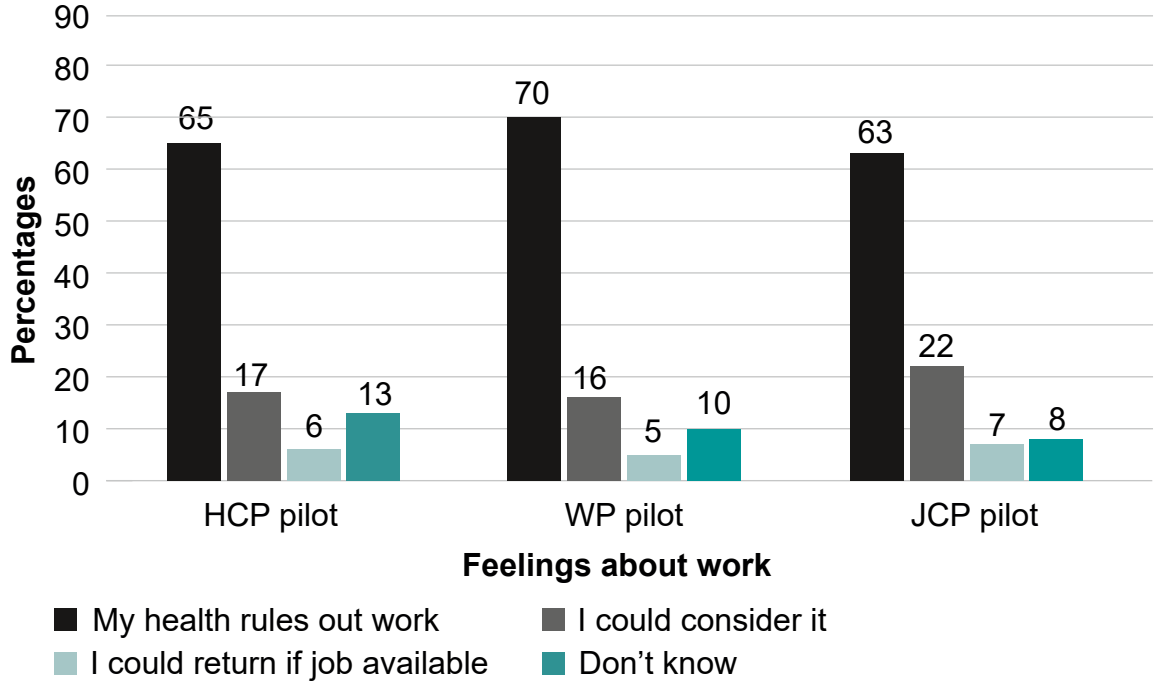
4.1.1 Baseline data

This section analyses baseline data collected by DWP for 1,304 individuals who were eligible for the pilots. The data is the result of a short survey conducted by Jobcentre Plus staff either during the first mandatory interview or during the ESA New Joiner's Work-Focused Interview between May and August 2014. The information collected focused on individual characteristics, and attitudes towards work and work-focused activity.

The baseline data was collected only from a restricted group of eligible claimants, not all of whom took part in the subsequent survey for the evaluation. It was therefore not possible to use this data for longitudinal analysis to identify changes at the individual level before and after the start of the programme. Instead, it is included here as background information about the profile of the claimants who took part in the pilots.

Using the baseline data, Figure 4.1 shows that at the outset of the pilot, around two-thirds of respondents reported that the presence of their health condition or disability ruled out the possibility of work at that time (65 per cent for the HCP pilot, 70 per cent for the WP pilot, and 63 per cent for the JCP pilot).

Figure 4.1 Feelings about work



Base: All respondents answering the DWP baseline survey

Around half the respondents reported that they did not know when they would be able to work (53 per cent in the HCP pilot, 61 per cent in the WP pilot, 47 per cent in the JCP pilot), and around one in six felt that they would never be able to work again (19 per cent in the HCP pilot, 15 per cent in the WP pilot, and 17 per cent in the JCP pilot).

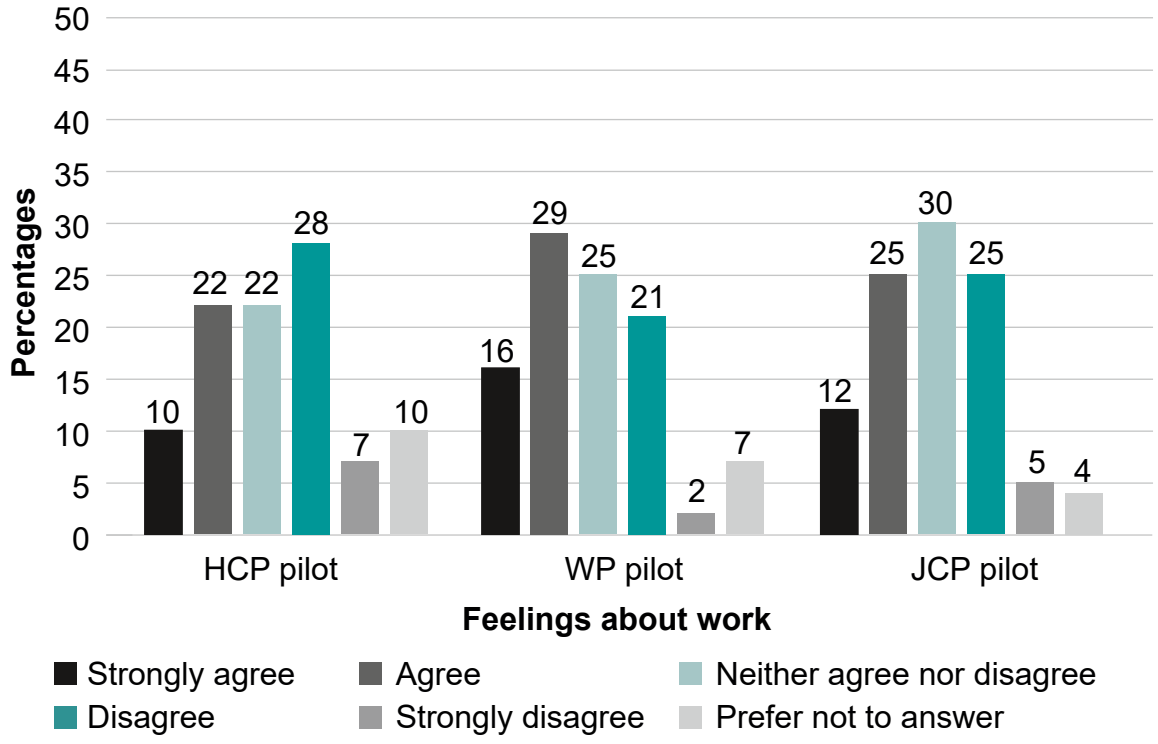
Despite this, more than half the respondents agreed or strongly agreed that they would be a 'happy person' if they were in paid work (58 per cent in the HCP pilot, 60 per cent in the WP pilot, and 60 per cent in the JCP pilot), and almost three-quarters of respondents agreed with the statement that work allowed them to contribute to society (75 per cent in HCP, 74 per cent in WP, 70 per cent in the JCP pilot). However, three-fifths of respondents agreed that the thought of paid work made them nervous (60 per cent in HCP, 57 per cent in WP, and 61 per cent in the JCP pilot).

Figure 4.2 shows respondent views on whether people were put under 'too much pressure' to look for work. Forty-five per cent of WP respondents agreed with this statement, 37 per cent of JCP pilot respondents, and 32 per cent of those on the HCP pilot.

No significant differences between pilot and control groups were noted for any of these questions on feelings about work.

Respondents were also asked whether they were currently doing any of a list of job-related activities, such as looking into possible future jobs or careers, voluntary work, updating their CV, looking for possible vacancies, doing permitted work or doing a training course. The majority of respondents said that they were not doing any of the activities mentioned (72 per cent for the WP pilot, 63 per cent for the HCP pilot and 49 per cent for the JCP pilot). Again, there were no significant differences between pilot and control groups.

Figure 4.2 People are put under too much pressure to look for work



Base: All respondents answering the DWP baseline survey

4.1.2 Demographic profile of survey sample

This section presents findings on the demographic profile of pilot participants drawing on the Wave 1 telephone survey. This was conducted between 15 and 24 months into delivery of pilot support so is not, therefore, pre-intervention baseline information. Nonetheless, the focus is on 'static' characteristics that we would not expect to change between waves.[27] See Appendix Tables 4.1 to 4.11 for responses to all demographic questions.

The majority of participants within each of the three pilots were White British, aged 45 or above without dependent children, had low levels of education and rented their own homes. Roughly half of the participants were female, and around half were single. Most respondents had been in paid employment at some point in the past (91 per cent on the WP pilot, 89 per cent on the HCP pilot, and 88 per cent on the JCP pilot). Most respondents also had contact with family on at least a weekly basis.

The majority of participants were in receipt of multiple benefits (90 per cent on the HCP pilot, and 88 per cent on both the JCP and WP pilots), which for most people was between two to four benefits (78 per cent on the HCP pilot, 73 per cent on the JCP pilot, and 70 per cent on the WP pilot). Aside from ESA, the benefits most commonly received were Housing or Council Tax Benefit and Disability Living Allowance.

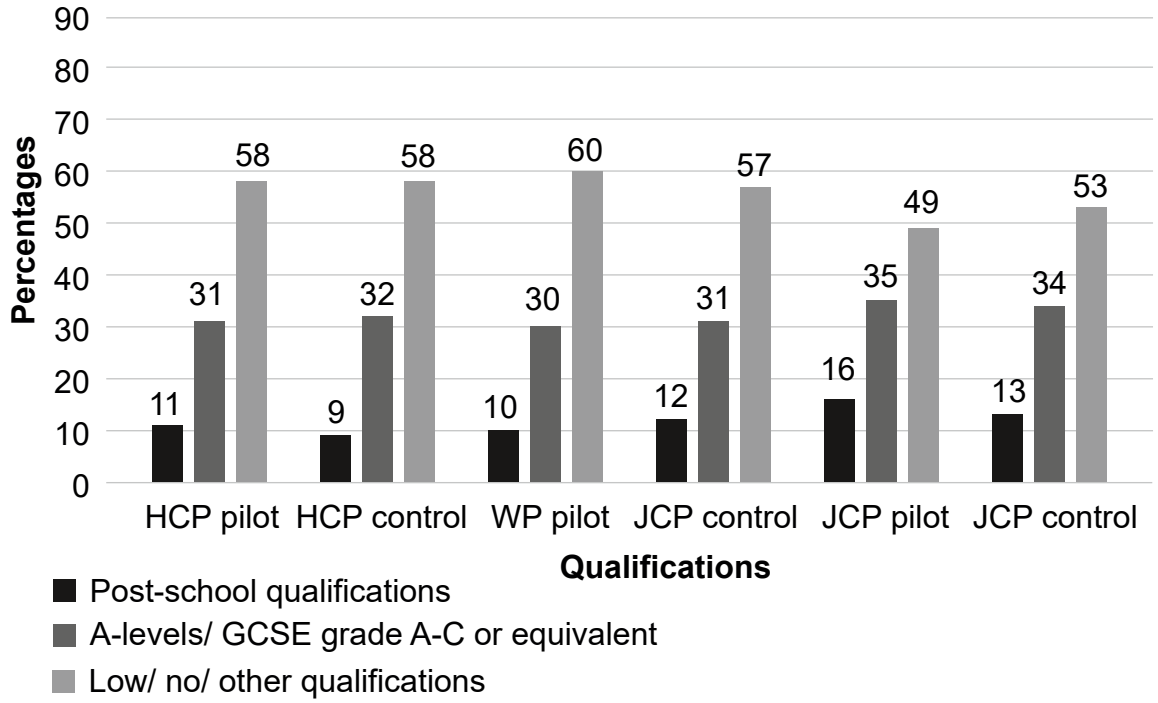
Within each of the three pilots, the demographic characteristics of respondents in the treatment and control groups were similar, with no significant differences found. However, while treatment and control groups were broadly similar for each pilot, there were differences across the three pilots, which is to be expected given the profile of the different geographical areas in which the pilots were organised. HCP

[27] As the focus is on static characteristics, Wave 2 data is not presented.

pilot participants, based in the Midlands, comprised a more ethnically diverse group than either WP pilot participants, based in the North East of England, and JCP pilot participants, in Southern England.

Those in the JCP pilot (and control group) also tended to have higher qualifications than those in the other two pilots. Figure 4.3 summarises the educational profiles of the respondents across the three pilots. It shows that the majority of participants had no or low qualifications[28].

Figure 4.3 Qualifications



Base: All Wave 1 respondents

4.2 Barriers to work

This section draws on data from in-depth interviews with pilot participants and staff to describe in more detail participants' health conditions, work histories and other barriers to work.

4.2.1 Health conditions

Health conditions and disabilities reported by pilot participants included a range of physical and mental health conditions, as well as learning disabilities, with some participants having a combination of conditions. The severity of health conditions and disabilities, and the extent to which claimants' lives were affected, varied. There were those who could manage daily life independently and work a small number of hours, while others had more limited mobility, were on strong medication or had regular hospital stays. Some participants reported unstable conditions, which meant that the impact on their ability to work fluctuated.

[28] For the purpose of this report, those with no GCSEs grade A-C or equivalent / better are categorised as having low qualifications.

As would be expected, there were examples of pilot participants whose health improved over the course of the pilot and others whose condition worsened. In all three pilots, around a third of participants had moved from the ESA WRAG to the Support Group by the time of the Wave 2 survey (28 per cent on the JCP pilot and WP pilot and 30 per cent on the HCP pilot). This suggests that either participants' conditions worsened over time or that there were inaccuracies in the assessment process which placed them into the ESA WRAG initially.

Physical health conditions

Participants' physical health conditions ranged from single medical issues, including musculoskeletal conditions, chronic fatigue and epilepsy, to multiple related or unrelated health issues. For example, one participant had ankylosing spondylitis (a form of chronic spinal arthritis causing curvature of the spine), nerve damage and fibromyalgia (a long-term rheumatic condition causing pain all over the body).

Whether they had single or multiple health issues, participants reported varying levels of discomfort, tiredness or pain. Difficulties in sitting and standing unaided were widely reported, as well as issues with mobility. Conditions also ranged from relatively temporary to chronic. For example, one participant was diagnosed with chronic arthritis in the knees, hands, elbows and back, while another was awaiting reparative surgery for a back problem, after which he was expecting a full recovery.

Mental health conditions

Anxiety and depression were the main mental health issues for which pilot participants were claiming ESA. Other conditions reported included bipolar disorder, personality disorder, post-traumatic stress disorder, panic attacks and agoraphobia. The extent to which these conditions affected participants varied, with some feeling fearful of, and others feeling unable to, leave the house or go out unaccompanied. For example, one claimant experienced panic attacks in social situations, while another reported needing to be accompanied if going somewhere new due to social anxiety. Participants diagnosed with mental health conditions such as bipolar disorder or schizophrenia often reported living isolated and secluded lives, having lost housing, family and social networks due to their conditions.

Learning disabilities

Participants reported a range of learning disabilities including autism, ADHD and dyslexia, and, in some cases, participants did not disclose a learning disability but it was inferred by the interviewer. The severity of these disabilities and their effect on participants ranged from minor disabilities to complex conditions which had a significant effect on their wellbeing and capabilities. For example, one participant suffered from ADHD and other mild learning disabilities, which affected her ability to communicate and follow instructions, restricting the types of jobs she was suitable for. Others who suffered from severe learning disabilities faced much more complicated barriers, like being unable to read or write, or requiring near-constant supervision if outside of the home.

Multiple and complex conditions

Many participants suffered from multiple health conditions and/or disabilities, which could include mental and physical health conditions and/or learning disabilities. Participants with multiple conditions either started their claim with multiple conditions or started off with one condition but developed other conditions over time. According to staff, claimants typically started off with a physical condition and their mental health subsequently deteriorated, either due to distress and isolation resulting from their physical condition or due to the side effects of their medication. For example, one participant's severe back pain had led to insomnia and depression.

4.2.2 Work histories

Five main types of work histories cold be discerned among respondents. These were:

- **No work experience:** This included long-term Incapacity Benefit claimants with severe conditions who had recently migrated to ESA. For example, one participant (aged 30-49) left school at the age of 13 when he was diagnosed with epilepsy, after which he did not work or gain any qualifications.
- **Long-term unemployed:** These participants had not worked for over ten years due to chronic health issues, sometimes combined with other factors such as caring responsibilities. For example, a woman with depression who was in her 40s had not worked for 15 years while she raised her children. Her depression worsened when her last child left school and she was unable to work.
- **Fragmented work history:** This group experienced recurring patterns of work and illness. For example, one participant working as a chef injured himself through heavy lifting. After returning to work he seriously damaged his back and had to leave work again.
- **Stable work history until illness:** These participants had stable careers until their health deteriorated. For example, a woman aged over 50 worked as a personal assistant until she was signed off work with depression and anxiety following a breakdown five years ago.
- **Working participants:** Some participants were in permitted work (i.e. working sixteen hours or less in paid work per week) or volunteering. For example, one participant with chronic arthritis worked nine hours a week as a freelance designer, while another participant with a mental health condition worked as a dog walker.

By the second year of the pilot, there were examples of participants who had moved into paid work on either a full or a part-time basis. The extent to which changes in employment were attributed to the pilots are discussed in full in Chapter 6.

4.2.3 Other barriers to work

As would be expected, participants' health conditions were considered a key barrier to work by both staff and participants themselves, as discussed above. However, staff and participants also described a number of other - both separate and interrelated - barriers affecting participants. These are discussed below.

Confidence

Participants' interviews indicated that low self-confidence and esteem, anxiety and pessimism about work all acted as barriers to them considering work as an option. Participants expressed doubts about their ability to do a job or do it well because of their condition and the side effects of their medication, and raised anxieties about making their health conditions worse as a result of working in an unsuitable role. One participant with a back problem, for example, raised concerns about working while on his medication '*for health and safety reasons'*. Staff observed a 'deep seated' fear among claimants of being made to do work that was beyond their capabilities.

There were also examples of participants whose confidence had been knocked by a negative experience of returning to work. For example, a female participant (aged 18-29) with a mental health condition had returned to work during the pilot but found it too stressful to maintain a job alongside raising her two children and being a registered carer for her partner.

Staff noted that lack of confidence was a significant barrier particularly for participants who had been on sickness benefits long-term. It was thought that participants' self-confidence and their hope of returning to work had depleted over time. This was considered to be due to a lack of improvement in their health, an onset of mental health issues, a lack of contact and support from Jobcentre Plus, and at the same time becoming increasingly socially isolated. In fact, some participants had become so isolated that staff felt they needed help reintegrating into mainstream society before considering work as an option:

> *'A lot of them haven't worked for a long, long time, so just that thought process of thinking about going to work was quite worrying for them*.'
>
> (Adviser, HCP Pilot, Wave 1)

Limitations in skills, experience and employability

Participants who had been claiming sickness benefits for a longer period of time also identified the need to upgrade their skills due to a lack of relevant work experience, skills and qualifications. For example, one participant could not use the latest version of the software necessary for his trade and could not afford training. He also identified his lack of recent work experience as an obstacle to finding work.

A lack of basic skills in literacy and numeracy was also identified by staff as an important barrier, as well as a lack of basic digital skills and computer literacy, especially among older and long-term unemployed participants. Staff also noted that many participants (including those who did have employment histories) lacked employability skills, including writing job applications and CVs and job interview techniques.

Participants who had been away from the labour market for a long time were also anxious about navigating modern workplaces. One participant said:

> *'I'd be really, really scared to go back to work […] just the fact that I haven't worked for so many years and the fact that everything has changed so dramatically from when I was employed, you know?'*
>
> (Woman, 30-49, JCP Pilot, Wave 1)

There was also a belief among claimants that their health conditions would discourage employers from recruiting them, and made them less employable than other candidates. This view was echoed by some staff, who suggested that employers would be disinclined to employ people with particular illnesses, such as epilepsy, or would not want to employ people needing time off for regular hospital appointments.

Motivation and mind-set

Staff argued that participants' *perception* of their health was sometimes a bigger barrier to work than the health condition itself because these perceptions focused on their limitations. This mind-set was thought to be particularly common among long-term claimants with chronic conditions who had not come into contact with Jobcentre Plus or other providers of work-related support:

> '*Sometimes they come here and they'll say "I don't know why I'm here, I've got this wrong with me and I can't do this or that" and so they do take a little bit longer to work with. Because they do come in with a bit of a negative attitude and it's about changing the way they think.*'
>
> (Adviser, WP Pilot, Wave 1)

Pilot staff noted that these perceptions were often reinforced by medical professionals, who had told participants that they would never work again, and in some cases by family members who lacked belief in participants' capabilities:

> *'I mean if you look at the benefit history and it's someone who has been on IB for 20 years, their fixation is very much, "Well, I can't work and a doctor told me all of those years ago that I would never work again".'*
>
> (Work coach, JCP Pilot, Wave 1)

According to staff, lack of motivation to work was also a key barrier for older participants who were nearing retirement age. One work coach explained that claimants who had reached their sixties were harder to engage and motivate because they had experienced a decline in their health due to old age, were too close to retirement age to view the pilot and employment as worthwhile or expected age discrimination from employers. In contrast, staff noted that younger people tended to be more hopeful about the possibility of returning to work.

In light of this, staff tended to identify three main groups of pilot participants in terms of their barriers to work.

- Firstly, there were participants with debilitating and chronic conditions who staff considered unable to work now and in the future and believed should be in the Support Group.
- Secondly, there were participants, mainly long-term claimants, who were described as experiencing 'entrenched worklessness' and were considered to be extremely resistant to engaging with the support and/or to working again.
- Thirdly, there were participants who also had significant and multiple barriers to work, but who were willing and able to work in the future.

Other barriers

Staff described a range of other issues which also acted as barriers to participants returning or considering returning to work, including:

- **caring responsibilities**, including raising children and caring for relatives;
- **drug and alcohol abuse issues;**
- **offending histories**, some of which could restrict the types and locations of potential jobs;
- **financial issues**, such as debt and poor credit ratings (which, for example, prevented participants from being able to start their own businesses);
- **financial disincentives**, for example to manage health conditions effectively, claimants often wanted part-time or flexible work, but expressed anxiety over managing financially on a low income; and
- **lack of knowledge about the support** available to help prepare for or enter work.

4.3 Summary

This chapter has summarised the characteristics of participants across the three pilots.

The majority of participants in the pilots were white, aged 45 or above, with low levels of education, with no dependent children aged under 16, and rented their accommodation. Respondents were evenly split between male and female. Most respondents had been in paid employment at some point in the past. Most also had contact with their family at least on a weekly basis.

There is no baseline data on work attitudes available for pilot participants, but data collected by DWP from a sample of claimants in scope of the pilots found that at the outset of the pilot, around two-thirds reported that their health condition or disability currently ruled out the possibility of work; around a half reported that they did not know when they would be able to work and around one in six felt that they would never be able to do so. The majority said that they were not currently undertaking any job-related activities.

While treatment and control groups were broadly similar for each pilot, there were differences in work-related characteristics across the three pilots, a reflection of the different geographical areas where the pilots were organised. Those in scope of the Work Programme pilot were more likely to say that the presence of their health condition or disability ruled out the possibility of work at that time and were less likely to be undertaking work-related activity. Those in scope of the JCP pilot were more likely to be undertaking such activities. Those in the JCP pilot (and control group) also tended to have higher qualifications than those in the other two pilots.

Qualitative interviews with participants and staff revealed that the severity of health conditions and disabilities and the extent to which claimants' lives were affected varied widely. There were those who could manage daily life independently and work a small number of hours, others had more limited mobility, were on strong medication or had regular hospital stays, and some had unstable conditions with fluctuating effects.

Some participants also suffered from multiple health conditions and/or disabilities. A common trajectory included participants who started off with a physical condition and subsequently saw their mental health deteriorate.

Participants' health issues were a key barrier to work, along with lack of confidence, anxiety and pessimism about returning to work. Indeed, staff felt that participants' mindset about work, which was linked to their perceived limitations, was a key barrier alongside their health conditions, particularly for longer-term claimants. Participants who had spent a long time away from the labour market also faced outdated skills and experience, while other separate or interrelated barriers included caring responsibilities; drug and alcohol abuse issues; offending histories; financial disincentives; problem debt; and lack of knowledge about the support available to help prepare for or enter work.

5 Support models and pilot delivery

This chapter examines the support models and the delivery of support in each of the three pilots in turn – the Jobcentre Plus (JCP) pilot, the Work Programme (WP) pilot and the Healthcare Provider (HCP) pilot. It first provides a description of the support delivered in each of the pilots and staff and participant views on that support, drawing on qualitative data. It then looks at how the pilot participants' experience of support differed from that of control group participants for each pilot, drawing on Wave 1 end-stage survey data (i.e. data for respondents who were between 20 and 24 months into the 24 month package of support). Subsequently, differences between the support received during the pilot and after the pilot are explored, including a review of the types of post-pilot support offered. The last section in the chapter integrates the qualitative and quantitative findings, comparing delivery across the three pilots.

5.1 Jobcentre Plus pilot

5.1.1 The support model and participant journey

The JCP pilot offered a maximum 530 minutes of contact time per year, with the same JCP work coach where possible[29], over a two-year period. The first three meetings were intended to be face-to-face, after which appointments could take place by telephone or in person. Each participant was required to have an action plan listing mandatory time-bound Work-Related Activity (WRA). In contrast, control group participants were entitled to 88 minutes of contact time per year with a work coach, though they were free to request more support if they wanted. They were also required to have an action plan and to complete time-bound WRA.

While the support model remained the same throughout the pilot, an organisational change that took place in the second year affected the way the support model was delivered in practice. As discussed in Chapter 2 the introduction of the new work coach delivery model which requires work coaches to support claimants across a range of benefits (e.g. Jobseekers Allowance, Universal Credit, ESA and Income Support) affected the amount of time work coaches spent with claimants. This issue is discussed in more detail later in this chapter.

[29] This was not always possible due to staff sickness, turnover and availability, particularly in smaller offices.

5.1.2 Referral process

When the pilot started, claimants were randomly assigned to either the control or the treatment group. A notification letter was sent to claimants assigned to the pilot group, explaining that they had been selected for the pilot and that participation was mandatory. In some instances, work coaches also provided an information leaflet or made a follow-up phone call to pilot participants to allay any anxiety about the pilot and emphasise its benefits.

Although not all participants remembered being notified about the pilot, for those who could, their initial reactions were mixed. One group of participants welcomed the offer of enhanced support and were keen to find out what this entailed. These participants tended to be closer to the labour market – either due to already being in permitted work or because of recent work history. Another group recalled feelings of anger and anxiety because they did not consider work to be an option due to their health and were concerned about being sanctioned as a result of being unable to engage fully with the support.

At the point of referral, work coaches reported receiving very basic details about participants such as their name and their health condition or disability. One view among work coaches was that more information regarding participants' health conditions (such as notes from the Work Capability Assessment) would have provided a more accurate understanding of participants' limitations. This view was countered by work coaches who placed greater importance on participants' own perceptions of their abilities and the constraints caused by their health.

5.1.3 Initial appointment

The purpose of the initial appointment was to introduce the pilot to participants, conduct an assessment of their support needs and to draw up an action plan. In their introduction to the pilot, work coaches reassured participants that the support was aimed at helping them to *progress towards* but not immediately move back into work.

The assessment of support needs involved a review of participants' attitudes and barriers to work, previous work experience and skills and work aspirations. There were two broad approaches to conducting the initial assessment: use of a baseline assessment tool developed specifically for the pilot or an open discussion-based approach. The latter approach was generally considered by work coaches to be the best way to get to know pilot participants and to get them to open up:

> *'I think you get to know customers more by […] talking to them, finding out about them, rather than asking them sets of questions. I think it's a more personalised approach you need, rather than, "I've got this tool that I've got to fill out with you".'*
>
> (Work coach, JCP pilot, Wave 1)

While the baseline tool was considered useful for collecting basic information, its use was not widespread. Work coaches who preferred not to use the tool thought it was too prescriptive in terms of wording and therefore lacked relevance for some participants. For instance, questions such as 'How far are you from the labour market?' were perceived as difficult for participants to understand and answer.

Furthermore, work coaches generally had extensive experience of working with ESA claimants and were confident that they could conduct appropriate and tailored assessments without using prescribed tools.

Pilot participants who remembered the initial appointment said they discussed their employment history, educational background, future work aspirations and their health with their work coach. Some participants noted with frustration that their health condition was omitted from the initial assessment and reported raising this themselves.

Participants who had reported feeling optimistic when they were notified about the pilot – who tended to be closer to work – said that, after the initial meeting, they continued to feel optimism that the support would help them progress towards work. Participants who did not share this level of optimism at the outset still did not feel ready to consider work as an option after the first meeting. Typically, this included participants who had been out of work for longer due to their health condition or disability.

5.1.4 Subsequent appointments

As explained above, work coaches were expected to provide a maximum of 530 minutes of support to pilot participants each year, over a two-year period. Generally, the frequency of appointments ranged from every two to six weeks, with each appointment lasting between 10 minutes and an hour, and in some exceptional cases up to two hours.[30] Work coaches were free to determine the length of appointments within the 530-minute guideline. In comparison, control group participants were entitled to 88 minutes per year of contact time with a work coach. Requests for more support by the control group were reported to be granted, depending on work coaches' capacity, but pilot participants were said to take precedence.

Pilot guidelines stipulated that the first three appointments should be face-to-face, followed by either face-to-face or telephone appointments. Work coaches indicated that there were some exceptions to this in practice, typically in relation to people with limited mobility due to physical disabilities or conditions such as agoraphobia. Appointments with these participants took place over the telephone or via a series of emails.

For subsequent appointments, work coaches preferred face-to-face meetings rather than telephone because they were lengthier (30-40 minutes compared to 10-20 minutes). These longer appointments enabled more in-depth discussion and facilitated closer and more collaborative relationships with participants. There were exceptions to this where participants had limited mobility, were engaging with external support as part of the pilot or where work coaches were satisfied with their motivation to engage with the support, in which case telephone appointments were viewed as appropriate.

Participants who found attending face-to-face interviews at the Jobcentre Plus office difficult included participants who had problems with mobility and those with mental health conditions who found attending face-to-face appointments stressful. In some instances, participants reported that their work coach had recognised this and offered telephone support instead.

[30] Where participants lived particularly isolated lives and wanted social interaction and pastoral support.

In the first year of the pilot, participants' and work coaches' accounts indicate that there were three factors that influenced the length and frequency of appointments: participants' proximity to the labour market, the type of activities being undertaken and their health condition or disability. Those considered by work coaches to be more 'work-ready' had lengthier and more frequent appointments as work coaches intensified the support needed to make the final steps towards securing employment, such as help writing job applications or CVs. Conversely, work coaches reported reducing the frequency and length of appointments if participants were engaged in activities such as attending a course or volunteering, or if their health presented significant constraints to engaging with the pilot.

The frequency of support sometimes changed in the first year. One district trialled a fortnightly meeting pattern, after initially holding appointments every six weeks. Some work coaches continued this routine with more work-ready participants but also noted that the frequency of meetings was limited by diary space. Work coaches also described setting more frequent appointments at the beginning of the pilot to secure motivation and willingness to participate, after which appointment frequency was relaxed.

Towards the end of the pilot some work coaches reported a drop in the frequency of appointments. This was due the introduction of the new work coach delivery model which requires work coaches to support claimants from all claimant groups (e.g. JSA, ESA and IS). Prior to the new delivery model, work coaches delivering the pilot only saw ESA customers.

The new delivery model affected the way work coaches interacted with and supported pilot participants. In the first year of the pilot, work coaches explained they were able to provide participants with consistent appointments at a frequency both the participant and work coach felt appropriate. During the second year, because of the operational changes, work coaches could no longer commit to regular appointments with participants. In some cases, the change to their role meant they no longer had control over their diary. Participants did not raise the change in frequency of appointments as an issue.

Work coach continuity

Pilot participants were intended to see the same work coach over the two-year pilot, however, organisational staffing changes also had implications for work coach continuity. Pilot participants who reported that their work coach had changed, in some cases up to three times, expressed mixed views on this. One view was that changing work coaches had little effect. In these instances, the transition from one work coach to another often had happened early on in the pilot. Others were more affected by the change, which had influenced their experience of the pilot. For example, a participant who had two work coaches leave in quick succession related this back to them personally which caused worry and concern.

5.1.5 Action plans and monitoring progress

Work coaches were expected to review progress on an ongoing basis. Action plans were developed in collaboration with participants with use of motivational interviewing techniques to encourage buy-in and ownership of actions. Action plans included work-related activity, which was described as mandatory tasks aimed at moving participants

closer to the labour market, for example seeking work experience or volunteering opportunities or writing a CV. Although the use of action plans was widespread, some work coaches would not use them because they did not want to mandate activities within a time-bound period, as this was considered unfair to participants coping with a health condition or disability.

Action plans were reported to be the main tool used to monitor participant progress by work coaches. They were used to capture achievements such as participants building the confidence to attend appointments alone, or starting to volunteer. Operational and district-level managers believed the baseline tool was also used regularly to monitor progress. However, as explained, its use was not widespread among work coaches because the questions were considered too restrictive and not always applicable to participants. In contrast, work coaches who did use the tool found it a good motivational device, as it helped demonstrate progress to participants.

Pilot participants had limited recollection of developing and reviewing action plans or undergoing baseline assessments, but they did recall reviewing activities during their appointments.

5.1.6 Mandation

The JCP pilot had two elements of conditionality, which, if breached, could lead to participants being put forward for a sanction. These were:

- attending all scheduled appointments with a work coach, and
- undertaking all WRA set by a work coach.

According to work coaches, throughout the pilot, failure to attend rates for appointments were low and participants usually gave advance notice if they could not attend an appointment. Common reasons for missing appointments were reported to be participants being too unwell or forgetting about the appointment, often as a result of a health condition. Work coaches believed they used good judgement about whether the reasons for non-attendance were genuine, having built strong relationships with participants.

Work coaches explained that there were instances where insufficient reasons had been given for non-attendance and on these occasions pilot participants were put forward for a sanction. There was also a group who persistently failed to attend appointments; these participants were also put forward for a sanction. Work coaches reflected that in these instances this often led to participants engaging with the pilot and attending subsequent appointments.

The type of WRA pilot participants were mandated to undertake varied greatly and was largely influenced by the severity of a participants' health condition and proximity to the labour market. For instance, participants with highly-limiting conditions such as agoraphobia might be asked simply to walk up to the front gate or around the back garden. Those closer to the labour market were given more work-focused activities, such as reviewing their CV or researching volunteering opportunities.

There were two opposing views on whether mandation was a useful tool for engagement. One was that mandation was necessary to ensure engagement with the pilot; the view was that if work coaches were not able to use this tool, participants

would not turn up to appointments. Others viewed mandation as a counterproductive approach that created a barrier to building a successful and trusting relationship with pilot participants:

> *'You want them on board. You want them to be working with you, not for them to think that you're part of the machinery that takes their money away from them.'*
>
> (Work coach, JCP pilot, Wave 2)

The decision to mandate activities was left to work coaches' discretion. Work coaches stressed the importance of ensuring that mandated WRA was within the capabilities of each participant and aimed to agree activities collaboratively with participants to avoid benefits being sanctioned unfairly:

> *'With this group it is mandatory that they do something, but I think as work coaches we have to be realistic in that as well, because I think if we set someone up to fail then we may as well pack up and go home. So it has to be achievable for that customer.'*
>
> (Work coach, JCP pilot, Wave 1)

In one district, Operational Managers were concerned that work coaches were only setting what they considered to be 'soft' work-related activities, such as requiring a participant to leave the house. This had been discussed with work coaches, who had been instructed to introduce more work-focused activities once initial 'soft' activities had been achieved by participants.

Work coaches said that they were understanding in situations where WRA was not completed. They reported giving participants the chance to explain why, rather than immediately putting them forward for a sanction, and said that more often than not there was a reasonable explanation. In instances where participants were put forward for a sanction, this was usually due to persistent refusal to engage with the pilot without good reason.

While participants were aware of the consequences of missing appointments, understanding of the conditionality associated with WRA was less evident. Some participants were also under the impression that they could be sanctioned even if they had a good reason not to comply such as ill-health, although these participants reported being corrected by their work coaches. There were two cases of participants experiencing a sanction in the qualitative interviews. The first was due to a participant missing the first appointment, which the participant reported being unaware of. The resulting financial hardship prompted the participant to ensure they attended all of their subsequent appointments. The second case involved a participant who received two sanctions. They presumed these sanctions were applied because the work coach did not believe they had been looking for work. Soon after they were put forward for the second sanction, they found part-time work. The participant did not experience a sanction this time, and believed this was due to them finding work.

5.1.7 Types of support provided

Work coaches could pick from a variety of in-house and external provision to support participants. This 'menu' of support included existing options as well as options tailor-made for pilot participants (and subsequently made available to other ESA claimants).

Though the support options were largely similar for pilot and control group claimants, more regular contact with the pilot group meant that work coaches had more opportunity to offer them the available support.

Toward the end of the second year of the pilot, the Local Supplier Framework came to an end. This resulted in some provision being discontinued and work coaches reported that this limited access to some external provision, but not all. Work coaches did not, however, think it had a negative effect on pilot participants as the provision would have already been offered to participants during their time on the pilot, if it had been relevant.

Core elements of JCP pilot support

Work coaches were in general given flexibility to decide which types of support to offer individual pilot participants and in what sequence. The exception to this was three core elements of support, which all pilot participants were expected to have engaged with:

- **Work Related Activity** - activities which are expected to help pilot participants move closer to the labour market
- **Better Off Calculation** (BoC) - to demonstrate the financial benefits of moving into work, with the underlying assumption that this would motivate participants to consider work as an option
- **Skills conditionality** – referral to the National Careers Service for support with skills and employability needs, for example help developing a CV and reviewing skills and abilities.

Although BoCs and referral to the National Careers Service were intended to take place within the first three appointments, there are indications from work coaches that neither of these core elements were used uniformly and in some cases not at all.

Work coaches who decided against undertaking BoCs felt that they applied undue pressure on participants who were not ready to consider work and were concerned that they only illustrated a financial benefit for full-time work, which was not felt to be a realistic goal for everyone on the pilot. Similarly, work coaches felt that a referral to the National Careers Service to build a CV immediately upon joining the pilot was not appropriate for all pilot participants, as work was not always a realistic option at that point.

Operations Managers reported that they gave permission for work coaches to use their discretion in relation to these elements and to introduce them when it was appropriate for individual participants.

Soft skills development

Work coaches explained that prior to engaging in employment-related activities, participants often needed to develop their soft skills such as confidence and motivation. The types of support available to develop soft skills included confidence-building classes, counselling, mentoring, outdoor fitness activities, musical instrument lessons and wellbeing courses.

In some cases, external providers delivered a menu of soft-skill support alongside health and employment related support. For example, in one district participants were referred to a centre set-up by a community collective which was mainly targeted at people with mental health conditions. The support available ranged from outdoor

activities to employment support. Work coaches explained the main purpose for the provision was to acclimatise participants to visiting and engaging in activities on a regular basis.

Work coaches also mentioned that pilot participants had access to confidence and motivation courses that were set-up for all ESA claimants to access.

For those who were ready for activities such as volunteering, exposure to work was also seen as a valuable way to increase confidence. Improving confidence and motivation was said to be particularly important for pilot participants who had been out of the labour market for long periods of time:

> *'Quite a lot of these people have been out of work for quite a period of time and it was about building their confidence to sort of get back into the - well, society to be honest with you, not just the working.'*
>
> (Work coach, JCP pilot, Wave 1)

Support to develop soft skills was contracted out to local colleges and community and voluntary organisations. In some instances, work coaches organised external contractors to undertake group sessions with their caseload, while in other cases, new provision was sourced to fill gaps. For example, in one district a local charity was sourced to deliver confidence building-courses. Overall, a mixture of new and established links with local organisations were utilised (see partnerships section below for more information).

Alongside contracted-out provision, the support work coaches provided in appointments was also seen as a key mechanism for building up participants' confidence and motivation.

Employment-related support

Employment related support offered to participants included help with:

- **employability skills:** such as writing CVs and job applications;
- **work experience:** volunteering, work experience or permitted work opportunities to help participants build up work experience and re-acclimatise to a work environment;
- **basic skills:** improving literacy, numeracy and IT;
- **employer engagement:** facilitating access to local employers; and
- **in-work support:** ongoing support to maintain work.

Support with employability skills was mainly provided by the work coach or through the National Careers Service. Access to courses and work experience or volunteering opportunities largely depended on what was available in the local area. In some instances, work coaches developed new links to provide participants with bespoke opportunities for their particular skill level and health condition. For example, links were made with organisations that had specialist knowledge of supporting people with health conditions to volunteer or with college courses that could tailor timetabling to individual participants (e.g. where medication meant that morning sessions were unsuitable).

Experiences of skills training were widespread and included CV-building workshops and courses in English, Maths, IT and bookkeeping.

Throughout the duration of the pilot there was limited evidence of employer engagement, which is likely due to the fact that pilot participants were not considered to be work-ready. In instances where work coaches had made efforts to engage employers, they used the Jobcentre Plus job broker model. This involved an employment co-ordinator developing links with local employers to encourage them to employ Jobcentre Plus claimants.

Across both years of the pilot, in-work support did not feature as a key part of the delivery model. Work coaches offered participants 'light touch' support which involved ensuring participants knew the work coach was available if needed, as well as phoning pilot participants every couple of months to check-in. Work coaches also referred some participants who had entered work to Work Choice.[31]

From the pilot participants' perspective, in-work support was a key gap in the provision. For example, one pilot participant who had moved into part-time work reported she would have welcomed a follow-up phone call from her work coach to check her transition into work had gone well. She would have also welcomed advice on increasing her hours while managing her health condition.

There was also limited evidence of post-pilot support. The exception being a work coach who had been signposting participants to Work Choice. The work coach explained that they were aware they were not supposed to be doing this, but highlighted they felt it would benefit certain participants who were close to work. For example, one participant who had severe learning disabilities was ready to find part-time work and the work coach felt it would be beneficial for them to continue working toward this goal with support from Work Choice.

Work coaches expressed concern about the move back to the standard offer of 88 minutes contact time post pilot. They were concerned that the drop-off in support in could undo the progress made during the pilot. Concerns were also raised that shifting back to seeing different work coaches under the standard offer could undo the trust developed through the continuity of work coach offered through the pilot.

Work coaches also raised concerns about participants being referred to the Work Programme. The Work Programme was viewed as being heavily work-focused, which was different to the JCP pilot approach. It was believed this type of support might be too intense for many of the participants, particularly those who were further away from the labour market.

Health-related support

While it was not a key focus of the JCP Pilot, work coaches signposted and sometimes referred participants to health-related support services. As discussed in Chapter 2, Work Psychologists were a source of advice and support for work coaches in relation to dealing with pilot participants, though there were reports that there was less access to Work Psychologists' support in the second year of the pilot (see Chapter 2). In some cases, Work Psychologists attended meetings with work coaches

[31] Work Choice is DWP's specialist disability employment programme. Provider organisations offer pre-work and up to two years in-work support. This includes one-to-one contact with an adviser who can help navigate access to additional in-work support such as through Access to Work. See: https://www.gov.uk/work-choice/overview

and participants to discuss the best approach to ongoing support. Work coaches also referred participants to sessions with Work Psychologists for advice on managing their health conditions.

Work coaches mainly signposted to services offering mental health support, from providers such as local mental health charities (e.g. Mind and Rethink) and Improving Access to Psychological Therapies (IAPT) services. Other types of health-related support included: drug and alcohol support, condition management, counselling, pain relief, support from Autism and Asperger's syndrome charities and around independent living from charities for specific conditions such as sight loss. There were examples of work coaches liaising directly with participants' GPs and social workers, but these were limited.

Pilot participants reported being signposted to health-related support such as local self-help support groups related to their particular health condition. However, they did not always take this support up, citing their health condition or disability as a barrier. For example, one participant explained that their work coach had signposted them to a support group for fibromyalgia, but they felt unable to attend because they experienced anxiety around strangers.

Other support work coaches offered participants included access to Troubled Families advisers and Citizens Advice for support with benefits.

5.1.8 Partnerships

Partnerships were made with external providers, either specifically for pilot participants or more generally. They were often facilitated by a partnerships manager.

Examples of partnerships developed specifically for pilot participants included a local college delivering a programme to support participants into volunteering and a musical instrument group set-up with a view to building confidence skills. A broad range of partnerships developed for all JCP claimants were also accessed including mental health support, housing support, skills and training, courses, volunteering and permitted work opportunities.

Jobcentre Plus staff reported that partnerships with local providers worked well when the following practices were adhered to:

- warm handover – work coach introduced participants to partners putting them at ease with the new service provider
- close working relationships – having a single point of contact at the provider gave work coaches ease of access to partnership's services and this made it easier to get feedback on participants' progress
- visiting provision – allowing work coaches to become familiar with provision so they could effectively market the service to participants.

Gaps in support

As described above, a mixture of new and established local providers were engaged to deliver support for the pilot and new provision was sourced to fill gaps. However, interviews with Jobcentre Plus staff highlighted that there were gaps identified in the support available for pilot participants that they were unable to fill. This included

support for people with learning disabilities, mental health support and support for condition-management. An Operational Manager explained that it was often difficult to source condition-management, and, when it was available, it came at a high cost:

> *'We're running another pilot as well for ESA which we're trying to source condition management and it's very expensive and it's clearly something missing, whatever customer group, whether they're 12 months or whatever. I think it needs to be addressed.'*
>
> (Operational Manager, JCP pilot, Wave 1)

Interviews with JCP staff during the second year of the pilot revealed a wider range of gaps in provision. This included a lack of availability of supported employment, counselling and mentoring. Gaps in provision varied across different districts and tended to be different and dependent on the availability of external provision in the local area. Further, the availability of provision was reported to be particularly patchy in rural areas.

Work coaches sometimes had difficulty sourcing or funding local provision that was delivered in the right format for this claimant group. This included consideration of problems with physical mobility, low confidence, social anxiety and the effects of medication. One-to-one or small group sessions would have worked well here. While efforts were made to commission new providers or adapt the mode of existing support to meet these needs (e.g. by tailoring timetables or providing smaller group support) this was not always possible. Likewise, within Jobcentre Plus offices, the lack of private space presented problems for participants who were unwilling to speak to work coaches in an open-plan environment. Though work coaches sometimes got around this by using colleagues' private offices, this was not considered practical because they did not have access to the information held at their work stations.

5.1.9 Aspects of support that worked well

Work coaches thought the JCP pilot worked well when participants trusted their work coach, where participants felt understood and were being listened to.

Jobcentre Plus staff explained that there were three key aspects of the delivery model that facilitated this:

- frequent and regular meetings with participants (e.g. meeting participants once every two to six weeks);
- time to listen and build rapport with participants; and
- flexibility to use a range of contact methods (e.g. face-to-face, phone, email) to maintain frequent contact with participants.

Frequent and regular meetings provided work coaches with the opportunity to build personal relationships and develop trust:

> *'The regularity of them coming in and talking to us meant that [...] we built relationships with them, and [...] they came to kind of trust us, [...] and our advice.'*
>
> (Work coach, JCP pilot, Wave 2)

Time spent with participants allowed work coaches to get to know participants' health conditions, barriers to work and aspirations. This helped work coaches to tailor and personalise their support, as well as build the trust of participants, which encouraged their continued engagement. Work coaches explained that once they had a more in-depth understanding of participants' needs they were able to able to personalise the journey, rather than offering a prescribed package of support:

> *'It wasn't a fixed structure that we had to do something at a certain time. We were able to adjust the journey that the customer had to each individual customer.'*
>
> (Work coach, JCP pilot, Wave 2)

The flexibility to support pilot participants via phone, face-to-face or email allowed work coaches to maintain contact with participants who could not always visit the Jobcentre due to their health condition or disability. There were two groups of participants where this proved particularly useful – participants those whose conditions worsened or fluctuated and where participants who could not initially visit the Jobcentre, largely due to issues relating to their mental health.

According to work coaches, specific support that worked well included Employment-related support, particularly permitted work and voluntary work were considered by staff as effective in moving participants closer to the labour market (for more detail on factors that led to positive participant outcomes please go to Chapter 7).

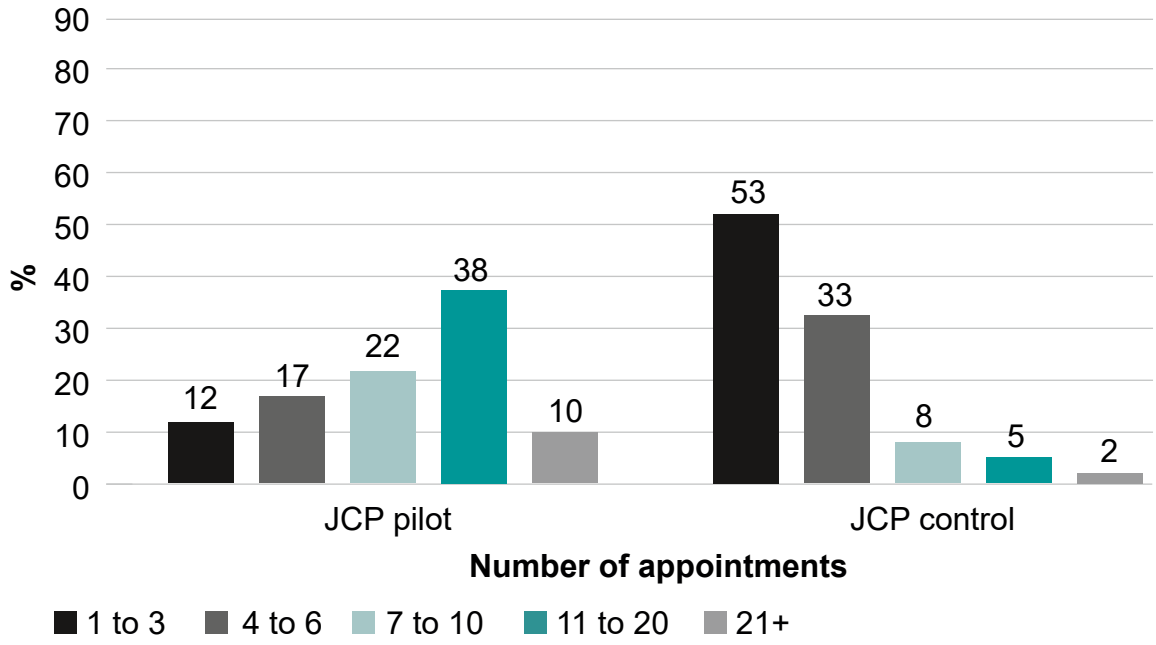
5.1.10 Comparing the support received by pilot and control group members

Appointments

Participants were asked how many appointments they had had with Jobcentre Plus since starting on the programme. JCP pilot participants reported a significantly higher number of appointments than JCP control participants. As shown in Figure 5.1, 38 per cent of JCP pilot participants reported 11 to 20 appointments, versus five per cent of JCP control participants, while ten per cent of JCP pilot participants reported 21 appointments or more, compared with two per cent of JCP control participants. On average[32], JCP pilot participants had attended 12.7 appointments with their work coach, while JCP control participants had attended only 4.5. This difference in the number of appointments between the two groups is consistent with the enhanced level of support the JCP pilot programme was intended to offer.

[32] The mean averages have been reported here.

Figure 5.1 Number of appointments with Jobcentre Plus

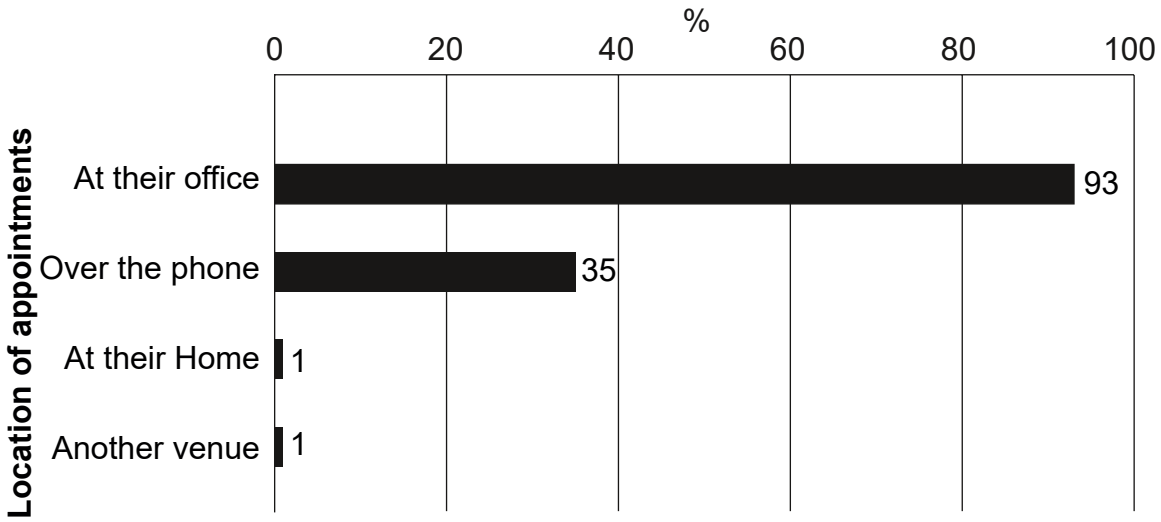


Base: All JCP pilot (466) and JCP control (599) respondents at Wave 1

Figure 5.2 shows that the majority of respondents had at least one appointment at JCP (93 per cent), with a far smaller proportion receiving at least one telephone appointment (35 per cent), an appointment at home (one per cent) or at another venue (one per cent).[33] There were no significant differences between pilot and control groups regarding appointment locations. The majority of participants (65 per cent) had face-to-face appointments only, while less than a third (29 per cent) reported a combination of face-to-face and telephone appointments, and less than a tenth (seven per cent) reported telephone-only appointments. Participants with a severely limiting health condition (within both pilot and control groups) reported significantly fewer appointments than those with a health condition that is not severely limiting (see Appendix Table 5.1). This reflects staff reports that the frequency and length of appointments were reduced if participants' health presented significant constraints to their engagement with the pilot.

[33] Participants were asked to select all locations that applied.

Figure 5.2 Location of appointments with Jobcentre Plus



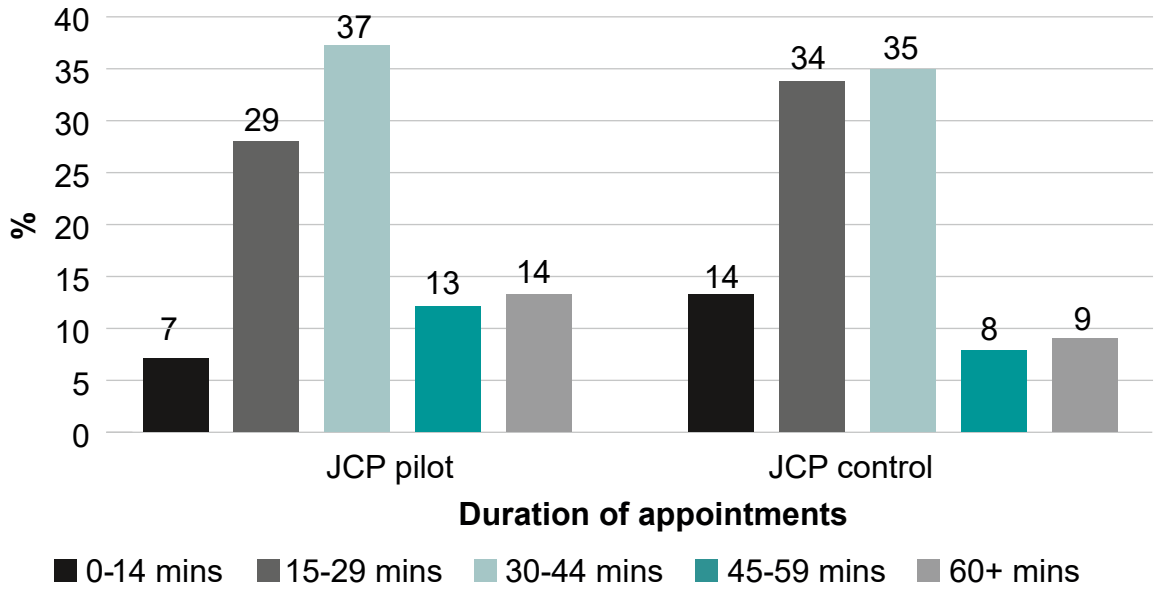
Base: All JCP pilot respondents (500) at wave 1

Over half of all participants on the pilot (56 per cent) reported that they met with their work coach at least once a month, compared with just 12 per cent in the control group. For the majority of JCP pilot participants, these appointments had always been the same frequency (63 per cent), while 19 per cent noted that appointments were more frequent at the start, and 12 per cent noted that appointments had become more frequent recently.

The length of appointments with Jobcentre Plus work coaches were significantly longer for participants in the JCP pilot compared to the control group. As shown in Figure 5.3, 27 per cent of JCP pilot participants reported that appointments typically lasted at least 45 minutes versus 17 per cent of JCP control participants. This includes 14 per cent of participants in the JCP pilot whose appointments typically lasted 60 minutes or more (versus nine per cent of the control group).

Considering the number of appointments and the duration of appointments, JCP pilot participants tended to have a lot more contact with their work coaches than JCP control participants. This, again, reflects the enhanced level of support the JCP pilot programme was intended to offer.

Figure 5.3 Duration of appointments with Jobcentre Plus

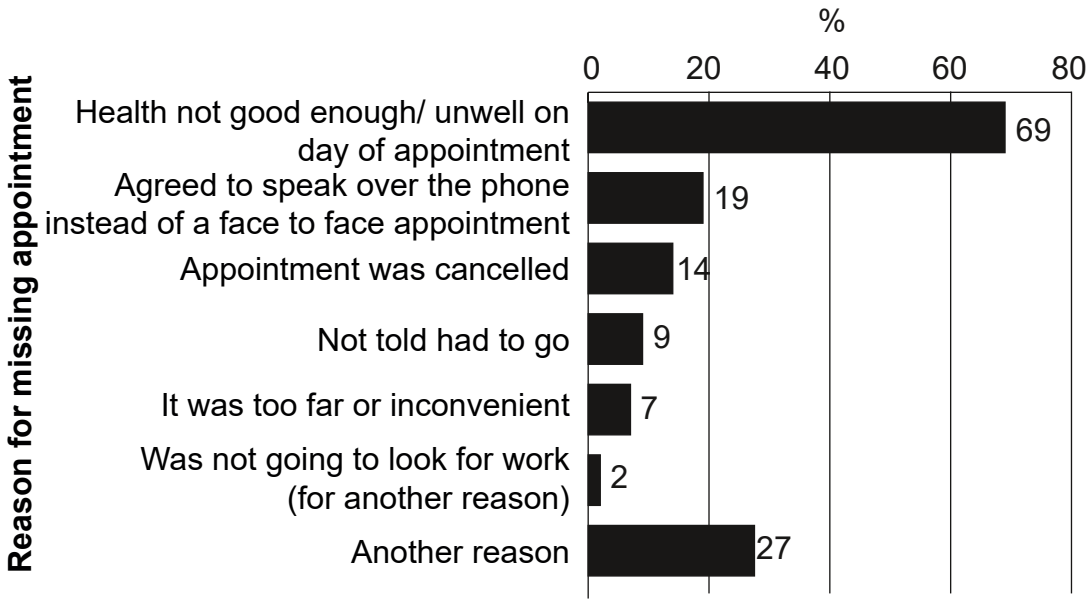


Base: All JCP pilot (466) and JCP control (612) respondents at Wave 1

When JCP pilot participants were asked[34] whether they had missed any appointments, the majority (62 per cent) had not. The 38 per cent that had missed an appointment were asked to give reasons for their non-attendance. As illustrated by Figure 5.4, by far the most common reason cited for missing an appointment was their health not being good enough or being unwell on the day of the appointment (given by 69 per cent of pilot participants who had missed an appointment). Other frequently-cited reasons included agreeing to speak over the phone rather than attending a face-to-face appointment (19 per cent) or the appointment being cancelled (14 per cent).

[34] This question was not asked of the JCP control group.

Figure 5.4 Reasons for missing an appointment with Jobcentre Plus

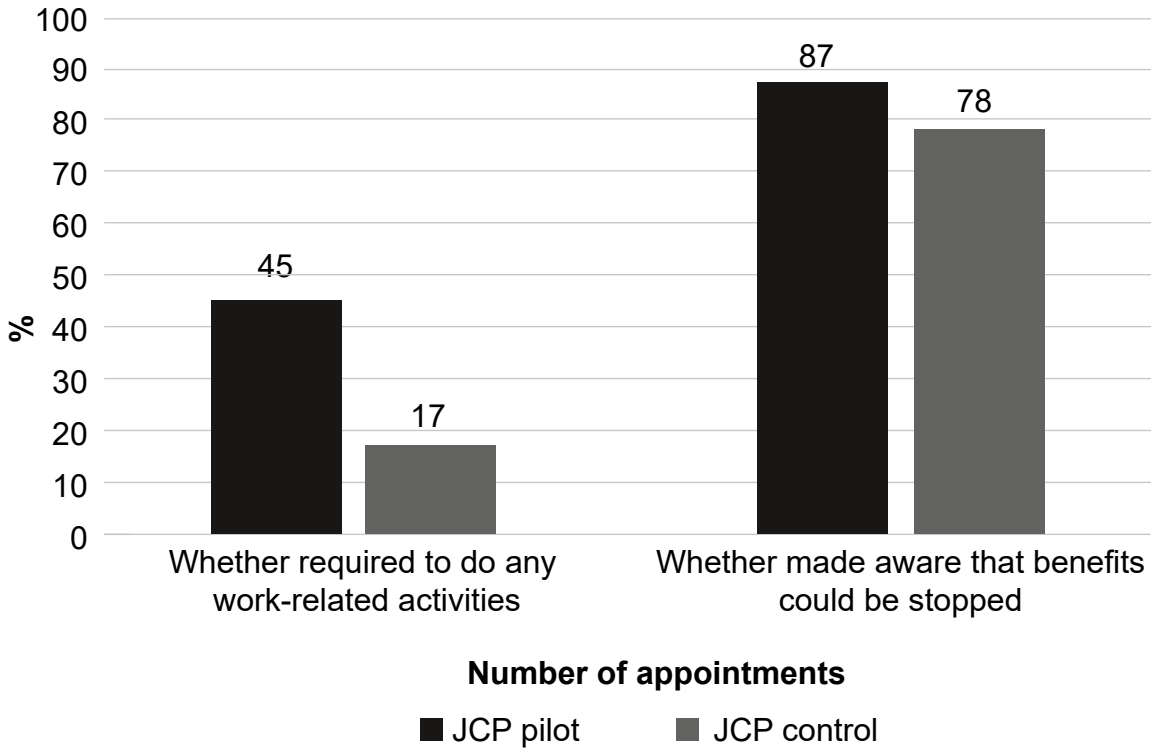


Base: All JCP pilot respondents who missed an appointment (192) at wave 1

Mandation

JCP pilot and control group participants were asked whether they were required to undertake work-related activities as part of their benefit claim, as well as whether their work coach had made them aware that their benefits could be stopped if they did not undertake compulsory activities (such as WRA or attending meetings). As shown in Figure 5.5 participants in the pilot group were significantly more likely to report that they were required to undertake work-related activities (45 per cent in the pilot group, versus 17 per cent in the control group), and were also significantly more likely to report being aware that their benefits could be stopped if they did not undertake compulsory activities (87 per cent in the pilot group, versus 78 per cent in the control group).

Figure 5.5 Whether JCP respondents were required to undertake work-related activities and made aware that benefits could be stopped

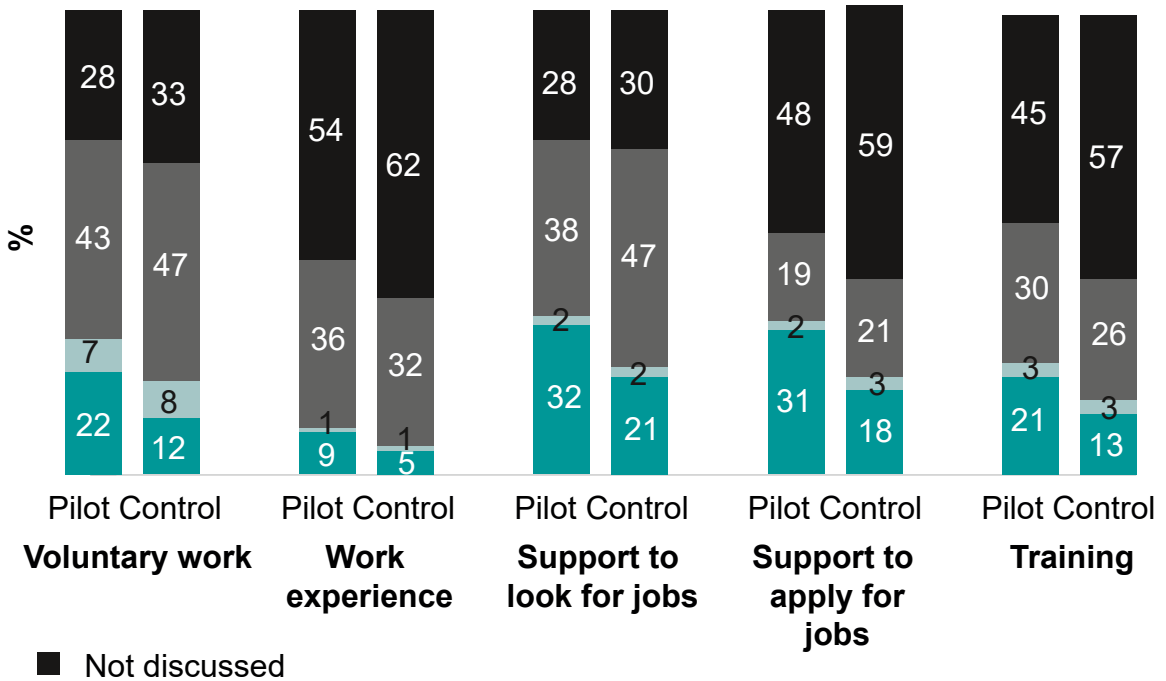


Base: All JCP pilot (497; 497) and JCP control (613; 616) respondents at Wave 1

Types of support offered and received

All JCP pilot and control participants were asked about the type of support they discussed and received from their work coaches, and more specifically whether any support received was *as a result* of the discussion they had had with their work coaches. The different types of support can be divided into three broad areas – employment-related, health-related, and other support – each of which is considered in turn (also see Appendix Tables 5.22 to 5.32).

Figure 5.6 Employment-related support discussed and received (JCP respondents)



Base: All JCP pilot and JCP control respondents: Voluntary work (491, 605); Work experience (482, 588); Support to look for jobs (490, 610); Support to apply for jobs (491, 614); Training (490, 615) at Wave 1

Looking at employment-related support, Figure 5.6[35] shows five types of employment-related support which might have been offered to JCP pilot participants. Support to look for jobs as well as support to apply for jobs or write a CV were discussed and received by a notable proportion of JCP pilot participants (32 per cent and 31 per cent respectively). For JCP control participants, just 21 per cent discussed and received support to look for jobs, while 18 per cent discussed and received support to write a CV or apply for jobs.

There were also higher levels of engagement in voluntary work and training or college courses amongst JCP pilot participants than JCP control participants. Twenty-two per cent of pilot participants discussed voluntary work with their work coach and went on to engage in voluntary work (as a result of the discussion) compared to 12 per cent of JCP control participants. For training or college courses, 21 per cent of JCP pilot participants discussed and received this type of support, compared with 13 per cent of JCP control participants.

For those JCP pilot participants that did go on to attend training or college courses as a result of discussions with their work coach, the majority reported attending one course (48 per cent), with fewer reporting attending two courses (32 per cent) or three or more courses (20 per cent).

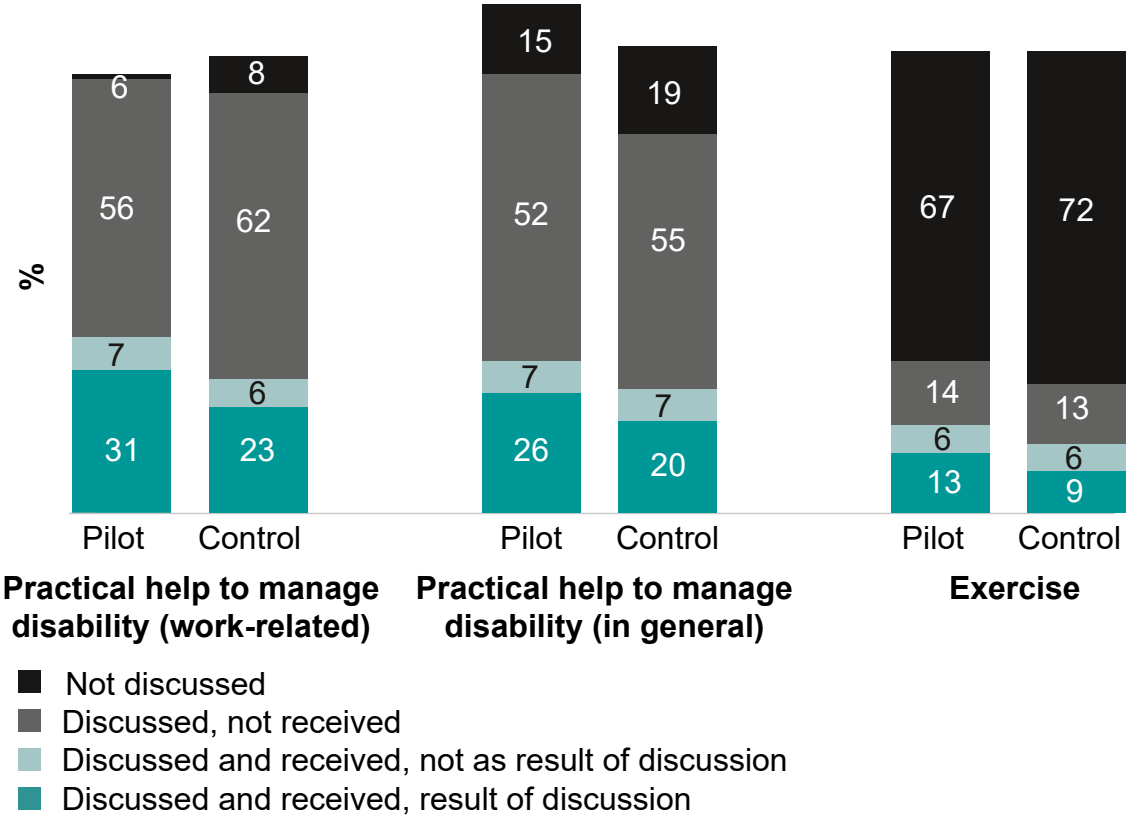
[35] Figures 5.6 to 5.8 only display the types of support where there was a significant difference between the JCP pilot and the JCP control group.

Courses on computing skills were the most common type of course attended, reported by 49 per cent of JCP pilot participants that received help with training or college courses. A range of job-specific training was also commonly mentioned, such as hair and beauty and gardening courses. In total, 24 job-specific training courses were mentioned and some form of job-specific training was mentioned by 37 per cent of participants that received help with training. One-quarter of JCP pilot participants (23 per cent) that received help with training or college courses reported attending maths and literacy courses, while training in personal development (such as confidence-building, social skills or interpersonal skills) was reported by ten per cent of JCP pilot participants (also see Appendix Table 5.27 and 5.28).

Overall, these higher levels of employment-related support for the JCP pilot group reflect the intended aims of the pilot to provide an enhanced offer of employment support.

Work experience was not discussed or received by the majority of participants in either the pilot or control group. However, JCP pilot participants were significantly more likely to have discussed and gone on to undertake work experience as a result of the discussion than control group participants (nine per cent, versus five per cent for JCP control).

Figure 5.7 Health-related support discussed and received (JCP respondents)

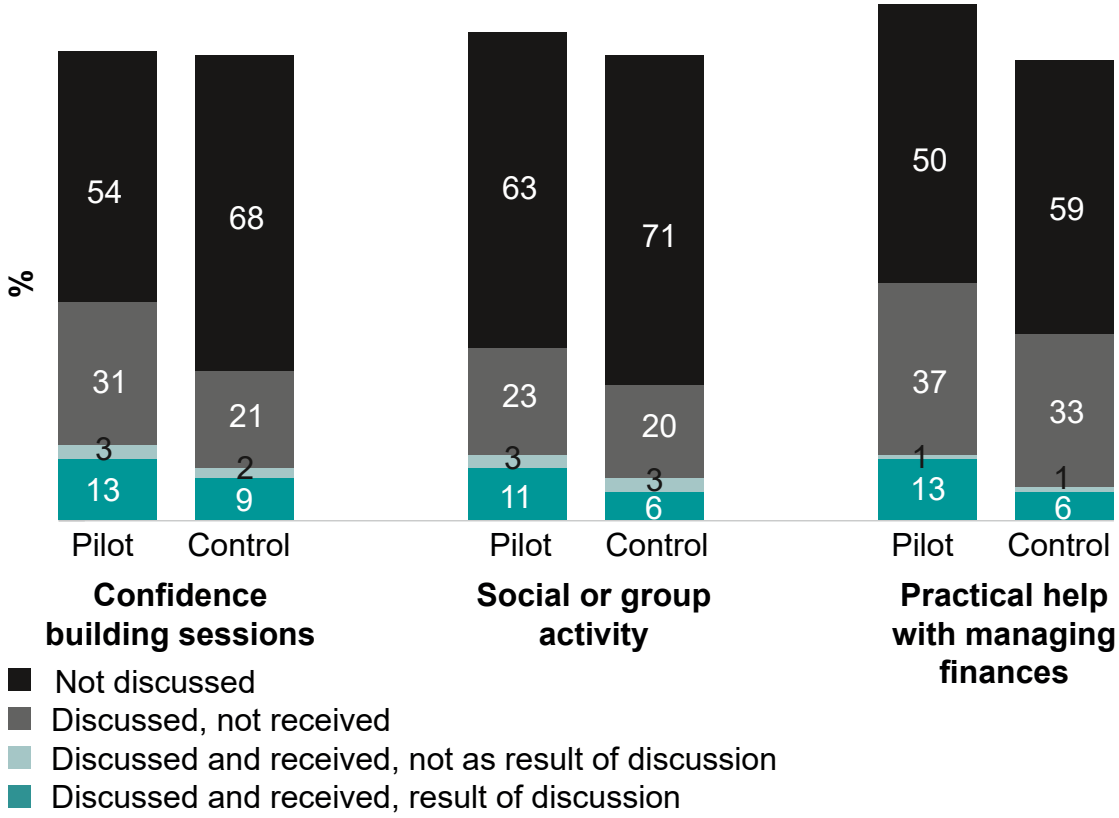


Base: All JCP pilot and JCP control respondents: Practical help... (work related) (476, 597); Practical help... (in general) (476, 591); Exercise (492, 599) at Wave 1

With regards to health-related support, JCP pilot participants were significantly more likely to have received practical help to manage their health condition in relation to work than JCP control participants (31 per cent of JCP pilot participants compared to 23 per cent of JCP control participants). Similarly, as shown in Figure 5.7, 26 per cent of JCP pilot participants discussed and received practical help to manage their condition or disability in general (i.e. not in relation to work) versus 20 per cent in the JCP control group.

Exercise was not discussed by many JCP pilot or control participants. However, while the overall proportions are low, JCP pilot participants were still significantly more likely to have discussed exercise, and gone on to do more exercise as a result of the discussion, than JCP control participants (13 per cent and nine per cent respectively).

Figure 5.8 Other support discussed and received (JCP respondents)



Base: All JCP pilot and JCP control respondents: Confidence building (474, 595); Social or group activity (479, 596); Practical help with managing money (478, 598) at Wave 1

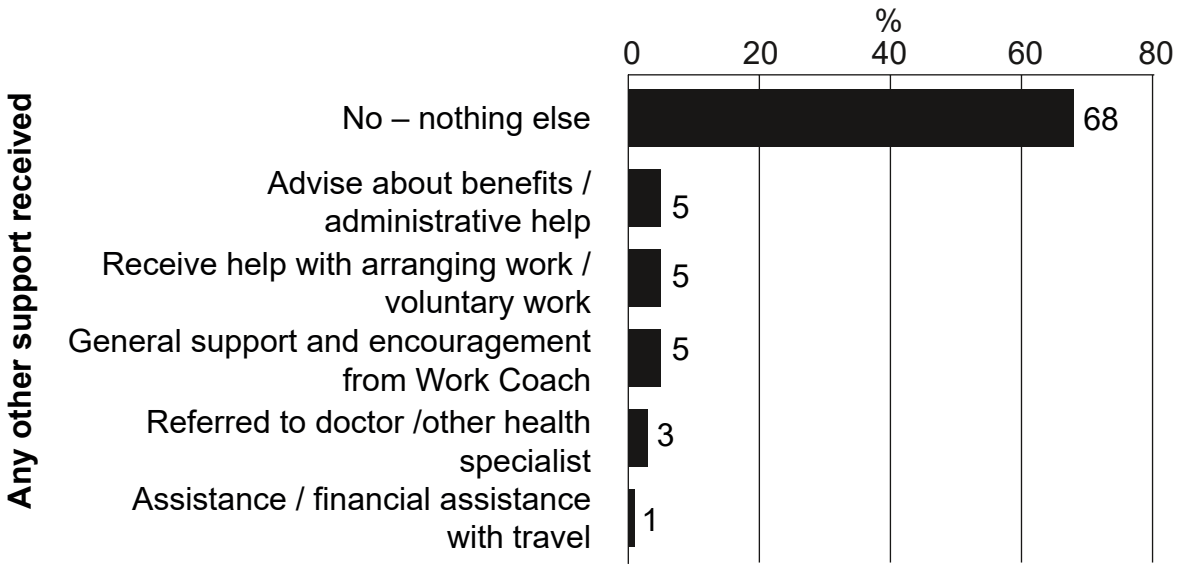
Some of the support JCP participants discussed and received was neither employment-related nor health-related. Figure 5.8 shows the other areas of support that participants might have discussed and received assistance with – confidence-building or assertiveness sessions, social or group activities, and practical help with managing money, debt or benefits.[36]

JCP pilot participants were significantly more likely to have discussed and received support in each of these three areas than JCP control participants. However, the proportion of pilot participants that reported accessing support in these three areas in general was low (13 per cent of JCP pilot participants and nine per cent of JCP control participants attended confidence-building or assertive sessions; 11 per cent of JCP pilot participants and six per cent of JCP control participants attended social or group activities; and 13 per cent of JCP pilot participants versus six per cent of JCP control participants accessed practical help with managing money, debt or benefits).

[36] These other areas of support were specified in the questionnaire rather than mentioned spontaneously by participants.

All JCP pilot participants were asked an open-ended, follow-up question on whether there was anything else they had done or had help with as a result of their appointments with a work coach. As shown in Figure 5.9, the majority of JCP pilot participants reported that no other support had been received (68 per cent). Among those who had received other support, pilot participants were significantly more likely than control participants to have received advice about benefits/administrative help (six per cent versus three per cent), and to have been referred to a doctor or other health specialist (3 per cent compared to none in the control group) (see Appendix Table 5.40).

Figure 5.9 Any other support received as a result of work coach appointments[37]



Base: All JCP pilot respondents who receive support (299) at wave 1

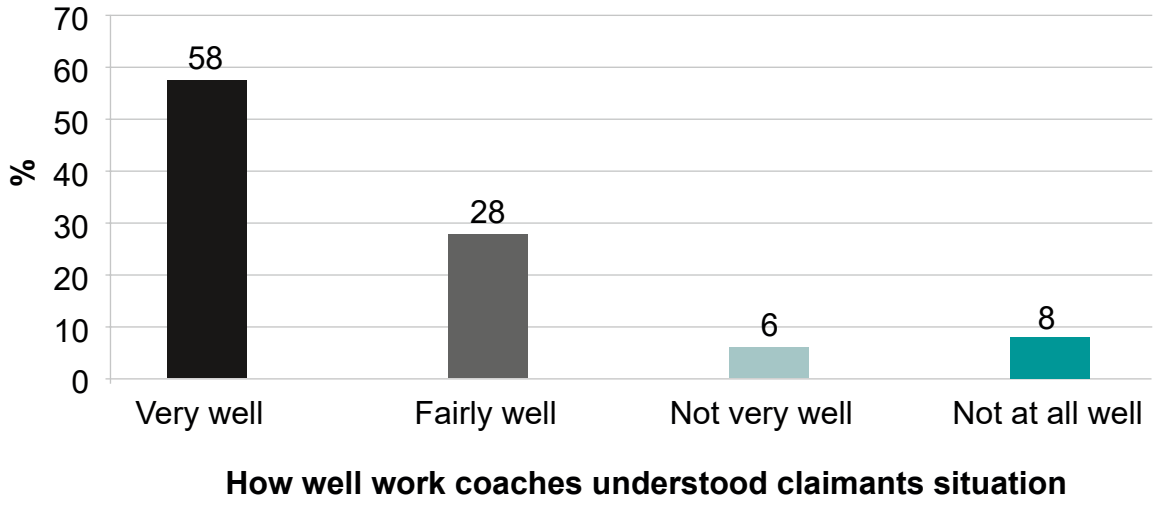
Satisfaction with support received

JCP pilot participants were asked to rate their experience of the pilot. The majority (84 per cent) said it was ‘very good’ or ‘good’, seven per cent said that it was ‘very poor’ or ‘poor’.

JCP pilot participants were also positive about their work coaches’ availability and understanding. The majority reported that there was always someone they could contact if they needed help or clarification (78 per cent), while the majority also felt their work coaches understood their personal situation very or fairly well – 58 per cent and 28 per cent respectively, as illustrated in Figure 5.10.

[37] Figure 5.9 shows the top six mentions only.

Figure 5.10 Extent to which Jobcentre Plus work coaches understood the respondent's situation

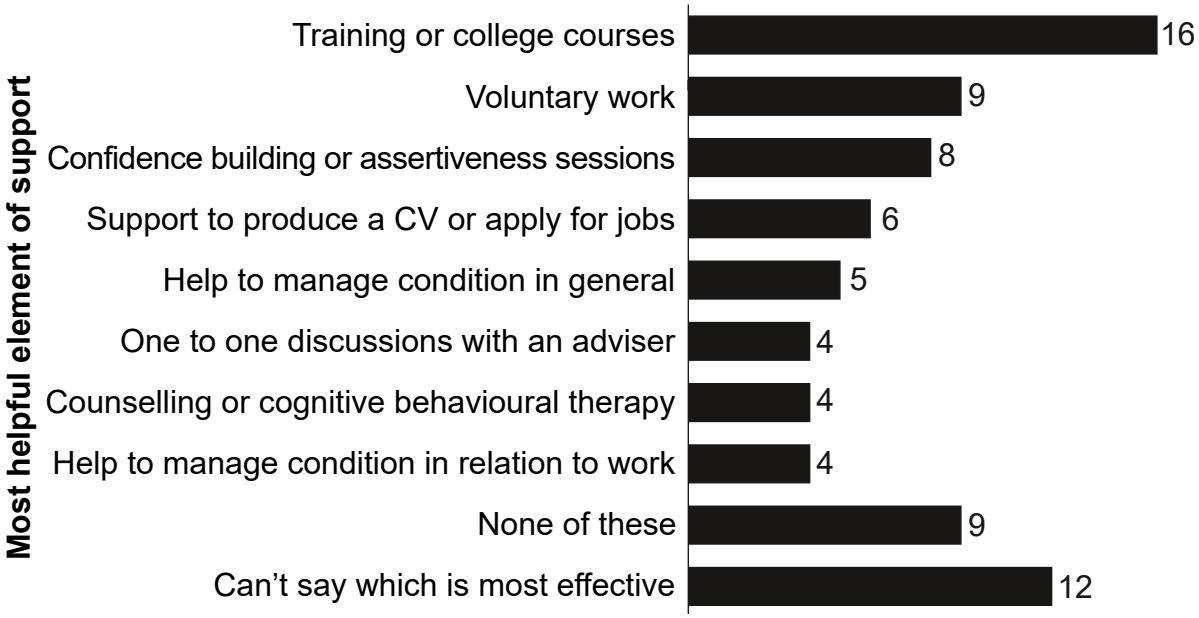


Base: All JCP pilot respondents (495) at Wave 1

The majority of JCP pilot participants were also satisfied with the support they received from their work coaches, with 70 per cent answering that there was nothing they disliked about it.

Among JCP pilot respondents who found more than one aspect of support helpful, it was the employment-focused support which was seen as the most helpful – training or colleges courses were most frequently cited (16 per cent), followed by voluntary work (nine per cent). This is shown in Figure 5.11.

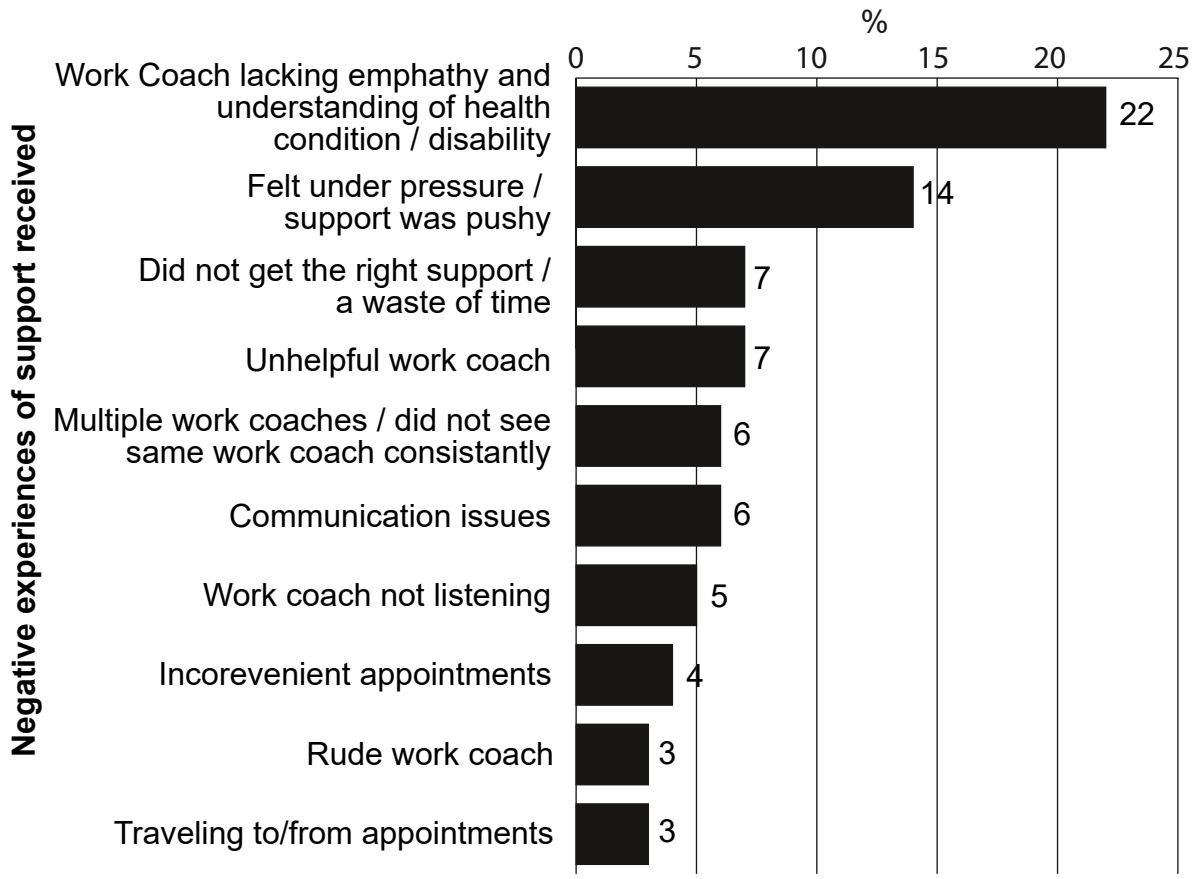
Figure 5.11 Most helpful element of support on the JCP pilot



Base: All JCP pilot respondents that found more than one aspect of support helpfull at wave 1 or Wave 2 (207)

For the 30 per cent of pilot participants that were dissatisfied with an aspect of the support received, the most common reason given was that their work coach lacked empathy and understanding of their health condition or disability (22 per cent), closely followed by participants feeling under pressure or that the support was pushy (14 per cent) – as shown in Figure 5.12. In addition to reporting dissatisfaction with their work coach's interpersonal skills, some JCP pilot participants mentioned dissatisfaction with their work coach's knowledge or skills (e.g. seven per cent answered that they did not get the right support), or mentioned an issue with appointments (e.g. four per cent reported that appointments were inconvenient). See Appendix Table 5.46 for the full list of reasons given.

Figure 5.12 What JCP pilot respondents disliked about the support they received (among those who were dissatisfied with an aspect of the support)[38]



Base: All JCP pilot respondents who disliked an aspect of the support they received (147) at wave 1

In-work support

Participants who moved into paid work whilst they were on the JCP pilot were asked about any in-work support they had received.[39] Since only a small number of participants moved in to work and responded to this question, it is not appropriate to report percentages or check for statistical significance. However, the types of support they reported include regular contact with JCP work coaches to discuss progress in work; support to manage their health conditions whilst in work; and referrals to external organisations providing further in-work support. This external support included personal development courses (such as confidence building, counselling or cognitive behavioural therapy); job-specific courses; attending health-related support groups; and support to manage benefits and tax credits whilst in work.

[38] Figure 5.12 shows the top ten mentions only.

[39] In-work support questions were only asked in the Wave 2 survey.

5.2 Work Programme pilot

5.2.1 The support model and participant journey

The support model for the Work Programme pilot was not specified in advance by DWP since WP providers operated under a 'black box' approach in which contracted providers were free to design their own provision. Interviews with WP provider staff showed, however, that there was widespread consistency in the support models described by providers. Most reported that they had not differentiated between pilot participants and other ESA claimants they worked with, and described an individually-tailored approach to support provision. There were two exceptions to this. One prime provider used external consultants to design diagnostic tools and advise them on how to work with this pilot group in particular. In another supply chain, specialist occupational health support had been purchased by the prime provider for ESA WRAG claimants in Payment Group 6 but this provision was not available to pilot participants (see section 3.2.5). Overall, there were no major changes in WP support models over the life of the pilot.

The WP providers used a mixture of in-house provision alongside referrals and signposting to partners providing more specialised support. Some external provision reported at Wave 1 was no longer available at Wave 2, but equally some new provision had begun. For example, one provider replaced some discontinued external provision with similar delivery in-house, and another introduced an in-house arts-based provision, which proved popular with pilot participants.

Support was predominantly delivered one-to-one, and all providers favoured face-to-face appointments as they believed these built better rapport, engagement and trust. All providers reported using a key caseworker model, with each participant allocated to an adviser who generally remained with the participant for the duration of the programme. In the later stages of pilot delivery most providers reported greatly reduced caseloads. This was partly due to the pilot drawing near to its end, so pilot referrals from JCP had stopped and many claimants had finished and exited, but also due to lower numbers of ESA and JSA referrals in general. Many providers had shed staff as a result of fewer claimants to work with, but individual advisers still had smaller caseloads than previously, which meant that they often had more time to spend with pilot participants.

5.2.2 Referral process

At the referral stage, providers reported that the amount of information they received from JCP about pilot participants had been variable. In general though, they received basic information, including participants' contact details, an outline of their benefit and/or work history, and their main health condition. In some cases, 'warm handovers' had been introduced after providers said that they were not getting enough information from the electronic handover.

Some providers said that they would have liked more information about pilot participants at the referral stage, to help advisers prepare for the first appointment. Some also felt that many participants were unprepared for the pilot, and so would have preferred to better work alongside JCP to help prepare participants and 'sell' the pilot to them prior to referral.

Participants interviewed said that they had found out about the pilot either from a work coach at JCP or by a letter. Most said that they were given basic information and some would have liked to know more at the outset about why they were being referred and what they would need to do while on the pilot. Some participants were nervous or apprehensive about what being on the pilot would mean for them. Participants generally remembered having been told by a work coach, or in the letter, that attending the WP was mandatory and some were concerned that this would lead to sanctions and loss of benefit if they needed to miss appointments due to their health condition.

5.2.3 Initial appointment

Participants usually had their first appointment with the provider two to four weeks after the initial referral notification, although a few instances of a longer timescale were reported. Providers reported that they had tried to conduct initial appointments face-to-face whenever possible. Occasionally though, they had done the initial appointment by telephone if necessary, e.g. if the participant was unable to leave their home. Some providers also said that they conducted home visits if needed, however they were constrained by time and by the need for two staff to attend for safety reasons, so they tried to keep home visits to a minimum. Participants' accounts reflected this, with most reporting that their initial appointment had been at the provider's office.

Most providers said that they began the initial appointment by outlining the pilot to participants, as many knew little about it and did not understand why they had been asked to attend. Staff noted that participants were often defensive and negative at this point, fearing they might be forced to find and take work that they were not ready for. Staff reassured participants by explaining that they would not be asked to do anything unreasonable, such as to apply for or take a job unless they wanted to, while also setting out their obligations on the programme. Several noted that they had reminded participants that their attendance was mandatory and that their benefits may be suspended if they did not comply.

The initial appointment typically included a fairly detailed assessment of the participant's starting point. Many provider staff used diagnostic tools and questionnaires, which participants filled out themselves. One prime provider commissioned an external disability specialist to develop a set of assessment tools specifically for the pilot group, covering a range of topics (wellbeing, everyday life, health condition management, etc.) against which participants graded themselves. Other provider staff reported using a combination of diagnostic tools and more open discussion. Advisers noted the importance of creating rapport with participants, especially as many had arrived in an apprehensive and negative frame of mind. They also said that some barriers to work were not revealed until later appointments, when more trust had been built up.

Topics covered in the assessment generally included health, skills and qualifications, employment history, whether the participant had a CV, whether they could work in groups, any drug or alcohol issues, confidence, and any support they were currently receiving. Responses were used to identify each participant's barriers to work and what might be needed to start to remove those barriers. Usually, initial appointments were conducted one-to-one, but one provider conducted the first part of the initial appointment in a group, followed by a one-to-one appointment with an adviser.

Participants' views of the initial meeting with their provider varied. Some found the experience stressful, partly as they had found it difficult to get to the provider offices and also because they did not know what to expect from the appointment. Others thought their adviser had understood their circumstances and put them at ease, and they found the meeting quite useful. A few participants said that they felt their adviser had not understood their health condition, and that as a result, the advice and support they offered was not relevant.

5.2.4 Subsequent appointments

The level of contact with participants specified in minimum service standards varied between prime providers – either fortnightly or monthly. Towards the end of the pilot, at Wave 2, some provider staff reported seeing some participants more frequently than this, as their reduced caseloads meant that they had more time. However, in the earlier stages of the pilot, providers aimed for at least one face-to-face contact with each participant every month, with some alternating face-to-face contact with telephone calls. Staff acknowledged that face-to-face appointments were not always possible with all pilot participants due to their health conditions and disabilities. In such cases, they mainly relied on telephone appointments to keep in touch.

Staff said that face-to-face appointments lasted 30 to 60 minutes on average, while telephone appointments generally lasted five to ten minutes. Staff and participants reported that on the whole, telephone contact had mainly comprised 'checking in' on any changes and to ask if anything else was needed, rather than more in-depth support.

All providers favoured face-to-face appointments over telephone contact, as they believed this built better rapport and encouraged participants to leave the 'comfort zone' of their home. All said that they had been able to accommodate participants who were not able to meet in an open plan office, by using private rooms at their premises. A few providers offered home visits supplemented by telephone contact, whereas others only offered telephone appointments as an alternative to meeting at provider premises. In the latter case, advisers thought that the progress they could make with participants was very limited.

Most of the participants interviewed had at least some regular face-to-face meetings, however a small number had telephone-only contact, due to the limitations posed by their health conditions. A few participants mentioned that accessibility issues at the provider's premises had made it difficult for them to attend face-to-face meetings, e.g. the lack of nearby parking. One participant reported that her adviser had visited her at home after an operation that had greatly reduced her mobility. While some of the participants had disliked having to travel to the provider for their appointments, and so preferred telephone appointments, others said that the face-to-face meetings had been more satisfying; they developed a closer relationship with their adviser and the appointments were more productive.

Most providers reported that the exact nature of contact was determined by the participant, their health, their needs and their attitude or willingness to engage. They tried to ensure that the appointments focused on moving participants forward in some way, rather than the discussion being dominated by participants' health conditions and what they could *not* do. Some advisers had received guidance from their managers saying that they should not discuss health issues with participants at all, but they often

found this to be unrealistic. Instead, they tried to reach a compromise, which balanced sensitivity to participants' health and circumstances with an approach that focused on what participants *could* do.

Participants reported that typical appointments covered how they were feeling, potential work options, and support or activities that they might like to try. Some participants felt that the face-to-face appointments in particular had been beneficial for them. Others, however, said they attended simply because they were told they had to do so in order to receive their benefit.

Work coach continuity

Some of the participants interviewed said that they had kept the same adviser throughout, and had been able to build up trust and rapport over time:

> *'It wasn't swapping and changing all the time. They were really good. You see them quite regularly, they know your case, they know what you are… It is good because you do build a rapport. You build a relationship with a person that you see regularly. Support's always there.'*
>
> (Man, 30-49, WP pilot, Wave 2)

However, several reported having changed advisers and this happened more than once for a few participants, which they found difficult as they felt they had to start again 'from scratch' with each new adviser.

5.2.5 Action plans and monitoring progress

All the providers interviewed had used action plans to guide the support provided to participants and to track their progress over time. Action plans were created during the initial appointment with an adviser or soon afterwards. There were no reported changes in the use of action plans over the life of the pilot.

A typical action plan initially contained a list of the participant's barriers; any special considerations, such as safeguarding or if the participant had a history of being violent; and a note of any key organisations they were already engaged with, for example, counsellors, GPs and community groups. Actions to overcome some of the participant's barriers were listed, including support interventions from the provider (such as courses or external referrals) and/or targets for participants to work towards before the next appointment. Some action plans also contained longer-term goals, such as finding work or becoming self-employed. Providers reported that the exact content of each participant's action plan was based on their individual needs, what they were capable of at that point in time, and the range of in-house support and external provision available. Each participant was asked to sign their action plan to signify their agreement and they were given a copy to take away.

Most providers reported that they updated the action plan at each meeting, and that they also tracked progress with regular reviews, typically every three months. These reviews had often included re-doing the initial assessment diagnostics with participants to see which barriers had been overcome and which still needed to be addressed.

Some participants interviewed remembered having an action plan, while others did not. Those who did remember it said that it was created fairly early on and typically included putting together a CV and having face-to-face meetings with their adviser.

5.2.6 Mandation

All providers reported that attending appointments was mandatory for participants. Aside from this, most providers said that they had kept some activities voluntary and made others mandatory.

According to providers, the fail to attend (FTA) rate among pilot participants varied considerably. Some said that, although it took time to build trust and engagement, once participants had engaged with the pilot, their attendance was usually good. However, some staff reported that some participants had not engaged with the programme in any meaningful way at all, and their FTA rate was high. High FTA rates were also reported as a result of health conditions, including severe conditions that were longstanding and limiting, and conditions that fluctuated over time, making it difficult for participants to attend when their conditions worsened. There were also reports of FTAs when participants were recovering operations, or because participants had been appealing the decision to place them in the ESA WRAG rather than the Support Group:

> *'I would say at least half of the claimants have responded really quite well and probably enjoyed programme. The other half, a quarter of them did it through gritted teeth. Did what they were asked… and some of the others just disappeared and didn't really engage at all.'*
>
> (Adviser, WP pilot, Wave 2)

Providers acknowledged that mandation had worked well with some participants, but had made others more anxious and more likely to withdraw from engaging, so they had used it with care. Some advisers had mandated participants to attend certain activities or courses when they believed this would be particularly beneficial for them, or when they felt there was no good reason for a participant not to attend. Others had preferred to use a voluntary approach wherever possible. For example, one adviser explained to her participants that they needed to want to do the course for her to refer them to it, and had found that this approach encouraged participants to volunteer for courses. Some advisers used mandation only when voluntary approaches had stopped working, while others avoided using it at all, preferring to focus on ways to voluntarily engage their participants.

The most common barrier to engagement mentioned by pilot staff was participant mindset, i.e. a tendency for participants to focus on their health condition and what it prevented them from doing. Pilot staff felt that this issue was compounded by the many years participants had received benefits without support or expectation that they would work again. Providers felt that this meant some participants had been very reluctant to engage with the Work Programme in any meaningful way:

> *'The fact that a doctor is telling them that they're not well and it's all about what they can't do. There's too little focus on what they can do.'*
>
> (Manager, WP pilot, Wave 1)

Some providers reported that they had put forward ESA claimants for a sanction, but were not aware of this being the case for pilot participants specifically. Some of the participants interviewed had experienced sanctions while on the pilot, however, and their experiences reflect the variable approach outlined by providers.

One participant, for example, reported that he had his benefits sanctioned for one week after he missed the regular call from the provider and did not call back within a set amount of time. He felt that this was unfair as it had not been explained to him, and he felt aggrieved that he did not have the option to appeal, because it was a first sanction. Another participant said she had been sanctioned three times for not attending appointments when she was in hospital or at other health-related appointments. In contrast, a third participant reported that she had missed some of the provider's telephone calls, but had not been sanctioned. She felt that her provider had been reasonable and had taken into account that she was often in pain. Several participants also described how they had needed to miss appointments on occasion, but if they telephoned their provider in advance to explain why, they were given a new appointment and no action was taken. A few participants said that the emphasis placed on sanctions for non-attendance had made them feel anxious and was unhelpful.

5.2.7 Types of support provided

Advisers had considerable freedom to work flexibly with participants, based on their initial assessment and ongoing appointments and reviews. Many providers believed that participants needed to develop soft skills such as increased confidence and motivation, before they were ready for employment-related provision. However, others reported that it was beneficial to engage participants in some work-related activity early on, such as working on their CV, partly because this was a good way of getting to know more about the participant. In general, providers did not offer health-related support, but referred and signposted participants elsewhere for this. The types of support delivered are discussed further in the sections below.

Aside from changes in the availability of some external provision, there were few changes in the types of support provided through the pilot over time. However, some providers interviewed at Wave 2 said that they became increasingly more skilled at meeting the needs of this group of participants as the pilot progressed.

Soft skills development

Participants' action plans often contained a mix of employment-related and other activities, but providers highlighted that many participants needed time before they were ready to have conversations about work. With this in mind, advisers often worked first on engaging participants through regular attendance at appointments and building their confidence and motivation before broaching employment-related activities more directly. This was achieved through a mixture of in-house provision and signposting to external organisations.

Some providers developed short courses specifically for the pilot. For example, one prime provider contracted an external organisation to deliver an '*emotional response to employment*' course specifically for pilot participants, which covered some of the most immediate barriers to work, such as confidence and fear of working in groups. Several others also referred their participants to organisations that delivered initial courses to build confidence and break down other barriers. Some providers supported participants to join group activities locally to build their confidence by going somewhere regularly each week and mixing with other people. Advisers also discussed hobbies and interests with participants and encouraged them to find out about things they might like to do in their community.

As the pilot progressed, there was evidence that some providers became more creative in engaging participants and developing their soft skills. For example, by the time of the Wave 2 fieldwork, one provider had introduced a weekly arts and crafts session at their premises for ESA claimants (including pilot participants). This informal session encouraged people to come in for a cup of tea and a chat, and provided an opportunity to do something creative. It was described as a much 'softer' form of provision than they had used before, but it was felt to have been successful in engaging ESA claimants, and encouraging them to actively participate. The provider developed this activity into a Community Interest Company, supporting claimants to produce arts and crafts to sell at local markets. This meant it had the potential to be not only an engagement activity but to also provide some business experience:

> *'We started off sitting and drawing but now it's all sorts of arts and crafts activities, photography, all sorts of things going on. And it's great. It's brought a lot of claimants out of their shadow… It's allowed us to start talking to them about ways of thinking about going back to work.'*
>
> (Manager, WP pilot, Wave 2)

In the later stages of the pilot, the same provider also engaged an external charity, specialising in working with people in the community, to do outreach work with ESA claimants who were reluctant to come into the provider offices, in order to encourage greater engagement. This partnership was said to have worked well, as the provider did not have the resources to do home visits, and it enabled them to support participants with a range of substantial issues including health, benefit difficulties, and social isolation.

Employment-related support

Employment-related support offered to participants included help with:

- **Employability skills:** e.g. CVs, job applications, and interview techniques
- **A Better Off Calculation**
- **Basic skills:** improving IT, English and maths
- **Work experience:** volunteering and permitted work opportunities
- **Self-employment options**
- **Employer engagement:** facilitating access to employers.

Most of the providers used employment-related support as part of their one-to-one sessions with participants. Most commonly, advisers worked with participants to ensure they had an up-to-date CV and many chose to do a Better Off Calculation early on as they found that participants were often surprised when they saw how much better off they would be, even in part-time work, due to in-work benefits they could receive.

Other employability activities were typically delivered later in the sequence of support, including cover letter writing and interview techniques, supporting participants to look for voluntary work opportunities, understanding the local labour market and the 'hidden' jobs market[40], and job search. Self-employment support was also commonly discussed

[40] The 'hidden' jobs market is a term used to describe jobs that aren't formally advertised. Jobseekers are informed that such jobs may be secured through the use of their social networks.

as an option, and providers reported that some participants had opted to go down this route. Some advisers said that they encouraged a number of their pilot participants to consider voluntary work, or permitted work, as a low-risk way of trying out work.

None of the providers offered any distinct employer engagement activity specifically for this pilot. In general, pilot advisers did not have a great deal of contact with employers, but most (larger) providers had specialist employer relationship teams that built relationships with local employers and proactively sourced vacancies, as well as work experience or work trial opportunities, for JSA and ESA claimants, including pilot participants. Some of the providers also had in-house specialists to advise and support participants with self-employment.

Some participants interviewed undertook work-related activity as a result of being on the pilot. This included getting help with their CV or engaging in job search with their adviser. A number of participants said that they had discussed voluntary work and some recalled having discussed paid work options, including permitted work or self-employment. Some felt that this support was useful as it helped them to know where to go when they felt ready to work. However, other participants did not think that they would be able to work in the future and complied rather than engaged with the work-related support offered.

Several of the providers offered in-house courses for improving employability and developing soft skills (such as CV development and confidence building), to which they referred participants if they were not ready for job search activity initially. Those that did not offer in-house courses generally referred participants to similar external courses instead. Several participants interviewed had been offered such group work or courses. Those that had attended generally found them to be quite useful. For example, one participant had attended a course called 'Kick Start to Employment', delivered by an external provider. It had involved CV development, looking at how to find work, mock interviews, discussing work protocols, and how to stay in work. It was a group course, but also included some one-to-one time with the facilitators. The participant enjoyed the course and said that it helped with his communication skills and his self-esteem:

> *'That was absolutely brilliant. The people who actually run it were so enthusiastic, you just got carried along with them… They put us first, we got on with what we wanted to do, where did we need help, rather than us going through everything with everyone. They had it tailored and fitted to you.'*
>
> (Man, 50+, WP pilot, Wave 2)

Some of the participants were also referred to IT courses, externally or in-house, and a few were referred to maths and English courses. Participants felt that IT courses, in particular, were very useful, in terms of skills development, knowing where and how to apply for jobs, and also because they increased their confidence more generally. Some participants also liked the fact that the courses had given them the opportunity to get out of the house and meet people, which made them feel less isolated.

A few participants said that their provider had not tried to talk to them about work. They thought that this was because their health condition was particularly bad at that time, and their provider appreciated that conversations about work would not be appropriate.

In-work support

Providers were able to support pilot participants in work for up to two years – as with other ESA participants on the WP. Providers said that this support was tailored to participant needs, and could vary over time. They generally felt that once pilot participants reached the employment stage, their needs were no different to those of other ESA claimants entering work. Some noted that, in general, ESA claimants needed quite intense support in the early months in work, with the first few weeks being the most critical.

In-work support (to ESA claimants generally) was mostly delivered by telephone, although some was by text and/or email, and could be obtained outside usual office hours if needed. Most of the contact was between the provider and the participant, but some providers said that they had also been in touch with employers if needed to help pre-empt or manage any difficulties.

Providers reported three basic models of in-work support for ESA claimants:

1. On entry to employment the participant was passed to a specialist in-work adviser or team to support them. Standard contact was every two or four weeks, depending on participant needs, which were assessed just before they moved into work. Participants were only contacted more frequently than this if they were felt to be at risk of leaving their job.
2. On entry to employment, the participant stayed with the adviser they had worked with throughout, in order to capitalise on the relationship that had been built up, and to prevent any problems or solve them quickly.
3. A flexible model in which decisions about whether participants stayed with their pre-work adviser, or went to a contact centre for in-work support, depended on how much support the participant needed and could change over time.

A few of the WP participants interviewed had entered work during the pilot, but only one mentioned receiving in-work support. This participant had a longstanding mental health condition, and had been unemployed for eight years prior to the pilot. As a result of the pilot and some external support, his mental health improved, and he gained work in a call centre. At first he received ‘light touch’ in-work support in the form of telephone calls from the provider, asking how he was getting on and reminding him that if he had any problems at work he could get in touch any time. After the in-work support ended, the participant’s mental health worsened, which impacted on his performance, and he was not able to manage this effectively. As a result, he lost the job. He blamed himself for this, but it is possible that longer and/or more intensive in-work support could have picked up these issues at an early stage, and prevented this outcome.

The other WP pilot participants in employment said that they had not required in-work support by the time of their research interviews. One had not been able to work as much as they had anticipated due to their health worsening, but said that their employer had been understanding and had reduced their hours so that they could stay in work.

Health-related support

Providers reported that, in general, they referred participants to external organisations for any required health-related support, since they felt it was best to leave health support to professionals who were qualified to provide it:

> *'They're going to have the whole range of health issues and ultimately we're employment advisers, not health advisers.'*
>
> (Manager, WP pilot, Wave 2)

This included referrals or signposting for support with mental health conditions and drug and alcohol problems (e.g. to counselling services). Advisers also encouraged participants to attend appointments with existing healthcare providers and to visit their GP regularly.

One provider delivered an in-house wellbeing course, which focused on self-belief, behaviours, and developing a positive attitude, but for more specialist support with specific health conditions referred participants to external providers. Another provider referred participants to a nearby company that offered a 13 week health-focused course. It covered managing health conditions, making the right use of GPs, getting the right referrals and medication and also touched on employment issues in its later stages.

An exception to the absence of health-focused support delivered in-house was the one subcontractor that introduced a Healthcare Practitioner role part way through the pilot[41], to provide more specialist support to both advisers and ESA claimants. The Healthcare Practitioner delivered group sessions focused on health management for participants with a range of health conditions and disabilities, and supported some participants on a one-to-one basis. They were also able to refer participants to more specialist health-related provision if needed. The funding for this provision ended shortly before the end of the pilot, but advisers were then given access to an externally provided occupational health telephone advice service. It was available to advisers needing health-related assistance with regard to particular participants. If required, advisers referred participants to the service. A nurse then telephoned each participant at home and, on the basis of the discussion, compiled a detailed report about the participant's health, medication and their barriers and attitude to work, which was then passed to the adviser. This reportedly gave advisers a better understanding of the participant's position and enabled more effective action planning.

Several participants interviewed said that their provider had assisted them in relation to their health, most often through referral or signposting to an external organisation. Examples of this included referrals to:

- Counselling services;
- Mental health support organisations, such as MIND;
- Drug and alcohol support organisations;
- Occupational therapists; and
- Services providing home aids and adaptations.

[41] This was not introduced as part of the pilot but as part of an organisational review of services for ESA claimants.

Participants were generally positive about these experiences of support, although some said that they did not expect their WP provider to help them manage their health condition. A small number of participants said that being on the WP felt stressful for them and this negatively impacted their health.

5.2.8 Partnerships

Providers emphasised the importance of partnerships in delivering the Work Programme effectively, and there were a number of examples of provision for pilot participants being delivered by external partners. The types of organisations most commonly referred or signposted to by almost all of the providers were:

- Mental health charities and community organisations;
- Local colleges and private providers for skills training;
- Specialist drug and alcohol services; and
- Free counselling services.

However, a wide range of external organisations and partnerships were cited by smaller numbers of providers as places to signpost participants to if they needed more specialist support. These included:

- GPs and health professionals;
- Local organisations for help with homelessness or domestic violence;
- Money and debt advice services;
- Housing associations;
- National Careers Service;
- Employment agencies;
- Probation service;
- Carers' support centres; and
- Voluntary sector, for voluntary work opportunities.

Providers mentioned a few challenges with regard to partnerships. Firstly, the ease of obtaining feedback from partners about participants was variable. Advisers felt that it was important to find out if participants had stopped engaging, so that they could encourage them to re-engage where necessary. Subcontracted partners were obliged to provide updates, but it was more difficult to get feedback from partners to whom participants had been signposted, and providers often relied on feedback from participants.

Secondly, some providers reported that co-operating with medical professionals was challenging at times, due to their perceived lack of understanding about the role of employability support:

> *'The medical profession, there seems to be quite a few closed doors there and I think it's something that's come up across the whole ESA concept, it's something we're still sort of challenging… that misunderstanding within the medical profession about what employability is.'*
>
> (Manager, WP pilot, Wave 1)

Thirdly, some providers highlighted that funding for community organisations had been declining, and they had increasingly needed to provide more support in-house than they had done in the past.

Gaps in support

Providers identified a number of key gaps in the external support available for pilot participants.

1. The first was an ongoing shortage of basic maths and English provision, including provision for people who could not read and write which was preventing them from making use of the support on offer.
2. The second was the lack of readily available free counselling, as funding for services changed or was withdrawn. Providers noted that while they had signposted participants to their GP for a referral to counselling, waiting lists had often been many months long.
3. Thirdly, advisers reported limited support more generally for people with mental health conditions.
4. Finally, advisers had encountered a few participants who were educated to a high level but out of work due to their health condition. Advisers said they did not really know how to support this group once they had looked over their CV. They felt that most WP provision was not suitable for these participants and, due to their level of education, they were not eligible for the courses which many other pilot participants were referred to. They thought that occupational health provision might be more suitable for these highly educated claimants.

One of the participants interviewed was in exactly this situation. She had a chemistry degree, and a varied work history, but also a serious mental health condition which had prevented her from working for several years. She did not feel that WP provision was appropriate for her or that there was anything suitable for her to be referred to, but felt that specialist occupational health support might have been helpful:

> *'A professional that understood my situation not just, you know, "Oh, she's got this illness," someone that actually knew what the illness entailed and maybe got some sort of support to, you know, help me get out the house or set me a goal.'*
>
> (Woman, WP pilot, Wave 2)

5.2.9 Aspects of support that worked well

Work coaches believed that the pilot had worked best when they had been able to gain the trust of the participants. They felt the following were key to this:

- Tailored, one-to-one support, at least to start with;
- Time to listen and build rapport with the participant, and understand their barriers;
- A strong focus on what participants *could* do, rather than what they could not do as a result of their health condition; and
- Striking a balance between pushing participants outside their comfort zone and not pushing to such a degree that they stopped engaging.

Providers felt that a combination of one-to-one support, together with courses and group work, was generally the most effective way to assist participants in overcoming their barriers. Accordingly, advisers encouraged participants to attend in-house groups and courses that were relevant to them, and also referred them to external providers. Providers found that bringing together people with similar barriers but different health conditions was productive, since it prevented participants from focusing only on their health and what it prevented them from doing. They also found that participants benefited from learning from and supporting each other, and some commented how group work and courses helped participants to form friendship groups:

> *'If you've got a mixed group everybody actually can say they also have confidence and self-esteem problems, and it doesn't matter what their disability is that's got them there in the first place, they understand they need to be motivated and look forward to what they're going to be doing next week or the week after.'*
>
> (Adviser, WP pilot, Wave 2)

Some advisers said that voluntary work and permitted work were an effective way for participants to try out work, rather than trying to move them towards full-time work straightaway.

> *'Permitted work is a really good tool given in the right circumstances. It's a carrot rather than a stick approach. These people already feel like they've been to hell and back. Threatening them doesn't do any good. It's showing them how much better their life could be.'*
>
> (Adviser, WP pilot, Wave 2)

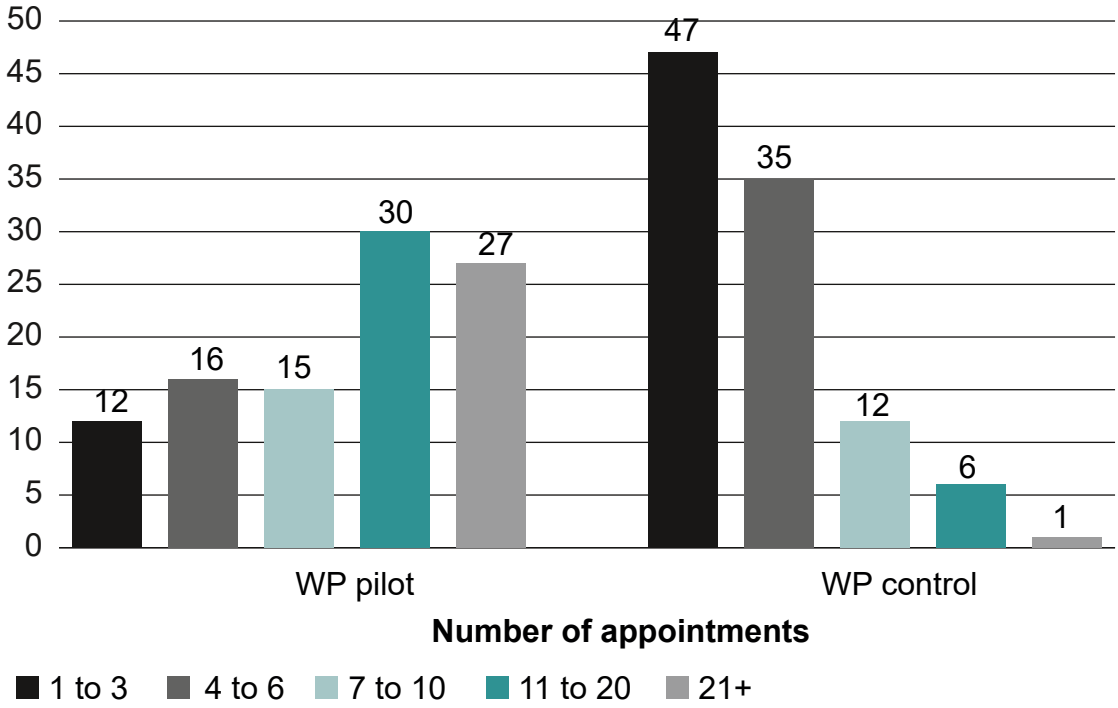
5.2.10 Comparing the support received by pilot and control group members

Appointments

Participants were asked to report the number of appointments they had had with their WP adviser since the start of the programme. WP pilot participants reported a significantly higher number of appointments than control participants. For example, 57 per cent of WP pilot participants reported 11 appointments or more, versus seven per cent of WP control participants. On average[42], as illustrated in figure 5.13, WP pilot participants had almost twice as many appointments as WP control participants (a mean of 3.4, versus 1.8 in the control group). Within both the pilot and control groups, participants with higher educational qualifications (i.e. at least one GCSE grade A*-C) reported significantly more appointments than those with lower educational qualifications (i.e. less than one GCSE Grade A*-C) (see Appendix Table 5.2).

42 The mean averages have been reported here.

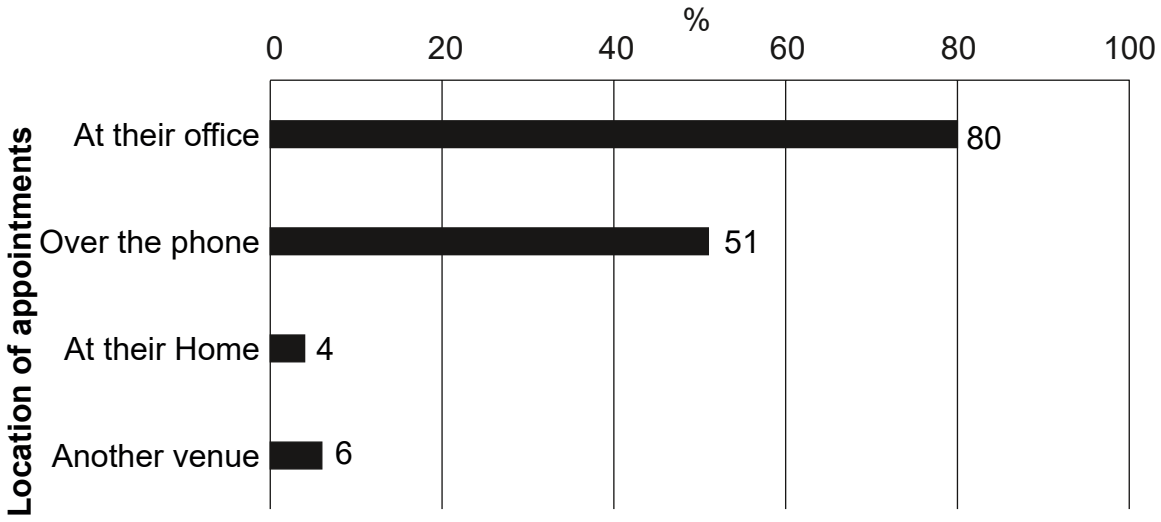
Figure 5.13 Number of appointments with Work Programme adviser



Base: All WP pilot (174) and WP control (418) respondents at Wave 1

Figure 5.14 shows that the majority of respondents had at least one appointment at the provider's office (80 per cent). Around half of respondents had at least one appointment that took place over the phone (51 per cent) and four per cent had an appointment at home. Just under half of WP pilot participants reported that they had face-to-face appointments only (48 per cent), while a higher proportion (40 per cent) reported that they had both face-to-face and telephone appointments. Just 11 per cent reported that they had only telephone appointments. There were no significant differences between pilot and control groups regarding appointment locations.

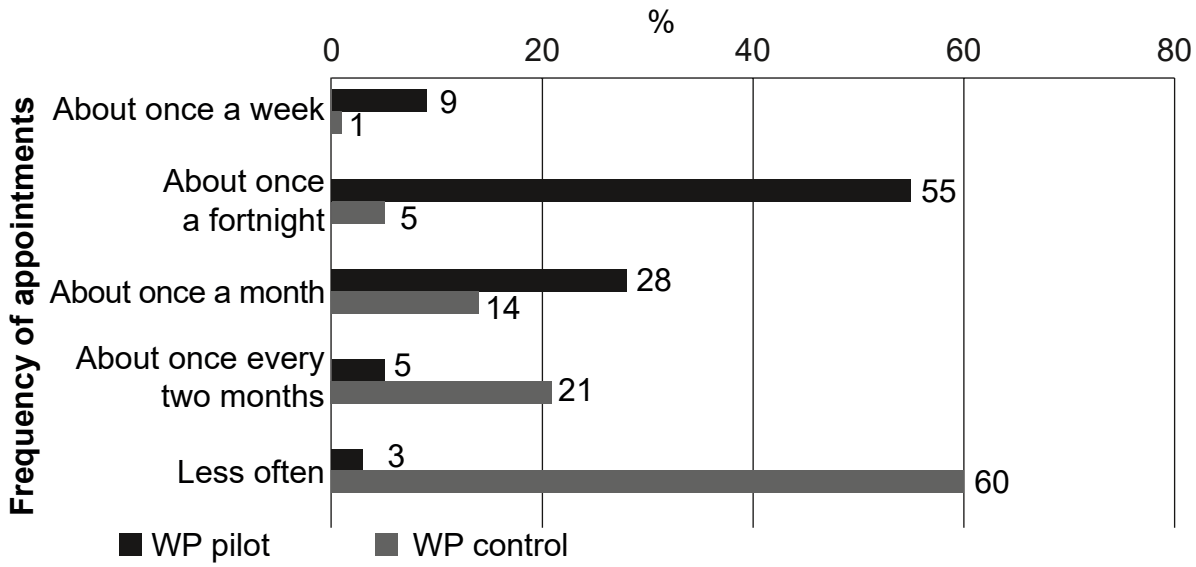
Figure 5.14 Location of appointments with Work Programme adviser



Base: All WP pilot respondents (202) at wave 1

WP pilot participants also met with their advisers more frequently than control participants. As Figure 5.15 shows, 64 per cent of WP pilot participants met with an adviser at least once a fortnight, while only six per cent of control group participants met with an adviser this frequently. For the majority of WP pilot participants (58 per cent), appointments had always been the same frequency (see Appendix Table 5.4). A small number of participants noted that appointments became more frequent in the later stages of the programme (19 per cent), while a similar number reported that they were more frequent at the start (17 per cent).

Figure 5.15 Frequency of appointments with Work Programme adviser

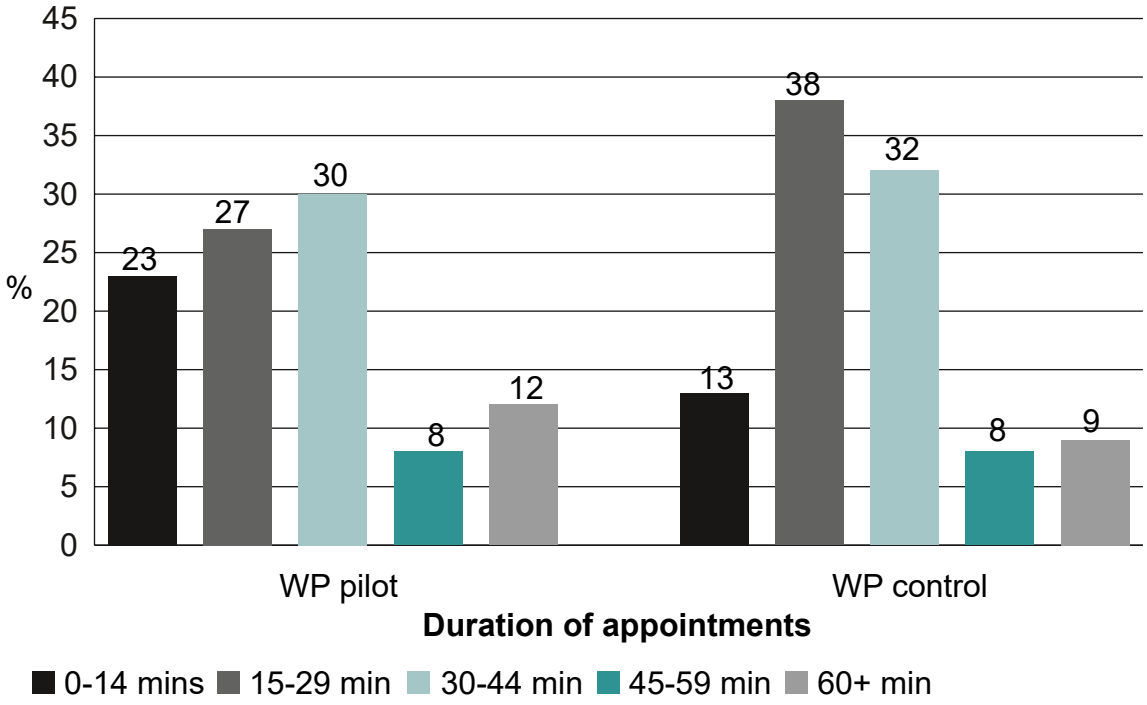


Base: All WP pilot (165) and WP control (365) respondents at wave 1

The majority of participants in both pilot and control groups reported that appointments typically lasted between 15 and 45 minutes. However, as Figure 5.16 shows, 20 per cent of WP pilot participants reported appointments typically lasting

45 minutes or longer, compared with 17 per cent in the control. This includes 12 per cent in the pilot group whose appointments typically lasted 60 minutes or more (versus nine per cent in the control).

Figure 5.16 Duration of appointments with Work Programme adviser

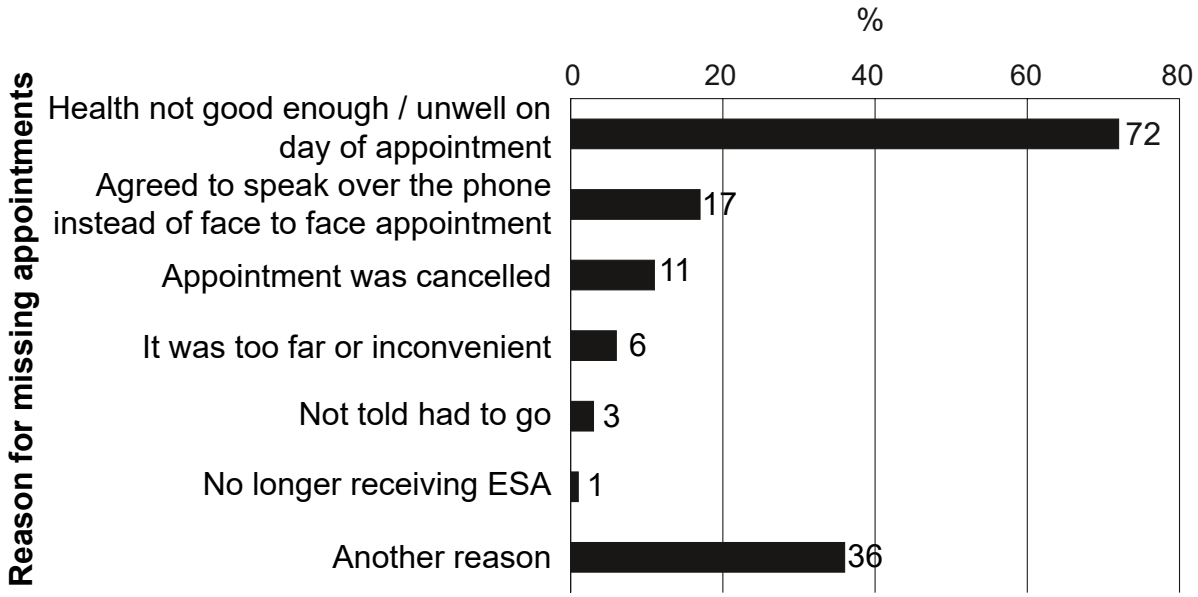


Base: All WP pilot (199) and WP control (430) respondents at Wave 1

The majority (62 per cent) of WP pilot participants said that they had not missed any of their appointments.[43] For the 38 per cent of participants that had missed an appointment, the most frequently cited reason was their health not being good enough or being unwell on the day of the appointment (72 per cent), as illustrated in Figure 5.17. The other main reasons pilot participants gave were agreeing to speak with their adviser over the phone rather than face-to-face (17 per cent) and the appointment being cancelled (11 per cent).

[43] This question was not asked of the WP control group.

Figure 5.17 Reasons for missing an appointment with Work Programme adviser

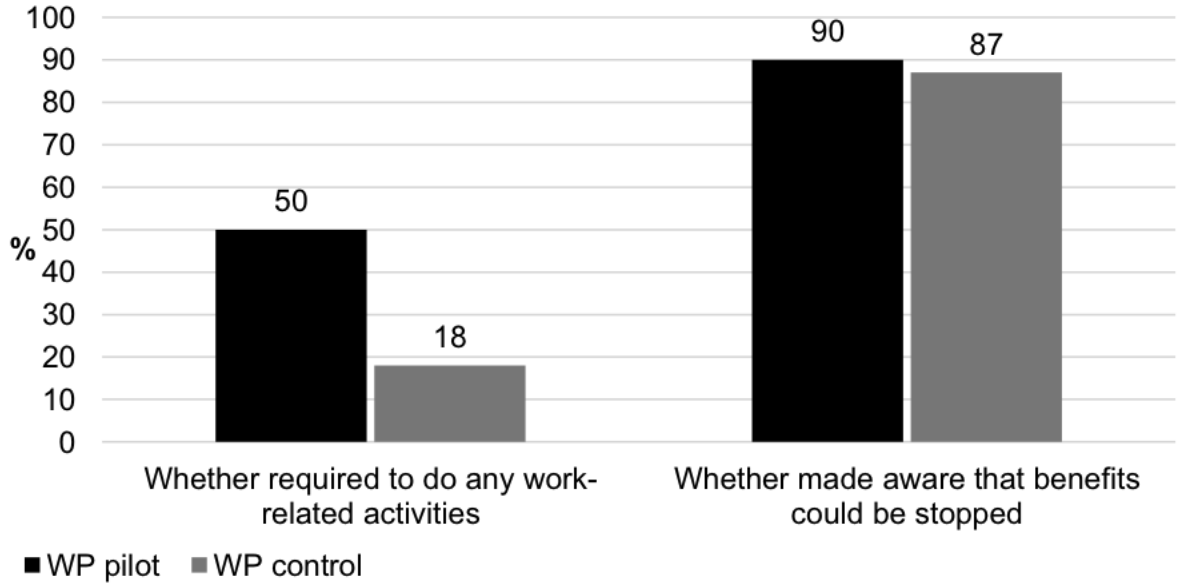


Base: All WP pilot respondents who missed an appointment (76) at wave 1

Work Related Activity and Mandation

WP pilot participants were significantly more likely to report having to take part in work-related activities than the control group participants (50 per cent, versus 18 per cent), as shown in Figure 5.18. However, similar proportions of pilot and control participants (90 per cent and 87 per cent respectively) reported being aware that their benefits could be stopped if they did not undertake compulsory activity (such as WRA or attending meetings).

Figure 5.18 Whether WP respondents were required to undertake work-related activities or were made aware that benefits could be stopped



Base: All WP pilot (201) and WP control (433) respondents at Wave 1

Types of support offered and received

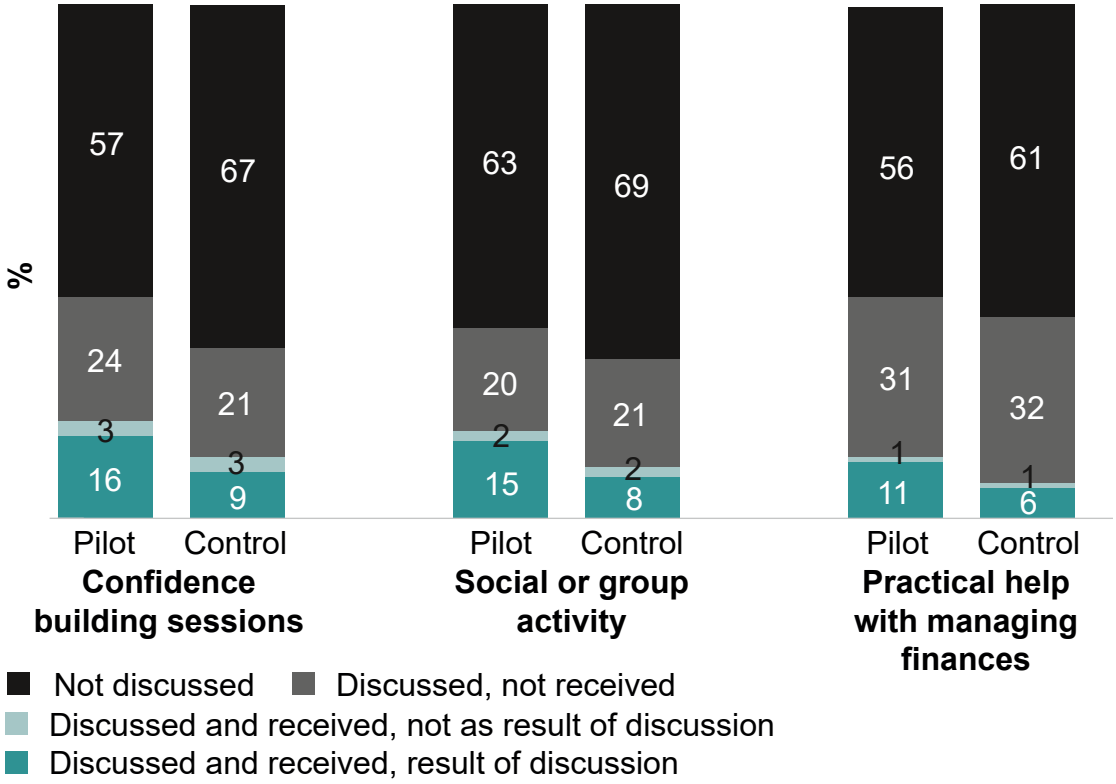
WP pilot and control participants were asked to provide feedback on any support they had discussed with and received from their advisers, and to mention whether the support received was *as a result* of this discussion with their advisers. This section first considers employment-related and health-related support participants might have discussed and received, before turning to look at other types of support (also see Appendix Tables 5.52 to 5.66).[44]

Pilot participants reported receiving a range of types of employment-related support. This included support with taking part in voluntary work, taking part in work experience and looking for jobs (also see Appendix Tables 5.55 to 5.58). The types of support reported and the proportions of claimants receiving support were broadly similar for WP pilot and control participants. However, pilot participants were significantly more likely than control group participants to have discussed CV writing and applying for jobs, and to have received support with this as a result of the discussion (44 per cent of WP pilot participants, versus 13 per cent in the control group).

Regarding health-related support, the main type of support received by WP pilot participants (as a result of discussions with their adviser) was help managing the impact of a health condition on their daily life and on their ability to work. However, much lower levels of support were received for this than for participants in the other two pilots. The extent of support received was also similar for WP pilot and control groups. None of the other forms of health-related support mentioned in the survey were received by more than 7 per cent of WP pilot participants and, again, levels were broadly similar for pilot and control groups.

[44] Please note Figure 5.19 in this section only displays the types of support where there was a significant difference between the WP pilot and WP control group.

Figure 5.19 Other support discussed and received (WP respondents)



Base: All WP pilot and WP control respondents: Confidence building sessions (192, 409); Social or group activity (193, 410); Practical help with managing finances (198, 417) at Wave 1.

Neither pilot nor control group participants were very likely to have discussed and received support in areas (as shown in Figure 5.19) such as confidence building or assertiveness sessions, social or group activities, or practical help with managing finances. However WP pilot participants were more likely to have discussed and received support in all of these areas than control group participants. For example:

- 16 per cent of WP pilot participants discussed and received support in confidence building or assertiveness, versus nine per cent in the control group.
- 15 per cent of WP pilot participants discussed social or group activities and went on to attend these, versus eight per cent in the control group.
- 11 per cent of WP pilot participants discussed and received practical help with managing money, debt or benefits, versus six per cent in the control group.

In-work support

Some participants who moved into work during the WP pilot received in-work support.[45] Base sizes were too small to analyse these results statistically. However, responses indicated that in-work support was delivered through a mixture of face-to-face, telephone and email contact. A variety of types of support were provided, including job specific support (such as advice on negotiating with employers), personal bespoke support (such as regular check-in contact to discuss progress in work) and support with childcare. Some participants were also referred to external organisations for in-work support. External support included counselling, confidence building courses, financial advice, and support groups to help manage specific health conditions.

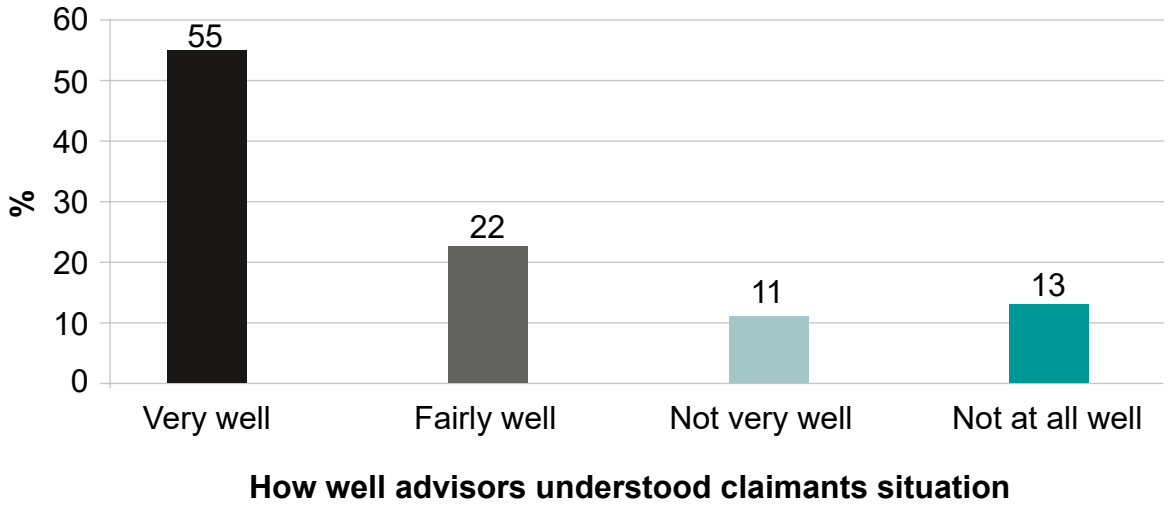
[45] In-work support questions were only asked in the Wave 2 survey.

Satisfaction with support received

WP pilot participants were asked to rate their experience of the pilot. The majority of pilot participants (88 per cent) said it was ‘very good’ or ‘good’.

Most WP pilot participants were also favourable about their advisers; 76 per cent felt that there was always someone they could contact if they needed help or clarification, while 77 per cent felt their advisers understood their situation very or fairly well (see Figure 5.20 and Appendix Tables 5.5 to 5.6).

Figure 5.20 Extent to which Work Programme advisers understood the respondent’s situation

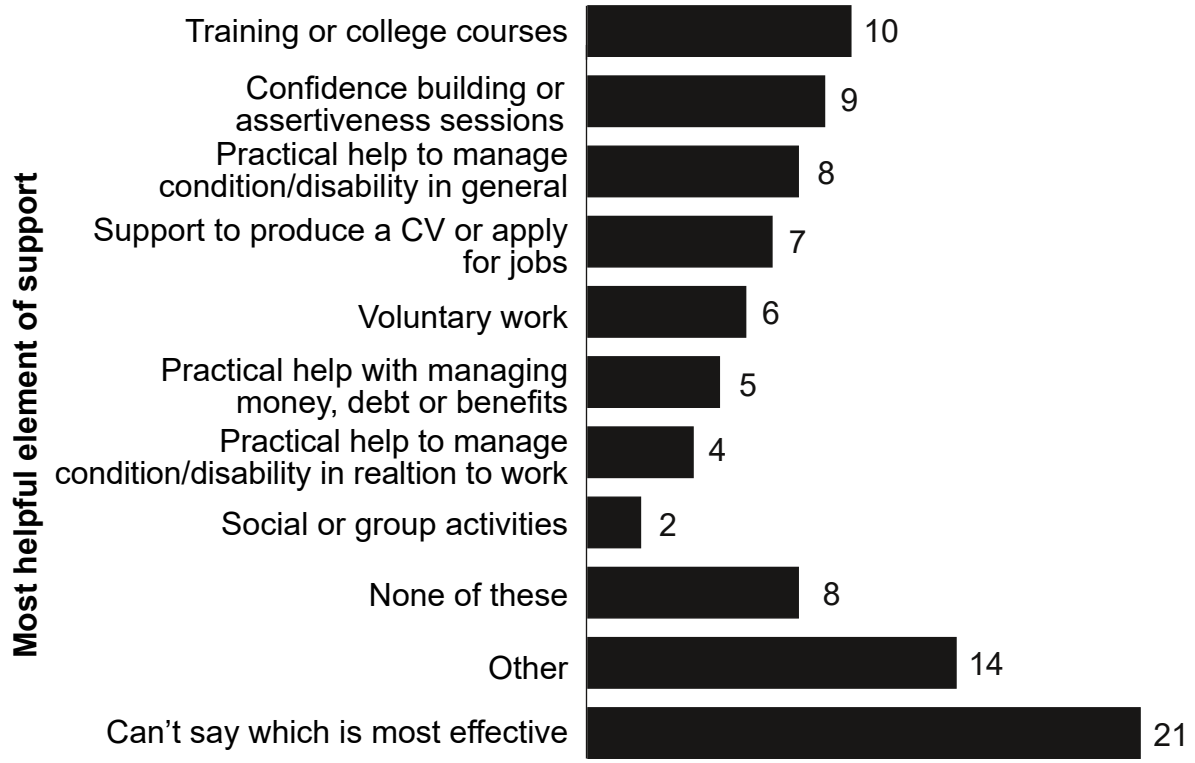


Base: All WP pilot respondents (202) at Wave 1

Overall, satisfaction with the support received from advisers was also high amongst pilot participants; 68 per cent answered that there was nothing they disliked about it.

Amongst WP pilot participants who found more than one aspect of support helpful, training or college courses were reported to be the most helpful (mentioned by 10 per cent), which could reflect the employment-support focus of the WP pilot. Yet, 21 per cent could not say what aspect of support was most helpful, which suggests that having a package of support is most helpful to some.

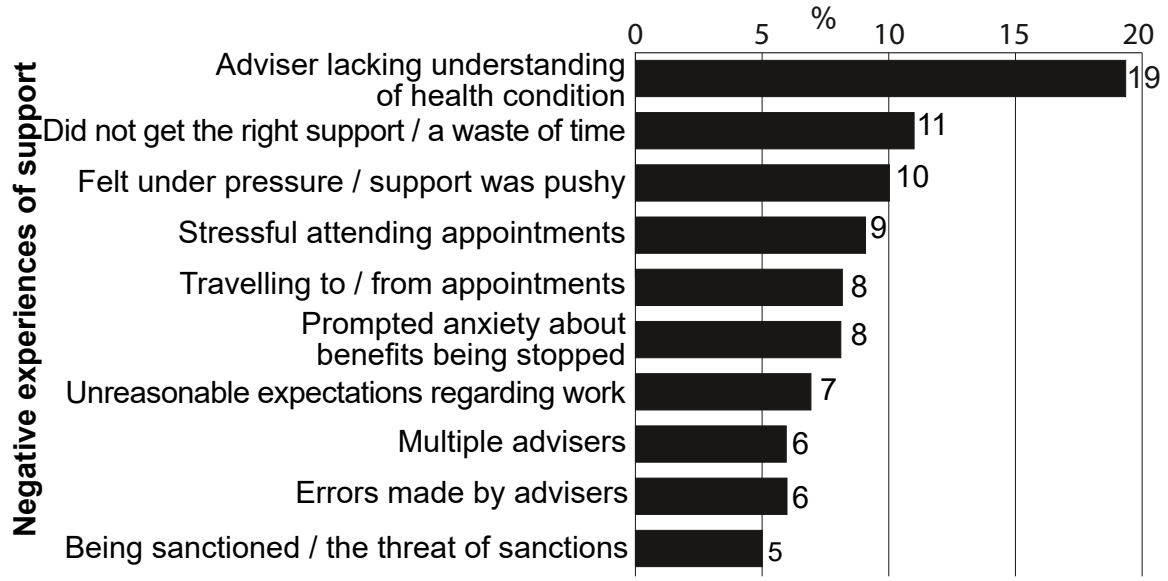
Figure 5.21 Most helpful element of support on the WP pilot



Base: All WP pilot end-stage respondents that found more than one aspect of support helpful at Wave 1 or Wave 2 (51)

For those that did express dissatisfaction with an aspect of the support received (32 per cent), the main reasons were related to their adviser's interpersonal skills – 19 per cent mentioned that their adviser lacked empathy and understanding of their health condition or disability, while ten per cent reported that they felt under pressure or that the support was 'pushy'. Issues around appointments were also highlighted (e.g. nine per cent found it stressful attending appointments, and eight per cent had difficulties with travelling to and from appointments). Some WP pilot participants also reported an issue with their adviser's knowledge or skills (e.g. 11 per cent reported not getting the right support or finding it a waste of time), while sanctions or the threat of sanctions was also challenging for some (five per cent). See Figure 5.22 and Appendix Table 5.46 for the full list of reasons.

Figure 5.22 What WP pilot respondents disliked about the support they received (among those who were dissatisfied with an aspect of the support)[46]



5.3 Healthcare provider pilot

5.3.1 The support model and participant journey

DWP guidance provided for the HCP pilot specified that a minimum of five appointments should take place with participants over a 24-month period, delivered by a healthcare professional. The first three appointments were required to take place in the first six months of the programme, with the fourth appointment taking place at around 12 months and the final appointment at around 18 months. Appointments were required to be conducted face-to-face, unless this was not possible for the individual participant.

In practice, the HCP provider maintained close fidelity to this minimum support model. The pilot managers felt that they had limited flexibility to vary the model and did not appear to be aware of the option of providing additional appointments above the five minimum at their discretion.

The model of support was based on bespoke one-to-one support, led by the health adviser's assessment of participant needs and it was intended that participants would have the same adviser throughout the pilot. Appointments were booked in to one-hour slots, and it was expected that the health adviser would spend 45 minutes talking to the participants and 15 minutes completing paperwork and administration, with advisers each having six appointments per day.

The HCP pilot covered a large geographical area. Where possible, appointments were held in the HCP providers' offices, and where this was not possible, advisers operated from rooms hired in other providers' premises. The support was delivered in a private space wherever possible.

The focus of the support provided was health-related and comprised a mix of one-to-one support during appointments, referrals to outside organisations and suggestions for external activities. There was limited access to additional in-house provision for pilot participants.

[46] Figure 5.22 shows the top ten mentions only.

5.3.2 Referral process

Participants were referred to the pilot by Jobcentre Plus. Their information was sent to the provider's contact centre, which allocated health advisers based on caseload and geography, and contacted participants to explain the pilot and arrange their first appointment. Contact centre staff reported that the information received from Jobcentre Plus varied, but most health advisers interviewed felt that the information provided was sufficient, as they saw the initial appointment as a means to find out more about the participant.

Participants interviewed were notified about the pilot from either their Jobcentre Plus office or by a letter from DWP. Regardless of the method of notification, participants reported an understanding that the pilot was mandatory and often recalled being aware of the structure of the support.

Their reactions were mixed; some participants were happy to take part because they had a previous positive experience of support from the provider, or they thought that health-related support could be helpful. Others were more sceptical as they were not sure if they were suitable for the pilot or were apprehensive about what it would involve. For example, some participants thought it would be similar to the Work Capability Assessment. Several participants were also confused and unsure what they would be doing in their appointments and desired more information:

> *'I kind of went into it blind. I mean it's more a case of "You've got to do this" and that was really all I ever knew… I don't mind doing it – it just would have been nice in the beginning to have perhaps have had a little bit more information than what I got.'*
>
> (Woman, 18-29, HCP pilot, Wave 1)

This was echoed by the pilot advisers, who felt that the lack of upfront information about the pilot from Jobcentre Plus was unhelpful for participants.

5.3.3 Initial appointment

The initial appointment on the pilot was booked into a one-hour slot. Health advisers typically began by explaining the pilot to participants, as many did not know what it would entail and some were worried that it would be focused on employment. This involved 'selling' the service to participants and reassuring them about the purpose of the appointments. Advisers emphasised that the support would be health-focused and that participants would not be 'forced' to look for work.

A number of participants welcomed this reassurance and reported that their adviser put them at ease, or that the appointment was less work-focused than they had anticipated.

> *'I was really, really scared. I was nearly sick in fact, but once they introduced themselves, they made me feel really comfortable... I was expecting they would be pushing me into a job…but there was none of that... I always thought [provider] was a back to work programme.'*
>
> (Man, 18-29, HCP pilot, Wave 1)

Participants then completed an assessment, which comprised a standardised form that the adviser and participant completed together. This covered barriers to work, health conditions and what support the participant was currently receiving and would need going forward. The assessment was described as conversation-based and a 'psycho-social' rather than medical assessment. Although the initial assessment was often described as participant-led, advisers explained that they used motivational interviewing techniques to encourage participants to be more open-minded and to consider the different options available to them.

As well as using the assessment to formulate an action plan, advisers also described using their clinical experience and observational skills to decide which support the participant might benefit from, and whether they were giving accurate answers. For example, advisers considered participants' attitude and willingness to complete suggested activities, and analysed their behaviour and actions.

Advisers said that it had been challenging to obtain all the initial assessment information in one hour. This was especially problematic if participants became upset or distressed as there was little time to comfort them, and as the appointments were back-to-back, advisers had little or no time to reflect on each case.

The majority of participants interviewed reported that their initial appointment was face-to-face and some explained that they would have preferred a telephone appointment, because they had to travel a considerable distance and were often reliant on lifts from family or friends. Some participants also reported difficulties with accessibility and parking, which was particularly challenging for people with physical health conditions.

Although it was intended the support would be delivered in a private space, some participants reported that their appointments had been in busy, open-plan offices, which made them uncomfortable about discussing personal issues.

5.3.4 Subsequent appointments

It was intended that the majority of appointments on the pilot would be conducted face-to-face, unless this was not possible due to a participant's health condition or because of their rural location. As with the WP pilot, face-to-face appointments were the preferred method of delivery for staff. Although there were staffing challenges at the beginning of delivery (see Chapter 2), which meant that some appointments were conducted by telephone, it was reported at Wave 1 that the vast majority of appointments were conducted face-to-face. Telephone appointments became increasingly common in the final two months of the pilot, due to a reduction in staff numbers as the pilot caseload reduced, and due to the large geographical area that the pilot covered. However, this change only affected a small number of participants, the majority of whom were already receiving telephone-only support due to their health condition, or were frequent 'non-attenders'. Hence, this was not seen to have had a significant impact on the quality of pilot delivery overall.

Although the HCP provider had discretion to provide additional support in between the five face-to-face appointments, health advisers were not always aware of this. Those who had been aware reported having limited time to undertake additional contact. Some were also worried about participants becoming dependent on this additional support, when there was limited flexibility to provide it regularly. Reflecting

this, participants rarely recalled having contact with their adviser outside the five appointments, but some would have liked this, for example if they had any queries or were simply having a 'bad day'.

Pilot staff thought that greater flexibility to schedule the five appointments when they were best for the individual, rather than at fixed intervals, would have been useful. They felt that some participants would have benefited from appointments in closer succession to motivate them, whereas others might have required a longer gap to deal with health issues or wider circumstances. Most of the health advisers also thought that more frequent or longer appointments would have been useful in some cases. For example, they felt that participants who were not receiving any support from other support services would have benefited from more frequent appointments, especially as the long period of time between the fourth and fifth appointment sometimes resulted in participants forgetting about the pilot and disengaging.

Some pilot participants also thought that the appointment structure was too rigid, and suggested that more frequent appointments would have improved the programme. These participants felt that this would have increased their engagement, incentivised them and allowed them to have a better recollection of what was discussed and agreed in their previous appointment:

> *'I would have liked more contact with somebody, at least once a month, because unfortunately with the best will in the world, people set you targets and then the months go on and you've forgotten what those targets are. You put it away and you think, I'll come back to it in a couple of days' time, and then the days go into weeks and the weeks go into months and it all turns into nonsense.'*
>
> (Woman, 50+, HCP pilot, Wave 1)

Adviser continuity

It was intended that participants would have the same health adviser throughout the pilot but, again, this was not always possible due to factors such as staff turnover, initial issues with resourcing (see Chapter 2) and reductions in staffing as the pilot wound down. Consequently, one of the main criticisms that participants had of the HCP pilot was that their adviser changed, sometimes more than once. Explaining their circumstances to different advisers was frustrating for participants, who sometimes struggled to discuss their health and history, or who became anxious when meeting new people:

> *'It was just the fact that the advisers kept changing and you had to repeat, even though they had the notes in front of them on the computer, you had to explain yourself again to a completely different adviser, so they understood where you was coming from.'*
>
> (Man, 18-29, HCP pilot, Wave 1)

Despite this dissatisfaction with changing advisers, participants' views of the health advisers on the pilot were generally positive. Advisers were described as understanding, friendly and helpful.

5.3.5 Action Plans and monitoring progress

The use of action plans was a contractual requirement of the HCP pilot, therefore all the health advisers completed action plans on a standard form that could be tailored to individual participants. The initial action plan was created during the first appointment and reviewed and updated at consecutive appointments to monitor participant progress. Advisers discussed with participants how they were feeling and their daily activities to identify any changes in circumstances, and set new goals on the basis of this. At the end of each appointment, the action plan was printed off for the participant to sign and take away with them.

According to advisers, the aims and activities on the action plan varied greatly based on participants' overall aims and what was realistic for them, but they tended to be more health-related than employment-focused. Typically, actions were aimed at improving participants' management of their condition in order to improve their health and wellbeing, with the understanding that doing so could move them closer to the labour market in the longer-term.

Participants who were interviewed appeared to have relatively similar tasks on their action plans, such as improving their diet and nutrition and getting into a better daily routine. Some participants found their action plan useful because it gave them activities to undertake that had improved their day-to-day lives and kept them on track. Some participants said it was also a useful document to take to their GP or to show to their family, to demonstrate what they had been doing to try and overcome their barriers and show the progress that they had made. Others were dissatisfied with their action plan. This tended to be because it was focused on employment-related tasks that were considered unsuitable by the participant (e.g. taking up voluntary work); because it recommended options that the individual felt they were already doing; or because it did not include activities that they were interested in, such as completing a training course. In addition, some participants were negative about their action plan because they did not think the support recommended would be able to help them with their health condition.

5.3.6 Mandation

All participants were mandated to attend the five appointments, but action plan activities were not compulsory, nor were the referrals to external support. Staff reported that the fail to attend (FTA) rate for appointments varied by area, but was generally very low.

Staff said that participants could be put forward for a sanction if they failed to attend an appointment and they were unable to contact them to find out why, although if the individual re-engaged this could be retracted. However, advisers reported that more commonly participants contacted them in advance of an appointment to explain why they could not attend and they would simply rearrange the appointment. Thus, sanctioning appeared to be rarely used on the HCP pilot. Participants interviewed appreciated advisers' flexibility and consideration in this.

Pilot staff felt that mandation could have negative consequences since initial appointments were often spent dispelling myths about the pilot 'forcing people into work', and dealing with participants' anger and upset. There was also a concern that in some instances, participants had been 'scared' into attending rather

than actively engaging with the process. However, staff also acknowledged that mandatory appointments were useful in some cases for encouraging attendance at appointments, and that once engaged with the pilot, participants were then motivated to make the most out of it.

Health advisers gave examples of participants who were initially reluctant to engage with the pilot, but who, over time, spoke about their needs and aspirations and were receptive to the advice given. One individual had taken up a voluntary role and another was able to better manage his pain after receiving advice:

> *'He was like a different man. He walked in, he was smiling. He came on his own. He said, you know what, I can't believe it, he said, I've read that information and I can't believe the difference it made. I'm pacing. I'm taking my pain relief, as you suggested.'*
>
> (Health adviser, HCP Pilot, Wave 2)

Participants' views about the mandatory aspects of the pilot also varied. Some could understand why it was mandated but said that they would have attended anyway, while others found the mandation stressful and unhelpful. Some participants admitted that they attended only because it was mandatory.

The majority of participants interviewed had not missed any appointments and, as noted previously, those that had were usually able to rearrange. However, one participant reported that a letter about a potential sanction had exacerbated her anxiety.

5.3.7 Types of support provided

Health advisers reported that the content of the support provided on the pilot was tailored to the individual's needs. However, the overarching intention of the support was to provide health advice and guidance in order to help participants cope with their conditions and improve their wellbeing.

Pilot staff explained that the sequencing of support was based on individual needs and priorities, and actions were discussed and agreed with participants at each appointment.

Health-related support

Health advisers had a target of ten referrals a month to external health provision and, as participants on the pilot had a wide range of physical and mental health conditions, the support and referrals reflected this diversity of needs. A common element of provision was encouraging participants to re-engage with NHS provision by referring participants back to their GP for a medication review. GPs were also recognised as an important gateway to other funding and provision.

Other health-related services referred or signposted to by HCP advisers included:

- Community Occupational Therapists to obtain new or improved equipment in participants' homes (such as items to enable them to get upstairs or to shower);
- Substance misuse services;
- Mental health teams, counselling, IAPT or Cognitive Behavioural Therapy;
- Pain management teams, fall and pain clinics and physiotherapy for participants with chronic physical conditions;

- Self-help groups or online support groups to prevent participants feeling isolated;
- Recovery Colleges to help people better understand their conditions; and
- Independent living support to help participants cope with their physical health conditions.

Advisers also reported regularly signposting individuals to the NHS Choices website and to specialist charities for particular conditions, such as Diabetes UK, as a source of information and support. Self-help guides and information leaflets were also provided, covering topics such as nutrition and pain management.

Participants also reported that the support focused on managing their conditions, and many said that their adviser had encouraged them to attend health appointments with their GP or the hospital. Health topics covered in their appointments included how to get into a routine, and advice on pain and condition management. Some participants said that they had been given relaxation booklets, information on breathing exercises, or guidelines on coping with their moods. Improving health through using diet plans and going to the gym were also commonly discussed.

Participants who were receptive to the advice and guidance they were given, or who took up signposting suggestions, generally found it useful. For example, one participant was referred to a group support session on thinking and feeling positive, which improved their confidence and made them feel more ready to take up voluntary work. Another participant was encouraged to see their GP, who changed their medication, which improved their wellbeing and mood. Several participants chose not to follow up on the health-related referrals made by the HCP provider – typically those who were signposted to counselling, as they had tried this before and found it unhelpful.

There were mixed views among participants about the health focus of the HCP pilot. Several participants said that they appreciated having a health adviser that understood their condition, who could provide relevant and useful advice and who did not 'push' them into work:

> *'It's nice to talk to somebody that understands that you've got an illness. It's terribly embarrassing...being able to talk to somebody that understands, and the advice to help you learn to manage your illness, your conditions. I find that very helpful.'*
>
> (Woman, 50+, HCP pilot, Wave 1)

In contrast, some participants would have preferred more work-focused support, such as information about training courses and support to apply for jobs. Where participants did feel work-ready, they often completed work-related activity using their own initiative or with external help, unrelated to the pilot. Conversely, a few participants said that the support was too employment-focused, as they felt they were encouraged to look for work or to consider self-employment when they weren't ready for this.

Holistic support

Participants were signposted to external organisations for support with a range of other challenges in addition to health, such as for benefits advice and debt. Organisations included Citizens Advice, Community Advice or legal services. Advisers believed that the support they offered needed to be holistic, as they felt that a variety

of issues aside from health could be preventing the individual from moving forwards. Encouraging self-care and socialising were also seen to be important elements of the provision by advisers, because these were likely to increase overall wellbeing and motivation.

Employment-related support

HCP staff did not view employment outcomes to be the aim of this pilot, and it was widely reported that participants were generally not ready for employment interventions straight away. For participants that became more work-ready during the pilot, advisers had the option to use the provider's employability resources, such as information on permitted work, a CV builder template, links to useful websites, a skills checklist, and a better off in work calculation. Other work-related activity that advisers reported using included referrals to:

- Learn Direct or other community training providers;
- Volunteering services; and
- Organisations specialising in employment support for people with mental health conditions.

Advisers felt that it was important to change participants' perceptions about working with a disability or health condition. They also wanted to make sure that participants knew that they had the option to do permitted work or voluntary work, rather than having to enter full-time work if this was not right for them. Participants were signposted to case studies of disabled people or individuals with health conditions in employment, to demonstrate what was possible. Advisers were also able to source volunteering opportunities and permitted work through their partnerships with external organisations (for example, the Prince's Trust).

Examples of work-related activity reported by participants included discussion of jobs they would like to do, some basic job search, and advice and support regarding permitted work or volunteering. Some participants interviewed were also referred to external employment support. Several of the interviewed participants entered voluntary work during or after the pilot.

5.3.8 Partnerships

The use of partnerships was an important aspect of HCP delivery in ensuring that the support provided was responsive to participants' needs. At the start of the pilot, advisers were told to try to create a partnership with one new service each month, and allotted business development days dedicated to making links with local organisations. Methods of establishing these partnerships included attending networking events and contacting local services to inform them of the pilot and the support being provided. Advisers appreciated having the time allocated to forging partnerships and doing outreach, and they felt this was important as they could see local provision first-hand and thus make more appropriate referrals. However, they faced some challenges in conveying the purpose of the pilot to providers, who, like participants, often had the initial impression that it was primarily employment-focused.

When a new connection was established, advisers would save this information on a spreadsheet that was accessible to all pilot staff. This resource was developed as the pilot progressed and was regarded as useful amongst staff. Some advisers appeared more proactive than others in creating partnerships and links with local provision, often linked to their prior experience.

Health advisers reported that engaging with GPs was sometimes difficult, as GPs seemed to feel that their professional judgement was being questioned or that the health advisers were challenging their role:

> *'I think often maybe they thought they were being sort of challenged … but I think when we explained to them what we were actually trying to get the client to ask them, … it was just about making sure that they had that condition management, that joint protection.'*
>
> (Health adviser, HCP Pilot, Wave 2)

They thought that having a standardised letter from DWP and/or the provider explaining the purpose of the pilot would have been useful for partnership working.

Other challenges raised by advisers included difficulty in tracking whether participants had taken up referrals/signposting, due to the lengthy gaps between appointments, and a lack of time to forge links with local organisations due to back-to-back appointments.

Gaps in support

A number of gaps in provision in certain areas were identified, as well as delays while new services established themselves. Cuts in funding were reported to have resulted in fragmented provision and long waiting lists in some areas. Examples given were reductions in funding for community learning, and an increasing pressure on community mental health teams and social services, especially Occupational Therapist assessments.

Advisers gave examples of participants becoming frustrated waiting for services such as counselling, or for specialist equipment. They provided participants with self-help resources so that they could learn more about managing their condition while they were waiting to access a local service. However, some interviewees felt that access to additional in-house resources would have helped overcome the gaps in external provision.

5.3.9 Aspects of support that worked well

Health advisers thought that the pilot had allowed participants to talk freely about their health and any other issues that were holding them back. They believed that the health-focused but holistic nature of this pilot was its key strength, and that the following aspects had facilitated this:

- providing, at the initial appointment, reassurance that the support would be health focused, and not about making them go back to work
- advisers' approach – combining their knowledge with an understanding, friendly and helpful manner
- careful sequencing of support so that participants were better able to cope with their health conditions and improve their wellbeing.

One pilot manager attributed the good level of engagement on the pilot to the health advisers' ability to successfully engage clients at the first meeting. This was achieved through clearly explaining what the support would involve, and providing participants with a welcome pack that included case studies of individuals who had been supported into work.

At subsequent appointments, the actions and goals chosen aimed to help participants to better manage their condition and improve their health and wellbeing. Advisers believed that through doing this, participants would become ready to re-engage with the labour market in the longer-term.

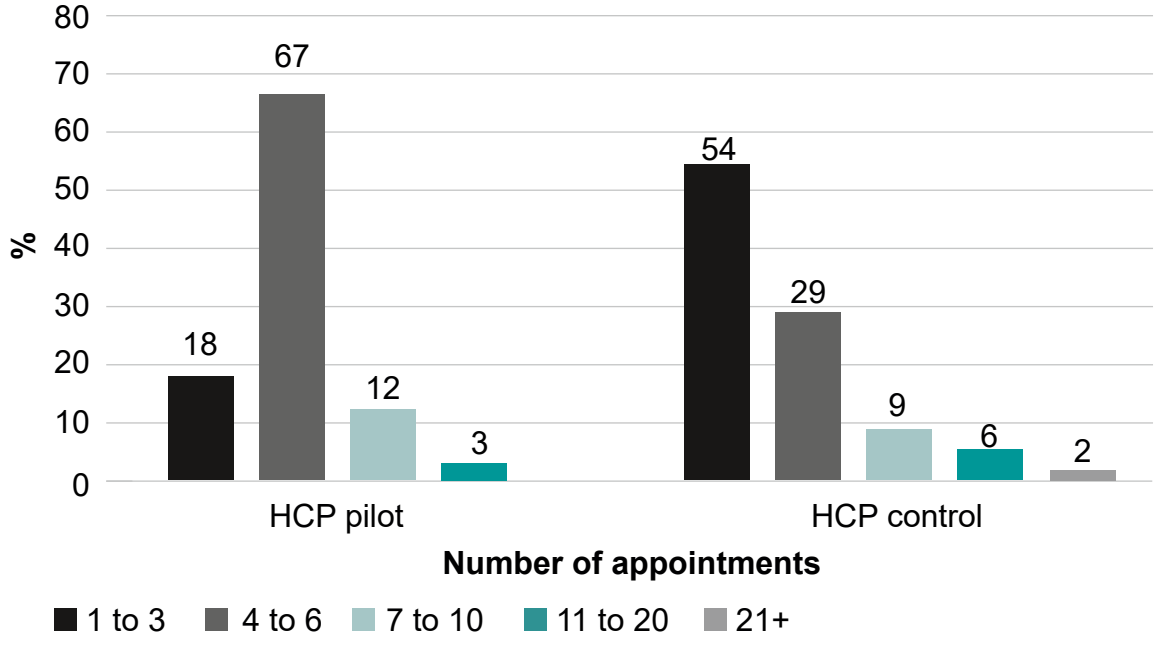
5.3.10 Comparing the support received by pilot and control group members

Appointments

Participants in the HCP pilot and control groups were asked about the number of appointments they had had with either a Healthcare Practitioner (pilot group) or with Jobcentre Plus (control group) since starting on the programme. As Figure 5.23 illustrates, HCP pilot participants were significantly more likely to report attending at least four appointments than HCP control participants. The majority of HCP pilot participants reported attending four or more appointments (82 per cent), whilst fewer than half of HCP control participants reported doing so (46 per cent).

Within both pilot and control groups, participants with a higher level of educational qualification (i.e. at least one good GCSE or equivalent) reported significantly more appointments than those with a lower education level (i.e. less than one good GCSE).

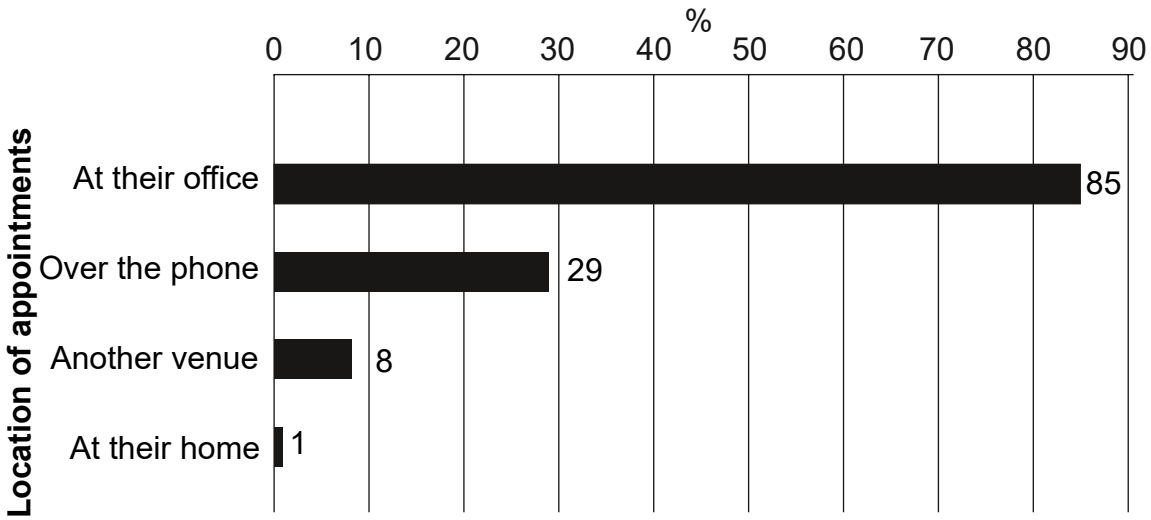
Figure 5.23 Number of appointments with provider



Base: All HCP pilot (346) and HCP control (421) respondents at Wave 1

Most HCP pilot respondents had at least one appointment at the provider's offices (85 per cent), while around a third had at least one appointment over the phone (29 per cent), and only a very small proportion had appointments at another venue[47] or at the participant's home (eight per cent and one per cent respectively), as shown in Figure 5.24. A high proportion (71 per cent) of HCP pilot participants reported that they had just face-to-face appointments, while around a fifth (21 per cent) reported that they had both face-to-face and telephone appointments. Very few reported having only telephone appointments (eight per cent). There were no significant differences between pilot and control groups regarding appointment locations.

Figure 5.24 Location of appointments with HCP Healthcare Practitioners



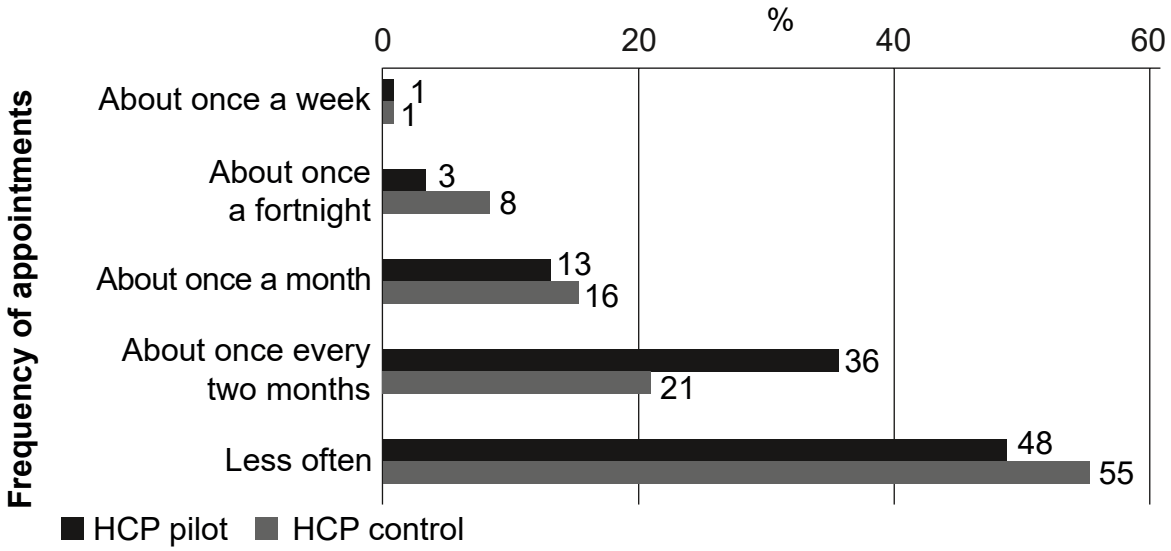
Base: All HCP pilot respondents (363) at wave 1

HCP pilot participants reported a significantly lower frequency of appointments than those on the JCP or WP pilots, with frequencies more similar to that of the HCP control group. As Figure 5.25 shows, only 17 per cent of HCP pilot participants reported appointments taking place about once a month or more frequently, compared with 25 per cent of HCP control participants. Around half of HCP pilot and control participants reported that appointments took place less often than once every two months (48 per cent in the pilot, and 55 per cent in the control group). This reflects the different support model in the HCP pilot (compared to the other two pilots) which delivered a fixed structure of five appointments over a two-year period.

The majority of HCP pilot participants reported that appointments had always been the same frequency (53 per cent), although around a third (35 per cent) reported that appointments were more frequent at the start, and very few (5 per cent) reported appointments becoming more frequent as the pilot progressed (see Appendix Table 5.13). Again, this reflects the support model of the pilot, which delivered three meetings in the first six months and then two subsequent meetings over the next 18 months.

[47] This may reflect the fact that the provider often operated out of other organisation's premises on an outreach basis.

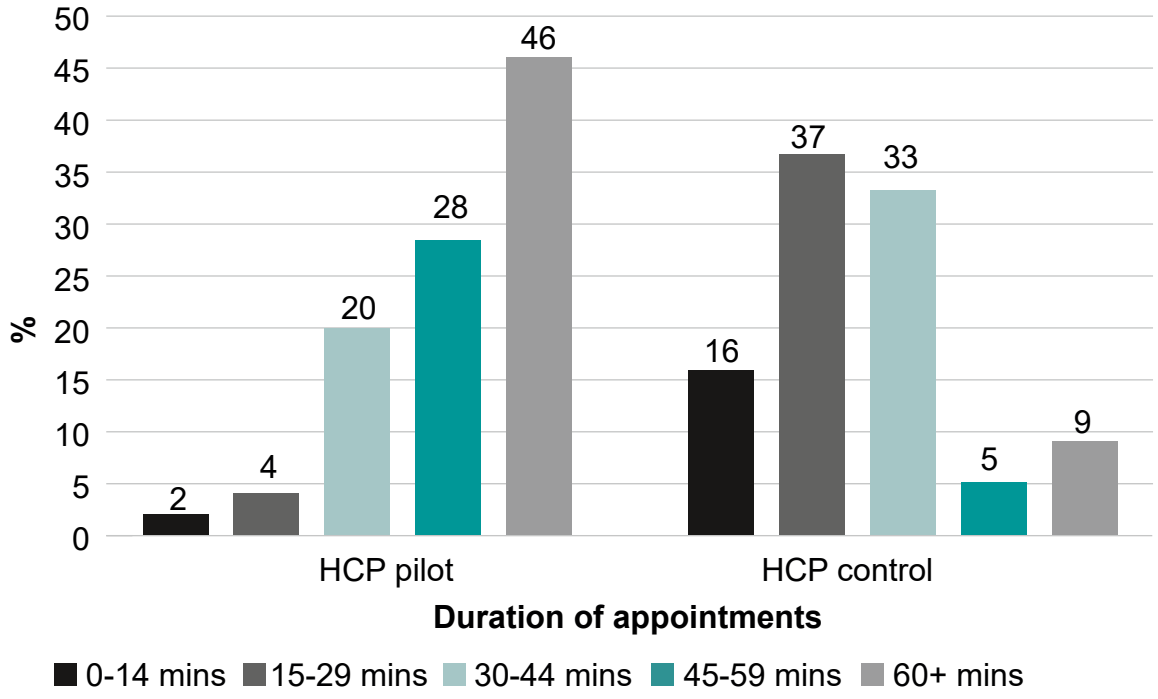
Figure 5.25 Frequency of appointments with providers



Base: All HCP pilot (328) and HCP control (353) respondents at wave 1

Participants were asked about the typical length of an appointment with a Healthcare Practitioner (pilot group) or with Jobcentre Plus (control group). As shown in Figure 5.26, the typical appointment length was significantly longer for HCP pilot participants than for HCP control participants. Nearly half (46 per cent) of HCP pilot participants reported that appointments lasted 60 minutes or more (versus ten per cent of the control group), while a further 28 per cent of HCP pilot participants had appointments lasting 45 to 59 minutes (versus just five per cent of HCP control participants).

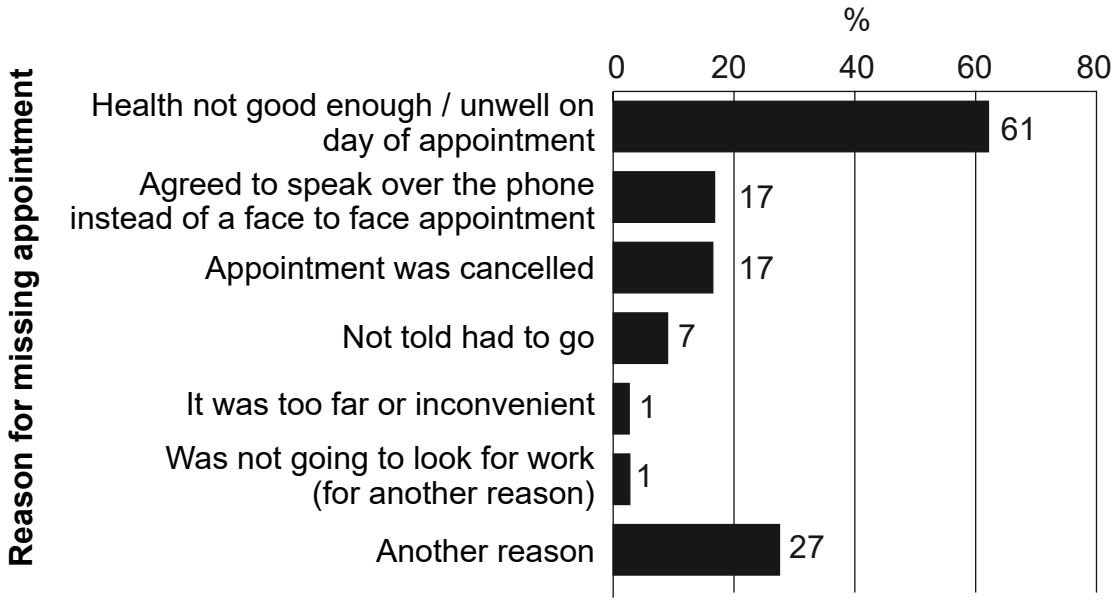
Figure 5.26 Duration of appointments with provider



Base: All HCP pilot (362) and HCP control (446) respondents at Wave 1

HCP pilot participants[48] were also asked to report whether they had missed any appointments. The majority of participants (77 per cent) had not missed an appointment. For the minority (23 per cent) that had missed an appointment, the top reason given was their health not being good enough or being unwell on the day of the appointment (61 per cent). As Figure 5.27 illustrates, agreeing to speak over the phone instead of having a face-to-face appointment, and the appointment being cancelled (both 17 per cent) were also frequently-cited reasons.

Figure 5.27 Reasons for missing an appointment with HCP provider



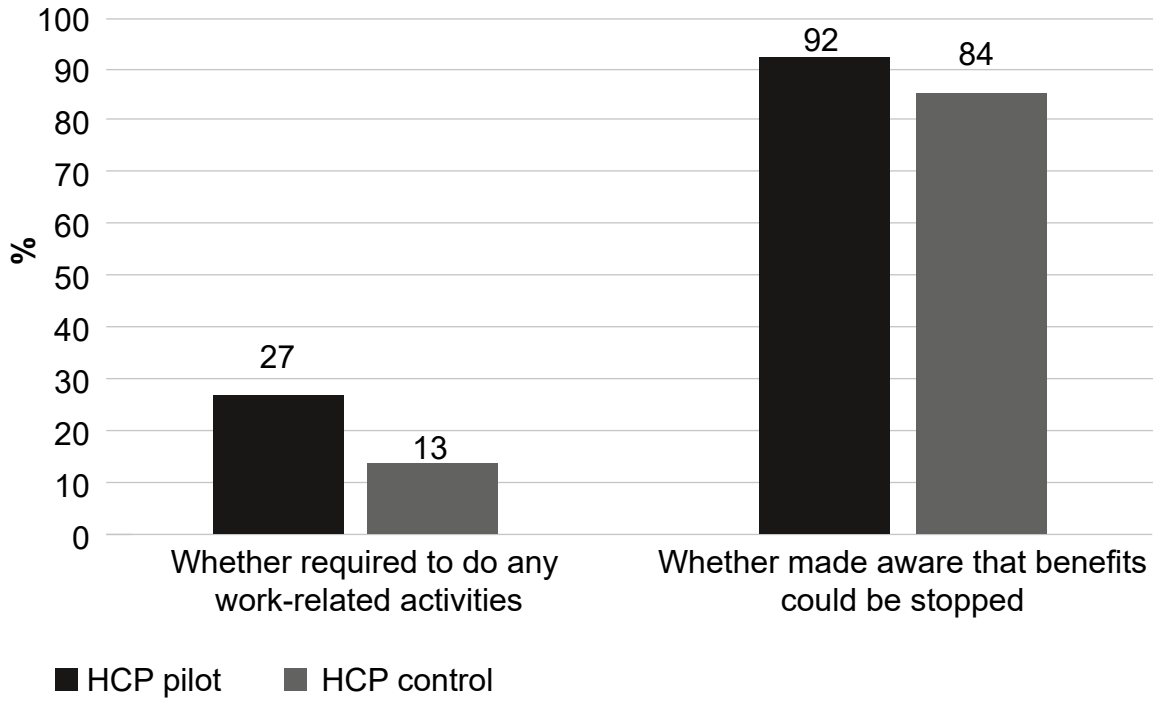
Base: All HCP pilot respondents who missed an appointment (82) at Wave 1

Mandation and Work Related Activity

Significantly more HCP pilot participants reported that they were required to undertake a work-related activity than HCP control participants (27 per cent versus 13 per cent) (see Figure 5.28). The vast majority of both pilot and control participants were aware that their benefits could be stopped if they did not undertake compulsory activity (in this case attending meetings), but the proportion was still higher in the pilot group than in the control (92 per cent, versus 84 per cent).

48 This question was not asked of the HCP control group.

Figure 5.28 Whether HCP respondents were required to undertake work-related activities and made aware that benefits could be stopped



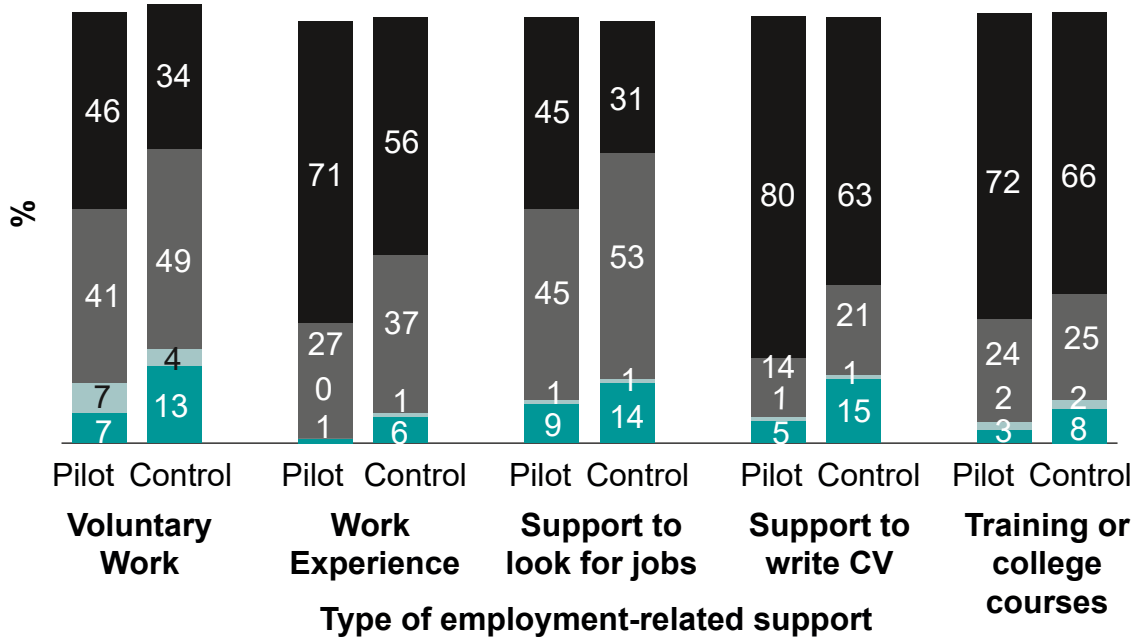
Base: All HCP pilot (361; 360) and HCP control (444; 448) respondents at Wave 1

Types of support offered and received

HCP pilot and control participants were asked to report on discussions with their advisers, the type of support they received, and whether this support was received *as a result* of the discussion with their adviser. This section considers the different types of support participants discussed and received, including employment-related, health-related and any other support (also see Appendix Tables 5.29 to 5.40).[49]

[49] Figures 5.29 and 5.30 only display the types of support where there was a significant difference between the HCP pilot and the HCP control group.

Figure 5.29 Employment-related support discussed and received (HCP respondents)



Base: All HCP pilot and HCP control respondents: Voluntary work (357, 444) Work experience (348, 431); Support to look for jobs (357, 446); training or college courses (353, 441) at Wave 1

With respect to employment-related support, HCP pilot participants were significantly *less* likely than HCP control participants to have discussed employment-related support or received such support as a result of these discussions. For example, work experience and applying for jobs or writing a CV were only discussed by a minority of both pilot and control participants, but still significantly fewer pilot than control participants discussed these topics (28 per cent of pilot participants versus 44 per cent of controls discussed work experience, and 20 per cent of pilot participants versus 37 per cent of controls discussed applying for a job or writing a CV).

Moreover, even where employment-related support was discussed with advisers, few participants went on to receive such support or undertake the suggested activities[50] . For example, both voluntary work and looking for jobs were discussed by the majority of both pilot and control participants, but no support was then received in most cases (41 per cent of pilot participants and 49 per cent of control participants discussed but did not go on to undertake voluntary work, while 45 per cent of pilot participants and 53 per cent of control participants discussed but did not subsequently receive support to look for jobs).

Overall, HCP pilot participants were significantly less likely to receive most types of employment-related support than controls, as shown in Figure 5.29. For example:

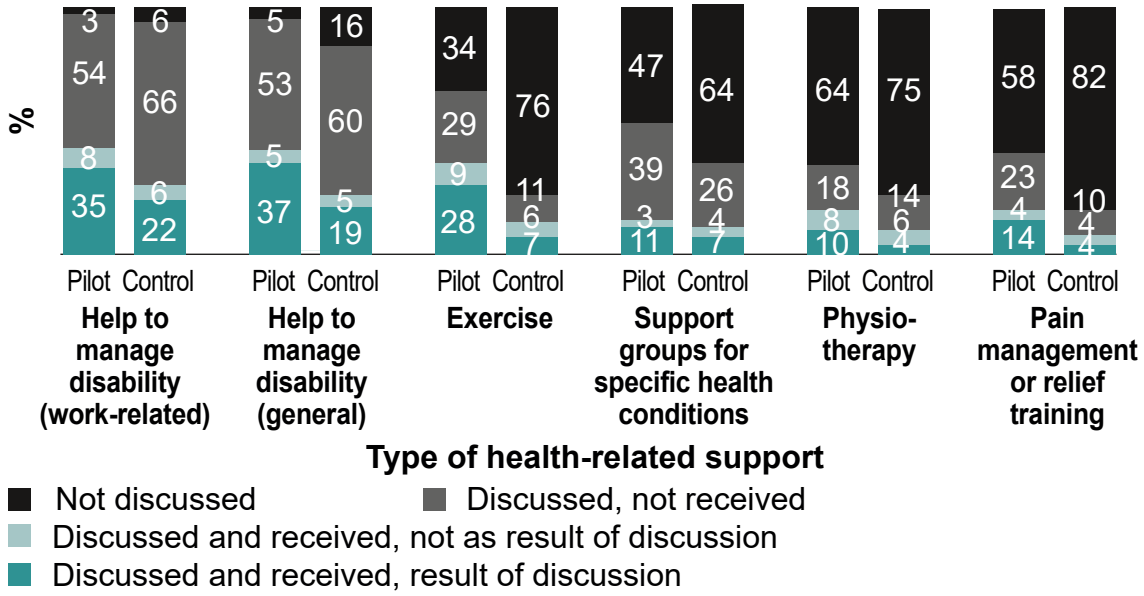
- voluntary work: seven per cent in the HCP pilot, versus 13 per cent in the control;

[50] Very few HCP pilot participants were in work during the Wave 2 survey. Those that were did not report receiving any in-work support.

- work experience: zero per cent HCP in the pilot, versus six per cent in the control;
- support to look for jobs: nine per cent in the HCP pilot, versus 14 per cent in the control;
- support to write a CV or apply for a job: five per cent in the HCP pilot, versus 15 per cent in the control; and
- training or college courses: three per cent in the HCP pilot, versus eight per cent in the control.

Again, this low level of employment-related support received by pilot participants is a reflection of the greater emphasis the HCP pilot placed on health-related support; meanwhile, the control group would likely be receiving some employment-focused support from Jobcentre Plus.

Figure 5.30 Health-related support discussed and received (HCP respondents)



Base: All HCP pilot and HCP control respondents: Help to manage disability (work: 348, 436; general: 348, 430); Exercise (358, 439); Support for specific health conditions (339, 428); Physiothereapy (351, 437); Pain management or relief training (347, 439) at Wave 1.

On the topic of health-related support (Figure 5.30), the most common types of support received (or activities undertaken) as a result of discussions with an adviser were practical help to assist with the management of a health condition or disability (both in relation to work and in general), and undertaking more exercise.

Notably, HCP pilot participants were significantly more likely to have discussed and received support in all six areas of health-related support shown in Figure 4.29, reflecting the health-focused orientation of the HCP pilot. For example:

- 35 per cent of HCP pilot participants discussed and received practical help to manage their condition or disability (in relation to work), versus 22 per cent of control participants;
- 37 per cent of pilot participants discussed and received practical help to manage their condition or disability (in general), versus 19 per cent of control participants; and
- 28 per cent of pilot participants discussed, and received support with, doing more exercise, versus seven per cent of HCP control participants.

Only a small minority of participants attended any of the following as a result of discussions with their adviser, although again numbers in the pilot group were significantly higher than in the control: physiotherapy (ten per cent for the pilot group, versus four per cent for the control); support for pain-management or relief (14 per cent versus 4 per cent), and attending support groups for specific health conditions (11 per cent and 7 per cent).

Regarding other support (not employment or health-related), confidence-building or assertiveness sessions were significantly more likely to have been discussed by HCP pilot participants than controls (58 per cent of pilot participants discussed this versus only 36 per cent of controls, and 11 per cent of pilot participants went on to receive such support as a result of the conversation, compared to six per cent of controls).

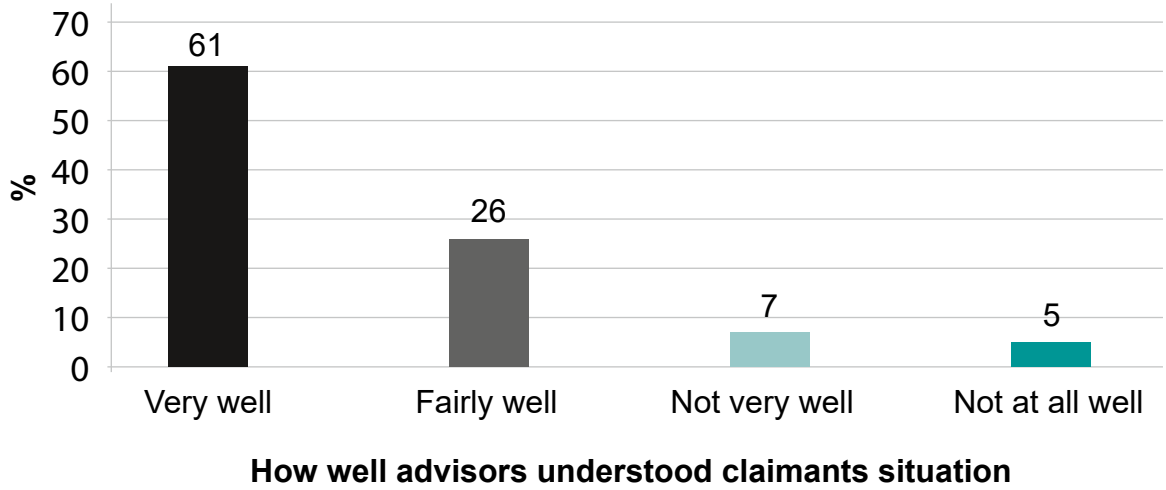
All participants were asked a follow-up question on whether there was anything else they had done or received help with as a result of their appointments. Similar proportions of pilot and control participants reported that *no* other support had been received (71 per cent and 72 per cent, respectively).

Satisfaction with support received

HCP pilot participants were asked to rate their experience of the pilot. The majority of pilot participants said it was 'very good' or 'good', and this was significantly higher than among their control group counterparts (89 per cent and 77 per cent, respectively).

Around two-thirds of HCP pilot participants also said that they could contact their support provider if they needed help or wanted clarification (68 per cent). The majority were also positive that their advisers understood their situation: 61 per cent felt their advisers understood their situation very well, while a further 26 per cent felt they did fairly well (see Figure 5.31 and Appendix Tables 5.5 to 5.6).

Figure 5.31 Extent to which advisers understood the respondent's situation



Base: All HCP pilot respondents (362) at Wave 1

Overall, HCP pilot participants were satisfied with the support received from their Healthcare Practitioners, with more than three-quarters (78 per cent) reporting that there was nothing they disliked about it.

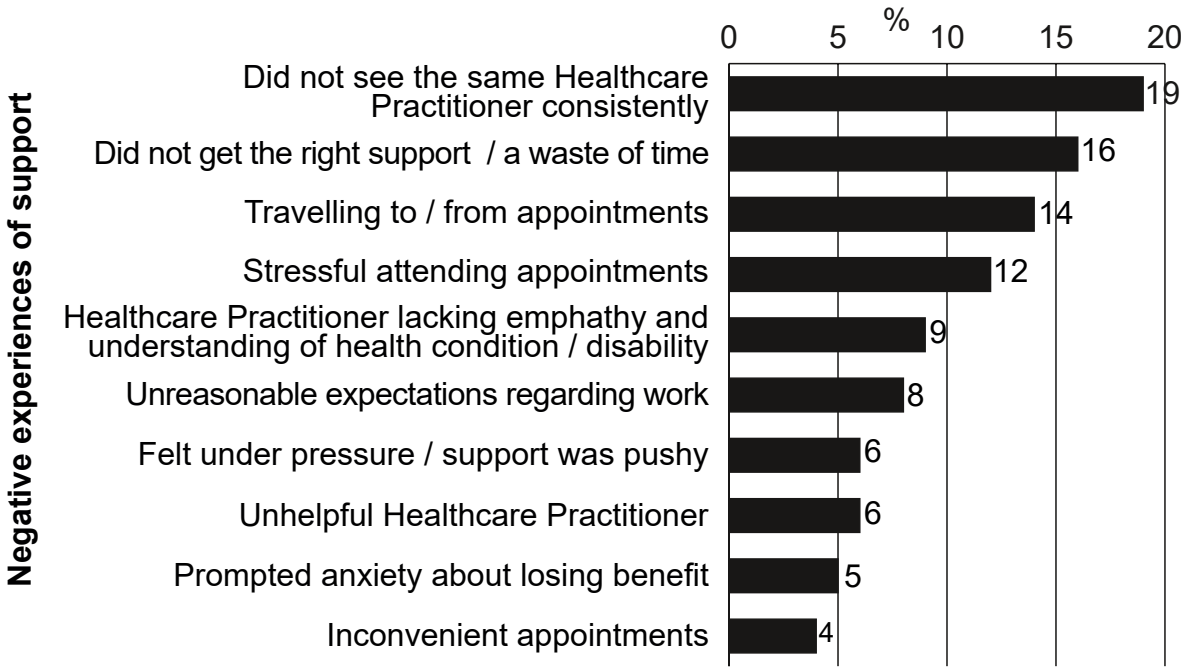
General help to manage their condition/disability was identified as the most helpful aspect of support received (mentioned by 13 per cent of those who found more than one aspect helpful), as shown in Figure 5.32. However, it is worth noting that 15 per cent could not say which was most effective, suggesting (that for some) support was most helpful delivered as a package in order to meet multiple support needs.

Figure 5.32 Most helpful element of support on the HCP pilot

Base: All HCP pilot end-stage respondents that found more than one aspect of support helpful at Wave 1 or Wave 2 (166)

For the 22 per cent that were dissatisfied with an aspect of the support received, the top reason given was having multiple Practitioners or not seeing the same Healthcare Practitioner at each appointment (19 per cent), followed by feeling that they did not get the right support, or finding the support a waste of time (16 per cent). Difficulties with travelling to and from appointments were also reported (14 per cent), as well as finding it attending appointments stressful (12 per cent) and feeling that advisers lacked empathy or understanding with regards to the respondent's health condition. See Figure 5.33 and Appendix Table 5.46 for the full list of reasons given.

Figure 5.33 What HCP pilot respondents disliked about the support they received (among those who were dissatisfied with an aspect of the support)[51]



Base: All HCP pilot respondents who disliked an aspect of the support they received (79) at Wave 1

5.4 Transitioning from pilot to post-pilot support

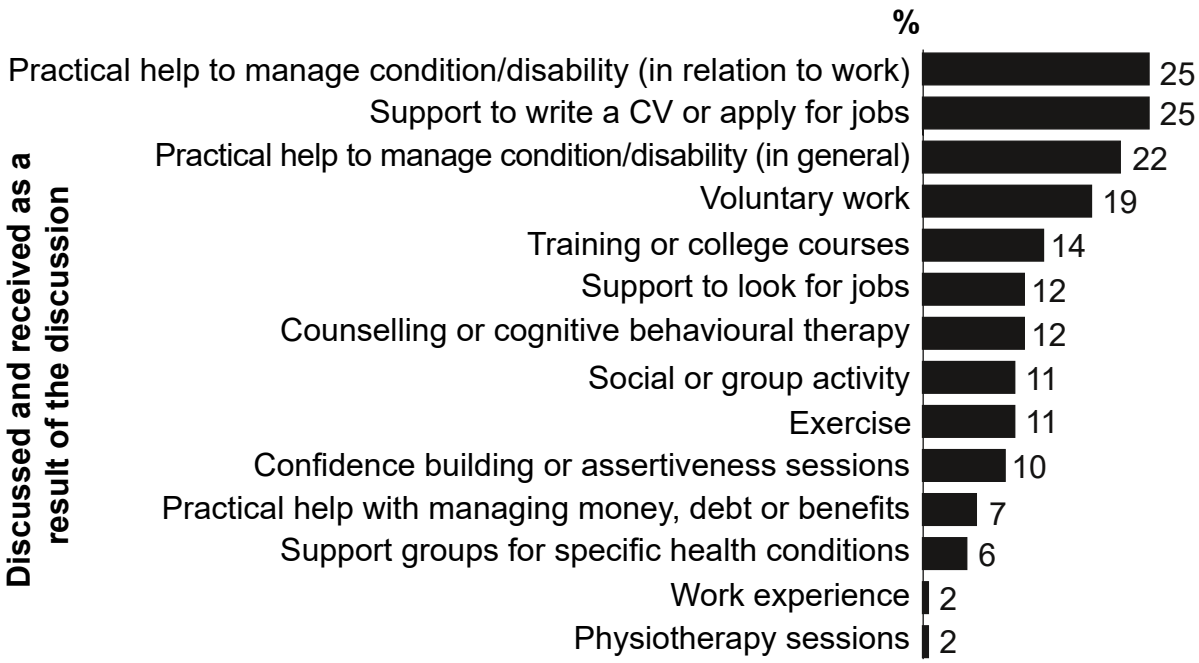
Wave 2 survey participants across the three pilots and control groups, who received at least two months of post-pilot support, were asked about the nature of this support. This section first explores the type of post-pilot support delivered on the JCP pilot only (since base sizes for these questions for WP and HCP participants were too small for statistical analysis).

Types of post-pilot support among Jobcentre Plus pilot participants

Those on the JCP pilot discussed and received (as a result of the discussion) a range of post-pilot support, ranging from support with developing employability skills to health-related support (see Figure 5.34). Employment-focused support was mentioned most frequently by JCP pilot participants, such as practical help to manage their condition or disability in relation to work, and support to write a CV or apply for jobs (both 25 per cent).

[51] Figure 5.33 shows the top ten mentions only.

Figure 5.34 Type of post-pilot support discussed and received on the JCP pilot



Base: All JCP pilot respondents that had received at least two months of post-pilot support at Wave 2 (ranging from 78 - 80)

JCP pilot participants were significantly more likely than the control group to have discussed and received (as a result of the discussion) certain types of post-pilot support, including:

- practical help to manage their condition or disability in relation to work (25 per cent of JCP pilot participants, compared to nine per cent in the control group); and
- support to write a CV or apply for jobs (25 per cent of JCP pilot participants, compared to 12 per cent in the control group).

5.5 Summary

Delivery model

Delivery models differed across the three pilots:

- the JCP pilot offered a maximum 530 minutes of contact time per year, with the same JCP work coach where possible over a two-year period;
- the WP pilot operated under a ‘black box’ model which meant pilot delivery was not prescribed. Interviews across different WP providers suggested that pilot delivery mirrored the support provided to all ESA customers on the Work Programme;
- the HCP pilot offered five appointments, three in the first six months of the pilot, with the fourth taking place after 12 months and the final after 18 months. The pilot was delivered by healthcare professionals.

Initial appointments and assessment

At the referral stage, pilot staff received basic information on pilot participants e.g. contact details, benefit and work history, and their main health condition. There were mixed views on whether this level of information was sufficient at this stage. One view held by delivery staff was that information about referrals was not important because this was gathered at the initial assessment stage. Another view, particularly from WP pilot staff, was that more information would have been useful to help prepare the initial appointment with pilot participants.

The purpose of the initial appointment was to assess pilot participants' needs and develop a personalised action plan. Pilot participants' needs were assessed in different ways across the different pilots:

- WP staff used a variety of diagnostic tools and questionnaires.
- JCP staff either used a baseline tool developed specifically for the pilot or an open-ended discussion, the latter being the preferred approach.
- HCP staff used a tool developed for the pilot which enabled an open-ended discussion about health conditions, treatment history, support networks and employment history. Health professionals also relied on their clinical experience in making client assessments.

Across all three pilots, staff and participants also described the initial appointment as an opportunity to put participants at ease about the pilot, making clear that participants were not expected to immediately look for work.

Subsequent appointments

Face-to-face support was offered to participants across all three pilots, and was the staff's preferred mode of delivery. According to survey respondents, most participants had at least one face-to-face appointment (93 per cent on the JCP pilot, 85 per cent on the HCP pilot, and 80 per cent on the WP pilot). Telephone appointments were organised if a face-to-face appointment was not possible due, for example, to participants not feeling well.

Continuity of the same adviser was sought across all three pilots. At the referral stage, pilot participants were appointed a staff member who was intended to support them for the duration of the two years. When asked in the survey if there was anything that they did not like about the support they received, a small minority of participants on all pilots reported that they did not see the same adviser consistently.

Fidelity to the pilot design was largely maintained in all three pilot models, however operational issues, most notably high staff turnover, affected delivery. For the JCP pilot, the introduction of the new work coach delivery model led to less frequent appointments in the second year of the pilot. Conversely, WP advisers tended to see pilot participants more frequently in the second wave due to reduced caseloads.

Action plans and mandation

Staff across all pilots used action plans to document participants' goals and activities. Activities tended to be reflective of participants' goals, meaning that they were not always work-related and in the HCP pilot they tended to be related more closely to managing a participants' health. Pilot staff also used action plans to monitor

participants' progress. Across all three pilots, staff held the view that goals and activities must be achievable for participants, otherwise they were likely to disengage from the activities.

Attending appointments was mandatory for all pilot participants. Staff reported low fail-to-attend rates and explained that where participants failed to attend this was often because of their health condition or disability. In the survey, across the three pilots, the majority of participants had never missed an appointment (77 per cent on the HCP pilot, and 62 per cent on both the WP and JCP pilots). Among those who had missed an appointment, the majority reported that this was due to their health condition or disability. In these circumstances, participants often gave staff advance notice. In all three pilots there were, however, some participants who persistently failed to attend or did not take part in Work-Related Activity because they did not want to engage with the pilot. In these situations, participants were put forward for a sanction. Across the three pilots, most survey respondents (92 per cent on the HCP pilot, 90 per cent on the WP pilot, and 87 per cent on the JCP pilot) were aware that they could be put forward for a sanction if they missed an appointment.

Across both JCP and WP pilots, staff could mandate participants to undertake work-related activities. While some staff members made use of mandation, viewing this as a useful tool to gain co-operation, others favoured a voluntary approach, feeling it was more likely to continue to engage participants. Among participants from all pilots there were examples of people being sanctioned for not engaging in activities they had been mandated to participate in.

Type of support provided

Staff delivering all three pilots explained that they had the flexibility to offer support that met individuals' needs and priorities in a sequence that worked specifically for them. Both JCP and WP pilots utilised a mixture of soft-skill, employment-related, and - to a lesser extent - health-related support. Soft-skill support was considered a key starting point by both JCP and WP staff. On the survey, 16 per cent of WP participants and 13 per cent of JCP participants attended confidence-building sessions. Courses that focused on confidence and motivation were seen as particularly useful for this participant group. Across both pilots, staff accessed external providers to deliver soft-skill support. In some cases, this was specifically for pilot participants, and for ESA customers more generally in others. Across both pilots, soft-skill support was delivered either in a group setting or on a one-to-one basis. WP providers in particular favoured group delivery but recognized that some participants were, at least initially, only able to work on a one-to-one basis, at least initially.

JCP and WP delivery staff tended to use employment related-support to a larger extent than HCP staff. This included a wide variety of employment-related activities, from Better Off Calculations (BoC) to more participatory activities like engaging in voluntary or permitted work. In the survey, CV-writing and job application support was commonly mentioned (by 44 per cent of WP pilot participants, and 31 per cent of JCP pilot participants). Across the two years of the pilot, JCP staff reported BoCs were infrequently used because they did not feel they were relevant for participants who could not see work as an option. Conversely, WP staff found participants responded positively to BoCs as they could see how much money they could earn, even with just 16 hours of permitted work.

Both JCP and WP staff reported that voluntary and permitted work tended to be an effective way of helping participants to begin to consider work as an option for them. In the survey, 22 per cent of JCP respondents and eight per cent of WP respondents took part in voluntary work as a result of the support they received on the pilot.

All three pilots also offered health-related support, with the HCP pilot offering the most extensive range of this type of support. Health-related support ranged from referring participants to their GP, to signposting participants to self-help groups, pain-management groups and mental health services. While JCP and WP pilots referred people to health-related support, staff explained that this was not the key purpose of these pilots. In the survey, the main activity HCP pilot participants took part in was support to manage their health condition or disability, both in general (37 per cent) and in relation to work (35 per cent).

The extent to which in-work support was provided varied across the pilots. WP delivery staff reported they could offer either intensive or light-touch in-work support, depending on the needs of the participants. JCP staff reported only being able to offer light-touch support to participants or referring them to Work Choice.

Partnerships

All three pilots used external partners to provide participants with support during the pilot. A wide range of partnerships were established across the three pilots. Across all three pilots there also appeared to be gaps in provision, depending on the landscape of provision in the local area.

Figure 5.35 below provides a summary of the headline survey findings for each of the three pilots. Where there is not a significant difference between the pilot and its control group, the control group findings have not been included. Furthermore, significant differences between each pilot and its control group have been highlighted with an asterisk (*).

Figure 5.35 Summary of survey findings on JCP, WP and HCP pilot support

Aspect of support	JCP Pilot and Control	WP Pilot and Control	HCP Pilot and Control
Number of appointments	* 48 per cent of pilot participants attended 11 or more appointments (versus six per cent of control participants)	* 57 per cent of pilot participants attended 11 or more appointments (versus seven per cent of control participants)	* 3 per cent of pilot participants attended 11 or more appointments (versus eight per cent of control participants)
	* 88 per cent of pilot participants attended 4 or more appointments (versus 47 per cent of control participants)	* 88 per cent of pilot participants attended 4 or more appointments (versus 53 per cent of control participants)	* 82 per cent of pilot participants attended 4 or more appointments (versus 46 per cent of control participants)
Location of appointments	93 per cent of pilot participants had at least one appointment that took place at a Jobcentre Plus office.	80 per cent of pilot participants had at least one appointment that took place at the provider's office.	85 per cent of pilot participants had at least one appointment that took place at the provider's offices.
	35 per cent of pilot participants had at least one appointment over the phone.	51 per cent of pilot participants had at least one appointment over the phone.	29 per cent of pilot participants had at least one appointment over the phone.
	Not asked of the control group	*Not asked of the control group*	*Not asked of the control group*
Frequency of appointments	* 56 per cent of pilot participants had an appointment about once a month (versus eight per cent in the control group)	* 28 per cent of pilot participants had an appointment about once a month (versus 14 per cent in the control group)	13 per cent of pilot participants had an appointment about once every month
Duration of appointments	* 64 per cent of pilot appointments lasted thirty minutes or more (versus 52 per cent in the control group).	* 23 per cent of pilot appointments lasted 14 minutes or less (versus 13 per cent in the control group). * 57 per cent of pilot appointments lasted between 15 and 44 minutes (versus 70 per cent in the control group) * 20 per cent of pilot appointments lasted 45 minutes or more (versus 17 per cent in control group).	* 74 per cent of pilot appointments lasted for 45 minutes or more (versus 14 per cent in control group). The rest of the control group appointments were shorter than 45 minutes.

Aspect of support	JCP Pilot and Control	WP Pilot and Control	HCP Pilot and Control
Missed appointments	62 per cent of pilot participants had never missed an appointment. Ill health was the main reason given (69 per cent) for missed appointments. *Not asked of the control group*	62 per cent of pilot participants had never missed an appointment. Ill health was the main reason given (72 per cent) for missed appointments. *Not asked of the control group*	77 per cent of pilot participants had never missed an appointment. Ill health was the main reason given for missed appointments (61 per cent). *Not asked of the control group*
Awareness of sanctions for missed appointments	* 87 per cent of pilot participants were aware that benefits could be stopped if they missed an appointment (versus 78 per cent in the control group).	90 per cent of pilot participants were aware benefits could be stopped if they missed an appointment	* 92 per cent of pilot participants were aware that benefits could be stopped if they missed an appointment (versus 84 per cent in the control group).
Top four activities taken part in as a result of support, focusing on significant differences between pilot and control groups	* Support to look for jobs (pilot: 32 per cent, control: 21 per cent) * Support to write a CV or apply for jobs (pilot: 31 per cent, control: 18 per cent) * Practical help to manage your condition/ disability in work (pilot: 31 per cent, control 23 per cent) * Practical help to manage your condition/ disability in general (pilot: 26 per cent, control: 20 per cent)	* Support to write a CV or apply for jobs (pilot: 44 per cent, control: 13 per cent) * Confidence-building or assertiveness sessions (pilot: 16 per cent, control: 9 per cent) * Social or group activity (pilot: 15 per cent, control 8 per cent) * Help with managing finances (pilot: 11 per cent, control: 6 per cent)	* Practical help to manage your condition/ disability in general (pilot: 37 per cent, control: 19 per cent) * Practical help to manage your condition/ disability in work (pilot: 35 per cent, control 22 per cent) * Exercise (pilot: 28 per cent, control: 7 per cent) * Pain management or relief training (pilot: 14 per cent, control: 4 per cent)
Overall experience of pilot	84 per cent reported 'good' or 'very good' overall experience	88 per cent reported 'good' or 'very good' overall experience	* 89 per cent reported a 'good' or 'very good' overall experience (versus 77 per cent in the control group)

Aspect of support	JCP Pilot and Control	WP Pilot and Control	HCP Pilot and Control
Main complaints about pilot	Among the 30 per cent of participants who were dissatisfied with an aspect of the support: Work Coaches lacking in empathy and understanding of their health condition or disability (22 per cent). Felt under pressure or support was too pushy (14 per cent) *Not asked of the control group*	Among the 32% of participants who were dissatisfied with an aspect of the support: Advisers lacking in empathy and understanding of their health condition or disability (19 per cent) Not receiving the right kind of support (11 per cent) *Not asked of the control group*	Among the 22% of participants who were dissatisfied with an aspect of the support: Not seeing the same Adviser consistently (19 per cent) Not receiving the right kind of support (16 per cent) *Not asked of the control group*

6 Pilot outcomes

This chapter investigates the outcomes of the three pilots, drawing on the survey data to examine:

- work-related outcomes, such as job applications made since being on the pilot, interviews attended and employment status;
- soft outcomes, including motivation to leave Employment and Support Allowance (ESA) and to find work, and feelings and attitudes towards work;
- the perceived effect of work on health for those participants who were employed, as well as the types of jobs participants had and, for those not in work, views on barriers to work;
- perceived outcomes of the pilots, considering participant views on whether the pilot support helped them in improving their health, moving towards work and overcoming barriers to work.

The final section of the chapter then summarises achievements across the three pilots.

6.1 Interpreting the data

For most analyses in this chapter, data is presented on both the pilot and control groups, and significant differences between the two groups can be interpreted as *indicative* of impact for each pilot. However, as discussed in Chapter 1, only the analysis being conducted by DWP can fully assess impact, as baseline equivalence of control and treatment groups and the randomisation process have not been verified.

For the analyses of *perceived impact*, data is presented only on the pilot groups, since these questions were not asked of the control group. This data does not indicate impact, but provides information on participant experiences of the pilot and so can be used to help to explain the other findings reported.

In the chapter, the outcomes for each pilot are reported separately. Care should be taken in comparing the outcomes across the three pilots since baseline data is limited and participants may have had different ‘starting points’ on some measures. In addition, the ‘business as usual’ support may be different for each pilot due to their different geographic locations.

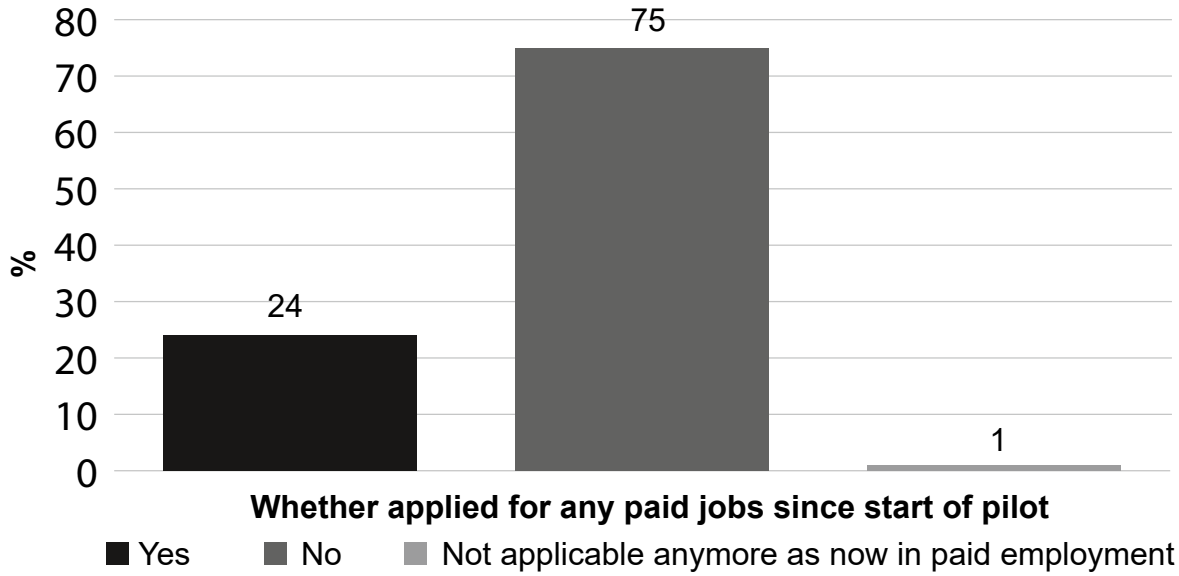
6.2 Jobcentre Plus pilot

6.2.1 Work-related outcomes

Job applications

The data suggests that JCP pilot support did not lead to participants making increased job applications compared with standard Jobcentre Plus support. Around one-quarter of JCP pilot participants (24 per cent) had applied for a paid job since starting on the pilot (see Figure 6.1), which was not significantly different to the control group.

Figure 6.1 Whether applied for any paid jobs since the start of the JCP pilot



Base: All JCP pilot end-stage respondents at Wave 1 or Wave 2 (410)

The number of jobs applied for varied from more than 21 applications (for 29 per cent of JCP pilot participants who applied for any jobs), to just one application (26 per cent of pilot participants who applied for any jobs) (see Figure 6.2). The jobs applied for included both part-time and full-time roles: 76 per cent and 44 per cent of the total number of applications respectively.

Figure 6.2 Number of jobs applied for since the start of the JCP pilot

Base: All JCP pilot end-stage respondents at wave 1 or Wave 2 that have applied for jobs (92)

A majority of JCP pilot participants who applied for jobs (62 per cent) subsequently went on to attend a job interview, but typically just one or two interviews (37 per cent and 20 per cent respectively). There were no significant differences between the JCP pilot and control group in relation to the number and types of job applied for, or the number of interviews attended.

Employment status

While there was no impact of the pilot on job applications made, JCP pilot support appears to have made a small but significant impact on employment status. Significantly more JCP pilot than JCP control group participants were in paid work as an employee at the time of the surveys (eight per cent, compared to four per cent). Overall, at Wave 1, more than three-quarters of JCP pilot participants (78 per cent) were not working because of sickness/ disability, while 15 per cent were undertaking voluntary/other unpaid work and eight per cent were in paid work as an employee[52] (see Appendix Table 6.10).

A very small minority of JCP pilot participants (four per cent) started a job they were no longer doing between the two waves of the survey. There were no differences in this compared with the control group, suggesting that pilot support had limited influence on rates of withdrawal from employment. The main reasons participants gave for having stopped working were health-related, for example because their health condition/disability was difficult to manage in work or because their health condition or disability had worsened.[53]

Despite a range of barriers and challenges to work, nearly two-thirds (64 per cent) of JCP pilot participants (including those currently in employment) were positive about getting a job in the near future, and the majority reported that it would take them a year or less to find work (79 per cent). There was no significant difference between the pilot and control group in this, suggesting that pilot support did not affect participants' views on the possibility of securing a job in the future.

[52] There are no apparent differences between waves, so only Wave 1 responses are mentioned here.

[53] Small sample sizes meant statistical analysis was not possible.

6.2.2 Experience of work

Types of job

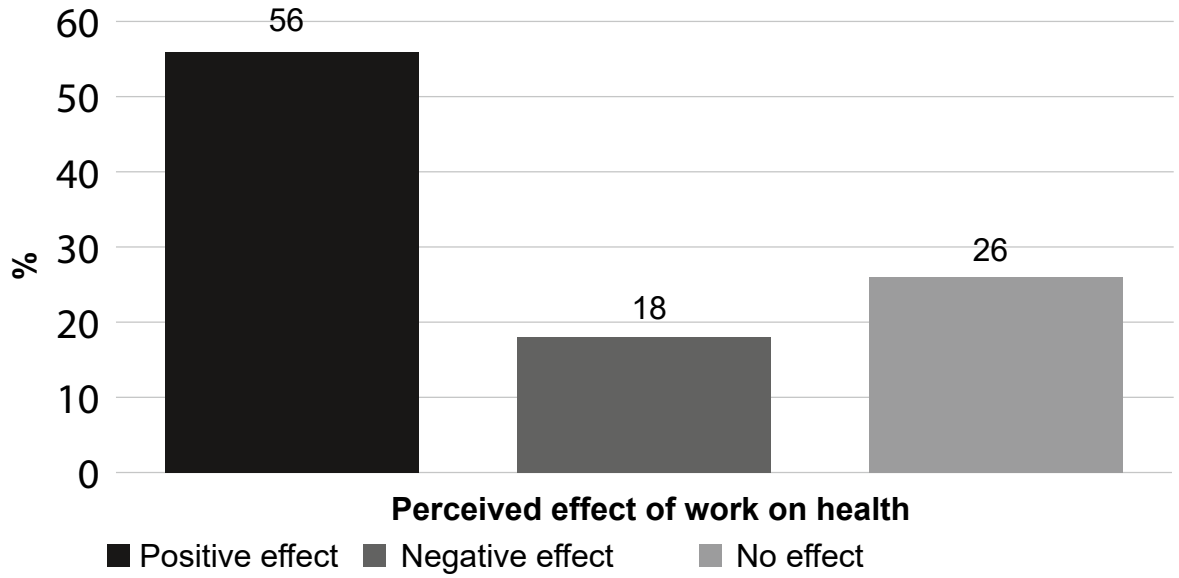
Among the small proportion of participants who were in paid work or who were self-employed at the time of the surveys, the type of work undertaken included both full-time and part-time work across a range of sectors and occupations.

For JCP pilot participants, the retail trade (14 per cent), the education sector (11 per cent), and the food and beverage service sector (10 per cent) were the sectors mentioned most frequently (see Appendix Table 6.14). The occupations mentioned most often included cleaners/domestics (15 per cent), care workers and home carers (10 per cent), and sales/retail assistants (9 per cent) (see Appendix Table 6.15).

Perceived effect of work on health

Among the 23 per cent of JCP pilot participants who were in paid, unpaid or voluntary work, there was no evidence that pilot support led to more positive perceptions of the effect of work on their health. As shown in Figure 6.3, the majority (56 per cent) of participants who were in work reported that working had had a positive effect on their health. Eighteen per cent reported a negative effect, and just over a quarter (26 per cent) said there had been no effect on their health. Of the 56 per cent of the JCP pilot group who reported a positive effect on their health, a third (33 per cent) said it had improved a lot, and nearly half (48 per cent) said it had improved a little. There were no significant differences in these measures between the JCP pilot and control groups.

Figure 6.3: Effect of working on participants' health: JCP pilot group who are in paid, unpaid or voluntary work



Base: All JCP pilot group participants in paid, unpaid or voluntary work (86)

Barriers to work

Among JCP pilot participants who were not working nor starting a job in the near future, health-related issues and a perceived lack of jobs were identified as the main barriers to work. For example, health issues/disabilities limiting the type of work they could do was cited by 71 per cent; lack of vacancies/too much competition for jobs that are of interest by 39 per cent; lack of jobs for people with their health issues/ disabilities by 38 per cent; and lack of jobs in their local area also by 38 per cent (see Appendix Table 6.16). In general, barriers were the same for both the pilot and the control group (see Appendix Table 6.17).

6.2.3 Soft outcomes

Effect of support on motivation to leave Employment and Support Allowance (ESA)

Overall the majority (58 per cent) of JCP pilot participants reported that the pilot had no effect on their motivation to leave ESA. Nonetheless, JCP pilot support appears to have improved motivation to leave ESA compared to standard Jobcentre Plus support, since a greater proportion of pilot participants (37 per cent) reported that the support they had received had increased their motivation to leave ESA compared to the control group (28 per cent). Additionally, those in the JCP control group were more likely to say that the support had no effect on their motivation to leave ESA, compared to those in the pilot group (66 and 58 per cent respectively). Only five per cent of participants reported a decrease in motivation to leave ESA as a result of support received (with no difference between the pilot and control group).

Participants who said that their motivation to leave ESA had increased as a result of the support received were asked the reasons for this. They chose from a list of pre-coded options and could select more than one answer. The most frequently cited reasons reported by JCP pilot participants for their increased motivation to leave ESA (as a result of the support received) were:

- encouragement from their adviser (54 per cent)
- increased confidence (49 per cent)
- desire to work (41 per cent)
- better management of their health condition (22 per cent).

See Appendix Tables 6.20 to 6.23 for a full breakdown of responses to these questions.

Participants' view of work and motivation to find employment

The JCP pilot also appears to have been successful in supporting more positive views of work compared with 'business as usual' support:

- nearly half (47 per cent) of the JCP pilot group reported a change in how they thought about work – a greater proportion than in the control group (37 per cent) – and nearly two-thirds (63 per cent) of these pilot participants now viewed work more positively;
- thirty-eight per cent of those in the JCP pilot group who were not in paid employment said that they were now more motivated to find work following the pilot support – a larger proportion than in the control group (27 per cent).

Overall, however, over half (54 per cent) of the JCP pilot group felt that their motivation to find work was no different as a result of the support.

Those in the JCP pilot group who said that their motivation to find work had increased as a result of the support received gave the following reasons:

- increased confidence (51 per cent);
- encouragement from their adviser (49 per cent);
- desire to work (36 per cent).

The reasons for increased motivation were similar across the pilot and control groups, but there were some differences, including:

- a higher proportion in the JCP pilot group (20 per cent), compared to the JCP control group (12 per cent), reported having gained new work-related skills as a reason for having improved motivation to find work;
- a higher proportion in the control group (five per cent), compared to the pilot group (one per cent), gave not wanting to go to adviser appointments as a reason for having improved motivation to find work.

JCP pilot participants who were not in employment at the end of the pilot, but who had said that their motivation to find work had increased as a result of the support received, were asked what more they had done to find work. The findings of this suggest that pilot support did not lead to changes in work-search behaviours among this group. Eighteen per cent of the JCP pilot group said that they had done nothing more to find employment, a third (33 per cent) were doing or considering doing training courses, around a quarter (26 per cent) were applying for more jobs, and a similar number were doing or considering voluntary work (25 per cent), a fifth were revising their CV and a similar proportion were focusing on managing their health (both 20 per cent). This last activity was reported by a higher proportion of those in the JCP control group (34 per cent), otherwise proportions in the pilot and control groups were similar.

See Appendix Tables 6.24 to 6.36 for a full breakdown of responses to these questions.

Participants' current feelings about, and attitudes to, work

The JCP pilot appeared to result in slightly more positive attitudes and views about work, compared with standard support, on some but not all measures. For example, a lower proportion of the JCP pilot group (63 per cent) felt unable to work due to a health condition, compared to the control group (71 per cent); and a higher proportion felt they could return to work 'right now' (16 per cent, compared to 11 per cent in the control group). Around a fifth of the pilot group (21 per cent) felt that they could consider a return to work 'on some days' (which was not significantly different to the control group).

However, there were no apparent differences between the pilot and control group in relation to other attitudinal measures:

- over two-thirds (69 per cent) agreed with the statement: 'Having almost any type of paid work is better than not working' while 17 per cent disagreed, and over half (53 per cent) agreed that 'People are put under too much pressure to find work' while 30 per cent disagreed. There were no significant differences between pilot and control group in this;

- of those in the JCP pilot group who were employed, self-employed, or about to start work at the end of the pilot, a clear majority (82 per cent) agreed with the statement: 'I am a happier person now I am in work/about to start working'. Again, there were no significant differences between pilot and control groups here;
- over two-thirds (67 per cent) of the JCP pilot group who were not working, or about to start working agreed with the statement 'I would be a happier person if I was in work', while 14 per cent disagreed. Half (50 per cent) agreed that 'The thought of being in paid work makes me nervous' while 37 per cent disagreed. There were no significant differences between pilot and control groups this time either.

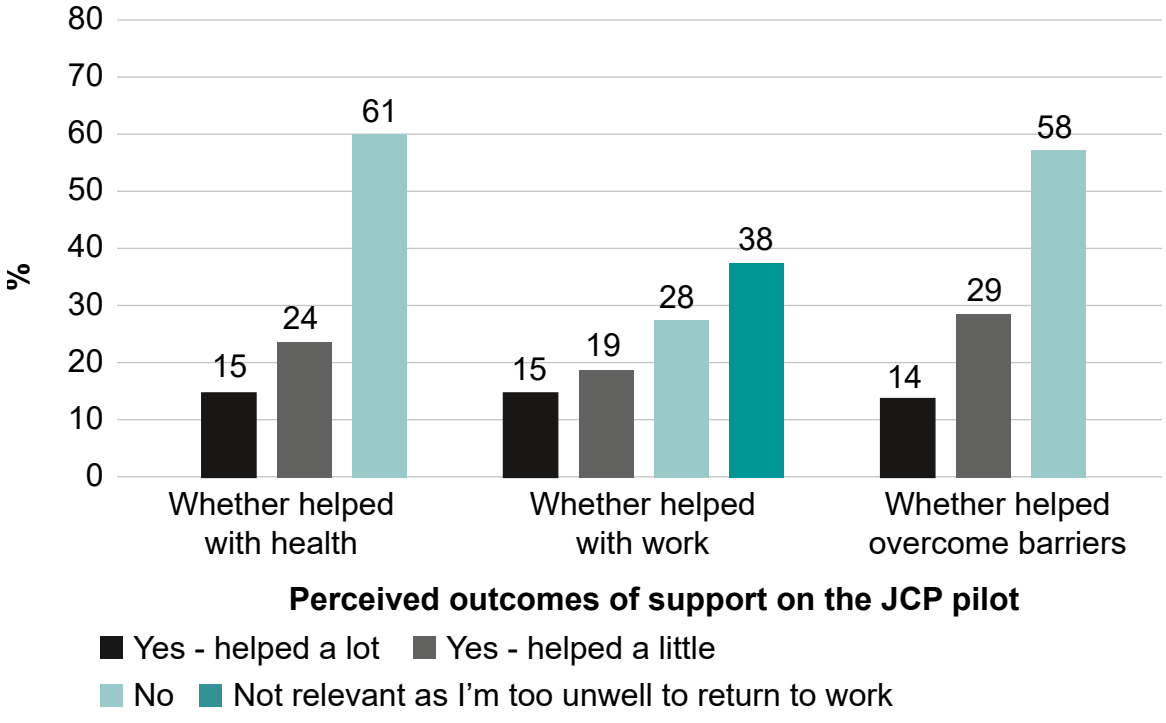
See Appendix Tables 6.37 to 6.46 for a full breakdown of responses to these questions.

6.2.4 Perceived outcomes

This section considers perceived outcomes of the pilot for the pilot group only - as these questions were not asked of the control group. As such, this data cannot be interpreted as indicating impact, but can be used to understand the experiences of those in the pilot group and help to explain the earlier findings.

The survey suggests that almost two-fifths of participants on the JCP pilot (39 per cent) felt that the support[54] had helped with their health, either a lot or a little, while around three-fifths (61 per cent) felt that the support had not done so. Similarly, around two-fifths (42 per cent) of pilot participants felt that the support had helped with their barriers to work, while just over a third (34 per cent) felt that the support had helped with moving towards work, although a further 38 per cent felt that it was not relevant because they felt too unwell to return to work (see Figure 6.4).

Figure 6.4 Perceived outcomes of JCP pilot support



Base: All JCP pilot end-stage respondents at Wave 1 or Wave 2 (408; 410; and 396)

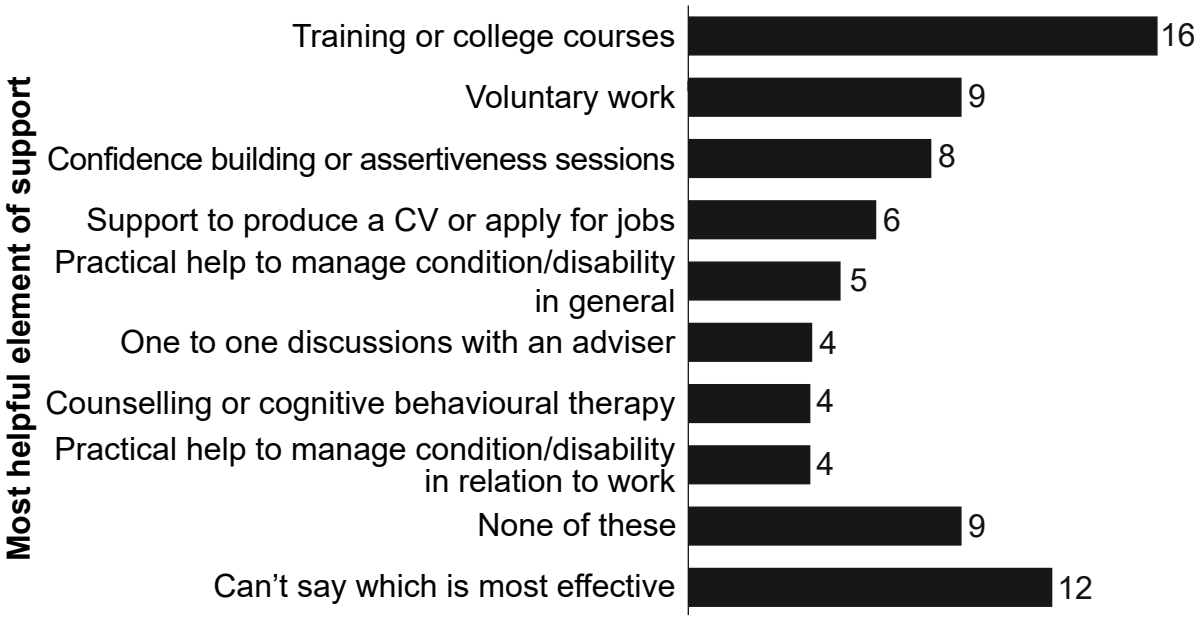
[54] For these questions, the 'support' includes appointments on the pilot.

Needing medical help that pilot advisers were unable to provide was the main reason that JCP pilot participants gave for finding the support unhelpful – either in overcoming their barriers to work (75 per cent), in relation to their health (72 per cent), or in moving closer to work (68 per cent).

Another commonly-cited reason was advisers not understanding their needs, which was mentioned by: 26 per cent who found the support unhelpful in managing their health, 25 per cent who found the support unhelpful in moving closer to work, and 22 per cent who found the support unhelpful in overcoming their barriers to work. Similar proportions also mentioned their adviser lacking the right skills and expertise. See Appendix Tables 6.1 to 6.3 for a full breakdown of responses to these questions.

Amongst JCP pilot respondents who found more than one aspect of the support helpful, it was the employment-focused support which was seen as the most helpful, for example: training or colleges courses was cited most frequently (16 per cent), followed by voluntary work (nine per cent), as shown in Figure 6.5.

Figure 6.5 Most helpful element of support on the JCP pilot



Base: All JCP pilot end-stage respondents that found more than one aspect of support helpfull at Wave 1 or Wave 2 (207)

6.2.5 Change in outcomes over time

An analysis of change over time in work and health-related outcomes was undertaken, which suggested that this was not affected by pilot participation. However, the small sample sizes for this analysis means the findings are tentative. The analysis has been included in full in Appendix B of the report.

6.3 Work Programme pilot[55]

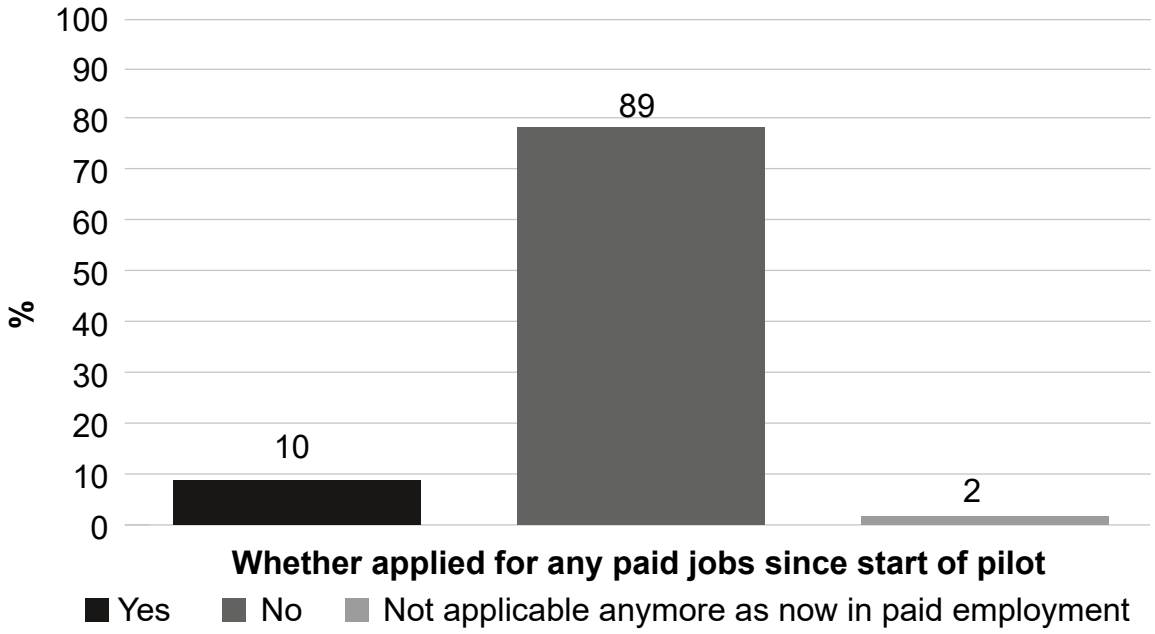
6.3.1 Work-related outcomes

Job applications

The data suggests that Work Programme pilot support did not lead to participants making increased job applications or being more likely to enter work compared with business as usual support.

One in ten WP pilot participants (10 per cent) had applied for a paid job since starting on the pilot (see Figure 6.6), which is not significantly different to the number in the control group. Small base sizes mean statistical analysis of the number and type of jobs and interview activities was not possible for this pilot (see Appendix Tables 6.5 to 6.9).

Figure 6.6 Whether applied for any paid jobs since the start of the WP pilot



Base: All WP pilot end-stage respondents at Wave 1 or Wave 2 (160)

Employment status

At the time of the Wave 1 survey, 88 per cent of WP pilot participants were not working because of sickness or disability, while seven per cent were doing voluntary/ other unpaid work and four per cent were in paid work as an employee.[56,57] These numbers are not significantly different to those for the control group (see Appendix

[55] It should be noted that the sample sizes for the WP pilot are smaller than the other two pilots and so confidence intervals are wider, which means that any differences between the pilot and control group would have to be greater to be able to be detected as statistically significant.

[56] There are no apparent differences between waves, so only Wave 1 responses are mentioned here.

[57] The low numbers of participants in employment across the pilots meant base sizes were not sufficient for statistical analysis on: whether jobs were part or full-time; sector; or perceived effects of employment on health. There were also insufficient responses to the question about barriers to employment for statistical analysis.

Tables 6.10 to 6.13). A majority (56 per cent) of WP pilot participants (including those currently in employment), however, thought that they would work in the future. This was, again, not significantly different to the control group.

6.3.2 Soft outcomes

Effect of support on motivation to leave Employment and Support Allowance (ESA)

As in the JCP pilot, the majority of WP pilot group participants (61 per cent) felt that the support they received had no effect on their motivation to leave ESA. There was also no evidence that WP pilot support increased motivation to leave ESA more than standard JCP support. Overall, 29 per cent said the support received had increased their motivation to leave ESA, with ten per cent reporting a decrease, which was not significantly different to the control group.

Since the number of participants in the WP pilot who felt the support they received had increased their motivation to leave ESA is small, the results cannot be analysed statistically. However, the reasons that were reported included having more confidence, support and encouragement from their adviser, and wanting to work. See Appendix Tables 6.20 and 6.23 for a full breakdown of responses to these questions.

Participants' view of work and motivation to find employment

There is no evidence to suggest that WP pilot support resulted in more positive views about work or changed participants' motivation to find employment than standard Jobcentre Plus support:

- Overall, 34 per cent of pilot participants felt that the support they received had changed how they thought about work (which was not significantly different to the control group).
- A larger percentage (13 per cent) of those in the pilot group said that they were now *less motivated* to find work as a result of the support they received, compared to those in the WP control group (seven per cent).
- There were no significant differences between the WP pilot and control groups in the proportion who reported no change in their motivation to find work as a result of the support received (63 per cent in the WP pilot group) or in the proportion whose motivation increased (23 per cent in the WP pilot group).

The small number of participants in the WP pilot who felt the support they received had increased their motivation to find work, and gave the reasons for this, means that results cannot be analysed statistically. However, the explanations given echo those given by JCP pilot participants outlined previously.

The number of participants in the WP pilot group answering the survey questions about additional activities undertaken to find work was also too small to be analysed statistically, but the activities cited were again similar to those reported by the JCP pilot group. See Appendix Tables 6.24 to 6.34 for a full breakdown of responses to these questions.

Participants' current feelings about, and attitudes to, work

There is no evidence to suggest that WP pilot support influenced participants' feelings about work more than standard JCP support.

As in the JCP pilot, the majority of the WP pilot group felt their health condition ruled out work as an option (82 per cent), and only eight per cent thought they could work now, if the right job came up, while 11 per cent felt they could consider a return to work 'on some days'. There were no significant differences between the WP pilot and control group in this.

In the WP pilot group, nearly three quarters (73 per cent) agreed with the statement: 'Having almost any type of paid work is better than not working' while 14 per cent disagreed and nearly two-thirds (61 per cent) agreed that 'People are put under too much pressure to find work' while 25 per cent disagreed. Again, there were no significant differences between the WP pilot and control group in this.

Of the WP pilot group who were not working, or about to start working, 59 per cent agreed that 'I would be a happier person if I was in work', however a higher proportion (23 per cent) of the WP pilot group disagreed with this statement, compared to the control group (16 per cent).

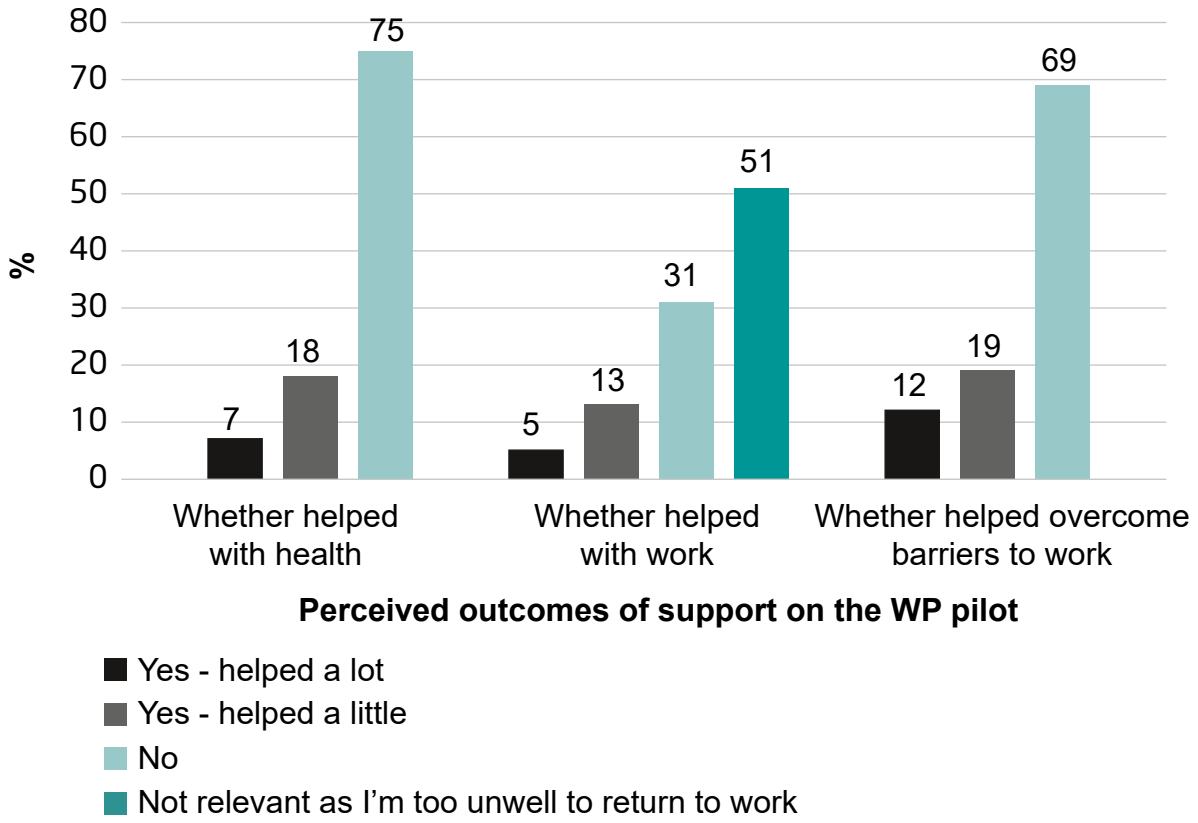
Exactly half of the WP pilot group who were not working, or about to start working, agreed with the statement 'The thought of being in paid work makes me nervous', and 36 per cent disagreed, with no significant differences between the WP pilot and control group.

See Appendix Tables 6.37 to 6.46 for a full breakdown of responses to these questions.

6.3.3 Perceived outcomes

As shown in Figure 6.7, when asked whether the pilot support had helped them to move towards work, more than half of those on the WP pilot (51 per cent) said moving towards work was not relevant because they were too unwell to return to work. Only 18 per cent answered that the support had helped a lot or a little with moving towards work. The majority of WP pilot participants (75 per cent) also felt that the support had not helped with their health, perhaps reflecting the work-focused rather than health-focused content of the WP pilot. However, a higher proportion, nearly one-third of WP pilot participants (31 per cent), felt that the support had helped them overcome some of their barriers to work.

Figure 6.7 Perceived outcomes of WP pilot support



Base: All WP pilot end-stage respondents at Wave 1 or Wave 2 (158; 160; and 159)

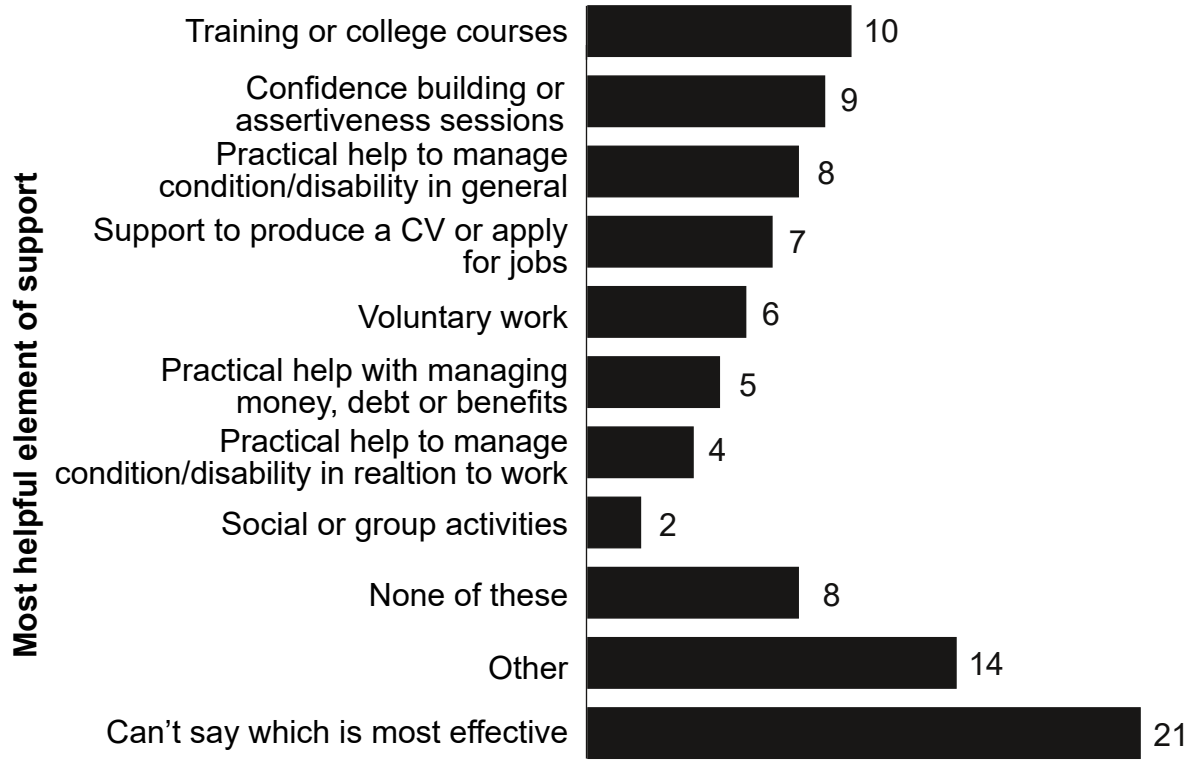
Participants' needing medical help that advisers were unable to provide was the main reason why support was viewed as unhelpful, especially among those who found it unhelpful in overcoming barriers to work (86 per cent), and in terms of managing their health (74 per cent).

The timing of support was also a key reason why it was viewed as unhelpful, particularly by WP pilot participants who felt support had not helped them with moving towards work (37 per cent), perhaps because many participants felt too unwell to move closer to work.

Advisers not understanding participants' needs, was a further reason why support was seen as unhelpful – either in moving them towards work (32 per cent), in managing their health (26 per cent) or in overcoming their barriers to work (21 per cent). Linked to this, WP pilot participants also frequently mentioned advisers lacking the right skills and expertise. See Appendix Tables 6.1 to 6.3 for a full breakdown of responses to these questions.

Amongst WP pilot participants who found more than one aspect of support helpful, training or college courses were reported to be the most helpful (mentioned by 10 per cent). However, 21 per cent could not say what aspect of support was most helpful, which suggests that having a package of support was most helpful to some on the WP pilot, rather than one particular aspect of support (see Appendix Table 6.4).

Figure 6.8 Most helpful element of support on the WP pilot



Base: All WP pilot end-stage respondents that found more than one aspect of support helpful at Wave 1 or Wave 2 (51)

6.4 Healthcare Provider pilot

6.4.1 Work-related outcomes

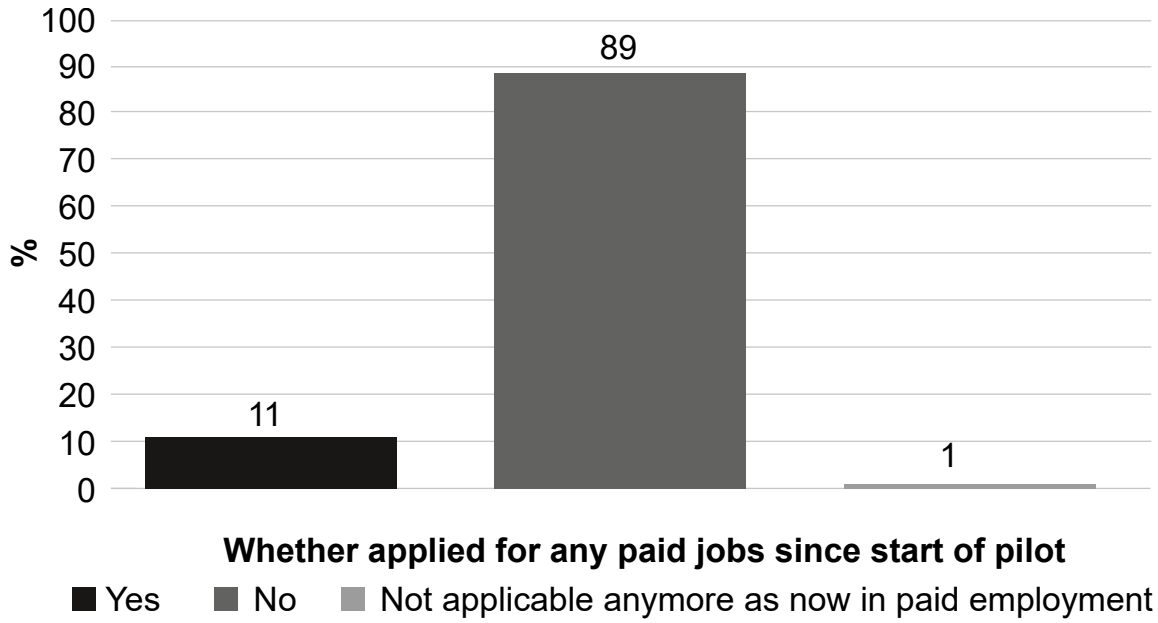
Job applications

As with the WP pilot, the data suggests that HCP pilot support did not lead to participants making increased job applications or being more likely to enter work compared with business as usual support.

Around one in ten HCP pilot participants (11 per cent) had applied for a paid job since starting on the pilot (see Figure 6.9), which was not significantly different to the number doing so in the control group.[58]

[58] Small numbers of responses to questions on the number and type of jobs applied for and interview activities do not allow for meaningful statistical analysis and so are not reported here (see Appendix Tables 6.5 to 6.8).

Figure 6.9 Whether applied for any paid jobs since the start of the HCP pilot



Base: All HCP pilot end-stage respondents at Wave 1 or Wave 2 (307)

Employment status[59]

Most HCP pilot participants at Wave 1 were not working because of sickness or disability (91 per cent). Just six per cent reported doing voluntary or other unpaid work, and two per cent were in paid work as an employee.[60] Again, this is not significantly different to the control group (see Appendix Tables 6.10 to 6.13). Between waves, just one per cent had started a job they were no longer doing (see Appendix B).

More than half of HCP pilot participants (55 per cent), including those currently working, thought they would get paid work in the future, with most of these (73 per cent) stating they thought it would take up to 12 months to do so. This picture was not significantly different in the control group (see Appendix Tables 6.18 and 6.19).

6.5 Soft outcomes

Effect of support on motivation to leave Employment and Support Allowance (ESA)

There was evidence of a slight impact of HCP pilot support on motivation to leave ESA. Although the majority of participants in the HCP pilot group (62 per cent) felt that the support they received had no effect on their motivation to leave ESA, just over a third (34 per cent) did report an increased motivation, which was a larger proportion than those in the HCP control group (26 per cent).

[59] The low numbers of participants in employment across the pilots meant base sizes were not sufficient for statistical analysis on: whether jobs were part- or full-time; sector; or perceived effects of employment on health. There were also insufficient responses to the question about barriers to employment for statistical analysis.

[60] There are no apparent differences between waves, so only Wave 1 responses are mentioned for 'current activities'.

Of those in the HCP pilot group whose motivation had increased, the most frequently cited reasons were:

- increased confidence (48 per cent);
- encouragement from their adviser (45 per cent);
- desire to work (39 per cent) and;
- better management of health condition (25 per cent).

See Appendix Tables 6.20 to 6.23 for a full breakdown of responses to these questions.

Participants' view of work and motivation to find employment

While the HCP pilot appeared to improve motivation to leave ESA, it did not appear to affect views of work or motivation to find employment more than standard JCP support. Thirty-five per cent of participants in the HCP pilot group said that the support they received had changed how they thought about work and, of this group, nearly two thirds (63 per cent) said that they now viewed work more positively, while 30 per cent felt the impact was neither positive nor negative. No significant differences are visible between the pilot and control group on either measure.

Of those in the HCP pilot group who were not in paid employment, the majority (63 per cent) felt that the support they received had not affected their motivation to find work. Nearly a third (32 per cent) were now more motivated to work, which was not significantly different to the control group. However, a smaller percentage of the pilot group (five per cent) reported a decreased motivation to find work, compared to the control group (15 per cent).

Participants who said that their motivation to find work had increased as a result of the support received were asked the reasons for this.

Mirroring the reasons for increased motivation to leave ESA, the most frequently cited reasons given by participants were:

- increased confidence (48 per cent);
- encouragement from their adviser (46 per cent) and
- desire to work (43 per cent).

Of HCP pilot participants who were not in employment at the end of the pilot but who reported increased motivation to find work, just over a third (35 per cent) had not done anything more to find work, while over a quarter (27 per cent) were focusing on managing their health, around a fifth (21 per cent) were doing or considering voluntary work, and a fifth (19 per cent) were doing or considering training. There were no significant differences between the pilot and control groups in these responses. See Appendix Tables 6.24 to 6.32 for a full breakdown of responses to these questions.

Participants' current feelings about, and attitudes to, work

The HCP pilot appears to have influenced participants' feelings about and attitudes to work to a similar degree as standard JCP support, with no evidence of more positive or negative outcomes in the pilot group.

The vast majority (80 per cent) of participants in the HCP pilot group felt that their health condition or disability ruled out work as an option. Only six per cent felt that they could return to work now, if the right job was available, while a further 14 per cent felt that 'on some days' that they could consider a return to work. These proportions were not significantly different in the control group.

Nearly two-thirds (65 per cent) in the HCP pilot group agreed with the statement that 'Having almost any type of paid work is better than not working' and only 17 per cent disagreed, while over half (53 per cent) agreed with the statement: 'People are put under too much pressure to find work' and 27 per cent disagreed. Again, this was not significantly different to the control group.

Of those in the HCP pilot group who were not working, or about to start working, the majority (60 per cent) agreed with the statement: 'I would be a happier person if I was in work', however this proportion was even larger in the HCP control group (69 per cent).

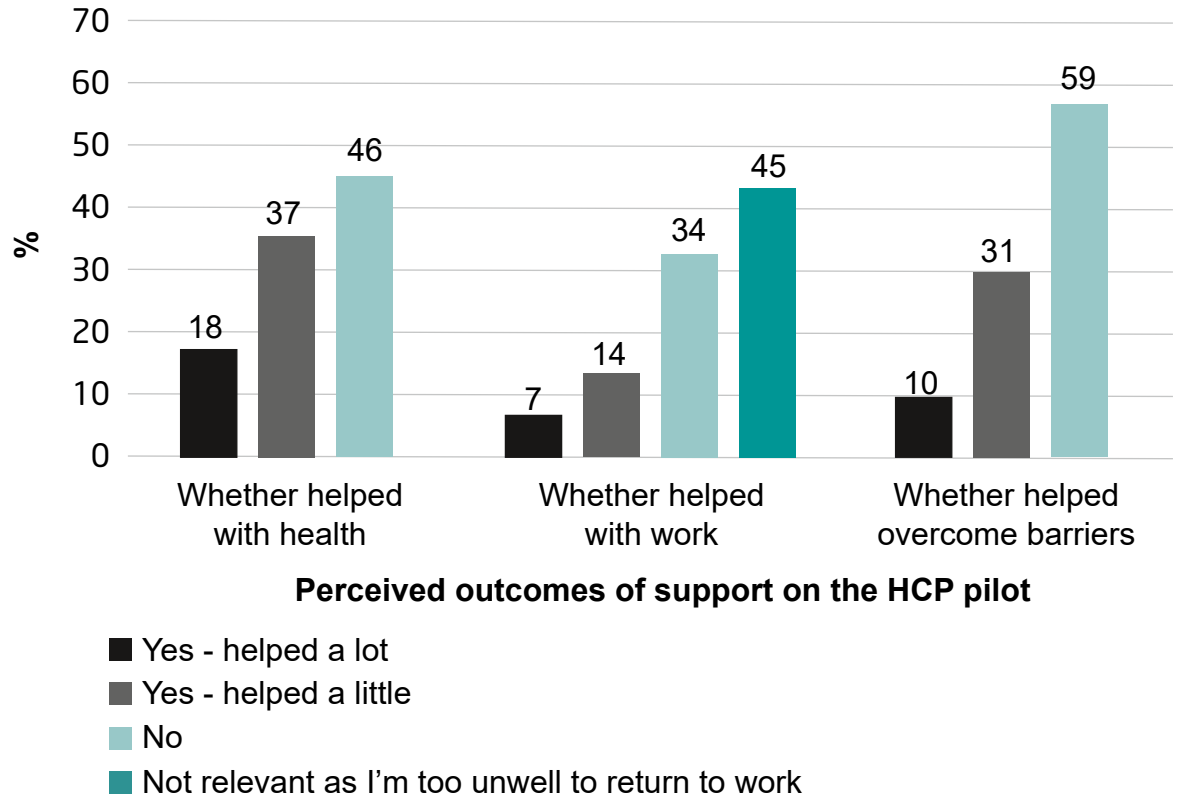
Around half (52 per cent) of the HCP pilot group who were not working, or about to start working agreed, and 36 per cent disagreed, with the statement: 'The thought of being in paid work makes me nervous'. This was not significantly different to the control group.

See Appendix Tables 6.37 to 6.46 for a full breakdown of responses to these questions.

6.5.1 Perceived outcomes of pilot

The majority of HCP pilot participants (54 per cent) said that the pilot support helped a lot or a little with their health. Relatively fewer participants (21 per cent) felt that the support helped with moving towards work, but nearly half (45 per cent) of respondents answered that moving towards work was not relevant because they were too unwell to return to work. Around two-fifths (41 per cent) of HCP pilot participants reported that the support helped with overcoming some of their barriers to work (see Figure 6.10).

Figure 6.10 Perceived outcomes of HCP pilot support



Base: All HCP pilot end-stage respondents at Wave 1 or Wave 2 (301; 306; and 298)

HCP pilot participants who did not feel the available support had helped with overcoming barriers to work (74 per cent), with moving towards work (73 per cent), or with their health (63 per cent) overwhelmingly cited needing medical help that advisers were unable to provide as the reason.

Other frequently cited reasons for the support being unhelpful also centred on advisers lacking appropriate skills, knowledge and understanding. For example, around one-fifth said that their adviser did not understand their needs (20 per cent of those that did not perceive support to have helped with their health; 19 per cent of those that did not perceive support to have helped with moving towards work; and 16 per cent of those that did not feel support had helped with overcoming barriers to work).

The timing of the support was also cited as a key reason for its unhelpfulness, especially by those who felt that the support was not helpful in moving them closer towards work (28 per cent). With many HCP pilot participants feeling too unwell to move closer to work, it follows that some would view the timing of the support as unhelpful. A full breakdown of responses to these questions is in Appendix Tables 6.1 to 6.3.

Reflecting the emphasis placed on health-related support in this pilot, participants identified general help to manage their condition/disability as the most helpful aspect of support received (mentioned by 13 per cent of those who found more than one aspect helpful), as shown in Figure 6.11. However, it is worth noting that 15 per cent could not say which aspect of the support was most effective, suggesting (that for some) support was most helpful when delivered as a package in order to meet multiple support needs.

Figure 6.11 Most helpful element of support on the HCP pilot

Base: All HCP pilot end-stage respondents that found more than one aspect of support helpful at Wave 1 or Wave 2 (166)

6.6 Summary: comparison of outcomes across the pilots

In this section we summarise the achievement of outcomes across the three pilots. When interpreting the data, it is important to note that:

- if data is presented on both the pilot and control group, significant differences between the two groups can be interpreted as **indicative of impact for that pilot (**albeit not a full assessment of impact;
- when data is presented only on the pilot groups, without comparison to the control group, outcomes should not be seen as an indicator of impact;
- in general, care should be taken in comparing the outcomes across the three pilots since baseline data is limited and participants may have had different 'starting points' on some measures.

6.6.1 Work-related outcomes

Across the three pilots, pilot support did not significantly affect the likelihood of participants applying for jobs, compared with standard Jobcentre Plus support. Similarly, pilot support did not affect participants' views on whether they would find paid work in future and the timeframes for this[61], compared with business as usual support.

[61] Base sizes were too small to statistically compare the WP pilot and control groups; differences between the JCP and HCP pilot and control groups were not significant.

The JCP pilot did, however, appear to be effective in achieving employment outcomes as there was a small but significant difference between the proportion of JCP pilot participants in paid work and control group participants (eight per cent, compared to four per cent). There were no significant differences between the pilot and control groups in paid work for the WP and HCP pilots.

Experience of work

Among the small proportion of participants who were in paid work or who were self-employed, the type of work undertaken included full-time and part-time work across a range of sectors and occupations.

Among those in work on the JCP pilot (base sizes were too small on the WP and HCP pilots for analysis), there was no evidence that pilot support led to more positive perceptions of the effect of work on their health compared with standard support. However, the majority (56 per cent) of JCP pilot participants who were in paid, unpaid or voluntary work reported that working had had a positive effect on their health.

Soft outcomes

The majority of participants in the three pilots considered that the support they had received had not affected their motivation to leave ESA or to find work. However, both the JCP and HCP pilots appeared to have an impact on these measures, with both pilots achieving better outcomes than standard Jobcentre Plus support:

- On the JCP pilot, 37 per cent of pilot participants reported increased motivation to come off ESA compared with 28 per cent in the control group (nine-point difference). On the HCP pilot, this was 34 per cent of HCP pilot participants versus 26 per cent in the control group (eight-point difference).
- Similarly, on the JCP pilot, 38 per cent of those who were not in employment said they were more motivated to find work, a larger proportion than in the control group (27 per cent) (11-point difference). On the HCP pilot, similar proportions of pilot and control groups reported an increased motivation to find work, but a smaller percentage of the pilot group (five per cent) reported a *decreased* motivation to find work, compared to the control group (15 per cent) (ten point difference).

In general, the three types of pilot support trialled did not affect participants' views on whether having almost any type of paid work was better than not working or whether people were put under too much pressure to work. The JCP pilot did, though, appear to have an influence on participants' feelings about how ready they were for work while the other two pilots did not:

- A lower proportion of JCP pilot participants (63 per cent) felt unable to work due to a health condition, compared to the control group (71 per cent), and a higher proportion felt they could return to work 'right now' (16 per cent compared to 11 per cent).

Table 6.12: Summary of statistically significant differences between pilot and control groups

Pilot outcomes	JCP pilot and control groups	WP pilot and control groups	HCP pilot and control groups
Whether applied for jobs	No significant differences	No significant differences	No significant differences
Employment	* eight per cent on the pilot were in work, (versus four per cent in the control group)	No significant differences	No significant differences
View on whether will get paid work in future and when this will be	No significant differences	No significant differences	No significant differences
Motivation to leave ESA	* 37 per cent reported increased motivation to come off ESA (versus 28 per cent in the control group) * 58 per cent said support had not affected motivation to come off ESA (versus 66 per cent in the control group)	No significant differences	* 34 per cent of HCP pilot participants reported increased motivation to come off ESA (versus 26 per cent in the control group)
Motivation to find work	* 38 per cent were more motivated to find work (versus 27 per cent in the control group) No significant differences	No significant differences * 13 per cent were less motivated to find work (versus seven per cent in the control group)	No significant differences * Five per cent were less motivated to find work (versus 15 per cent in the control group)
Whether views work more positively	* 47 per cent reported that pilot support had changed how they thought about work (versus 37 per cent in the control group)	No significant differences	No significant differences

Pilot outcomes	JCP pilot and control groups	WP pilot and control groups	HCP pilot and control groups
Views on readiness to work	* 63 per cent felt unable to work due to a health condition (versus 71 per cent in the control group) * 16 per cent felt they could return to work right now (versus 11 per cent in the control group)	No significant differences	No significant differences
Attitudes to work	No significant differences	* 23 per cent on the pilot disagreed that they would be happier in work (versus -16 per cent in the control group)	* 60 per cent in the pilot group said they would be a happier person if they were in work (versus 69 per cent in the control group)

7 Achieving pilot outcomes

This chapter draws on qualitative data from staff and participants regarding which types of support and approaches to delivery were most and least effective in moving participants towards and/or into work and how participants' circumstances and barriers may have facilitated or limited this.

7.1 Introduction

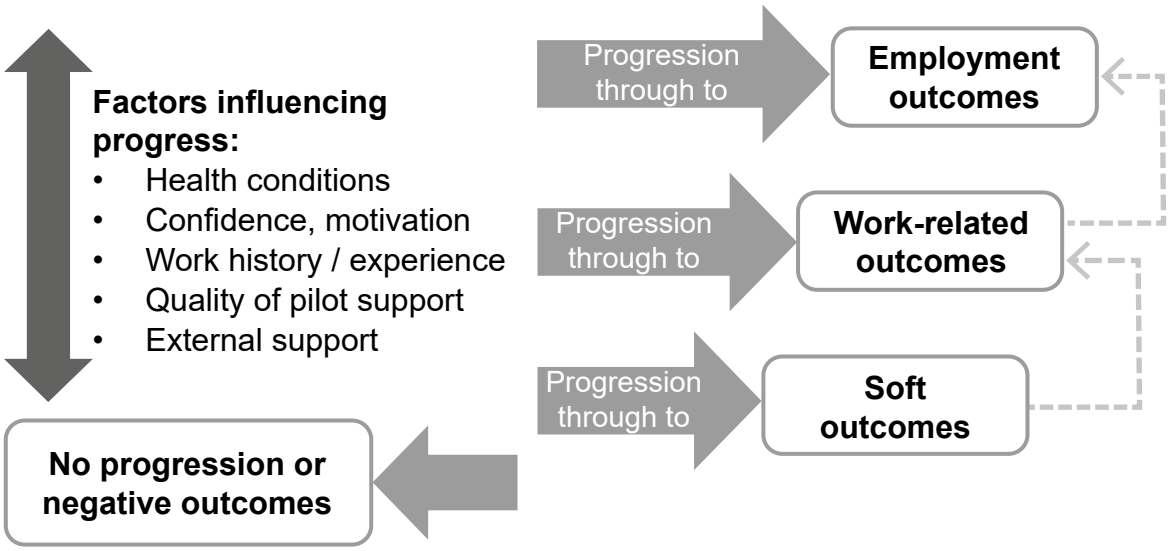
This chapter draws on qualitative data from staff and participants regarding which types of approaches and which elements of support were most and least effective in moving participants closer to and into work, and what prevented or limited this progress. It also considers how this interacted with the needs and circumstances of pilot participants. The chapter first considers the range of participant journeys towards work and what influenced these. It then examines which elements of provision worked best in facilitating participant outcomes.

7.2 Participant journeys towards work

Pilot participants experienced a range of customer journeys through the pilot, often towards different outcomes. As illustrated in Figure 7.1 and described in detail below, four main participant journeys were identified:

- Progression through to work outcomes;
- Progression through to work-related outcomes;
- Progression through to soft outcomes; and
- No progression or negative outcomes.

Figure 7.1 Participant journeys through pilot support



While participant journeys were not always clear-cut or linear, a broad pattern of 'steps' emerged. This began with engagement with the pilot; the development of confidence, motivation and positive mindsets; training and work experience; and then progression into employment. As illustrated above, movement through this overarching journey, as well as participants' start and end points, were influenced by:

- Participants' health conditions which could either support or inhibit progress;
- Participants' work history, experience and 'distance' from the labour market;
- Participants' confidence, motivation, and willingness to engage with the pilot;
- Quality of pilot support; and
- External support received, either formal through health and other support services or informal through family, friends or ex-colleagues.

As described in more detail below, there were a number of variations to participants' journeys through the pilot support. In some cases, soft or work-related outcomes catalysed subsequent engagement with more work-focused support or resulted in work outcomes among pilot participants. However some pilot participants who achieved positive outcomes as a result of the pilot (either work, work-related or soft outcomes) did not sustain these outcomes. In other cases, participants remained a long way away from further progression at the end of the pilot, and these outcomes were seen as final at the time of interview.

Of the factors influencing the direction and outcomes of participants' journeys listed above, participants' health in particular was pivotal to how far they progressed towards employment and the extent to which they sustained outcomes. Severe and fluctuating health conditions posed significant barriers to the engagement and progress of pilot participants. By the same token, improvements in health could stimulate movement towards soft, work-related and work outcomes, and there was evidence that pilot support could help to improve participants' health and wellbeing.

7.2.1 Progression through to soft outcomes

Increased confidence, motivation and outlook were commonly reported soft outcomes across the three pilots by both staff and participants. Staff felt that improvements in confidence and self-esteem were particularly important, because they helped participants to believe that work might be possible for them in future. This fostered a more positive outlook where participants felt more in control of their lives and more optimistic about their future.

Staff reported that growth in confidence and changes to outlook had brought about increased levels of motivation, and this was reflected in improvements to participants' daily routines, activities and social interactions. For WP and JCP pilots, this was seen in:

- Better attendance at appointments, both in person and on their own;
- Increased engagement with pilot activities, such as group sessions or hobbies; and
- Changes in demeanour from intimidated and anxious to open and proactive.

In the case of the HCP pilot, which had a more limited schedule of contact, this was reportedly seen in participants undertaking activities outside of the pilot (see improvements in health and wellbeing, later in this section). These changes were considered by staff as a good measure of progress on the pilot, particularly for people with mental health conditions such as anxiety and depression.

Soft outcomes were widespread across pilot participants, regardless of specific demographic characteristics, work history or time away from work (with the exception of those who were already close to the labour market and participants who did not reportedly experience any positive outcomes at all, as discussed below). However, of those who experienced soft outcomes, participants reached different points:

- **Planning next steps towards work –** this included exploring vocational training or volunteering, or working towards more concrete work ambitions (for example, learning to drive in order to get a driving job, or making crafts to sell). The case illustration below provides an example of this.
- **Needing more support to progress towards work –** some felt they needed more pilot support to progress on the journey towards employment and to decide on next steps.
- **Not considering work as an option –** a group of participants saw the development of soft skills as a final outcome. They tended to be older, to have been out of work long-term and to have multiple or severe health conditions. These participants had progressed as far as they could and were not considering further work-related activities or work, mainly due to their health.

Case illustration

A man in his forties, with qualifications and a career in building and construction had been unable to work since a psychiatric illness in 1988. He had been taking anti-psychotic medication ever since, the side effects of which often made him feel tired and unwell. He was depressed and unmotivated when he started on the WP. He saw two different advisers over the course of the programme, and found them 'very very helpful' and 'knowledgeable'. He liked having an assigned adviser, so that they could get to know each other over time, and he also appreciated that his advisers did not put pressure on him to return to work, but respected that he needed to wait until his health improved.

His motivation and confidence increased while he was on the WP and his views about going back to work developed to the point where he was thinking about the kinds of work that would be suitable for him to go back to. He felt that it would be possible for him to work in his previous career, but to start at a lower level than before in order to keep it as stress-free as possible.

> *'I was so, so depressed, I just didn't want to do much. And then they started us with the Work Programme and I started thinking, yeah, I could go back to work here, I just started looking into it… It was really helpful, really motivated my brain again.'*
>
> (Man, 30-49, WP pilot, Wave 2)

Improvements in health and wellbeing

Improvements in health were considered an important soft outcome from the pilot. As reflected in pilot results, such improvements were emphasised most by HCP pilot staff, since they were viewed as a desired outcome for this pilot – in contrast to the JCP and WP pilots, which were more work-focused. The improvements in health and wellbeing experienced by participants and observed by staff include:

- **Lifestyle –** changes to diet; sleeping patterns; physical activity levels; leaving the house; daily routines; social interaction; and alcohol intake and smoking.
- **Outlook –** improvements to mood; positive thinking about options for the future; reduced anxiety; increased confidence; motivation; and independence.
- **Management of health issues** – health; medication; and pain management. The case illustration below provides an example of this.

Case illustration

A HCP participant had a range of complex health conditions following a stroke, and the pilot support he received was primarily health-focused. Prior to his stroke, he had done manual work for many years. He had applied for less physically intense jobs since, but without success. These rejections had made him feel demoralised, which in turn had reduced his motivation to address his health. His adviser persuaded him to go to see his GP, which he had been putting off doing, and as a result he was referred to counselling appointments and hospital tests. He thought that without the encouragement to see his GP his health would have deteriorated substantially:

> *'If I hadn't have gone I probably wouldn't be alive now, yes, so they do give you advice and they really speak to you like, "You must, this is the first thing on your list, you must do this ASAP... It gives you that push, because when you get to a certain age you think, "Oh, I don't care no more," and they just give you that push.'*
>
> (Man, HCP pilot, Wave 2)

The participant said that the support had given him the confidence to talk about his health issues without feeling 'stupid'. He found the advisers very friendly and helpful, but he would have liked the support to last longer.

The ways in which elements of pilot support contributed to these improvements in health are discussed in the Section 7.3.

7.2.2 Progression through to work-related outcomes

A range of work-related outcomes were reported by staff and participants, which were facilitated by permitted work[62], voluntary work, vocational training, and work placements. As discussed below, participants used these forms of support to build links with previous roles and sectors, develop concrete career plans, and start learning/ training in order to transition to new sectors.

While participants across all pilot groups engaged with work-related activity, the purpose and outcome of this activity varied across participants. The following groups were observed.

- **Maintaining links with a previous role or sector –** some participants used permitted work to maintain links with a role they had worked in before the onset of a health condition, without having to commit to a full-time or long-term contract.
- **Developing career plans** – a further group of participants used permitted work and work experience opportunities to develop their career goals and next steps towards employment. This was especially valuable for those who had been out of the labour market long-term or had never worked.

[62] People claiming ESA are allowed to undertake some 'permitted work', which can include paid employment or self-employment, without this reducing the amount of their benefits. To be eligible, claimants may earn up to £107.50 per week, after tax and NI deductions, and work for up to 16 hours per week.

- **Learning/ training to transition to new sectors** – across all three pilots, participants acquired new skills through attending courses in order to gain the qualifications needed for their chosen vocation, and in some cases to change career.
- **Work-related outcomes as the end goal** – for a subset of participants, work-related outcomes (such as volunteering in local charity or coffee shops and taking basic skills courses) were believed to be the final outcome at the point of the interview, rather than steps towards employment. It was generally recognised by staff across pilots that, while these outcomes may not result in paid work, they would not have been expected of these participants at the beginning of the pilot and were therefore a valued pilot outcome. Similar to those achieving only soft outcomes, these participants were typically:
    - Older (aged over 50) with a long period spent out of the labour market, and who had stable or fragmented work histories (had worked until the start of their condition, or had been in and out of work due to their condition);
    - Individuals with longer-term health issues; and
    - Individuals with more significant learning difficulties.

In some cases (see case illustration below), engagement with work-focused support occurred after the pilot ended, as was sometimes seen in longitudinal interviews with participants who had completed the pilot.

Case illustration

A HCP participant who had been out of the labour market while raising her three children had developed a physical health condition as well as depression and anxiety, which prevented her from wanting to leave her home. At Wave 1, she reported feeling reluctant to attend the pilot, although she found the advisers helpful and supportive. With time and encouragement from her advisers, she started leaving the house occasionally to take short walks or go to the local shops. When interviewed at Wave 2, several months after the pilot support ended, the participant had started voluntary work at a local charity shop. She felt that she would not have pursued this opportunity had it not been for the pilot support. In retrospect, she reported that the pilot had helped her move forward with her life:

> *'If it weren't for them [HCP provider] I'd be stuck in the house with the "I can't be bothered and I can't do it" attitude and "every time I go out the door I'm going to have a panic attack" attitude. Now I think a lot differently to what I did back then.'*
>
> (Woman, 30-49, HCP pilot, Wave 2)

7.2.3 Progression through to work outcomes

As discussed in Chapter 5, a small minority of pilot participants entered work (eight per cent of JCP participants, four per cent of WP participants and two per cent of HCP participants). The type of work undertaken by participants across the pilots varied; it included full-time and part-time work across a range of sectors and occupations.

Reflecting this, those pilot participants who were in paid work at the time of the qualitative interviews were employed in a range of sectors, and with a variety of employment contracts and hours, including self-employment and zero hour contracts. These participants can be split into two groups as described further below; those who sustained these work outcomes and those who did not.

Sustained work outcomes

It was more common across the claimant sample for participants to enter and stay in work. Experiences of being in work were nonetheless mixed. Often the experience was positive, helping to build participants' confidence in their skills and abilities (see case illustration below). In some cases, participants even started taking steps towards progressing in work. In other cases, participants moved to another more suitable job after experiencing difficulties (these are outlined in the next section).

Case illustration

A JCP pilot participant aged under 30, who had dropped out of college due to mental health issues and had no previous work experience, entered a full-time retail job while on the pilot. He reported having benefited from a good relationship with his work coach and from being able to discuss an action plan with someone who believed in him:

> '*In a way, she made me believe I could do it, she made me believe in myself.*'

He was referred by his work coach to a Princes Trust work experience opportunity, which involved shadowing employees in the retail sector. This gave him his first flavour of work. He was then offered a temporary contract with the same employer, before being offered a permanent role. The participant felt that the support of his work coach and the opportunity to undertake a course that addressed his lack of exposure to work were instrumental in achieving a work outcome. He also benefited from a session with a National Career Service adviser to think about what roles would be suitable for him based on his personality and interests, which had prompted him to consider retail:

> *'Well, I suppose, technically, it has affected my skills. Not only has it brought to light what skills I have, but in a way it's taught me some new ones.'*
>
> (Man, age 18-29, JCP Pilot, Wave 2)

Un-sustained work outcomes

As Chapter 5 showed, a number of participants who entered work while on the pilot did not sustain this work. Qualitative interviews found that this was due to one or more of the following circumstances:

- Difficulties coping financially after leaving ESA;
- Difficulties managing irregular hours (for those on flexible contracts);
- Difficulties with health (work could put a strain on health while health issues, such as anxiety, could make working more difficult); or
- Simply because work contracts had come to an end.

Within this group, some participants experienced un-sustained work outcomes after reaching the 52-week limit of their permitted hours and taking paid work, despite not feeling ready to (see the case illustration below). These participants took jobs of more than the permitted 16 hours a week to make working financially viable without receiving benefits, but did not sustain these jobs, either because they struggled financially or because they experienced negative health impacts from the increased hours and pressures of work.

Case illustration

After being out of work for 8 years due to a physical injury, a 50+ male WP participant got a position in a central government department. However, the pressure of performance targets and his reported lack of experience caused a relapse in his mental health condition. This claimant did not pass his probation and experienced this as a difficult setback. He was not looking for another position at the time of the interview.

7.2.4 No progression or negative outcomes

Interviews with participants and staff indicated that a number of participants did not achieve outcomes from their participation in the pilot, at least within the timeframe of the evaluation. Participants and staff reported a range of factors that inhibited progress, relating both to participant circumstances and barriers as well as to the nature of support delivery (delivery of support is discussed in the next section).

A common factor limiting progress across all three pilots was the impact of some participants' disabilities and health conditions on their attendance and engagement with pilot provision. The participant group concerned had more severe and/or multiple health conditions, in addition to very low confidence and motivation and a long history of worklessness. As a result, these participants judged themselves to be unsuitable for the pilot support and believed that they were unable to make progress towards employment.

Some of these participants had been placed under special arrangements, such as telephone-only contact (see Chapter 4), which aimed to reduce the expectations and pressure on them, therefore limiting the amount of progress they might make. Others were still mandated to attend the pilot, despite their belief that they were too unwell or in some cases that the resulting pressure to participate in the pilot had negatively impacted on their health.

Pilot staff agreed that severe and fluctuating health conditions posed significant barriers to engagement and progress, citing transfers to the Support Group during the pilot as evidence of this. They also raised concerns that the pilot may have been too much for some participants to cope with, and that rather than encourage progress, participation may have had a detrimental impact on some people's health.

Pilot staff also suggested that for participants with very complex needs, such as a learning disability, the provision of support via the pilot was not appropriate and that referral to a more specialist programme was required. There was also evidence from staff and participants that the pilots lacked suitable support for those who were well qualified, for example, participants with degrees, whose main or only barrier to work was their health condition.

7.3 Effectiveness in the delivery of pilot support

In this section, we consider which aspects of the pilot support were most effective in enabling positive impacts for participants, drawing on the views of both provider staff and participants, as collected during qualitative interviews. We consider a range of elements of support in turn, drawing out what was perceived to be beneficial across the pilots and highlighting differences between the three pilots where relevant.

7.3.1 Achieving positive outcomes

As outlined in the previous section, pilot outcomes ranged from soft outcomes (such as improvements in confidence and wellbeing), to work-related outcomes (such as take up of training or voluntary work, or entry into full-time paid work). For the achievement of soft outcomes, three key elements of support were considered by staff and participants to be important. These were:

- One-to-one adviser support;
- Group support around soft skills, including confidence, motivation and work-related attitudes; and
- Health-focused support to assist in the management of health conditions, which could be delivered by a health professional as part of the pilot or through referral to support in the community, including NHS services.

For the achievement of work-related and sustained work outcomes, in addition to the types of support cited above, staff and participants additionally identified the following elements of support as important:

- Skills development;
- Permitted work and voluntary work;
- Employability support and support with the transition into work; and
- In-work support.

In addition, staff and participants also highlighted as crucial the way in which support was delivered. This included:

- Personally tailored support;
- Flexibility in delivery;
- Support of the requisite intensity and duration;
- A holistic focus on addressing a range of potential barriers;
- The skills and capabilities of staff; and
- The importance of partnership working.

Each of these elements and ways of working are discussed in turn below. Alongside these elements of pilot support, staff and participants indicated that participants' own drive to make the most of the pilot support, as well as other personal factors, such as previous work experience, improvements in health and informal support networks were also important in the achievement of outcomes.

7.3.2 Adviser support

Pilot staff highlighted the importance of developing effective working relationships with participants, and felt that these relationships underpinned the delivery of effective support. Likewise, many participants indicated that support from their adviser was one of the most positive elements of the pilot and which contributed to their willingness to engage with the programme, and to act on the advice and guidance offered.

Across all three pilots, the adviser or work coach was felt to have played a particularly crucial role in facilitating soft outcomes. Participants reported that it was helpful when advisers were understanding, empathetic and non-judgemental, and provided the following types of support:

- Emotional support: listening and being someone to talk to;
- Support and motivation by advising and coaching, but not applying undue pressure;
- Support with planning, suggesting possibilities and next steps;
- Reassurances and a belief in participants' employability; and
- Practical information and support about future work options e.g. part-time work or self-employment.

Drawing on these approaches, three main features of adviser support appear to have promoted soft outcomes in pilot participants. Discussed in turn below, they include building trust and motivation, changing participants' mindsets and providing holistic support.

Building trust and motivation

The continuity of support from the same adviser over time was highlighted, both by staff and participants, as particularly important to achieving improvements in participants' motivation and outlook. In addition, meeting with the same person over a period of time could gradually build up trust and momentum:

> *'She [the adviser] made me believe I could do it, she made me believe in myself... It definitely made me feel more motivated. I remember feeling more motivated after every session.'*
>
> (Man, 18-29 JCP pilot, Wave 2)

Pilot staff agreed on the importance of enabling a trusted adviser-participant relationship to develop. They felt that it could take time to develop a rapport with a participant, but that once trust had been established it became easier to motivate participants and move them forwards:

'We established a good rapport, and through that I was able to encourage her more effectively, because she trusted me, and she felt that I knew her and understood her skills and her issues.'

(Work coach, JCP pilot, Wave 2)

Both JCP and WP pilot participants emphasised the importance of the regularity of appointments in developing their relationship with pilot staff. The importance of continuity was also emphasised by some staff who noted a negative impact on working relationships with participants when advisers changed. A number of participants also identified frequent changes to their adviser as disruptive to progress because it meant establishing a new relationship, which could take time.

Challenging participant mindsets

Staff across the three pilots reported that a key outcome of pilot support was a change in participants' mindset towards picturing a future with work in it and away from the limitations posed by their health conditions.

In achieving this change, staff across the three pilots emphasised the importance of building a relationship of trust; not being forceful, threatening or rushing; and focusing on the claimants' interests, skills and aspirations in order to motivate them. Pilot staff spoke of the importance of striking a balance between 'pushing' participants enough to move them forwards, but not so much that they resisted and disengaged from the provision altogether.

Striking this balance was also important to participants. For example, a HCP pilot participant reported that his mindset about work had changed because his adviser was there to offer support. It was important to him that his adviser cared about his wellbeing and was not trying to push him into work, but instead supported him towards a position where he was ready for it.

While staff across the three pilots emphasised the importance of changing participants' mindsets, there were some differences in emphasis in how this was achieved.

HCP pilot staff drew on their role as health specialists who understood individuals' health conditions. This enabled them to persuade participants of their capability to engage in work-related activities. Indeed, HCP staff believed that the advisers' health specialism was a key strength of the pilot:

'The fact that we were health professionals, the fact that we could understand what they were saying about their health. They felt we were taking them seriously. That we did challenge perhaps their views on their health, whether it was about work, or what they could and couldn't do in their daily life. I think all those things made a massive difference.'

(Adviser, HCP pilot, Wave 2)

An example of the success of this approach is seen in the case of one pilot participant who had been taking a lot of medication since sustaining a head injury. He reported that talking things through with his health adviser had been transformative; it had helped him to take stock of the way he was living and look at his heavy reliance on pain medication. As a result he met with a specialist at his local hospital and slowly came off the medication. At the time of the interview, he had started to do regular exercise and for the first time in 25 years he felt ready to go back to work:

'I want to rebuild my life. I have started to do yoga, I have started to do physical stretching… I want to work now. I want to do something now, I don't want to wait. I want to do something now, even if it is a couple of days a week.'

(Man, 30-49, HCP pilot, Wave 2)

For the **JCP and WP pilots**, staff felt that in order to progress participants towards work, a focus on employment in the one-to-one support provided was important. This included starting to have early conversations with participants about their work aspirations, introducing the idea of work as a possibility, and suggesting possible strategies for achieving these aspirations through options such as volunteering, work experience and permitted work. Better Off Calculations (BOCs) were also thought to be useful in changing participants' motivations and attitudes towards work.

The process of action planning and goal setting was also identified as important in moving participants forward. **JCP staff** in particular emphasised the importance of jointly identifying goals with pilot participants and setting intermediary goals to work on from one appointment to the next. This was reported to be motivating for participants as it provided the 'momentum' to help them move forwards. One JCP participant reported that the incremental appointment schedule suggested by her work coach had allowed her to slowly build up the confidence to attend the JCP office and over time this had reduced her anxiety levels.

A tool commonly used by **WP pilot staff** was to encourage participants to support one another through group activities where they could work collaboratively to identify goals and opportunities for each other. They also used 'positive examples', by introducing participants to claimants who had been in similar situations and who had made progress in order to inspire them.

Holistic support

Staff across the three pilots also highlighted the need to provide holistic support to address a range of barriers, such as practical support on housing or financial issues. One WP participant, for example, reported that the pilot had brought about a substantial positive impact on his mental health. He had received support from his adviser with a housing issue and had also completed several courses. He felt that this had eased his depression and made him feel more optimistic about the future:

'They've woken up a part of me that I thought I'd lost years ago… because before I just thought, "This is your life, you're going to be sat in this chair until the day you die".'

(Man, 50+, WP pilot, Wave 1)

There were also participants who had been supported to apply for benefits and allowances, such as Personal Independence Payments, which were perceived to make life easier and more manageable.

7.3.3 Soft skills workshops

In addition to the one-to-one adviser support, in-house and external courses were reported by claimants and staff to be an important part of the package for the achievement of pilot outcomes. This included soft skills workshops as well as courses on basic skills and other vocational provision (see Section 6.3.5). Participants

reported that the courses which addressed 'soft outcomes', such as confidence, were particularly helpful in progressing them to the stage where they felt ready to seek and enter work, by addressing barriers and changing the way they thought about undertaking work-related activity.

Particular emphasis was placed on soft skills development in the WP pilot, where several providers delivered in-house courses covering elements of employability (for example CV development) alongside soft skills (e.g. confidence building). Those providers that did not have in-house courses referred participants to similar external courses instead. WP pilot staff also placed a particular emphasis on engaging pilot participants in group activities. They felt that the peer support that developed from these was a key strength of the pilot. Group sessions were felt to be important for building confidence through working with others, and for developing supportive relationships between peers, which could also encourage greater engagement with other aspects of the programme:

> *'It's just the fact that they came in with the same group... they were just getting used to seeing other people in their positions. They were looking at what they could and couldn't do and there's an element of camaraderie in it as well.*
>
> (Adviser, WP pilot, Wave 2)

There were several examples of participants progressing towards work as a result of soft skills courses. For example, a JCP pilot participant who had been out of work for 10 years due to a drug addiction was referred to an externally-run course focusing on attitudes to work. Following the course, the participant successfully applied for a part-time job as a delivery driver. He explained that the course had helped him on three levels:

- In understanding where his fears around work came from;
- In strengthening his confidence that he could find and hold a job; and
- In providing advice on applying for jobs and support around preparing for job interviews.

Another JCP participant with a mental health condition was also referred to a confidence-boosting workshop, which he found helpful and motivating. After this, he attended an appointment with the National Careers Service, progressed from there to a work experience placement and subsequently entered employment.

7.3.4 Health-focused provision

Addressing health needs

There was evidence from across the pilots regarding the need to appropriately manage participants' health conditions in order to achieve work and work-related outcomes. The **HCP pilot** was delivered by health professionals and improvements in health were viewed as the key outcome for this pilot. Thus, as described in Chapter 5, receiving practical help to manage their health condition was the main element of support received by HCP pilot participants and receipt of this support was significantly higher than in the control group.

Improvement in participants' health was not a key aim of the **JCP and WP pilots**, and it was the view of some staff on these pilots that their role was to focus on the things that people could do, rather than on their barriers, which included their health conditions. Thus JCP and WP staff generally referred or signposted participants to health-related support to help overcome these barriers while remaining focused on an individual's capabilities in one-to-one support sessions. Some JCP staff acknowledged that this approach may have left participants feeling that their health issues were ignored.

Nonetheless, both JCP and WP pilot staff concurred on the benefits of having access to specialist health-related support. This included the facility to draw on specialist expertise in areas such as occupational health and work psychology, which was said to be effective both in supporting advisers in their work with participants and in providing direct support to participants.

JCP pilot staff also noted that pilot participants had more opportunities to be referred to external health services than the control group, and they made use of this (including referrals to counselling, condition management, diet, nutrition and wellbeing programmes, and support groups). Reflecting this, JCP participants were significantly more likely to receive help with managing their health condition than the control group, as described in Chapter 4.

In addition to providing health-focused support themselves, HCP pilot staff also signposted participants to a range of external resources. This included accessing health services available in the community or via a GP, making use of online self-help resources, and accessing occupational therapy services to source home aids and adaptations. Encouraging participants to re-engage, or engage in a more active way, with GP services was viewed by HCP pilot staff as potentially transformative for participants' ability to manage their health condition. One example was a HCP participant who reported a positive experience of getting a referral to a clinical psychologist through the pilot:

> '*I'm certainly managing it [my health] better than I was doing. Because like, I honestly don't believe I would have gone and sorted anything out about me depression, I think I'd have just basically just sat there and basically like just got worse probably... Because until I'd spoke to her I didn't have any intentions of going and seeing doctors and whatever, you know.*'
>
> (Man, 30-49, HCP pilot, Wave 2)

In other cases, participants were already engaged with other health support, and in cases of severe mental health or drug issues often had another support worker provided by a hospital, local council or charity. Some of these participants reported that they benefited from having the dual support both through the pilot and independently. Staff from across the pilots also recommended closer working partnerships with other healthcare professionals, both in order to offer specialist support to participants that needed it, but also to help address 'mixed messages' about ESA claimants' capabilities in relation to work.

7.3.5 Skills development

Across all three pilots, referrals and signposting to training courses were used in two ways:

- **To build up participants' confidence.** For example, one WP participant, who had learning disabilities and had never worked before, felt that his confidence had improved as a result of a basic skills course that he was referred to by his adviser. As a result, the participant was considering further work-related activities and hoped to find voluntary work as a next step.
- **To develop job-specific skills.** For example, one JCP pilot participant had an aircraft engineering background but decided to pursue a career in IT since his back problems prevented him from continuing in his previous role. With his work coach, he developed an action plan and was referred to a vocational college that specialised in supporting individuals with physical and learning difficulties. At the time of interview, the participant was undertaking a two-year university degree:

  '*I think by far the most useful thing she did was got my application to college. I certainly owe [adviser] a big thank you for getting me into college because that's what's started me moving forward really*.'

  (Man, 18-29, JCP pilot, Wave 2)

There were examples of other participants with similar experiences, such as a HCP participant studying GCSE English as part of a longer-term plan to become an ESOL teacher, and a WP participant training to be a mental health counsellor.

Of the three pilots, the JCP pilot made the most use of training courses for improving participants' skills, take-up of which was significantly higher among the pilot group than among the controls. A wide range of courses were utilised in the JCP pilot, including English and Maths, IT and bookkeeping. However work coaches sometimes had difficulty sourcing or funding local provision that was delivered in the right format for this claimant group, as discussed in Chapter 5.

7.3.6 Permitted and voluntary work

Support options that offered some form of work experience were seen by staff and participants as valuable opportunities to engage (or re-engage) participants with job search or working life, and to 'test' how a job might fit around their health needs and lives more generally, without the fear of losing benefits. Staff considered that such opportunities could also help to refine a person's job search, through increasing their awareness of what a particular job might entail, and could also potentially lead directly on to paid work or training.

Both staff and participant accounts indicated that for those who felt ready to work and who were actively seeking employment, experiencing work through permitted hours or as work experience was an important stepping stone. These experiences allowed participants to regain confidence in their skills, develop new ones and to experiment with different roles and work sectors. This helped open their eyes to their own potential and helped shape their future work aspirations.

Again it was the JCP pilot that made the most use of voluntary work, with take-up significantly higher for pilot participants than the respective control group. In cases where participants were ready to make this step into employment, but support to access unpaid work was not provided, this was viewed as a deficiency in the pilot support - as expressed by some participants on the HCP pilot.

Permitted work

As mentioned in Section 6.2 permitted work could offer participants the opportunity to maintain links with a sector or profession that they had worked in before the onset of a health condition, without having to commit to a full-time contract. An example of this was one JCP pilot participant, who was doing 13 hours of permitted work as a phlebotomist, which had been her full-time job before a diagnosis of chronic fatigue. Her work coach had suggested permitted work and this had prompted her to explore opportunities with an ex-colleague. At the time of the interview, she felt that her permitted hours were manageable and she was hoping to return to full-time work in the future once her health improved further.

Permitted work could also be used to help shape participants' next steps towards employment for those who had been out of the labour market for a longer period of time. An example of this was one participant who undertook permitted work for ten hours a week in a youth charity, after being out of work for four years due to multiple physical health problems. Importantly, the role confirmed to the participant that she wanted to make a career change and she subsequently sought and entered work in retail. At the time of the interview, she was training to become a supervisor as part of a long-term plan to enter management.

Volunteering

Staff across all three pilots also mentioned volunteering as a stepping stone into paid employment. Volunteering helped participants address their fears of the workplace, since they could engage with it without committing to a job, while simultaneously gaining work experience:

> *'Most customers who reached a job outcome initially did some voluntary work, which enabled them to gain experience and break down the fear of the workplace.'*
>
> (Adviser, WP pilot, Wave 2)

Staff also explained that volunteering opportunities helped increase participants' confidence about their ability to work and helped to broaden their skills. Staff also highlighted the usefulness of voluntary positions in helping participants to understand the type of work they wanted to do in the future. For example, one HCP pilot participant was doing unpaid work experience in a bingo hall and had decided to seek paid work there. This participant had never had a job before, so was hoping the work experience opportunity would improve his chances of securing a job.

7.3.7 Supporting the transition into work

Employability support

A key element of support delivered by advisers was employability support, for example, talking to participants about their existing skills and experience and helping them to develop or improve their CV. Participants spoke about gaining confidence in their capabilities through this type of support:

> *'That CV, that made me up on a high for about two or three weeks… it did make me feel that there is a life out there.'*
>
> (Woman, 30-49, JCP pilot, Wave 2)

This type of support was utilised more extensively on the JCP and the WP pilots. In the case of the JCP pilot, employability support was provided by the work coach or via a referral to the National Careers Service whereas on the WP pilot, the support was delivered by the adviser or through in-house or external group-based support. Staff on both pilots emphasised the importance of providing such support at the right time for participants. WP advisers reported that employability activities, such as cover letter writing and interview techniques, tended to be delivered later in the sequence of support. On the JCP pilot, work coaches felt that the stipulated referral to the National Careers Service to build a CV within the first three appointments was not appropriate for all pilot participants so in many cases they either delayed this or did not use it at all.

Self-employment support

Practical advice from advisers was also helpful for participants wanting to enter self-employment. Two participants in the qualitative interviews were self-employed at the Wave 2 interview and reported that advice from their work coach on in-work entitlements (such as tax credits) had contributed to their successful transition into self-employment. One participant, for example, wanted to be self-employed in manuscript digitalization. He felt confident that he had the skills to develop a business in this area but was not sure how he would cope financially. Being told by his work coach that he would be eligible for tax credits helped to turn this idea into a financially viable option for him:

> '*It completely made the difference between not working and working*.'
>
> (Man, 50+, JCP Pilot, Wave 2)

However, there were other participants who were interested in self-employment who would have liked to receive more support in pursuing this. Some participants on the JCP pilot said that they had wanted to access self-employment courses but that this support had not been available. JCP staff also highlighted inadequate self-employment support as a pilot limitation. Some WP providers had specialist self-employment support in-house.

Employer engagement and job brokerage

There was limited evidence of employer engagement or job brokerage conducted specifically for the pilots. JCP staff used their standard job broker model, which involved an employment co-ordinator developing links with local employers to encourage them to employ Jobcentre Plus claimants. WP providers had specialist employer relationship teams that built relationships with local employers and

proactively sourced vacancies (as well as work experience or work trial opportunities) for JSA and ESA claimants. However there had been no pilot-specific activity with employers across the three pilots. This was identified as a weakness by some staff, who felt that working with employers was crucial in order to educate them about the benefits of recruiting people with health conditions and disabilities, and to facilitate the availability of suitable employment opportunities:

> *'I think that's the key thing if you could get more employers that were willing to give these people a try.'*
>
> (JCP pilot, Operational Manager, Wave 1)

7.3.8 In-work support

In-work support was another area where there was no pilot-specific provision. JCP work coaches concurred that they did not provide any in-work support for pilot participants while WP pilot staff reported that they used their standard in-work support for WP participants, which usually comprised telephone support via a specialist call centre.

Some participants who had entered work while on the pilot reported receiving insufficient transitional support to help them adjust to being in employment and to cope with any difficulties that arose at work. In some cases, this caused considerable difficulties for participants, because the work turned out to be unsuitable for them, their health worsened, or they felt worse off and became indebted.

As mentioned earlier, some work outcomes were not sustained due to a perceived unsuitability of the job for the participant in question, or due to them not being prepared for working life. In one example, a JCP pilot participant accumulated debt from fuel and parking costs when she moved from receiving ESA and wages from permitted work to only receiving a wage from part-time work. She also found the work environment stressful due to increased hours and because of a lack of experience in her role. Eventually she left the job but managed to find another position in a sector in which she had more experience.

Participants felt that more timely or intensive in-work support from advisers and work coaches who were familiar with their circumstances may have prevented some of these difficulties from occurring, or assisted a swifter resolution. Participants who voiced a need for in-work support sought an adviser to talk with during the move into work, as well as transitional financial support. Some participants also suggested the need for more information about employment terms and conditions.

7.3.9 The overall approach to support provision

Finally, this section moves from considering individual elements of support to considering the key ingredients of effective provision for this claimant group.

Personally tailored approach

The pilots provided an opportunity for staff to work flexibly with participants and to tailor support individually according to each participant's support needs. Staff indicated that this flexibility and personalisation was a vital part of successful delivery. Likewise, participants valued flexibility in the way support was delivered, for example, where the content and mode of delivery matched their needs.

There was some variation in the degree of personalisation afforded to staff by each pilot:

- WP providers had considerable flexibility to work with participants; the only constraint being that they had to see them at least as often as the minimum service requirement (i.e. at least once every two or four weeks).
- JCP staff said that the additional time they had with participants allowed them to tailor support appropriately, although they felt that the suggested order was too prescriptive at times. For example, they felt that mandating people to do a CV or have a Better off Calculation at the beginning of the support, and that the requirement for participants to go to the National Careers Service by the third meeting were not appropriate for all participants. They also felt that they had less flexibility about the frequency of appointments with pilot participants than they had with their regular caseload.
- HCP staff were generally free to work with participants as they saw fit within each appointment, but felt that there was insufficient flexibility to vary the number of appointments and the timing of these over the course of the pilot.

Generic support that was not felt to be tailored to individual circumstances was reported by participants as limiting their progress. Some described the support as a 'tick-box approach', rather than being tailored to their needs:

> *'What I didn't like was… probably just ticking a box and saying, "Yes I've done that" and "I've done that, right okay, next step," rather than looking more in depth at the person. But that was probably due to, as I say, time constraints and the number of people they were looking at.'*
>
> (Man, 50+, WP pilot, Wave 2)

Some participants also reported that their advisers had recommended unsuitable support, training or employment opportunities, which did not mirror their needs, interests or capabilities. One HCP participant, for example, felt as though the adviser was assigning them to 'any course' with spare capacity, rather than exploring more suitable options and tailoring support accordingly. More highly qualified participants in particular raised the unsuitability of support. For example, one participant with professional experience in the science industry explained how their adviser was unable to move beyond basic employment and skills advice and make tailored recommendations.

Despite the health focus of the HCP pilot, some participants reported that the health-focused support was too generic and that this limited their progression. These tended to be individuals who were already in contact with other relevant health services and who felt that the pilot largely repeated what had already been provided to them externally, hence missing an opportunity to co-ordinate with external providers or

build upon prior progress. For example, one participant said that they were already receiving counselling support through their GP, and felt that the pilot support was very similar without any additional value.

Flexibility in the mode of delivery

Staff emphasised that the mode of delivery of both in-house support and external provision had to be delivered in flexible formats to take account of participant needs (such as physical mobility barriers, low confidence, social anxiety and the effects of medication).

Providers were able to alter their mode of delivery to take account of these factors to a certain extent. For example, participants welcomed the flexibility offered by the use of the telephone where they were not able to attend face-to-face appointments. However participants also cited accessibility barriers such as:

- Provider offices not being readily accessible in terms of geographic location and distance (especially for those from rural areas) and in terms of the accessibility of the premises;
- A lack of privacy with appointments held in an open plan office where conversations with advisers could be overheard; and
- A need for home visits where they were unable to attend the provider premises.

The intensity and duration of support

Staff from the JCP and WP pilots suggested that the frequency of support was an important feature of the pilots. It was thought that attending regular appointments in an office environment had a positive impact on participants, since it enabled them to develop a routine which emulated aspects of the work environment. Some participants also concurred that regular and face-to-face support was helpful in introducing more structure into their daily routines and facilitating the development of a positive relationship with their adviser.

Conversely, limitations in the intensity of support including inconsistent and infrequent appointments) were identified, in the HCP pilot in particular, as a significant impediment to participant progress. Some HCP, and also JCP, participants reported that the support was too infrequent for effective progress. They felt that the length of time between appointments was too large to develop the momentum necessary to overcome the barriers they faced. For example, one participant explained how engaging with the pilot had initially helped them to *'start getting back into the world'* but the long gap between appointments meant that they did not progress much further than this.

This criticism was also echoed by HCP pilot staff who felt that the support may have better met claimant needs if a greater number of appointments were offered, since the infrequent support risked losing any momentum built:

> *'The gap between the third and the fourth [appointment] and the fourth and the fifth was quite large, and they would have preferred them to be either closer, or more of them to fill that gap in, because you kind of lose the momentum if you're not careful, you know, that's quite a big gap.'*
>
> (Manager, HCP pilot, Wave 2)

As reported in Chapter 4, HCP pilot managers did not appear to be aware of, and had not made use of, the ability to offer additional appointments on top of the five minimum mandatory appointments at their discretion.

Appointment length was also identified as a factor limiting progress. Participants found that short appointments were not always sufficient to cover the range of barriers they faced in order to foster lasting change. For example, one participant complained that their appointments would typically last for 30 minutes, which they felt was not enough time to receive the required level of support. Participants suggested that appointments should be extended in order to facilitate effective progress and outcomes:

> *'Sometimes it does feel a bit rushed, because you're only allowed half an hour, and then, by the time you've got talking and that, the half hour just went by like a flash.'*
>
> (Man, 50+, WP Pilot, Wave 2)

Many WP and some JCP staff believed that the two-year duration of the pilot was not long enough to work with this claimant group, in light of their barriers. Staff across all three pilots believed that if participants could stay on the pilot longer or go on to receive similar support elsewhere, then their progress could be built on and would continue. However, without regular follow-on support staff believed that many claimants would slip back again at the end of the pilot:

> *'The majority, by the time we've got to two years they need another two years to get them into work. What we find is they go back to the job centre and they're just left again. So we've put two years in putting them where they need to be... A lot of them go back to square one again.'*
>
> (Adviser, WP pilot, Wave 2)

In particular, staff thought that for this group to achieve employment outcomes, a longer programme of three to four years would be needed depending on the participant, as well as better preparation for participants prior to the pilot.

Staff capabilities

A range of factors were reported to facilitate the delivery of effective one-to-one support by advisers. These included:

- Well-trained and knowledgeable advisers with the appropriate level of skills and experience for working with this participant group;
- Adequate staffing levels to ensure caseloads were manageable and advisers had adequate time available for individual participants;
- Access to more specialist staff and services to support advisers' own delivery and for referral of participants with particular needs; and
- Peer support and the sharing of good practice across teams.

Staff in all three pilots thought that there should have been additional adviser training on health conditions. Some staff said that they had not felt confident to work with this group, particularly near the start of the pilot. They suggested that there was also a need for increased specialist/ medical input that advisers could draw on as required. However, JCP staff did feel that having a single team dealing with the pilot group built

staff capabilities by providing opportunities to share resources, knowledge and ideas. Staff had been able to support each other and to help each other with challenges as they arose.

While some participants across all three pilots criticised staff for lacking expertise, communication and interpersonal skills, and an understanding of health conditions, the nature of this varied by pilot. Participants from both the WP and JCP pilots stated that pilot staff had limited experience of providing support and guidance to individuals with disabilities and health conditions, and as such, were unable to provide helpful, informed recommendations. One WP participant with psychosis and borderline personality disorder stated that pilot staff could not provide effective advice and guidance because they did not understand the mental health condition and how it impacted on the participant's day-to-day life.

In the participant survey, advisers lacking empathy and understanding of participants' health conditions or disabilities were the most commonly reported cause of dissatisfaction among JCP and WP pilot participants.

Conversely, some participants on the HCP pilot felt as though the provision was too health-focused and that advisers lacked the professional knowledge required to provide effective employment-related advice and guidance. Participants reported that they were left feeling unsupported, as a result of unsuitable employment and training advice.

Partnership working

All three pilots reported the use of a range of partners to which they referred and signposted participants for more specialist provision. Effective partnerships assisted the pilots to provide or broker access to a broad and holistic package of support. This enabled them to link participants with support which they would either not have had the motivation to seek out for themselves, or would have struggled to find. The benefits of partnership working and joining up services for employment, health, social care and others, underpin, many reported, examples of good practice in this area of employment support.[63]

However, the effectiveness of partnership working was dependent on advisers knowing about the provision in their area and keeping track of the changes in availability that occurred over the duration of the pilots. Staff highlighted that the support required was not always available or that there were long waiting lists. The lack of suitable mental health provision, long waiting lists for talking therapies, and a dearth of basic skills provision were cited as examples by WP staff. Likewise, JCP staff reported difficulty in accessing appropriate provision for some participants, which led to disappointment and undermining of the participant/adviser trust that had been built up over time.

[63] 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.

7.4 Summary

Participant journeys toward work

Pilot participants experienced a range of journeys through the pilot, often towards different outcomes. Four main participant journeys were identified:

- Progression through to work outcomes;
- Progression through to work-related outcomes;
- Progression through to soft-outcomes; and
- No progression or negative outcomes.

Although participant journeys were not always clear-cut or linear, a broad pattern of 'steps' emerged. This began with engagement with the pilot, followed by the development of confidence, motivation and positive mindsets, followed by training and work experience, and then progression into employment.

Movement towards work was influenced by a range of factors, including personal factors (such as work experience and motivation) as well as external factors (such as the quality of pilot support and the use of other forms of support e.g. health specialists). The state of participants' health conditions, however, were perhaps the most pivotal of all to the progress participants made.

Some pilot participants achieved positive outcomes but did not sustain them or remained a long way from movement into work at the end of the pilot. This was particularly the case for participants who were older and/or had more severe or multiple health conditions.

Achieving positive outcomes

There were **three key elements** of support that facilitated soft-outcomes, such as improvements in confidence, motivation and wellbeing:

- **One-to-one adviser support –** staff and participants believed this was most effective when participants were supported by one adviser continuously, whom they saw with enough frequency; when advisers had the skills and ability to build a trusting relationship with participants and to challenge mindsets; and where staff were able to provide holistic support that addressed a range of barriers e.g. money and housing, as well as health.
- **Support aimed at developing confidence, motivation and work-related attitudes –** staff emphasised the importance of providing both internal and external support to develop soft skills, including courses aimed at improving participant confidence and motivation, addressing barriers, and changing the way they thought about work-related activities.
- **Health-focused provision –** the HCP pilot was provided by healthcare professionals and improvements in health were considered a key outcome of the pilot. While the JCP and WP pilots were not focused on health provision, staff emphasised the importance of referring or signposting participants to health-related support, such as occupational health and work psychologists.

For the achievement of **work-related** and **sustained work outcomes,** staff and participants identified the following elements of support as important:

- **Skills development –** across all three pilots, referrals and signposting to training courses, which varied from basic skills courses to specialist vocational courses, were used to build participants' confidence and soft-skills, as well as developing job-specific skills.
- **Permitted work and voluntary work –** both permitted and voluntary work allowed participants to regain confidence in their skills and develop new ones, while experimenting with different roles and sectors without fear of losing benefits.
- **Employability support –** employability support was used extensively by the JCP and WP pilots and involved participants discussing their existing skills and experience to develop or improve their CV. Participants reported gaining confidence in their abilities via these discussions.
- **In-work support –** across the pilots there was no specific provision for in-work support. Pilot participants who entered work reported receiving a lack of transitional support to help them adjust to being in employment.

Key ingredients for effective support

There were five key ingredients which, combined, led to effective provision for this claimant group:

- **Personally tailored approach –** the pilots enabled staff to work flexibility with participants, tailor support individually and work according to each participant's support needs.
- **Flexibility in the mode of delivery –** delivery of in-house support and external provision provided in flexible formats that took account of participants' needs, such as physical mobility barriers, low confidence and social anxiety.
- **Intensity and duration of support –** JCP and WP staff engaged with participants frequently, providing them with a regular routine that emulated aspects of the work environment.
- **Staff capabilities –** this included a range of features, such as well-trained and knowledgeable staff; adequate staffing levels to ensure caseloads were manageable; access to more specialist staff and services; and peer support which facilitated the sharing off good practice.
- **Partnership working –** effective partnerships allowed all three pilots to provide, or broker access to, a broad and holistic package of support. Participants were linked with support which they would not have had the motivation to seek out for themselves or would have struggled to find.

8 Conclusions

This chapter presents conclusions from the findings of the evaluation of the Employment Support Allowance (ESA) Work Related Activity Group (WRAG) 18-24 month prognosis pilots. The pilots sought to test the effectiveness of three models of support aimed at supporting participants towards work. They were delivered by Jobcentre Plus, Work Programme providers and healthcare professionals. This chapter reviews the key findings from the evaluation which may support the successful design and implementation of these services in future.

8.1 Pilot participant characteristics

Across all the pilots, staff reported that participants had high levels of support needs, including health conditions that were often multiple and complex, in addition to other barriers, such as a lack of recent work experience or caring responsibilities. Staff felt it to be inappropriate for some participants to be on the programme. This included people with degenerative or terminal illnesses[64] and some of those with learning disabilities. This view was supported by the survey finding that 28-30 per cent of pilot participants moved from the ESA WRAG to the Support Group between Waves 1 and 2 of the survey. This may indicate changes in participants' circumstances, such as a worsening of their health condition, or may suggest a need to review the assessment process for referral to employment support, as outlined in Improving Lives (DWP, 2016).

Some staff also felt that other demographic characteristics (such as age) were important barriers. It was felt that older participants were harder to engage and motivate because they were too close to retirement age to view the pilot and employment as worthwhile, and age discrimination from employers was anticipated. Some staff questioned whether the pilot was an appropriate use of resources for such participants.

8.2 Referral timing

Linked to the findings above, some staff and participants questioned the timing of referrals, and suggested that this should be related more closely to a claimant's personal circumstances. Some participants indicated that their referral had come too soon and they were not well enough participate. In contrast, other participants indicated that they would have benefitted from an earlier referral to the pilot. A number of staff also noted that some participants had been left too long without any intervention. They believed that if support had been provided earlier, participants' barriers may have been less entrenched.

[64] JCP guidance states that claimants with a terminal diagnosis should not be referred to the pilot.

8.3 Pilot duration

Despite the two-year duration of the pilot, a number of staff reported that work and work-related outcomes were difficult to achieve for many participants within the timescale of the intervention. This was supported by data from the participant survey which found that only a minority of pilot participants had made job applications – 24 per cent on the JCP (Jobcentre Plus) pilot, and ten per cent on the WP (Work Programme) and HCP (Healthcare Provider) pilots[65] – and very few had entered paid employment – eight per cent from the JCP pilot, four per cent from the WP pilot and two per cent from the HCP pilot.[66]

Staff suggested this was due to the severity of participants' health conditions and/or to their perceived distance from the labour market. For some, this suggested a need for support beyond two years, with some staff noting the importance of recognising the need for long-term investment in the pilot group in order to ultimately achieve work outcomes. It was also suggested, however, that there were some pilot participants for whom full-time paid work may never be appropriate.

8.4 Performance targets and contract design

In line with views on participant characteristics and the achievability of outcomes within the timescale of the pilot, staff generally felt that the perceived lack of emphasis on work outcomes for this pilot was appropriate. Some staff within the WP and HCP pilots also suggested that the use of targets for the achievement of soft or intermediate, rather than purely job outcomes, might be appropriate. This was often linked to their views on the pilot funding models.

Most WP pilot providers felt that the payment by results funding model, based solely on job outcome payments, would not be sustainable for supporting the pilot group in the longer term, as so few participants would be able to achieve sustained work. Despite this, providers stated that this did not affect their delivery of support on this pilot. There was, however, some evidence that this was not always the case in practice. For example, findings presented in Chapter 2 give some indication that the payment model led to a focus on participants who were perceived to be closer to work in order to achieve job outcome payments. There was also some evidence of the way in which the WP performance target for ESA claimants in payment group 6 (PG6), appeared to have prioritised elements of enhanced service delivery (e.g. occupational health support) for this group, which was not available to pilot participants. This illustrates how performance targets for specific groups can drive provider behaviour.[67]

[65] At similar to levels to the control groups in each case.

[66] At similar levels to the control group except for the JCP pilot, where the figure of 8 per cent was higher than the 4 per cent seen for the control group, suggesting that the pilot may have had an impact on this.

[67] The Work Programme evaluation (DWP, 2014) also noted that the development of services for the ESA participant group appeared to be driven by factors such as performance management in relation to the target for PG6, rather than the programme payment model itself.

The payment model used in the HCP also appeared to have a clear impact on pilot delivery. The service fee based model paid the HCP providers for the delivery of a specified service (five appointments with a healthcare professional). Managers indicated that if a job outcome payment model had been used instead, this would likely have resulted in a different pilot design with additional employability provision. However, they also felt that the support needs of the pilot group, and their perceived distance from the labour market, required a funding model which included some element of service or attachment fee, in addition to outcome payments, to sustain delivery. This view was also echoed by WP pilot providers. Some also suggested that an outcome payment model which included the achievement of soft or intermediate outcomes, such as participants moving into voluntary work, might be appropriate.

These findings align with other research evidence on the impact that commissioning and funding models can have on the effectiveness of employment support for disabled people and those with health conditions.[68]

8.5 Delivery models

The evaluation captured details of pilot delivery models and staff and participant views on which types of support and delivery methods were most effective in moving participants towards or into work. Key findings on each of the pilot models are presented below, along with an overview of what were considered to be important features of effective delivery.

When considering the reported outcomes of each pilot it is important to bear in mind that the three pilots were established in different geographic areas and each had its own control group. This limits the extent to which conclusions can be drawn about the comparative effectiveness of each pilot, since labour markets in the three areas may vary, business as usual support may differ, and the pilot participants may also vary in some important respects. Indeed, baseline data indicated that those in scope of the JCP pilot were more likely to be undertaking work-related activities at the outset and tended to have higher qualifications than those in the other two pilots. This means that the positive findings from the JCP pilot could be interpreted either as an indication that the JCP pilot delivered more successful support than the WP and HCP pilots, or that the support delivered by the JCP pilot was more effective for participants who were closer to or more receptive towards work.

When considering the findings it is also important to keep in mind that, despite some indicators of successful impact (for the JCP pilot in particular), the majority of survey respondents across all three pilots felt that their health was a key barrier to them working and that the support provided had not helped them to move closer to work.

8.5.1 JCP pilot

The JCP pilot appeared to have some impact on the employment status of participants, with a small but significant difference between the proportion of JCP pilot and control group participants reporting that they were in paid work at the time of

[68] A discussion on the commissioning of this area of employment support can be found in Purvis, A., et al (2014) Op cit.

the survey (eight per cent, compared to four per cent). The JCP pilot also appeared to have some success in enabling participants to think more positively about work. Although the majority of participants considered that the support they received had *not* affected their motivation to leave ESA or to find work, the JCP pilot did have some effect. Thirty seven per cent of participants reported an increased motivation to leave ESA, compared with 28 per cent in the control group, and 38 per cent said they were more motivated to find work as a result of pilot support, compared with 27 per cent in the control group.

Chapter 5 showed that the JCP pilot delivered a wide range of work-focused support and that JCP pilot participants generally received or took up all forms of employment-related support in greater numbers than their comparable control group. In particular, 31 per cent of JCP pilot participants reported they had received help to apply for jobs, compared with 18 per cent in the control group, and 22 per cent of JCP pilot participants reported they had undertaken voluntary work as a result of support, compared with 12 per cent in the control group. This may reflect the additional time that JCP pilot work coaches were able to spend with participants, and/or may suggest that the JCP pilot work coaches were able to deliver more effective work-focused support, as compared to business-as-usual support.

Qualitative findings from the first wave of research suggested that the use of work coaches with previous ESA experience and/or health and disability specialisms and the use of specialist staff to support frontline delivery were particularly effective features of the JCP pilot. At Wave 1 in particular, JCP work coaches reported that they felt well-supported and received useful advice on supporting pilot participants from managers, peers (through case conferencing) and from specialists, such as Work Psychologists. However, at Wave 2 there appeared to have been a move to a more generalist model, with reduced specialist support. Work coaches also reported positively with regard to the flexibility they had to personalise support around participants' needs, and to seek out or adapt external provision at Wave 1, although this was somewhat curtailed by Wave 2.

8.5.2 WP pilot

Survey findings suggest that the WP pilot did not have a significant impact on work or work-related outcomes for participants. WP pilot participants were not significantly more likely than their control group counterparts to be in paid or voluntary work at the time of the surveys, or to say that the pilot had increased their motivation to leave ESA or to enter work.

Given that participant engagement levels in the WP pilot (in terms of frequency and duration of meetings) were higher than for their respective control group, the lack of reported work-related outcomes does not appear to reflect limited contact time with WP advisers, and may rather be related to the *nature* of support offered and/or participants' responses to it. Whilst WP delivery staff reported offering a wide variety of employment-related activities, the degree to which various elements of support were utilised by participants varied. For example support applying for jobs or developing a CV was commonly reported by WP pilot participants (44 per cent received this, which was significantly higher than among the control group), but voluntary work, for example, was reported much less frequently (taken up by only eight per cent, at a similar level to the control group).

Soft skills development activities, such as confidence building and group or social activities, were taken up more frequently by the WP pilot group (compared to the control group), and pilot staff suggested that this resulted in a range of soft outcomes, such as improvements in confidence, self-esteem, motivation and outlook. WP pilot staff also felt that this was reflected in changes to the extent, quality and content of participants' engagement with the programme over time. However, this level of engagement does not appear to have resulted in an enhanced motivation among pilot participants to find work or to leave ESA, as compared to the control group.

8.5.3 HCP pilot

Unsurprisingly given its delivery model, the main support activity reported by HCP pilot participants was practical help to manage their health condition or disability, both in general and in relation to work. This was reported much more frequently by the pilot group than their control counterparts (37 per cent compared to 19 per cent for help to manage their condition in general, and 35 per cent compared with 22 per cent for help to manage their condition in relation to work). Consequently, the HCP pilot was perceived by just over half of participants (54 per cent) to have had a positive impact on their ability to manage their health condition or disability. Qualitative findings suggest that participants who felt that the support had not helped them with this tended to have multiple or complex health conditions and felt that the type of support offered was not intensive or specialist enough to address their needs. The limited intensity and flexibility of the support (in terms of the appointment schedule and frequency) was also perceived to be problematic by pilot staff.

HCP pilot participants were, however, significantly less likely to receive most types of employment-related support than their respective control group (who received the standard Jobcentre Plus Offer support). For example, just five per cent of HCP pilot participants reported receiving support to write a CV or apply for a job, compared to 15 per cent in the control group. This low level of employment-related support was linked to the emphasis placed on delivering health-related support in the pilot. This is reflected in the finding that only around a fifth of participants (21 per cent) felt that the pilot had helped them move closer to work.

The limited delivery of employment-related support in the HCP pilot was in line with the views of the delivery staff regarding the aims of the pilot. They strongly believed that the goal of the pilot was to empower participants to take responsibility for their health and wellbeing in order that they could improve their quality of life. This was understood as enabling participants to start thinking about work, and to prepare them for moving into work at some time in the future but not necessarily within the timescale of the pilot.

The limited amount of employment support delivered was, however, perceived to be a key weakness by some pilot participants, in particular those who felt more work-ready. In some of these cases, participants reported undertaking work-related activity using their own initiative or with external help, unrelated to the pilot.

8.5.4 Key features of effective delivery models

Evidence from all three pilots indicated that effective employment support for the pilot group should take into account the health-related needs of participants and appropriately tailor the delivery of support. It is also important to utilise the skills and expertise of health professionals and specialist services, either directly for participants or to support the advisers working with them. However, findings from the HCP pilot also suggest a need to maintain an employment-related focus, as the limited amount of employment support received on this pilot was perceived to be a key weakness by some.

To meet the needs of the very diverse participant group, the evaluation also indicated that effective delivery must offer flexible and personalised support to take account of individual needs. This echoes the findings from other research studies in this area of employment support (DWP, 2016). This flexibility should include the timing, focus and intensity of support, the mode of appointments, the sequencing of support and access to a range of specialist services. Some staff also suggested the need for broad-based holistic support. Premises should be accessible and offer privacy where required, and home visits may be appropriate for some participants.

The extent to which in-work support was provided varied across the pilots, although in general it was fairly limited. Some participants who had entered work while on the pilot reported receiving insufficient transitional support to help them adjust to being in employment and to cope with any difficulties that arose at work. In some cases these participants subsequently left their employment. When considering future employment-related support for the pilot group, it is perhaps relevant to consider the design of the DWP specialist disability employment programme, Work Choice, which offers a considerable element of in-work support. This research suggests that more timely and intensive support from advisers and work coaches who were familiar with pilot participants and their circumstances may have helped to address the difficulties faced.

Finally, external partnerships were regarded as key to the effective delivery of pilot support, and limitations or inconsistencies in the available provision were cited as a key challenge. Access to further specialist support was important for many participants, in particular for those with learning difficulties.

8.6 Adviser capability and support

A key element of effective support in all three pilots was reported to be the development of positive one-to-one participant-adviser relationships. The importance of one-to-one support and the quality of the participant-adviser relationship are also cited as important within wider research relating to this area.[69] It has been found to be of '*vital importance'* across a range of types of DWP programmes[70], with Improving Lives (DWP, 2016) describing it as *'at the heart of each person's journey through the welfare system.'*

[69] For example, Hasluck, C. and Green, A. (2007) What works for whom? A review of evidence and meta-analysis for the Department for Work and Pensions
Purvis, A et al (2013) Evaluation of the Work Choice Specialist Disability Employment Programme

[70] DWP (2013) The disability and health employment strategy: the discussion so far

Within the pilots it was reported that time was needed to establish these working relationships effectively and that staff turnover could disrupt this. This was a particular problem for the HCP pilot where staffing was a key challenge during the early stages of implementation, although there were some challenges to the continuity of adviser support across the three pilots. Such challenges were typically due to ensuring adequate staffing levels so that caseloads remained manageable and so that staff had adequate time to spend with individual participants to build up a trusting relationship.

Having advisers with appropriate levels of skills and experience working with this participant group was also thought to be important to successful pilot delivery. In the JCP and WP pilots, which were delivered by employment advisers, access to specialist support from health professionals, such as Work Psychologists and occupational health practitioners, was valued, both for staff support and for direct support to pilot participants. In both of these pilots, the main complaint about pilot support reported by dissatisfied participants was that their work coach or adviser lacked empathy or understanding of their health condition or disability.

Staff delivering the pilots felt it was important to receive training, both in techniques for working with participants (with motivational interviewing thought to be particularly effective) and in respect to the health conditions and disabilities likely to occur among this participant group. In particular, staff from across the pilots felt that more training in mental health conditions would have been especially useful. Processes such as shadowing more experienced colleagues, case conferencing, and group supervision were felt to be effective mechanisms for frontline staff on the JCP and HCP pilots. When this support was reported to have diminished, e.g. during the second wave of interviews with JCP staff, it was viewed as a key challenge to effective delivery.

8.7 Provision of information

Participants and providers both articulated a need for improvements to the provision of information in a number of areas:

- At the point of referral, so participants were clear about what the pilot involved;
- In referral information, so that provider staff had a better understanding of participant background and support needs;
- From providers to participants, so participants were clearer about what support was available and what would be involved in the pilot; and
- At the point of handover from the pilot back to Jobcentre Plus, to facilitate appropriate follow-on support.

8.8 Organisational priority

Overall, the delivery of the pilot interventions in line with their original design was found to be subject to a range of factors, including competing demands within delivery organisations. The relative priority that organisations placed upon the delivery of the pilot appeared to be an important factor in determining successful implementation.

Within the JCP pilot, staff suggested that the pilot needed to sustain a higher organisational profile and priority in order to ensure resources and attention were not diverted to competing requirements. Within the WP and HCP pilots, organisational priorities appeared to be driven by contractual requirements, such as the achievement of funded outputs or outcomes or other contractual performance targets. It is important, therefore, to consider the potential impact of these factors, alongside the other key delivery findings outlined above, during the design and implementation of future interventions.

8.9 Summary

Across all the pilots, staff reported that the participant group had high levels of complex support needs and that it was inappropriate for some participants to be on the programme due to the severity of their conditions. This view was supported by the survey, which found that almost one third of pilot participants moved from the ESA WRAG to the Support Group during the pilot. This may suggest a need to review the assessment process for referral to employment support.

Staff also suggested that the severity of participants' health conditions and/or their perceived distance from the labour market meant that work and work-related outcomes were difficult to achieve within the two-year duration of the pilot. The participant survey found that only a minority of pilot participants had made job applications and very few (between two and eight per cent across the pilots) had entered paid employment. The majority of survey respondents across all three pilots felt that their health was a key barrier to them working and that the support provided had not helped them to move closer to work. The majority were, however, positive about the pilots overall, with over 80 per cent reporting a good or very good experience.

Overall, the JCP pilot appeared to have had some effect on employment outcomes – with eight per cent of participants in employment at the time of the survey, compared with four per cent in the control group – and to have had an effect on participants' motivation to find work and their readiness to work. The HCP pilot also appeared to have some effect on participants' motivation to leave ESA. The WP pilot did not appear to have an effect on these outcomes.

An exploration of delivery models identified a number of key features that were reported to be effective. The key lessons include:

- Support should consider participants' health-related needs and utilise specialist services as appropriate, whilst maintaining an employment-related focus.
- Support needs to be flexible and personalised to take account of diverse participant needs.
- The development and maintenance of positive and consistent one-to-one adviser-participant relationships is crucial.
- Advisers require appropriate levels of skills, experience and support when working with this participant group.
- Access to specialist support for adviser staff and for the direct support of participants is important and external partnerships can be an important route to facilitate this.

Generally, the pilots offered limited in-work support, which could have been useful for some participants. Participants and providers also articulated a need for improvements to the provision of information in a number of areas, such as at the point of referral.

Finally, the relative priority that organisations placed upon the delivery of the pilot appeared to be an important factor in determining successful implementation. Within the WP and HCP pilots this appeared to be driven by contractual requirements, such as the achievement of funded outputs, outcomes or other performance targets. It is important, therefore, to consider the potential impact of these factors during the design and implementation of future interventions.

Appendix A: Additional detail on research methodology

This appendix provides more detail on the research methodology of the evaluation, focusing primarily on the participant survey (including the CATI development process, fieldwork and data processing procedures for Waves 1 and 2 of the survey). Following a description of the sample design, discussion turns to the pilot, the main stage fieldwork period (including response rates) and finally data management (coding and editing, derived variables and weighting). A key to the district labels used for the reporting of the qualitative research is also included.

A.1 Sample and selection

The sample frame at Wave 1 included all ESA claimants recruited to the three pilots between November 2013 and December 2014. From this original sampling frame, three types of cases were removed: cases without at least one telephone number, cases that had already been selected for the piloting of the questionnaire, and cases where there was evidence that the claimant made a payment to one of the providers.[71] Following these removals, the total number of cases for the Wave 1 main stage survey included 10,529 individuals. A total of 2,575 individuals took part in the Wave 1 survey. These individuals provided the sample frame for the Wave 2 survey, excluding those who did not want to be re-contacted. Table A.1 shows how the sample was divided across the three pilot and control groups at each wave of the survey.

[71] We were advised by DWP to exclude these cases because this payment could signify contamination (e.g. people with a control group marker being referred to pilot provision).

Table A.1 Sample profile at Wave 1 and Wave 2

Sample type	Number of cases at Wave 1	Number of cases at Wave 2
HCP pilot	1,436	333
JCP pilot	1,921	455
WP pilot	1,998	187
HCP control	2,411	409
JCP control	1,735	578
WP control	1,028	405
TOTAL	**10,529**	**2,367**

A.2 Piloting the survey

A pilot survey was conducted at both waves in advance of the main stage fieldwork.

Wave 1 pilot

At Wave 1, the pilot served to test the questions themselves, the structure and flow of the questionnaire and its length. A random sample of 130 cases across treatment and control groups were selected. Consistent with the main stage fieldwork, all 130 cases were sent a letter to inform them about the research and give them the chance to opt out. The letters allowed for an eight day opt out period (see letter in Appendix C). A total of 36 individuals opted out of the survey during this period.

Following a face-to-face briefing led by the NatCen research team, pilot fieldwork was conducted over six days (14 August 2015 to 19 August 2015). Thirty-two pilot interviews were achieved.

Fieldwork was followed by a face-to-face debrief (20 August 2015) with five interviewers who had participated in the pilot. The structure of the questionnaire was generally seen to flow and to work well. Some questions were deleted to reduce repetition and to shorten the questionnaire, while the wording of other questions was refined.

Wave 2 pilot

The Wave 2 pilot was conducted to test any new questions, as well as the structure, flow, and questionnaire length. A total of 80 pilot cases were drawn: 28 were Wave 1 pilot respondents, and the remaining 52 cases were randomly selected Wave 1 main stage respondents.[72] As with the main stage fieldwork, these individuals were sent an advance letter to remind them about the research and the opportunity to take part in a follow-up interview (see letter in Appendix C).

[72] Only those that agreed to be re-contacted (at the Wave 1 pilot or main stage) were selected.

Pilot fieldwork ran from 10 June 2016 to 21 June 2016. Fieldwork continued after the target number of interviews (n = 20) was achieved in an attempt to interview participants in employment. In total, 38 pilot interviews were achieved, one of which was with a respondent in employment.

The face-to-face pilot debrief with four interviewers indicated that the structure and content of the survey was working well, including the new questions, and only minor revisions were required. The interview length was also as per the target (20 minutes on average).

A.3 Fieldwork

A.3.1 Briefing and interviewer numbers

At Wave 1 and Wave 2, all survey interviewers received a face-to-face briefing from a member of the NatCen research team or a senior member of the NatCen Telephone Unit.[73] Briefing materials were developed by the NatCen research team. Each briefing included an introduction to the study and the policy background, guidance on making contact with respondents, and information on introducing and conducting the interviews. Interviewers were also taken through a practice version of the CATI, to familiarise themselves with the questions and survey routing.

A.3.2 Fieldwork quality control procedures

Throughout fieldwork, interviewer performance was closely monitored. At least one senior member of the telephone unit was present when interviewing was taking place, which meant that there was an ongoing process of reinforcement of the basic principles of good interviewing practice.

A.4 Response

Response rates by sample type at Wave 1 are summarised in Table A.2. The overall response rate at Wave 1 was 24 per cent of the original sample, 29 per cent of those with valid contact details, and 44 per cent of those who were contacted by an interviewer.

73 Half of the Wave 1 fieldwork was sub-contracted to the market research company QRS. Quality control processes and procedures were built into the contractual agreement with QRS, so QRS interviewers were accountable to the same standards as NatCen interviewers. All QRS interviewers were briefed using materials provided by the NatCen research team, and the initial QRS briefings were led by the NatCen research team. There were checks to ensure consistency across the QRS and NatCen telephone units, with close collaboration between the two teams.

Table A.2 Wave 1 response rates by sample type

Sample type	HCP pilot	JCP pilot	WP pilot	HCP control	JCP control	WP control	TOTAL
			Percentage				
Productive	25	26	17	22	27	26	**24**
Partially productive	0	0	0	0	0	0	**0**
Refusal prior to interview	25	22	38	24	16	18	**23**
Other refusal[74]	16	19	14	16	17	17	**17**
Direct contact, but unproductive[75]	14	15	12	13	15	14	**14**
No direct contact[76]	20	19	19	24	24	25	**22**

The overall response rate at Wave 2 was 65 per cent of the original Wave 2 sample, 66 per cent of those with valid contact details, and 86 per cent of those who were contacted by an interviewer. Wave 2 response rates by sample type are detailed in Table A.3.

[74] 'Other refusal' includes refusal by proxy and those who refused because they were not available during fieldwork. This is the same for the Wave 1 and Wave 2 response rates.

[75] 'Contact, but unproductive' includes those where there were language barriers; the respondent was unwell; the respondent was away from home; or the respondent was physically or mentally unable to take part. This is the same for the Wave 1 and Wave 2 response rates.

[76] 'No direct contact' includes those where the phone number was disconnected; contact could only be made with a fax/modem; or it was a wrong number. This is the same for the Wave 1 and Wave 2 response rates.

Table A.3 Wave 2 response rates by sample type

Sample type	HCP pilot	JCP pilot	WP pilot	HCP control	JCP control	WP control	TOTAL
			Percentage				
Productive	68	67	69	62	64	64	**65**
Partially productive	0	0	0	0	0	0	**0**
Refusal prior to interview	0	0	0	0	0	0	**0**
Other refusal	8	9	9	9	10	11	**9**
Direct contact, but unproductive	2	1	1	1	1	1	**1**
No direct contact	22	21	21	28	25	25	**24**

A.5 Coding and editing

The CATI programme ensures that the correct routing is followed throughout the questionnaire, and applies range and consistency error checks. These checks allow interviewers to clarify and query any data discrepancies directly with the respondent. A separate 'in-house' editing process was also used, which covered some of the more complex data checking, combined with a coding process for open answers.

The data was coded by a team of coders under the management of the NatCen Operations team. The NatCen research team provided a set of coding and editing instructions for coders, which included guidance on 'other' responses, open questions and SIC/ SOC coding. Coders reviewed all 'other' responses entered in the CATI programme to check if they could be back coded into existing codes, or whether they needed to be assigned to a new code identified by the research team. The code frames for the open questions were developed by the researchers based on verbatim responses from some of the first completed interviews. Where a respondent gave details of their employment and employer, it was coded to the Standard Occupation Classification (SOC) 2010 at the four digit level, and to Standard Industrial Classification (SIC) 2007 at the two digit level.

A.6 Derived variables

Because the final data was the product of a complex CATI programme, some variables needed for analysis had to be recoded or created by combining existing variables.

Derived variables used in the analysis fall into the following types:

1. Key demographic variables, which were grouped into categories for ease of analysis (e.g. age and qualification levels).

2. Those combining responses from a number of different variables to create a particular measure (e.g. combining responses to questions about types of support to measure whether support was not discussed, discussed and received, discussed but not received, or discussed and received as a result of the discussion with the adviser).

A.7 Weighting

A.7.1 Opt-out weights at Wave 1

The sampling frame for the main stage Wave 1 survey included 10,529 cases eligible for issue. A significant proportion opted out from the study (23.3%), leaving 8,081 in the sample. It was reasonable to assume that people who opted out might be systematically different from those who did not opt out from the study. We used information available on the sampling frame to check this hypothesis, including information related to the study design (e.g. whether the participant was in the pilot or control group, the stage of the programme, provider name) and participant characteristics (age, gender, district, health status). The variables that were significant in the bivariate analysis were entered into a logistic regression that modelled the relationship between an outcome variable (in this case whether issued or opted out) and a set of predictor variables. Variables found to predict respondents' behaviour were:

- Age and gender of respondent (10 categories)
- Stage of support (mid/ end) (2 categories)
- Pilot/ control allocation (6 categories)
- Health status (3 categories).

The model generated a predicted probability for each respondent. This is the probability the respondent would not opt out from the study, given the characteristics listed above. Respondents with characteristics associated with opt-out (such as older age groups) were under-represented in the sample and therefore received a low predicted probability. The non-response weights were then generated as the inverse of the predicted probabilities: respondents who had a low predicted probability got a larger weight, increasing their representation in the sample. Application of the weights to the sample issued at Wave 1 makes it representative of the full sample, including opt-outs, with regards to the characteristics included in the model.

A.7.2 Non-response weight at Wave 1

A similar model-based weighting technique was used to develop the Wave 1 non-response weights. Response behaviour at Wave 1 was modelled using data from the sampling frame, since data for both respondents and non-respondents were needed.

Only eligible cases were entered into the model (7,404). 2,575 respondents completed the interviews (34.8%), and these respondents were compared to those who completed the interview only partially, refused to take part in the study, whose eligibility was unknown or did not take part in the study for any other reason (other than ineligibility). A similar process was then followed as for the opt-out weights,

differing only in the application of opt-out weights to the non-response model (in order to remove the bias that could be accounted for by the opt-out weights). The variables that were significant in the bivariate analysis were entered into a logistic regression that modelled the relationship between an outcome variable (in this case response behaviour at Wave 1) and a set of predictor variables. Variables found to predict respondents' behaviour were:

- Age and gender of respondent (10 categories)
- Provider's name (5 categories)
- Health status (3 categories).

The resulting non-response weights were trimmed to remove outliers.

The final Wave 1 weight applied was the product of the opt-out weight and non-response weight at Wave 1. Application of the weights to the Wave 1 respondents makes the achieved sample representative of the sampling frame (i.e. the full sample including those who opted-out before Wave 1 fieldwork and those who did not respond) with regards to the characteristics included in the models at both stages of the weighting.

A.7.3 Non-response weight at Wave 2

The sample frame for the Wave 2 survey was those who had taken part in the Wave 1 survey and given permission to be re-contacted. A small minority of respondents (73) had passed away between the two waves of the survey and were removed from the sample frame. 2,502 cases were subject to non-response modelling at Wave 2. 1,540 interviews were completed at Wave 2 (61.6%).

A similar model-based weighting technique was used to develop the Wave 2 non-response weights. However, due to the longitudinal design of the study, we were able to use additional information collected from respondents at Wave 1, which, combined with information from the sampling frame, was used to predict response behaviour at Wave 2. A number of variables were considered as potential predictors of non-response. The following were found to be significant in the logistic regression model:

- Age and gender of respondent (10 categories)
- Whether in the treatment or control group (2 categories)
- District (14 categories)
- Ethnicity (2 categories)
- Tenure status (2 categories)
- Rating of their experience on the pilot (5 categories).

This means that these variables were (at least partially) responsible for the bias introduced by non-response at Wave 2.

The final Wave 2 longitudinal weight is the product of the Wave 2 non-response weight and the Wave 1 weight. The longitudinal weight corrects for any measurable differential non-response at Wave 2 and Wave 1, aligning the Wave 2 respondents' profile with the profile of the sample eligible for issue at Wave 1 (on the variables used in weighting). It was applied for analysis of responses at both Wave 1 and Wave 2.

A.7.4 Sample efficiency of data

Adding weights to a sample can affect the sample efficiency. If the weights vary greatly (i.e. they have very high and/or very low values) the weighted estimates will have a larger variance. More variance means standard errors are larger and confidence intervals are wider, so there is less certainty over how close the estimates are to the true population value.

The effect of the weighting on the precision of survey estimates is indicated by the effective sample size (neff). The lower the effective sample size, the lower the level of precision. The efficiency of a sample is given by the ratio of the effective sample size to the actual sample size. The range of the weights, the effective sample size and sample efficiency for both sets of weights are given in Table A.4.

Table A.4 Range of weights and sample efficiency

	N	Minimum	Maximum	Mean	Neff	Efficiency
weight_W1 Non-response weight at Wave 1	2575	0.65	2.10	1.00	2499	97%
weight_W2 Non-response weight at Wave 2	1540	0.57	2.38	1.00	1446	94%

A.8 Qualitative research: District key

Table A.5 provides a key to the district labels used for reporting the qualitative research sample in Chapter 2.

Table A.5 District Key

District Number	District Name
Jobcentre Plus pilot	
District 1	Avon, Severn and Thames District
District 2	Devon, Cornwall and Somerset
District 3	Greater Wessex
District 4	Berkshire, Surrey and Sussex
HCP Pilot	
District 11	Black Country
District 12	Derbyshire
District 13	Leicestershire and Northamptonshire
District 14	Lincolnshire, Nottinghamshire and Rutland
District 15	Staffordshire and Rutland
WP pilot	
District 21	Durham and Tees Valley
District 22	North East Yorkshire and the Humber
District 23	Northumberland, Tyne and Wear

Appendix B: Exploratory quantitative analysis

This appendix describes the results from an exploratory analysis which examined change in responses over time from Wave 1 to Wave 2. The small sample size of participants responding to these questions in both waves of the survey means that the findings from this analysis are tentative.

B.1 Change in the nature of appointments between pilot and post-pilot support

Exploratory analysis to investigate change in the nature of appointments between pilot and post-pilot support was carried out. The aim of this analysis was to facilitate a better understanding of the transition from pilot to post-pilot support in terms of the mode, frequency and duration of appointments. Multinomial logistic regression modelling, including exploration of relative change[77], showed that appointment attributes did not change greatly in the transition from pilot to post-pilot support. However, due to small sample sizes of participants who completed both the Wave 1 and Wave 2 surveys, these findings are tentative.

The main finding was that participants generally reported shorter appointments after the pilot, but most appointments were still delivered face-to-face. Similar proportions reported either less frequent or the same frequency of appointments after the pilot:

- **Duration of appointments –** the majority of participants (78 per cent) reported the same or shorter appointments in Wave 2 compared to Wave 1. Amongst JCP pilot participants, 45 per cent reported the typical appointment duration as approximately the same between waves, compared to 32 per cent who reported that appointments were typically shorter in Wave 2 than Wave 1.
- **Mode of delivering appointments –** most participants (94 per cent) had appointments via the same mode (comparing face-to-face appointments with other modes) at Wave 2 as at Wave 1.[78] This was the case for each of the three pilots.
- **Frequency of appointments –** more than two-fifths (45 per cent) of participants across the three pilots reported less frequent appointments at Wave 2 compared to Wave 1, while a similar proportion (42 per cent) reported the same frequency of appointments at Wave 1 and Wave 2. However, HCP participants received more frequent appointments during post-pilot support than in the other two pilots

[77] Multinomial logistic regression is fitted when the dependent variable (change variable in this setting) is nominal. Relative Risk Ratios (RRR) were calculated. A RRR here is the ratio of the probability of being in a group, to the probability of being in a comparison group.

[78] 'Face-to-face' appointments were defined as having the appointment either at the provider's office, at the participant's home or in another venue. 'Other modes' primarily included telephone calls.

(21 per cent on the HCP pilot reported that appointments were more frequent; this was 8 per cent on the JCP pilot and 13 per cent on the WP pilot). This reflects the fact that appointments were relatively infrequent on the HCP pilot.

B.2 Change in health-related and work-related outcomes over time

An investigation into the change in work-related and health-related outcomes between Wave 1 and Wave 2 was undertaken. The analysis considered differences between the pilot and control group for each pilot and whether being in the pilot group increased the likelihood of a change in outcome between waves.[79]

Logistic regression analysis showed that the majority of participants across the three pilots reported the same health-related and work-related outcomes over time, and there was no strong evidence to support an association between change in perceived physical or mental health condition status over time and participation in the pilots.[80]

Neither was there strong evidence to support an association between participating in the pilot and a change in levels of happiness and anxiety from Wave 1 to Wave 2. Thus, the transition from more intensive pilot support to standard Jobcentre Plus support does not appear to have led to lower levels of happiness or increased levels of anxiety.[81]

Finally, there was also no strong evidence to support an association between changes in work-related activity between the two surveys and pilot participation.[82]

[79] It should be borne in mind that the Wave 1 survey was not a baseline measure but was carried out when participants were 15 to 24 months into the pilot. The Wave 2 survey was carried out when the majority of respondents had exited the pilot and moved back on to standard JCP support.

[80] The following categories were used: mental health condition status (including depression, anxiety, fatigue or memory loss); other mental health condition status (including learning disabilities but excluding depression, anxiety, fatigue or memory loss); and physical health condition status. Change was defined with a binary indicator (no change in status was used as the reference group in modelling).

[81] Four questions were selected for investigation: “Overall, to what extent do you feel the things you do in your life are worthwhile?”, “Overall, how satisfied are you with your life nowadays?”, “Overall, how anxious did you feel yesterday?”, and “Overall, how happy did you feel yesterday?”. Participants answered questions on a scale from zero to ten. This was dichotomised into the region zero to three and four plus, to explore the proportion reporting the most negative feelings or low levels of anxiety.

[82] The outcomes considered here were “Are you doing voluntary or other unpaid work (full-time or part-time)?”, “Are you in education or training?” and “Are you not working because of sickness or disability?”.

Appendix C: Research tools

C.1 Survey instrument

Wave 1 Survey Questionnaire

SAMPLE FILE VARIABLES

Startdate

Start date on programme

Group

Programme type

1. HCP
2. WP
3. JCP
4. HCP control
5. WP control
6. JCP control

Month (derived variable)

Month from start date

NOTE: At all questions the interviewer can record Don't know or Refusal to answer unless it states NODK/NOREF

SECTION A: Introduction

IntroQ

INTERVIEWER - INTRODUCE SURVEY

Good morning/ afternoon / evening, my name is.... I'm calling from NatCen Social Research. We have been asked to carry out a survey about the services and support provided via [Jobcentre Plus / WP Provider / HCP Provider]. You should have recently received a letter from us about this survey. The survey is designed to get some feedback on the support and advice you've received since you've been claiming ESA which will help DWP and Jobcentres improve the services they provide.

IF SAY NO LONGER RECEIVING ESA: Even though you are no longer receiving Employment Support Allowance we would still like to speak to you about your experience whilst you were on ESA.

Although the Department for Work and Pensions have asked us to carry out this research, I am working for a research institute that is completely impartial and separate from the Government.

Just to be clear, nothing that we ask you about will affect your benefits or the support you receive in any way, now or in the future. Your answers will be treated in strict confidence by the evaluation team. We will use the information you and others give us to produce statistics on what everyone has said. This will help DWP to understand the way in which people have been supported and may help to make improvements.

Your participation will be anonymous. This means we will not pass on any names to DWP or anything that could identify you. The report we write will not include any names and it will not be possible for anyone else to tell that you have taken part.

INTERVIEWER: CODE WHETHER CONSENT GAINED:

1. Yes
2. Make an appointment to call back
3. No – THANK AND END

SECTION B: Details of the support received under JCP, HCP and WP pilots [Do NOT ask control groups]

SECTION C: Attitudes to work and work-related activities [Ask all six groups]

SECTION D: Current activity at interview [Ask all six groups]

SECTION E: Background info [Ask all six groups]

SECTION B: Details of the support received under HCP, WP and JCP pilots

AIMS

This section asks about

- Nature of the support provided, including frequency of contact, length of each session and type of advice and support
- Referrals or signposting to other organisations and the type of support provided by these organisations
- Reasons for any non-attendance at meetings/appointments
- Views on most helpful aspects of support and views on what could be improved

HCP, JCP and WP only (do not include controls)

{ASK IF HCP, WP or JCP}

BAnyCon

Have you had any contact with [HC Provider/WP Provider/Jobcentre Plus] since

INTERVIEWER NOTE: IF PARTICIPANT DOESN'T RECOGNISE PROVIDER NAME, DESCRIBE AS 'THE ORGANIZATION THAT THE JOBCENTRE WOULD HAVE REFERRED YOU TO FOR SUPPORT WHILST YOU ARE ON ESA'

[TEXTFILL: Month of pilot start]?

1. Yes
2. No

{If BAnyCon =2, No, don't know}

BAnyConCk

ADD IF NECESSARY: You might have received a letter or a phone call from someone offering you some advice and support in relation to health and work. It would have been around [Month]. Do you recall this?

1. Yes
2. No

{If BAnyConCk=2, No}

INTERVIEWER: THANK RESPONDENT AND CLOSE INTERVIEW

{If BAnyCon =1, Yes or BAnyConCk=1}

BAnyApp

And have you had any appointments with [HC Provider/WP Provider/Jobcentre Plus] since [TEXTFILL: Month of pilot start]?

1. Yes
2. No

{If BAnyApp= 2, No]

BAnyAppCk

ADD IF NECESSARY: The appointments would have been about your health and the possibility of moving towards to work. Do you recall having any appointments like this since [TEXTFILL: Month of pilot start]?

1. Yes
2. No

{BAnyAppCk= 2, no}

BWhyNoApp

After [HC Provider/WP Provider/Jobcentre Plus] contacted you, why did you not have any appointments? READ OUT

MULTICODE

1. Nobody mentioned arranging an appointment
2. You couldn't see how the appointments were relevant to you so you decided not to go
3. You were no longer receiving ESA
4. Your health wasn't good enough
5. You weren't going to look for work (for another reason)
6. Another reason, specify

7. NOT READ OUT: No particular reason

{If BWhyNoApp=6, another reason}

BNoAppOth

INTERVIEWER: PROBE AND RECORD.

{BWhyNoApp = ANY}

THANK RESPONDENT AND CLOSE INTERVIEW

{If BAnyApp =1, Yes or BAnyAppCk= 1, yes}

BMandat

Did your adviser tell you that you **had to** attend further meetings about work and health with [HC Provider/WP Provider/Jobcentre Plus] as part of your claim for benefits?

1. Yes – told **had to attend**
2. No

{If BAnyApp =1, Yes or BAnyAppCk= 1, yes }

BNumbApp

How many appointments have you had with [HC Provider/WP Provider/Jobcentre Plus] since [TEXTFILL: Month of pilot start]?

ADD IF NECESSARY: IT DOESN'T MATTER IF YOU CAN'T REMEMBER EXACTLY.
INTERVIEWER: PROBE FOR NUMBER AND RECORD

{If BAnyApp =1, Yes or BAnyAppCk= 1, Yes }

BAppLoc

Where did the appointments with [HC Provider/ WP Provider / Jobcentre Plus] take place?

MULTICODE

1. At the their office
2. At your home
3. Another venue
4. Over the phone

{If BNumbApp =>1}

BAppFreq1

How often did you have appointments (either face-to-face or on the phone) with a [HC Provider/ WP Provider / Jobcentre Plus] adviser… READ OUT …

1. About once a week
2. About once a fortnight
3. About once a month
4. About once every two months
5. Less than once every two months

{If BAppFreq1 = 5, Less than once every two months}

BAppFreqYr

How many appointments (either face-to-face or on the phone) with a [HC Provider/ WP Provider / Jobcentre Plus] adviser did you have in a year?

INTERVIEWER: RECORD NUMBER

{If BAnyApp =1, Yes or BAnyAppCk= 1, Yes}

BAppFreq2

Since [TEXTFILL: Month of pilot start], have appointments always been [TEXTFILL: response to **BAppFreq1]** or has the frequency of appointments changed? READ OUT:

1. Yes, always been [TEXTFILL: response to **BAppFreq1]**
2, Appointments were more frequent at the start
3, Appointments have been more frequent recently
4, DO NOT READ OUT: Other (Please specify: INTERVIEWER RECORD VERBATIM)

{If BAnyApp =1, Yes or BAnyAppCk= 1, Yes}

BLong

Thinking about the appointments (either face-to-face or over the phone) you have had with [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus], how long did the meetings usually last?

INTERVIEWER CODE IN MINUTES. CODE 888 IF VARIES

[SOFT CHECK IF INTERVIEWER ENTERS >240 MINUTES]**{Ask for HCP claimants only}**

BTypeHCP

What type of healthcare professional did you normally meet with:

1. Occupational therapist
2. Physiotherapist
3. Psychologist
4. Nurse
5. Other, please specify

{ASK IF BTypeHCP=4, other}

INTERVIEWER RECORD

{ASK IF HCP, WP or JCP}

BCheck

Can I check, before you started to attend appointments at [HC provider/WP Provider/ Jobcentre Plus] what did you think would happen to your benefits if you did not do what was asked of you?

DO NOT READ OUT.

IF STOPPED: Is that stopped temporarily or permanently?

IF REDUCED: Is that reduced temporarily or permanently?

1. Benefit stopped temporarily
2. Benefit stopped permanently
3. Benefit reduced temporarily
4. Benefit reduced permanently
5. Something else
6. Nothing

{If BAnyApp=1, yes or BAnyAppCk= 1, Yes }

BAppContx

I'd now like to ask about what you discussed during the appointments.

I realise it may be difficult to remember the details, but {If BNumbApp=1: we'd really appreciate if you could think back to the types of things you talked about during your appointment with [HC Provider/ WP Provider / Jobcentre Plus] / If BNumBapp = >1: we'd really appreciate if you could think back to the types of things you talked about during your most recent appointment with [HC Provider/ WP Provider / Jobcentre Plus]}. What you tell us about the advice and support you have received will be held in the strictest confidence. The research findings will not identify you and no personal information will be shared with any third parties.

BAppContDis

I am now going to read out some of the types of topics that you might have discussed during the appointments. Which of the following topics did you discuss during your {TEXTFILL: your appointment/your most recent appointment} with [HC Provider/ WP Provider / Jobcentre Plus]?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY

SINCE [MONTH], HAVE YOU DISCUSSED

1. How your health/disability impacts on your ability to work
2. How your health/disability impacts other areas of your life
3. Training or college courses
4. Voluntary work options
5. Work experience
6. Physiotherapy sessions
7. Doing more exercise e.g. at local gym
8. Pain management or relief training
9. Counselling or cognitive behavioural therapy
10. Relaxation sessions
11. Building confidence, being assertive

12. Support groups for specific health conditions e.g. mental health support group
13. Social or group activity e.g. walking groups
14. Addiction services
15. Job interviews
16. Looking for work
17. The financial impacts of getting a paid job
18. Applying for jobs or writing a CV
19. Other (Specify)

{IF BAppContDis = ANY}

BAppContDisOther

Are there any other topics you discussed with [HC Provider/ WP Provider / Jobcentre Plus] that were not mentioned?

CODE ALL THAT APPLY

1. Benefits
2. Money or debt
3. Healthier lifestyle
4. Equipment or adaptations
5. Family issues
6. Other (Specify)

{IF BAppContDis = ANY}

BAppContSupp

I am now going to read out some of the activities you might have undertaken or practical help or advice that you might have received as a result of your recent discussions/appointments with [HC Provider/ WP Provider / Jobcentre Plus]. Have you received or taken part in any of the following?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.CODE ALL THAT APPLY

SINCE [MONTH], HAVE YOU HAD ADVICE OR SUPPORT WITH

1. Received practical help to manage your condition/disability
2. Attended training or college courses
3. Participated in voluntary work e.g. for a charity
4. Participated in some unpaid work experience
5. Attended physiotherapy sessions
6. Attended exercise sessions e.g. at gym
7. Attended pain management sessions
8. Received counselling or cognitive behavioural therapy
9. Attended relaxation sessions

10. Attended self-help groups
11. Attended confidence building or assertiveness sessions
12. Support groups for specific health conditions e.g. mental health support group
13. Attended social or group activity e.g. walking groups
14. Attended addiction services,
15. Received support to look for jobs
16. Received support in preparing for job interviews
17. Produced a CV or applied for jobs
18. Other, please specify.

{Ask if BAppContSupp=2, attended training or college courses}

TrainCollNo

How many training or college courses did you attend?

INTERVIEWER: RECORD

{Ask if BAppContSupp=2, attended training or college courses}

TrainCollTyp

Please could you tell me what each of these training or college courses were about?

Training or college courses 1:

Training or college courses 2:

Training or college courses 3:

Training or college courses 4:

Training or college courses 5:

{IF BAppContDis = ANY}

BAppContSuppOth

Are there any other forms of advice, activities or practical help you have received or taken part in that were not mentioned?

INTERVIEWER: PROBE FULLY, ASK IF ANYTHING ELSE THAT HASN'T BEEN MENTIONED

CODE ALL THAT APPLY

1. Received advice or support with benefits
2. Received advice or support with money or debt
3. Received advice or support with healthier lifestyle
4. Received advice or support equipment or adaptations
5. Received advice or support with family issues
6. Other (Specify)

{If BNumbApp=>1}

BAppContPrevDis

Thank you for telling me about your most recent appointment. I'd also like to ask you about your previous appointments with [HC Provider/ WP Provider / Jobcentre Plus] to get a full picture of all the support you have received. Thinking back to previous appointments since [Month] which of the following topics did you discuss?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY

SINCE [MONTH], HAVE YOU HAD DISCUSSED

1. How your health/disability impacts on your ability to work
2. How your health/disability impacts other areas of your life
3. Training or college courses
4. Voluntary work options
5. Work experience
6. Physiotherapy sessions
7. Doing more exercise e.g. at local gym
8. Pain management or relief training
9. Counselling or cognitive behavioural therapy
10. Relaxation sessions
11. Building confidence, being assertive
12. Support groups for specific health conditions e.g. mental health support group
13. Social or group activity e.g. walking groups
14. Addiction services
15. Job interviews
16. Looking for work
17. The financial impacts of getting a paid job
18. Applying for jobs or writing a CV
19. Other (Specify)

{If BNumbApp=>1}

BAppContPrevDisOth

Are there any topics you discussed that were not mentioned?

CODE ALL THAT APPLY

1. Benefits
2. Money or debt
3. Healthier lifestyle
4. Equipment or adaptations
5. Family issues
6. Other (Specify)

{If BNumbApp=>1}

BappContPrevSupp

Thinking back to previous appointments with [HC Provider/ WP Provider / Jobcentre Plus] since [Month] what types of activities, practical help or advice have you received or taken part in of the following….

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY

1. Received practical help to manage your condition/disability
2. Attended training or college courses
3. Participated in voluntary work e.g. for a charity
4. Participated in some unpaid work experience
5. Attended physiotherapy sessions
6. Attended exercise sessions e.g. at a gym,
7. Attended pain management sessions,
8. Received counselling or cognitive behavioural therapy
9. Attended relaxation sessions
10. Attended self-help groups
11. Attended confidence building or assertiveness sessions
12. Support groups for specific health conditions e.g. mental health support group
13. Attended social or group activity e.g. walking groups
14. Attended addiction services,
15. Received support to look for jobs
16. Received support in preparing for job interviews
17. Produced a CV or applied for jobs
18. Other, please specify.

{Ask if BappContPrevSupp=2, attended training or college courses}

TrainCollNo2

How many training or college courses did you attend?

INTERVIEWER: RECORD

{Ask if BappContPrevSupp=2, attended training or college courses}

TrainCollTyp2

Please could you tell me what each of these training or college courses were about?

College or training courses 1:

College or training courses 2:

College or training courses 3:

College or training courses 4:

College or training courses 5:

{If BNumbApp=>1}

BappContPrevSuppOth

Are there any other forms of advice, activities or practical help you have received or taken part in that were not mentioned?

CODE ALL THAT APPLY

1. Received advice or support with benefits
2. Received advice or support with money or debt
3. Received advice or support with healthier lifestyle
4. Received advice or support equipment or adaptations
5. Received advice or support with family issues
6. Other (Specify)

{If BNumbApp=>1}

BHlpHealth

Have your appointments [HC Provider/ WP Provider / Jobcentre Plus] and any follow up support or activities helped you to manage your health condition/disability?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

1. Yes- a lot of help
2. Yes- a little help
3. No

{If BHlpHealth=3, No}

BHlpHealthUnhelp

Why do you think your appointments [HC Provider/ WP Provider / Jobcentre Plus] and any follow up support or activities did not help you to manage your health condition/ disability?

1. The timing of the support was wrong
2. The appointments were too far apart
3. The appointments were too close together
4. Adviser did not understand your needs
5. Adviser did not have the right skills / expertise
6. The support did not meet your needs
7. You did not need help to manage your condition / disability
8. Other (please specify)

{If BNumbApp=>1}

BHlpWork

Have your appointments [HC Provider/ WP Provider / Jobcentre Plus] and any follow up support or activities helped you to move toward work?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

1. Yes- a lot of help
2. Yes- a little help
3. No

{If B BHlpWork=3, No}

BHlpWorkUnhelp

Why do you think your appointments and any follow up support or activities from [HC Provider/ WP Provider / Jobcentre Plus] did not help you to move toward work?

1. The timing of the support was wrong
2. The appointments were too far apart
3. The appointments were too close together
4. Adviser did not understand your needs
5. Adviser did not have the right skills / expertise
6. The support did not meet your needs
7. You did not need help to manage your condition / disability
8. Other (please specify)

{If BHlpHealth = 1, 2 or BHlpWork = 1,2}

BMstHlp

Thinking about the period since [MONTH], of all the help that you have received [HC Provider/WP Provider/Jobcentre Plus] which do you think have been the most helpful to you?

INTERVIEWER PROBE FULLY: What else has been helpful to you?

CODE UP TO 4 OPTIONS. IF MORE THAN 4, CODE THE FIRST 4 TO APPLY.

[Response list: include any coded at **BAppContSupp and BAppContPrevSupp**

17. Can't say which is most effective
18. None of these

{If BHlpHealth = 1, 2 or BHlpWork = 1, 2}

BHowHelpful

In what way has [TEXTFILL: Response 1 to BMstHlp] been helpful?

1. In managing my health condition / disability
2. In moving towards work
3. In general
4. Other (please specify)

{If BHowHelpful = 3, in general}

BHowHelpfulBen

What other benefits have you experienced as a result of [TEXTFILL: Response 1 to BMstHlp]?

INTERVIEWER: RECORD VERBATIM

TEXTLOOP: Ask question BHowHelpful and BHowHelpfulBen for all responses listed in BMstHlp

{If BAnyApp =1, Yes or BAnyAppCk= 1, Yes }

BMiss

Did you ever miss an appointment or appointments that they had arranged?

1. Yes
2. No

{IFBMiss=1, yes}

BMissWhy

I am going to read out some possible reasons for missing an appointment or appointments. Please tell me which apply to you. READ OUT

MULTICODE

1. You were not **told** you had to go
2. You were no longer receiving ESA
3. The appointment was cancelled
4. Your health wasn't good enough/you were unwell on the day of the appointment
5. You weren't going to look for work (for another reason)
6. It was too far or inconvenient
7. You agreed to speak over the phone instead of a face-to-face appointment.
8. Another reason
9. NOT READ OUT: No particular reason

{If BAnyApp =1, Yes or BAnyAppCk= 1, Yes }

BRef

As part of the support you are receiving, advisers can refer ESA claimants to other organisations or services for further help. For example, mental health services, CAB, self-help groups, debt advice. Can I just check did your adviser suggest or refer you to any other organisations or services?

1. Yes
2. No

{IF BRef =1, yes}

BRefFollow

And were you in touch with these organisations or services after your adviser told you about them?

1. Yes
2. No

{IF BRefFollow = 1, Yes}

BProNumb

Roughly, how many other organisations or services did you have help from?

ADD IF NECESSARY: IT DOESN'T MATTER IF YOU CAN'T REMEMBER EXACTLY

INTERVIEWER: RECORD

{IF BProNumb=any}

BProvName

Please could you tell me their name/s {[**IF BProNumb >3]** Could I ask you to think of the three organisations or services that you were most frequently in contact with for the following questions}

INTERVIEWER: THIS WILL BE USED IN TEXTFILLS.

IF NOT SURE OF NAME, ASK FOR TYPE OF SERVICE PROVIDED.

Organisation / service 1:

Organisation / service 2:

Organisation / service 3:

INTRO: Please think of the advice and support you received from [TEXTFILL: Organisation / service 1] for the following questions.

{BProvName = 1/2/3, organisation/service 1/2/3}

BProvCont

What sort of help did you receive or take part in from [TEXTFILL: Organisation / Service 1]?

SPONTANEOUS

MULTICODE

1. Received practical help to manage your condition/disability
2. Attended training or college courses
3. Participated in voluntary work e.g. for a charity
4. Participated in some unpaid work experience
5. Attended physiotherapy sessions
6. Attended exercise sessions e.g. at a gym
7. Attended pain management sessions
8. Received counselling or cognitive behavioural therapy
9. Attended relaxation sessions
10. Attended self-help groups
11. Attended confidence building or assertiveness sessions

12. Support groups for specific health conditions e.g. mental health support group
13. Attended social or group activity e.g. walking groups
14. Attended addiction services,
15. Received support to look for jobs
16. Received support in preparing for job interviews
17. Produced a CV or applied for jobs
18. Other, please specify.

{Ask if BProvCont =2, attended training or college courses}

TrainCollNo3

How many training or college courses did you attend?

INTERVIEWER: RECORD

{Ask if BProvCont =2, attended training or college courses}

TrainCollTyp3

Please could you tell me what each of these training or college courses were about?

Training or college courses 1:

Training or college courses 2:

Training or college courses 3:

Training or college courses 4:

Training or college courses 5:

{IF BProvCont = ANY}

BProvContOth

Are there any other forms of help have you received or taken part in that were not mentioned?

CODE ALL THAT APPLY

1. Received advice or support with benefits
2. Received advice or support with money or debt
3. Received advice or support with healthier lifestyle
4. Received advice or support equipment or adaptations
5. Received advice or support with family issues
6. Other (Specify)

TEXT LOOP: **Ask questions BProvCont and BProvContOth for all organisations / services listed in BProvName]**

{IF BRefFollow = 1, yes}

BOthHelp

And did [Organisation / service 1, 2 and/or 3] suggest any other activities you might do to help with your health or to help you to move towards work that we have not so far mentioned?

1. Yes
2. No

{If BOthHelp = 1, yes}

BOthHelpWhat

What did they suggest?

INTERVIEWER: PROBE AND RECORD VERBATIM

{If BOthHelp = 1, yes and answer BOthHelpWhat}

BOthHpFol

And did you do what they suggested?

1. Yes
2. No

{IF BRefFollow = 1, Yes}

BProvHlpHealth

Thinking about all the other organisations / services you have had help from (outside of the support from [HC Provider/ WP Provider / Jobcentre Plus], has your involvement with these other organisations / services helped you to manage your health condition/disability?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

1. Yes- a lot of help
2. Yes- a little help
3. No

{IF BRefFollow = 1, Yes}

BProvHlpWork

Has your involvement with other organisations / services helped you to move toward work?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

1. Yes- a lot of help
2. Yes- a little help
3. No

{If BProvHlpHealth = 1, 2 or BProvHlpWork = 1,2}

BProMstHelp

Thinking about the period since [MONTH], of all the help that you have received from the other organisations / services that have provided you with advice or support, which do you think have been the most helpful to you?

INTERVIEWER PROBE FULLY: What else has been helpful?

CODE UP TO 4 OPTIONS. IF MORE THAN 4, CODE THE FIRST 4 TO APPLY.

[Response list: include any coded at **BPrMtNat**

17. Can't say which is most effective
18. None of these

{If BHlpHealth = 1, 2 or BHlpWork = 1,2}

BProMstHelpHow

In what way has [TEXTFILL: Response 1 to BProMstHelp] been helpful?

1. In managing my health condition / disability
2. In moving towards work
3. In general
4. Other (please specify)

{If BHowHelpful = 3, in general}

BProMstHelpHowBen

What other benefits have you experienced as a result of [TEXTFILL: Response 1 to BProMstHelp]?

INTERVIEWER: RECORD VERBATIM

TEXTLOOP: Ask question BHowHelpful and BHowHelpfulBen for all responses listed in BMstHlp

{ASK IF HCP, WP or JCP}

BPrhlpr

Since [MONTH] when you started dealing with [HC Provider/WP Provider/Jobcentre Plus] {IF BRefFollow = 1, yes [and organisation / service 1/2/3]} to receive more advice and help, have you felt that there was always someone who you could contact to get help or clarify things with?

1. Yes
2. No

{ASK IF HCP, WP or JCP}

BPrWork

At any point during the time that you were dealing with [HC Provider/WP Provider/ Jobcentre Plus] {IF BRefFollow = 1, yes [and organisation / service 1/2/3]} were you ready and able to think about paid work?

1. Yes
2. No

[If BPrWork=1, yes]

BPrWCa

Did they understand what work you would be suitable for you?

1. Yes
2. No

{IF BPrhlpr = ANY}

BPrUnd

How well did you feel that the adviser[s] that you spoke to understood your situation?

READ OUT

1. Very well
2. Fairly well
3. Not very well
4. Not at all well

{IF BPrhlpr = ANY}

BSuggest

Is there anything else [HC Provider/WP Provider/Jobcentre Plus] could have done to help you manage your health or move towards work?

INTERVIEWER: PROBE FULLY

1. Yes
2. No

{Ask if BSuggest = 2, yes}

BSuggO

Please specify

INTERVIEWER: PROBE FULLY, IS THERE ANYTHING ELSE AT ALL THAT WOULD HAVE HELPED YOU WITH MOVING TOWARDS WORK, MANAGING YOUR HEALTH OR EVEN HELPING WITH WIDER ISSUES IN YOUR LIFE?

INTERVIEWER: RECORD VERBATIM

{ASK IF HCP, WP or JCP}

BNeg

Has there been anything you didn't like about the support you received from [HCP/ WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH]?

1. Yes
2. No

{Ask if BNeg= yes}

BNegO

Please specify

INTERVIEWER: RECORD VERBATIM

SECTION C: Attitudes to work and work-related activities

AIMS

This section asks people in both the control and the three pilot groups about whether the support provided has:

- Increased or decreased motivation to come off ESA and reasons for this
- Helped to overcome barriers to work experienced previously
- Increased or decreased motivation to find work and reasons for this.
- Helped respondents to get closer to finding work, and why
- Raised or lowered long-term ambitions
- Affected the way people think about work

{ASK ALL}

CRate

Thinking about the support that you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH], how would you rate your experience overall? Would you describe it as.....READ OUT

1. …very good,
2. Good,
3. Fair,
4. Poor,
5. Or very poor?

{ASK ALL}

CSoft1

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] increased or decreased your motivation to leave Employment and Support Allowance, for example to move onto JSA, move into work, start your own business, enter full-time study, retire…?

IF INCREASED PROBE FOR: increased a lot / a little?

IF DECREASED PROBE FOR: decreased a lot / a little?

1. Increased a lot
2. Increased a little
3. Decreased a little
4. Decreased a lot
5. No effect on motivation

{Ask if CSoft1 = 1, increased a lot or 2, increased a little}

Csoft1In

Why has it increased your motivation to leave Employment and Support Allowance?

DO NOT READ OUT. PROBE TO CODE.

CODE ALL THAT APPLY

1. Increased confidence
2. Better health
3. Better management of condition
4. Support / encouragement from adviser
5. Gained new work-related skills
6. Thought people in work are always better off financially
7. Didn't want to stay on the scheme
8. Didn't want to go to the appointments
9. Didn't want to have to keep going to the Jobcentre
10. Didn't want to do the activities asked of me
11. Want to work / get a job
12. Other (RECORD VERBATIM)

{ASK IF CSoft1In = 12, Other}

CSoft1InO

What else increased your motivation to leave Employment and Support Allowance?

{ASK ALL}

CBarr

Now thinking back to [MONTH, YEAR], shortly before you started receiving support from [HP Provider/WP Provider/Jobcentre Plus] did any of the following make it difficult for you to get back to work at that point?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY.

AND DID ANY OF THE FOLLOWING MAKE IT DIFFICULT FOR YOU TO GET A JOB…

1. Family or caring commitments
2. Health issues/disabilities limit kind of work can do
3. The time involved in getting to interviews or to a workplace
4. The cost involved in getting to interviews or to a workplace
5. Lack of vacancies/too much competition for jobs interested in
6. Lack of jobs in local area
7. Lack of jobs for people with respondent's health issues/disabilities
8. Lack of jobs for people with caring responsibilities
9. Not having right skills for jobs interested in
10. Not interested in working/ don't want a paid job

11. Financially worse off in paid work
12. Lack of work experience
13. Drug or alcohol problems
14. Criminal record
15. Housing problems
16. Transport/travel difficulties
17. Something else – RECORD VERBATIM
18. None of these

{ASK IF CBarr = 17, Something else}

CBarrO

What else?

{Ask if CBarr NOT = 18, none of these}

CBAwar1

Have you made [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] aware of this issue/these issues?

1. Yes
2. No

{Ask if CBAwar1 = 1, Yes}

CBAwar2

And were Jobcentre Plus aware of these barriers before [MONTH]?

{Ask if CBarr = 1-17}

CBHlp

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] helped you towards overcoming the barriers to getting back to work that you have mentioned?

INTERVIEWER IF YES PROBE: Has it helped a little or a lot?

1. Yes – a lot of help
2. Yes - a little help
3. No

{If CBHlp=3, No}

CBUnhelp

Why do you think the support you have received from [HC Provider/ WP Provider / Jobcentre Plus] did not help you towards overcoming the barriers to getting back to work that you have mentioned?

1. The timing of the support was wrong
2. The appointments were too far apart
3. The appointments were too close together

4. Adviser did not understand your needs
5. Adviser did not have the right skills / expertise
6. The support did not meet your needs
7. You did not need help to manage your condition / disability
8. Other (please specify)

{Ask if CBarr = 1-17}

CRemBar

Thinking about the barriers that you mentioned you experienced before you started on the pilot, which (if any) would you say still make it difficult for you to get back to work. READ ALL

MULTICODE

{Response code list= all coded at CBarr}

{ASK ALL}

CIntroWork:

I'd now like to talk about finding work.

IF NECESSARY: Work may not be an option for you, but we need to make sure we ask everyone the same questions to get the full picture.

{Ask if CIntroWork =1, yes/continue}

CSrch

Since [MONTH}, have you applied for any paid jobs?

1. Yes
2. No

{If CSrch= Yes}

CSchN

How many paid jobs have you applied for?

1..996

[Soft check if >300]

{If CSrch= Yes}

CJobtype

What kinds of paid jobs have you been applying for?

1. Full-time – over 30 hours a week
2. Part-time – 30 hours a week or less
3. Other (please specify)

{If CSrch= yes}

CInt

And have you attended any job interviews since [MONTH]?

1. Yes
2. No

{If CInt= yes}

CIntN

How many job interviews have you been to?:

1..96

[Soft check if >50]

[Soft check if >CSchN]

{If CSrch= yes}

CSugg

And can I just check, did anyone at your [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] suggest that you apply for any of these jobs?

1. Yes
2. No

{Ask all}

CSoft2

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] increased or decreased your motivation to find work?

…

INTERVIEWER : IF INCREASED: Has it increased a lot or a little?

IF DECREASED: Has it decreased a lot or a little?

1. Yes – increased a lot
2. Yes – increased a little
3. Yes – decreased a lot
4. Yes – decreased a little
5. No

{Ask If CSoft2= 1, increased a lot OR 2, increased a little}

Csoft2In

Why has it increased your motivation to find work?

DO NOT READ OUT. PROBE TO CODE.

CODE ALL THAT APPLY

1. Increased confidence
2. Better health
3. Better management of condition
4. Realised what I am capable of doing
5. Support / encouragement from adviser

6. Gained new work-related skills
7. Didn’t want to stay on the scheme
8. Didn’t want to go to the appointments
9. Didn’t want to have to keep going to the Jobcentre
10. Want to work / get a job
11. Other reason [Please Record Verbatim]

{ASK IF CSoft2In = 11, other reason}

CSoft2InO

What other reason?

RECORD VERBATIM

{Ask If CSoft2= 1, increased a lot OR 2, increased a little}

Csoft2do

What more have you done to find work since this you started on this scheme?

DO NOT READ OUT. PROBE TO CODE.

CODE ALL THAT APPLY.

1. Doing/considering other voluntary work
2. Doing/considering training courses
3. Doing/considering getting qualifications or certificates
4. Applying for more jobs
5. Applying for different types of jobs
6. Revising CV
7. Focusing on managing my health
8. No change - not done anything more
9. Other [Please Record Verbatim]

{ASKI IF CSoft2Do = 9, Other}

CSoftDoo

What other reason?

RECORD VERBATIM

{Ask If CSoft1= 3, Decreased a little OR 4, Decreased a lot}

CSoft2De

Why has it decreased your motivation to find work?

DO NOT READ OUT. PROBE TO CODE.

CODE ALL THAT APPLY.

1. Lack of support from adviser
2. Being on the scheme put me off work

3. Negative attitude of staff/adviser
4. Lack of opportunities/jobs
5. Reduced confidence
6. Being on the scheme has made my health worse
7. My health has deteriorated
8. Other reason [Please Record Verbatim]

{ASK IF CSoft2De = 8, Other}

CSoft2DeO

What other reason?

RECORD VERBATIM

{ASK ALL}

CSoft3

On a scale of 0 to 5, with 0 being not at all and 5 being yes – a lot, has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] helped you get closer to finding paid work?

:0-5

{GRID}

{ASK IF CSoft3=1-5}

Csoft3a

I am going to read out a number of ways that the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] may have helped you get closer to finding paid work.

For each one, please tell me, on a scale of 0-5 how much this has helped you, if at all.

1. Gained more work-related skills
2. Helped me to manage my condition better
3. Gained job search skills
4. Financial support
5. Advice/encouragement from adviser
6. Increased confidence
7. Realised what I am capable of doing
8. Other help (please specify)

:1-5

{ASK IF ESoft3a = 8, Other help}

CSoft3ao

In what other way has it helped you get closer to finding work?

RECORD VERBATIM

{ASK ALL}

CSoft4

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] helped you to feel more confident about getting a job?

INTERVIEWER IF YES PROBE: Has it helped a little or a lot?

1. Yes – a lot of help
2. Yes - a little help
3. No

{ASK ALL}

CSoft5

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH] raised or lowered your long-term WORK-RELATED ambitions?

INTERVIEWER IF YES PROBE: Has it raised or lowered your long-term ambitions?

1. Yes – raised WORK-RELATED ambitions
2. Yes – lowered WORK-RELATED ambitions
3. No effect

{ASK ALL }

CWExp

Has the support you have received from [HCP/WP/JCP: HC Provider/ WP Provider / Jobcentre Plus] since [MONTH} had an impact upon how you think about work?

1. Yes
2. No

{ASK IF CWExp=Yes}

CWECh

On a scale of 0 to 5, with 0 being more negatively and 5 being more positively, how do you now view work?:

0-5

{ASK ALL }

CWFeel

Which of the following is closest to how you currently feel about work?

1. My health condition/disability rules out work as an option
2. On a good day I could consider a return to work
3. I could return to work now if the right job was available
4. Don’t know/prefer not to answer

{Ask all}

CWkAtt1

I am now going to read out some statements. Please can you tell me how much you agree or disagree with each of them.

Having almost any type of paid work is better than not working.

Do you…READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{Ask all}

CWkAtt2

People are put under too much pressure to find work

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{Ask all}

CWkAtt3

Once you've got a job, it's very important to hang on to it, even if you don't really like it

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{Ask all}

CWkAtt4

I am willing to change career or retrain to find a job

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,

4. Disagree,
5. Or strongly disagree?

SECTION D: Current activity at interview

AIMS

This section asks people in both the control and the three pilot groups about:

- Their current benefit and employment status
- For those not in work, it asks about barriers to finding work and how many months they think it will take to find work
- Whether they have experienced any sanctions

{ASK ALL}

IntroD

I would now like to ask some questions about your current circumstances

{ASK ALL}

DEmp

Thinking about the present time, what are you doing at the moment? We are interested in your main activity.

INTERVIEWER: ASK AS OPEN ENDED QUESTION: USE LIST TO CODE AND PROBE IF NECESSARY

SINGLE CODE ONLY. CODE FIRST TO APPLY

1. In paid work as an employee
2. Working as self-employed
3. Unemployed and actively looking for work
4. In education or training
5. Not working because of sickness or disability
6. Looking after the home or family full-time
7. Doing voluntary or other unpaid work (full-time or part-time)
8. Something else

NO DK/NO REF

{ASK ALL}

DRestTime

What else do you do in the rest of your time?

CODE ALL THAT APPLY

1. In paid work as an employee
2. Working as self-employed

3. Unemployed and actively looking for work
4. In education or training
5. Not working because of sickness or disability
6. Looking after the home or family full-time
7. Doing voluntary or other unpaid work (full-time or part-time)
8. Something else

{Ask if DEmp= 3, Unemployed and actively looking for work}

DStJob

Do you have a job that you are about to start in the near future?

1. Yes
2. No

{Ask if DEmp=1, In paid work OR 2, self employed}

DHour

Is this full-time – that is over 30 hours a week – or part-time?

1. Full-time – over 30 hours a week
2. Part-time – 30 hours a week or less

{Ask if DEmp=1, In paid work OR 2, self employed}

DEarn

How much is your take home pay from this job, that is after tax and other deductions?

1..999997

[Soft check if DEarn > 50,000]

{ASK IF DEarn = any]

DPeriod

What period does this cover?

1. One week
2. Two weeks
3. Three weeks
4. Four weeks
5. Calendar month
7. Two Calendar months
8. Eight times a year
9. Nine times a year
10. Ten times a year
13. Three months/13 weeks
14. Six months/26 weeks

15. One Year/12 months/52 weeks
16. Less than one week
17. One off/lump sum
18. None of these

{Ask if DEmp= in paid work OR self employed}

DRole

What is your role in this job?

RECORD VERBATIM

{Ask if DEmp= in paid work OR self employed}

DStrtM

When did you start this work, please can you tell me the month?

INTERVIEWER: ENTER MONTH HERE AND YEAR AT THE NEXT QUESTION

{Ask if DEmp= in paid work OR self employed}

DStrtY

And the year?

INTERVIEWER: ENTER YEAR

[SOFT CHECK IF DATE IS BEFORE START DATE ON SCHEME]

[HARD CHECK IF DATE IS IN THE FUTURE]

{Ask if DEmp= in paid work OR self employed OR DStJob=Yes about to start new job}

DHlp

Has the advice and support you have received since [MONTH] helped you to get this job?

INTERVIEWER IF YES PROBE: Has it helped a little or a lot?

1. Yes – a lot of help
2. Yes - a little help
3. No

{Ask all}

DPriorEver

Have you ever had a paid job?

1. Yes
2. No

{Ask if DPriorEver =1}

DPriorWhn

Prior to [STARTDATE] how many months has it been since you last had paid work?

(INTERVIEWER: ENTER MONTHS)

{ASK IF (DEmp NOT = 1, employed OR 2, self employed) AND (DStJob =2,no)}

DBarr

What would you say is preventing you from finding work?

DO NOT READ OUT.

PROBE FULLY: What else?

CODE ALL THAT APPLY

1. Family or caring commitments
2. Health issues/disabilities limit kind of work can do
3. The time involved in getting to interviews or to a workplace
4. The cost involved in getting to interviews or to a workplace
5. Lack of vacancies/too much competition for jobs interested in
6. Lack of jobs in local area
7. Lack of jobs for people with respondent's health issues/disabilities
8. Lack of jobs for people with caring responsibilities
9. Not having right skills for jobs interested in
10. Not interested in working/ don't want a paid job
11. Financially worse off in paid work
12. Lack of work experience
13. Drug or alcohol problems
14. Criminal record
15. Housing problems
16. Transport/travel difficulties
17. Something else – RECORD VERBATIM
18. None of these

{IF DBarr= 17, Something else}

DBarrO

INTERVIEWER: RECORD VERBATIM OTHER BARRIERS

{If DEmp= 1,Paid work OR 2, self employed}

DEver

Do you think you will get paid work at some point in the future?

1. Yes
2. No

{Ask if DEmp=1, Paid work or 2, self-employed and DEver=1,yes}

DWhen

How many months do you think it will take for you to find work?

INTERVIEWER: ENTER NUMBER OF MONTHS

{Ask all}

DWkAtta

Please could you tell me how much agree or disagree with this/these statements.

{IF DEmp = 1 or 2 employed or self employed or DstJob=Yes}

DWkAttb

I am a happier person now [TEXTFILL DEmp=employed or self employed: “I am in work” / DStJb=yes: “I am about to start working”]

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{IF Demp = NOT 1 or 2 employed or self employed or DStJob=No}

DWkAttc

I would be a happier person if I were in work.

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{IF Demp ne 1 or 2 employed or self employed or DstJob=No}

DWkAttc

The thought of being in paid work makes me nervous

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{Ask all}

DBen

Do you receive any of the following benefits or tax credits at the moment?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY.

INTERVIEWER: READ OUT ACRONYMS. CODE ‘Housing or Council Tax Benefit’ OR ‘Child Benefit’ IF EITHER RESPONDENT OR PARTNER RECEIVES THEM.

FOR OTHER BENEFITS ONLY CODE WHERE RESPONDENT IS THE RECIPIENT.

1. Do you or your partner receive Housing or Council Tax Benefit?
2. Do you or your partner receive Child Benefit?
3. Disability Living Allowance (DLA)
4. Statutory Sick Pay (SSP)
5. Incapacity Benefit
6. Income Support
7. Job Seekers Allowance (JSA)
8. National Insurance Credits for Incapacity
9. Employment and Support Allowance (ESA)
10. Carer’s Allowance
11. Working Tax Credit
12. Child Tax Credit
13. Universal Credit (UC)
14. Personal Independence Payment (PIP)
13. Another benefit or tax credit not already mentioned [RECORD VERBATIM]
14. None (DO NOT READ OUT)

{If DBen=13, another benefit}

DBenO

INTERVIEWER: RECORD OTHER BENEFIT RECEIVED

{If DBen = NOT 9 ESA}

DESAChk

Can I check, has your claim for Employment and Support Allowance ended?

1. Yes
2. No

{If DESAChk = 1}

DESAStop

When did your claim for Employment and Support Allowance end?

INTERVIEWER: RECORD MONTH/YEAR

{Ask all}

DSanc

Can I just check have you had your benefits stopped or reduced for any reason by Jobcentre Plus since [MONTH]?

INTERVIEWER: IF YES: Were they stopped or reduced?

CODE ALL THAT APPLY

1. Yes - stopped
2. Yes - reduced
3. No (EXCLUSIVE CODE)

{**If FSanc=yes 1 or 2}**

DSWhy

Why was this?

DO NOT READ OUT. CODE ALL THAT APPLY OR RECORD VERBATIM IF UNABLE TO CODE.

1. Missed an appointment at the Jobcentre you were told you had to attend
2. Missed an appointment with (PROVIDER NAME) you were told to attend
3. Missed an appointment with outside service you were told you had to attend
4. Did not undertake activities that you were told you had to
5. You were told that you were not preparing work
6. Got a job
7. Reported a change in circumstances
8. Another reason – RECORD VERBATIM

{If DSWhy=another reason}

DSWhyO

INTERVIEWER: ENTER OTHER REASON

{If DSanc=yes 1 or 2}

DSanUn

At the time, how well did you understand why your ESA payment was being stopped or reduced; did you …READ OUT…

1. Fully understand,
2. Partly understand,
3. Not understand very much,
4. Or did you not understand it at all?

{Ask if DSanc = yes 1 or 2}

DSanRules

What was the effect of having your ESA payment reduced / stopped - did it make you…READ OUT

1. ..more likely to follow what you are asked to do by [WP Provider, HP Provider, Jobcentre Plus],

2. Less likely to follow what you are asked to do by [WP Provider, HP Provider, Jobcentre Plus],
3. Or did it make no difference?

{Ask if DSanc = yes 1 or 2}

DImpact

How did this impact upon your everyday life, did it mean you... READ OUT…

CODE ALL THAT APPLY

1. …had to borrow money or use credit cards or go into debt
2. …had to go without food or reduced the amount you spent on food
3. …delayed buying things you wanted (non-food items)
4. …got behind on paying bills or rent
5. …couldn't afford to go out
6. …and did it have any other impact?
7. SPONTANEOUS: Had no impact

{If DImpact=Other}

DImpOth

INTERVIEWER: ENTER OTHER IMPACT.

SECTION E: Background info

AIMS

This section collects background information on

- Age
- Sex
- Ethnicity
- health conditions and disabilities and the extent to which these impact on daily life
- Qualifications
- Interaction with family and friends
- Tenure
- How well the respondent feels generally these days

{Ask all}

IntroE

We are now very close to the end of the interview. In this final section I would like to collect some background information so that we can find out how the schemes have helped different types of people

ESex

INTERVIEWER: CODE SEX OF RESPONDENT

1. Male
2. Female

{Ask all}

EAge

First please can you tell me what was your age last birthday?

18…65

{Ask all}

EMar

And are you ...

READ OUT. CODE FIRST THAT APPLIES.

1. Married
2. In a civil partnership
3. Living with partner
4. Single (or engaged but not living with a partner as a couple)
5. Widowed
6. Divorced
7. Separated

{Ask all}

EChild

And can I just check do you have any dependent children aged under 16?

INTERVIEWER IF YES: How many? IF NO, CODE 0.

0..19

{Ask all}

EEthnic

To which of these groups do you consider you belong...READ OUT

1. ... White,
2. ... Black,
3. ... Asian,
4. ... Or another group?
5. DO NOT READ OUT Prefer not to say

{If EEthnic=2, Black}

EBlk

Do you consider yourself to be...READ OUT

1. ...Black African,

2. Black Caribbean,
3. Or another group?
4. DO NOT READ OUT Prefer not to say

{If EEthnic=3, Asian}

EAsi

Do you consider yourself to be...READ OUT

1. ...Bangladeshi,
2. Chinese,
3. Indian,
4. Pakistani,
5. Or another group?

{Ask all}

EDisab

This question asks you about any health conditions, illnesses or impairments you may have. Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?

1. Yes
2. No

{If EDisab=Yes}

EDisE

Do any of these conditions or illnesses affect you in any of the following areas?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

CODE ALL THAT APPLY.

1. Depression
2. Stress or anxiety
3. Fatigue or problems with concentration or memory
4. Pain or discomfort
5. Dizziness or balance problems
6. Problems due to alcohol or drug addiction
7. Problems with arms or hands
8. Problems with legs or feet
9. Problems with neck or back
10. Arthritis
11. Difficulty with seeing
12. Difficulty with hearing
13. Speech problems

14. Skin conditions or allergies
15. Chest or breathing problems
16. Heart or blood pressure problems
17. Problems with bowels, stomach, liver, kidneys or digestion
18. Mental health condition (other than depression/stress)
19. Learning difficulties
20. Progressive illness not covered above
21. Other health or disability issue

{If EDisE= 21, Other}

EDIsO

INTERVIEWER PLEASE RECORD OTHER WAY AFFECTED.

{If EDisab=Yes}

ESever

To what extent, if any, does/do your health condition/s or disability/ies limit your ability to carry out everyday activities - a great deal, to some extent, a little or not at all?

INTERVIEWER: CODE FOR EFFECT OF ALL DISABILITIES

IF HEALTH CONDITION FLUCTUATES, ASK FOR GENERAL EFFECT

1. A great deal
2. To some extent
3. A little
4. Not at all

{Ask all}

EQual

What is the highest level of education qualification that you have?

INTERVIEWER: PROBE TO CODE. PRESS F9 FOR HELP SCREEN

1. Degree or higher degree or equivalent; NVQ or SVQ levels 4 or 5
2. Higher educational qualification below degree level
3. A levels or Highers; NVQ or SVQ level 3
4. A level or GCSE equiv (grades A-C); CSE grade 1; NVQ or SVQ level 2
5. GCSE grades D-G; CSE grade 2-5; NVQ or SVQ level 1
6. Other quals (inc vocational and foreign quals below degree level)
7. No formal qualifications

INTERVIEWER HELP SCREEN:

Degree or Degree equivalent, and above
- Higher degree and postgraduate qualifications
- First degree (including B.Ed.)

- Postgraduate Diplomas and Certificates (including PGCE)
- Professional qualifications at degree level e.g. graduate member of professional institute, chartered accountant or surveyor
- NVQ or SVQ level 4 or 5

Other Higher Education below degree level
- Diplomas in higher education & other higher education qualifications
- HNC, HND, Higher level BTEC
- Teaching qualifications for schools or further education (below Degree level standard)
- Nursing, or other medical qualifications not covered above (below Degree level standard)
- RSA higher diploma

A levels or equivalent
- A level or equivalent
- AS level
- SCE Higher, Scottish Certificate Sixth Year Studies or equivalent
- NVQ or SVQ level 3
- GNVQ Advanced or GSVQ level 3
- OND, ONC, BTEC National, SCOTVEC National Certificate
- City & Guilds advanced craft, Part III (& other names)
- RSA advanced diploma 122

GCSE/O Level grade A*-C, vocational level 2 and equivalents
- NVQ or SVQ level 2
- GNVQ intermediate or GSVQ level 2
- RSA Diploma
- City & Guilds Craft or Part II (& other names)
- BTEC, SCOTVEC first or general diploma
- O level or GCSE grade A-C, SCE Standard or Ordinary grades 1-3

Qualifications at level 1 and below
- NVQ or SVQ level 1
- GNVQ Foundation level, GSVQ level 1
- GCSE or O level below grade C, SCE Standard or Ordinary below grade 3
- CSE below grade 1
- BTEC, SCOTVEC first or general certificate
- SCOTVEC modules
- RSA Stage I, II, or III
- City and Guilds part 1
- Junior certificate

{Ask all}

EUMeetFam

How often do you get together with your family and relatives?

INTERVIEWER: Exclude getting together with family for professional reasons such as work.

1. Daily
2. Every week (not every day)

3. Several times a month
4. Once a month
5. At least once a year
6. Never

{Ask all}

EUMeetFri

How often do you get together with your friends?

INTERVIEWER: Exclude getting together with friends for professional reasons such as work.

1. Daily
2. Every week (not every day)
3. Several times a month
4. Once a month
5. At least once a year
6. Never

{ASK ALL}

ETenure

And, thinking about where you live, do you (or your household) own or rent your accommodation?

INTERVIEWER: PROMPT TO CODE

1. Own it outright
2. Buying it with the help of a mortgage or loan
3. Part own and part rent (shared ownership)
4. Rent it
5. Live there rent-free (including living with parents)
6. Squatting

{ASK ALL}

EWell1

My last few questions relate to how you are generally feeling these days.

For each of the following four statements I would like you to give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’.

Overall, to what extent do you feel the things you do in your life are worthwhile?:0..10

{ASK ALL}

EWell2

Overall, how satisfied are you with your life nowadays? 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{ASK ALL}

EWell4

Overall, how anxious did you feel yesterday?: 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{ASK ALL}

EWell3

Overall, how happy did you feel yesterday?; 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{ASK ALL}

ELink

That is the end of the survey. To help us to understand how different types of support help different people it would be very useful if we could link the answers that you have given today with the records held by DWP on your employment and benefit history. This would only be used for research purpose and would not affect your benefits or support in any way. Would you be happy for us to do this?

1. Yes
2. No

Permission to recontact

{ask all}

EPer

Would it be possible to contact you again in for example, seven or eight months to conduct a follow-up interview? You do not have to agree to an interview at this stage, I’m just asking if we might be able to call you to find out if you are interested)
INTERVIEWER NOTE: IT IS IMPORTANT THAT AS MANY RESPONDENTS AS POSSIBLE AGREE TO BE CONTACTED AGAIN FOR THE FOLLOW UP INTERVIEWS. THE NEXT INTERVIEW WILL BE VERY SIMILAR, BUT SHORTER.

1. Yes
2. No

{ask if EPer= Yes }

EAddchk

Could I just check I have your correct contact details?

INTERVIEWER: READ OUT CONTACT DETAILS AND MAKE ANY AMENDEMENTS NECESSARY

IF ONLY HAVE 1 PHONE NUMBER PROMPT FOR ANOTHER

NAME…

PHONE NUMBER 1

PHONE NUMBER 2

EStable

And in case you move house or change your telephone number between now and any further interviews, it would be useful to have contact details for a friend or relative who could put us in touch with you. We would not share any of your information with them or say anything about what the survey is about. Could we have these details?

PROMPT: Don’t forget to tell this person that you have given us their contact details

1. Yes
2. No

{if EStable=yes)

EStabAd

INTERVIEWER: ENTER STABLE PHONE NUMBER.

NAME…

PHONE NUMBER

EEnd

INTERVIEWER THANK RESPONDENT AND CLOSE

Wave 2 Survey Questionnaire

SECTION A: Introduction

s1

Hello. My name is ...
I am phoning from NatCen Social Research on behalf of the Department for Work and Pensions.
Please could I speak to…?

1. Respondent/Proxy answers phone
2. Transferred to respondent
3. No answer
4. Wrong number
5. APPOINTMENT
6. Refused
7. Not Available During Fieldwork
8. Language Barrier
9. Deceased
10. Physically/mentally incapable of taking part
11. Late Opt-outs

IntroQ

INTERVIEWER - INTRODUCE SURVEY

We spoke to you previously in [INSERT W1 SURVEY MONTH] 2015. You took part in a feedback survey about the services and support provided to people as part of their Employment and Support Allowance (ESA) claim. We are calling to follow-up, to hear about your recent experiences of support you've received since we last spoke to you. You should have recently received a letter from us about this survey.

Although the Department for Work and Pensions have asked us to carry out this research, I am working for a research institute that is completely impartial and separate from the Government.

Just to be clear, nothing that we ask you about will affect your benefits or the support you receive in any way, now or in the future. You will not be identified in any research findings. Your answers will be treated in strict confidence by the evaluation team, unless you tell us that you or someone else is at risk. We may have to let the authorities know if you or someone else is at risk.

The interview should take around 20 minutes to complete.

Is it okay to do the interview now?

[ADD IF NECESSARY: Even if your situation is still the same as when we last spoke, we'd like to carry out a short interview with you. This will be really helpful to the Department for Work and Pensions and Jobcentre Plus to improve the services they provide.]

[ADD IF NECESSARY: At the end of the last survey we asked whether you'd be happy to be re-contacted to take part in a follow-up survey in 8 to 11 months' time. You agreed to be re-contacted.]

[ADD IF NECESSARY: The survey is designed to find out what you think about the support and advice you've received since you've been claiming ESA which will help the Department for Work and Pensions and Jobcentre Plus improve the services they provide.]

IF SAY NO LONGER RECEIVING ESA: Even though you are no longer receiving Employment Support Allowance we would still like to speak to you about your experience whilst you were on ESA.

[ADD IF NECESSARY: We will use the information you and others give us to produce statistics on what everyone has said. This will help DWP to understand the way in which people have been supported and may help to make improvements.]

INTERVIEWER: CODE WHETHER CONSENT GAINED:

INTERVIEWER: RECORD WHETHER INTERVIEWING A CLAIMANT OR A PROXY WITH THE CONSENT OF THE CLAIMANT (NOTE: PROXY INTERVIEWS ARE ONLY ALLOWED IN EXCEPTIONAL CIRCUMSTANCES)

1. Yes – claimant consented to interview
2. Yes – claimant consented to PROXY interview
3. Make an appointment to call back
4. No – THANK AND END

SECTION B: Details of post-pilot support received

AIMS

This section asks about the support received by respondents who have completed the 24 months package of support and received at least two months of post-pilot support. Questions are asked of those in the control and pilot groups. This section asks about

- Nature of the support provided, including frequency of contact, length of each session and type of advice and support

{Ask all}

BESA

Are you still claiming Employment and Support Allowance?

1. Yes
2. No

{Ask if BESA=1, yes}

BWRAGCk

And are you still in the Work-Related Activity Group? This means that you are not required to apply for work, but you are required to participate in work preparation activities like attending interviews with an adviser who can help with things like job goals and improving your skills.

READ OUT

1. Yes, I am still in the Work-Related Activity Group
2. No, I have moved into the Support Group, so I don't have regular interviews with advisers
3. Don't know

Post-pilot support for those who completed the pilot at least two months earlier

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk =1}

BNumbApp

How many appointments have you had with Jobcentre Plus since [PILOT END DATE], including both telephone and face-to-face appointments?

ADD IF NECESSARY: IT DOESN'T MATTER IF YOU CAN'T REMEMBER EXACTLY. INTERVIEWER: PROBE FOR NUMBER AND RECORD

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk = 1}

BAppLoc

Since [PILOT END DATE], where have the appointments with a Jobcentre Plus Work Coach taken place?

READ OUT. MULTICODE.

INTERVIEWER: DO NOT CODE MORE THAN ONE IF THEY ONLY HAD ONE APPOINTMENT.

1. At the their office
2. At your home
3. Another venue
4. Over the phone

{If BNumbApp >1}

BAppFreq1

Since [PILOT END DATE], how often have you had appointments (either face-to-face or on the phone) with Jobcentre Plus … READ OUT …

1. about once a week
2. about once a fortnight
3. about once a month

4. about once every two months
5. less than once every two months

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk = 1}

BLong

Thinking about the appointments (either face-to-face or over the phone) you have had with Jobcentre Plus since [PILOT END DATE], how long did the meetings usually last?

INTERVIEWER CODE IN MINUTES. ASK FOR AVERAGE IF RESPONDENT SAYS IT VARIES.

[SOFT CHECK IF INTERVIEWER ENTERS >240 MINUTES. SET UPPER LIMIT TO 300]

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk = 1}

BAppContx

I'd now like to ask about what you have discussed during the appointments with Jobcentre Plus since [PILOT END DATE], and about what happened after your appointments.

I realise it may be difficult to remember the details, but we'd really appreciate if you could think back to the types of things you talked about during your appointments with a Jobcentre Plus Work Coach. What you tell us about the advice and support you have received will be held in the strictest confidence. The research findings will not identify you and no personal information will be shared with any third parties.

[DP INSTRUCTION: For each statement at BDisc that equals 'Yes' ask BFollUp for that statement immediately after. If BFollUp equals 'Yes' for that same statement follow-up with BEsaLink. Once all relevant questions have been asked for that statement move onto the next statement listed.]

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk = 1}

BDisc

Since [PILOT END DATE], during your appointments with Jobcentre Plus did you discuss [TEXTFILL: Statement 1a, 2a, 3a etc.]

DO NOT READ OUT. SINGLE CODE.

1. Yes
2. No
3. Don't know

{If BDisc = 1, yes}

BFollUp

And did you go on to receive or take part in:

a) [TEXTFILL: Statement 1b, 2b, 3b etc.]

DO NOT READ OUT. SINGLE CODE

1. Yes
2. No
3. Don’t know

{If BDisc = 1 and BFollUp = 1)

BEsaLink

And was this as a result of the discussions you had with a Jobcentre Plus Work Coach during your appointments as part of your ESA claim?

1. Yes
2. No
3. Don’t know

TEXTFILLS

	Statement a	**Statement b**
1	how your health/disability impacts on your ability to work	practical help to manage your condition/ disability (in relation to work)
2	how your health/disability impacts other areas of your life	practical help to manage your condition/ disability (in general)
3	voluntary work options	voluntary work
4	work experience	work experience
5	physiotherapy sessions	physiotherapy sessions
6	doing more exercise	exercise
7	pain management or relief training	pain management or relief training
8	counselling or cognitive behavioural therapy	counselling or cognitive behavioural therapy
9	building confidence, being assertive	confidence building or assertiveness sessions
10	support groups for specific health conditions	support groups for specific health conditions
11	social or group activity	social or group activity
12	addiction services	addiction services
13	looking for work	support to look for jobs
14	money, debt, or benefits	practical help with managing money, debt or benefits
15	applying for jobs or writing a CV	support to write a CV or apply for jobs
16	training or college courses	training or college courses

{Ask those who completed the pilot at least two months before start of fieldwork, PFlag = 1 AND BWRAGCk = 1}

BSupportOth

And is there anything else that you have done or had help with as a result of your appointments?

INTERVIEWER: PROBE AND RECORD VERBATIM.

1. No – nothing else

SECTION C: Attitudes to work and work-related activities

AIMS

This section asks people in both the control and the three pilot groups who are still on the pilot or only recently completed about whether the support provided has.

- Increased or decreased motivation to leave ESA
- Increased or decreased motivation to find work and reasons for this.
- Helped to overcome the barriers mentioned at the previous interview
- Influenced how they think about work
- helped them to manage their health condition/disability
- helped then to move towards work

This section asks all respondents (both pilot and control and at all stages of pilot/ post-pilot support):

- That have applied for jobs since the last interview
- About their attitudes to work

Views on pilot support and short-term outcomes for those who are still within the 24-month period or completed within the last month (control and pilot)

{Ask all those who are still on the pilot or only recently completed, ASK IF PFlag = 2}

Crate

Thinking about the support that you have received from [If PGroup = HCP or WP: PROVIDER NAME] [If PGroup = JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART], how would you rate your experience overall? Would you describe it as.....READ OUT

1. …Very good,
2. Good,
3. Fair,
4. Poor,
5. Or very poor?

{Ask all those who are still on the pilot or only recently completed, ASK IF PFlag = 2}

CSoft1

Has the support you have received from [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART] increased or decreased your motivation to leave Employment and Support Allowance…?

IF INCREASED PROBE FOR: increased a lot / a little?

IF DECREASED PROBE FOR: decreased a lot / a little?

1. Increased a lot
2. Increased a little
3. Decreased a little
4. Decreased a lot
5. No effect on motivation

{Ask if CSoft1 = 1, increased a lot or 2, increased a little}

Csoft1In

How has it increased your motivation to leave Employment and Support Allowance?

DO NOT READ OUT. IF NECESSARY PROBE TO CODE USING THE FOLLOWING PHRASES:

– Is there anything about the requirements of ESA WRAG generally that has increased your motivation to leave?

– Have there been any changes in your confidence levels that might be relevant here?

– Have there been any changes in your health that are relevant here?

– Has anyone supported or encouraged you to leave?

– Are your feelings about work relevant here?

MULTICODE.

1. Increased confidence
2. Better health
3. Better management of condition
4. Support / encouragement from adviser
5. Gained new work-related skills
6. Thought people in work are always better off financially
7. Didn’t want to stay on the scheme
8. Didn’t want to go to the appointments
9. Didn’t want to have to keep going to the Jobcentre
10. Didn’t want to do the activities asked of me
11. Want to work / get a job

12. Other (Please specify)

{Ask if in Wave 1 xCBarr_1-16, 22, 23, 24, 25 = 1 or (length of xCBarr_O > 1) AND PFlag = 2}

CBHlp

When we last spoke to you, you mentioned that certain things made it difficult for you to get back to work. You mentioned:

{TEXTFILL RESPONSES FROM W1 SURVEY}

Has the support you have received from [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART] helped you towards overcoming these barriers to getting back to work?

INTERVIEWER IF YES PROBE: Has it helped a little or a lot?

Yes – helped a lot

Yes – helped a little

No

{If CBHlp = 3, No}

CBUnhelp

Why do you think the support you have received from [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART] did not help you towards overcoming the barriers to getting back to work?

READ OUT. MULTICODE.

1. You need medical help that they could not give you
2. The timing of the support was wrong
3. The appointments were too far apart
4. The appointments were too close together
5. Adviser did not understand your needs
6. Adviser did not have the right skills / expertise
7. You did not need help to manage your condition / disability
8. Other (please specify)

{Ask all those who are still on the pilot or only recently completed, ASK IF PFlag = 2}

CHlpHealth

Have your appointments with [If HCP or WP: PROVIDER NAME] [If JCP: JobCentre Plus] since [PROVSTART] and any follow up support or activities helped you to manage your health condition/disability?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

1. Yes- helped a lot
2. Yes- helped a little
3. No

{If CHIpHealth = 3, No}

CHIpHealthUnhelp

Why do you think your appointments with [If HCP or WP: PROVIDER NAME] [If JCP: JobCentre Plus] since [PROVSTART] and any follow up support or activities did not help you to manage your health condition/disability?

READ OUT. MULTICODE**.**

1. You need medical help that they could not give you
2. The timing of the support was wrong
3. The appointments were too far apart
4. The appointments were too close together
5. Adviser did not understand your needs
6. Adviser did not have the right skills / expertise
7. You did not need help to manage your condition / disability
8. Other (Please specify)

{Ask all those who are still on the pilot or only recently completed, ASK IF PFlag = 2}

CHIpWork

Have your appointments with [If HCP or WP: PROVIDER NAME] [If JCP: JobCentre Plus] and any follow up support or activities helped you to move toward work?

INTERVIEWER IF YES, PROBE: Has it helped a little or a lot?

INTERVIEWER IF respondent answers ‘No’ or ‘I wish I could’ PROBE: Is that because the support has not been effective for you, or because you are too unwell to return to work?

1. Yes - helped a lot
2. Yes - helped a little
3. No
4. Not relevant as I’m too unwell to return to work

{Ask if CHIpWork_W = 1, 2}

CHIpWorkMst

What support or activity was most helpful in helping you to move towards work?

ADD IF NECESSARY: Please think of all your appointments with [If HCP or WP: PROVIDER NAME] [If JCP: JobCentre Plus] and any follow up support or activities.

PROMPT TO CODE. SINGLE CODE.

1. One-to-one discussions with an adviser
2. Practical help to manage your condition / disability (in relation to work)
3. Voluntary work
4. Work experience

5. Physiotherapy session
6. Exercise
7. Pain management or relief training
8. Counselling or cognitive behavioural therapy
9. Confidence building or assertiveness sessions
10. Support groups for specific health conditions
11. Social or group activity
12. Addition services
13. Support to look for jobs
14. Practical help with managing money, debt or benefits
15. Support to write a CV or apply for jobs
16. Training or college course
17. Collaborative working between advisers and other service providers
18. Other (specify)

{If CHlpWork = 3, No}

CHlpWorkUnhelp

Why do you think your appointments with [If HCP or WP: PROVIDER NAME] [If JCP: JobCentre Plus] since [PROVSTART] and any follow up support or activities did not help you to move towards work?

READ OUT. MULTICODE.

1. You needed medical help that they could not give you
2. The timing of the support was wrong
3. The appointments were too far apart
4. The appointments were too close together
5. Adviser did not understand your needs
6. Adviser did not have the right skills / expertise
7. You did not need help to manage your condition / disability
8. Other (specify)

ALL - Whether respondents have applied for jobs since the last interview

{Ask all}

CIntroWork:

I'd like to talk about finding work. Work may not be an option for you at the moment, but we need to make sure we ask everyone the same questions to get the full picture.

{Ask all}

CSrch

Since [INSERT W1 SURVEY MONTH] 2015, have you applied for any paid jobs?

1. Yes
2. No
3. Not applicable – already in paid employment

{If CSrch = Yes}

CSchN

How many paid jobs have you applied for since [INSERT W1 SURVEY MONTH] 2015?

1..996

[Soft check if >300]

{If CSrch = Yes}

CJobtype

What kinds of paid jobs have you been applying for since [INSERT W1 SURVEY MONTH] 2015?

READ OUT. MULTICODE.

1. Full-time – over 30 hours a week
2. Part-time – 30 hours a week or less
3. Other (specify)

{If CSrch = yes}

CInt

And have you attended any job interviews since [INSERT W1 SURVEY MONTH] 2015?

1. Yes
2. No

{If CInt = yes}

CIntN

How many job interviews have you been to since [INSERT W1 SURVEY MONTH] 2015?:

1..96

[Soft check if >50]

[Soft check if >CSchN]

Whether those who are still on the pilot *or* have only recently completed applied for jobs as a result of support received and consider support to have impacted on how they think about work (pilot and control)

{If CSrch = yes AND PFlag = 2}

CSugg

And can I just check, did anyone at [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] suggest that you apply for any of these jobs?

1. Yes
2. No

{Ask all those who are still on the pilot or only recently completed, ASK IF PFlag = 2}

CWExp

Has the support you have received from [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART] had an impact on how you think about work?

1. Yes
2. No

{Ask If CWExp = Yes}

CWECh

Since [PROVSTART], do you now view work more positively or more negatively?

READ OUT.

1. More positively
2. More negatively
3. Neither more positively nor more negatively

{Ask all those who are still on the pilot or only recently completed, IF PFlag = 2, AND if CSrch ≠ 3, Not applicable – already in paid employment}

CSoft2

Has the support you have received from [If HCP or WP: PROVIDER NAME] [If JCP, JCPC, HCPC or WPC: JobCentre Plus] since [PROVSTART] increased or decreased your motivation to find work? …

INTERVIEWER : IF INCREASED: Has it increased a lot or a little?

IF DECREASED: Has it decreased a lot or a little?

1. Yes – increased it a lot
2. Yes – increased it a little
3. Yes – decreased it a lot
4. Yes – decreased it a little
5. No change

{Ask If CSoft2 = 1, increased a lot OR 2, increased a little}

CSoft2In

Why has it increased your motivation to find work since [PROVSTART]?

DO NOT READ OUT. PROBE TO CODE.

MULTICODE.

1. Increased confidence
2. Better health
3. Better management of condition
4. Realised what I am capable of doing
5. Support / encouragement from adviser
6. Gained new work-related skills
7. Didn't want to stay on the scheme
8. Didn't want to go to the appointments
9. Didn't want to have to keep going to the Jobcentre
10. Want to work / get a job
11. Other reason (Please specify)

{Ask If CSoft2 = 1, increased a lot OR 2, increased a little, AND if CSrch ≠ 3, Not applicable – already in paid employment}

Csoft2do

What more have you done to find work since [PROVSTART]?

DO NOT READ OUT. PROBE TO CODE.

MULTICODE.

1. Doing/considering other voluntary work
2. Doing/considering training courses
3. Doing/considering getting qualifications or certificates
4. Applying for more jobs
5. Applying for different types of jobs
6. Revising CV
7. Focusing on managing my health
8. No change - not done anything more
9. Other (Please specify)

{Ask If CSoft2 = 3, Decreased a little OR 4, Decreased a lot}

CSoft2De

Why has it decreased your motivation to find work since [PROVSTART]?

DO NOT READ OUT. PROBE TO CODE.

MULTICODE.

1. Lack of support from adviser
2. Being on the scheme put me off work
3. Negative attitude of staff/adviser
4. Lack of opportunities/jobs

5. Reduced confidence
6. Being on the scheme has made my health worse
7. My health has deteriorated
8. Other reason [Please Record Verbatim]

Attitudes to work of all respondents

{Ask if CSrch ≠ 3, Not applicable – already in paid employment}

CWFeel

Which of the following is closest to how you currently feel about work?

READ OUT.

1. My health condition/disability rules out work as an option
2. On some days I could consider a return to work
3. I could return to work now if the right job was available

{Ask all}

CWkAtt1

I am now going to read out some statements. Please can you tell me how much you agree or disagree with each of them.

ADD IF NECESSARY: Please answer by giving your personal opinion as it stands right now.

Having almost any type of paid work is better than not working.

Do you…READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

ADD IF NECESSARY: Please answer by giving your personal opinion as it stands right now.

{Ask all}

CWkAtt2

People are put under too much pressure to find work

Do you… READ OUT…

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

SECTION D: Current activity at interview

AIMS

This section asks people in both the control and the three pilot groups – completers and non-completers about:

- Their current benefit and employment status
- For those not in work, it asks about barriers to finding work and how many months they think it will take to find work
- Whether they have experienced any sanctions
- This is to provide us with up-to-date information on how their circumstances may have changed.

Current benefit and employment status of all respondents

{Ask all}

IntroD

I would now like to ask some questions about your current circumstances, as we realise that your circumstances may have changed since we last spoke to you.

{Ask all}

DEmp

What are you doing at the moment? Are you…?

READ OUT. MULTICODE.

INTERVIEWER: If respondent answered *'health rules out work as an option'* at CWFeel, please add: Some of these options may not be relevant to you, as you have already mentioned that your health rules out work as an option, but I am still going to read out all of the options, as it's important that everyone is asked the same question.

[DP INSTRUCTION: Do not allow codes 1 and 2 (employed) to be selected with either of the unemployed codes (codes 3 and 5)]

1. In paid work as an employee
2. Working as self-employed
3. Unemployed and actively looking for work
4. In education or training
5. Not working because of sickness or disability
6. Looking after the home or family
7. Doing voluntary or other unpaid work (full-time or part-time)
8. Something else

{Ask if DEmp = multiple responses}

DRestTime

Which of these is your main activity?

INTERVIEWER: ASK AS AN OPEN ENDED QUESTION. SINGLE CODE ONLY.

[PROGRAMMIMG: Response codes = answers to DEmp. Do not include a 'Don't know' option]

{Ask if not working at Wave 1 AND not working at Wave 2,

(DEmp1 ≠ 1 or DEmp2 ≠ 1 at Wave 1) AND (DEmp1 ≠ 1 and DEmp2 ≠ 1 at Wave 2)}

DEmpStill

Did you start a job since [INSERT W1 SURVEY MONTH] 2015, which you are no longer doing?

1. Yes
2. No

{Ask if DEmp1 = 1 or DEmp2 = 1, working in paid work or self-employed}

DPerm

Is this work permitted work?

ADD IF NECESSARY: Permitted work is work you are allowed to do while you are on Employment and Support Allowance (ESA). It does not affect the amount of ESA you receive.

1. Yes
2. No

{Ask if working at Wave 1 AND not working at Wave 2,

((DEmp1 = 1 or DEmp2 = 1 at Wave 1) AND (DEmp1 ≠ 1 and DEmp2 ≠ 1)) OR DEmpStill = 1, Yes}

DEmpNotW

[IF DEmp = 1 or 2 AND DEmp ≠ 1 or 2: When we spoke to you in [INSERT W1 SURVEY MONTH] 2015 you were working.] Why are you no longer working? Is it because….?

READ OUT. MULTICODE.

1. The contract ended
2. You disliked the work
3. The work was unsuitable (given your health condition/disability)
4. Your health condition/disability was difficult to manage in work
5. Your health condition/disability worsened
6. Your employer did not take your health condition/disability into account
7. Family or caring commitments
8. You were financially worse off in work
9. Transport or travel difficulties

10. Other (specify)

{Ask if (DEmp1 = 1 or DEmp2 = 1 at Wave 1) AND (DEmp at Wave 2 = 1 or 2)}

DEmpck

When we spoke to you in [INSERT W1 SURVEY MONTH] 2015 you also said you were working. Is your current job *different* to the one you told us about when we last spoke to you in [INSERT W1 SURVEY MONTH] 2015?

1. Yes
2. No

{Ask if DEmp = 3, Unemployed and actively looking for work}

DStJob

Do you have a job that you are about to start in the near future?

1. Yes
2. No

{Ask if DEmp = 1, In paid work OR 2, self-employed}

DHour

Is this [TEXTFILL IF DRestTime = 1: paid work as an employee] [TEXTFILL IF DRestTime = 2: self-employed job] full-time – that is over 30 hours a week – or part-time?

ADD IF NECESSARY: We are interested in finding out what may have changed since we last spoke to you.

1. Full-time – over 30 hours a week
2. Part-time – 30 hours a week or less

{Ask if DEmp =1, In paid work OR 2, self-employed}

DEarn

How much is your take home pay from this job, that is after tax and other deductions?

ADD IF NECESSARY: We are interested in finding out what may have changed since we last spoke to you.

1..999997

[Soft check if DEarn > 50,000]

{Ask if DEarn = any}

DPeriod

What period does this cover?

READ OUT. CODE FIRST THAT APPLIES.

ADD IF NECESSARY: We are interested in finding out what may have changed since we last spoke to you.

1. One week
2. Two weeks

3. Three weeks
4. Four weeks
5. Calendar month
6. Two Calendar months
7. Eight times a year
8. Nine times a year
9. Ten times a year
10. Three months/13 weeks
11. Six months/26 weeks
12. One Year/12 months/52 weeks
13. Less than one week
14. One off/lump sum
15. None of these

{Ask if DEmp = 1, in paid work OR 2, self-employed AND DEmpck = 1}

DSic

What does the firm or organisation you work for mainly make or do?

RECORD VERBATIM

{Ask if DEmp = 1, in paid work OR 2, self-employed AND DEmpck = 1}

DSoc1

What is the name or title of your job?

RECORD VERBATIM

{Ask if DEmp =1, in paid work OR 2,self-employed AND DEmpck = 1}

DSoc2

What kind of work do you do most of the time?

INTERVIEWER: IF NECESSARY ADD: What materials or equipment do you use?

RECORD VERBATIM

{Ask if DEmp =1, in paid work AND DEmpck = 1}

DManage

Do you have managerial duties or are you supervising other employees at all?

DO NOT READ OUT. MULTICODE

(DP INSTRUCTION: if code 3 is selected, do not allow any other codes to be selected.)

1. Yes, managerial duties
2. Yes, supervisory
3. No, neither

{Ask if DEmp=1, in paid work AND DEmpck = 1}

DNumEmp

Including yourself, how many people work at the place where you work?

DO NOT READ OUT. SINGLE CODE

1. 1 or 2
2. 3-24
3. 25-499
4. 500 or more

{Ask if DEmp =2, self-employed AND DEmpck = 1}

DSEEmp

Are you working on your own or do you have employees?

DO NOT READ OUT, SINGLE CODE.

1. On own/with partner(s) but no employees
2. With employees

{Ask if DSEEmp =2, with employees AND DEmpck = 1}

DNumSE

How many people do you employ at the place where you work?

DO NOT READ OUT. SINGLE CODE

1. 1 or 2
2. 3-24
3. 25-499
4. 500 or more

{Ask if DEmp = 1, in paid work OR 2, self-employed AND DEmpck = 1}

DStrtM

When did you start this work, please can you tell me the month?

INTERVIEWER: ENTER MONTH HERE AND YEAR AT THE NEXT QUESTION

{Ask if DEmp = in paid work OR self-employed AND DEmpck = 1}

DStrtY

And the year?

INTERVIEWER: ENTER YEAR

[HARD CHECK IF DATE IS IN THE FUTURE]

{Ask if DEmp1 = 1, in paid work OR DEmp2 = 1, self-employed OR DEmp7 = 1, Doing voluntary or other unpaid work}

DEmpImp

Has being in [TEXTFILL IF DEmp1 = 1 or DEmp2 = 1: paid] [IF DEmp7 = 1: voluntary or other unpaid] work affected your health, either positively or negatively?

ADD IF NECESSARY: Please only think about changes to your health that are a direct result of being in paid work.

DO NOT READ OUT. SINGLE CODE.

1. Had a positive effect on my health
2. Had a negative effect on my health
3. Not affected my health either positively or negatively

{Ask if DEmpImp = 1, 2}

DEmpHealth

Would you say your heath has [IF DEmpImp = 1: improved] [IF DEmpImp = 2: worsened] a lot or a little as a result of being in [TEXTFILL IF DEmp1 = 1 or DEmp2 = 1: paid] [IF DEmp7 = 1: voluntary or other unpaid] work?

READ OUT. SINGLE CODE.

1. A lot
2. A little
3. No change

{Ask if DEmp = 1, in paid work OR 2, self-employed}

DEmpSupp

Have you received support from a Jobcentre Plus adviser or any other organisations since you started your job?

We are interested in any help you received to settle into your job, remain in work, or progress in your role. This could include someone contacting you to check how you're getting on.

DO NOT READ OUT. SINGLE CODE.

1. Yes
2. No

{Ask if DEmpSupp = 1, Yes}

DSuppMode

And how did you receive this in-work support. Was it by...?

READ OUT. MULTICODE.

1. Telephone
2. Email
3. Face-to-face
4. Other

{Ask if DEmpSupp = 1, Yes}

DSuppType

What type of in-work support did you receive?

READ OUT. MULTICODE.

1. Regular contact to check how you're getting on
2. Financial advice, including help with in work benefits
3. Support to arrange childcare
4. Support to manage your health/disability in work, including access to any aid or equipment
5. Support to liaise/negotiate with your employer
6. Referrals to organisations that can provide support
7. Other (please specify)

{Ask if DSuppType = 6, referrals to organisations}

DSuppRef

What types of organisations were you referred to? Was it organisations that offer….

READ OUT. MULTICODE.

1. Support to manage your health/disability in general
2. Physiotherapy sessions
3. Exercise
4. Pain management or relief training
5. Counselling or cognitive behavioural therapy
6. Support to build your confidence
7. Support groups for specific health conditions
8. Social or group activities
9. Addiction services
10. Support to develop job specific skills
11. Help to sort out and changes to your benefits and any tax credits
12. Other (specify)

Whether support received has helped those in employment to get the job (those who are on the pilot or have recently completed)

{Ask if not working at Wave 1 AND working at Wave 2, DEmp1 = 1, in paid work or DEmp2 = 1, self-employed or DStJob = 1, Yes about to start new job

AND DEmpck = 1

AND PFlag = 2}

DHlp

Has the advice and support you have received since [PROVSTART] helped you to get this job?

INTERVIEWER IF YES PROBE: Has it helped a little or a lot?

1. Yes – a lot of help
2. Yes - a little help

3. No

{Ask if DStJob = 2, no}

DBarr

What would you say is currently preventing you from finding work?

DO NOT READ OUT. IF NECESSARY PROBE TO CODE USING THE FOLLWING PHRASES:

– Do you have any other commitments that prevent you from finding work?

– Are there any practical issues that prevent you from finding work?

– Is there anything about the job market that prevents you from finding work?

– Does your health, or do present circumstances, prevent you from finding work?

MULTICODE.

1. Family or caring commitments
2. Health issues/disabilities limit the kind of work respondent can do
3. The time involved in getting to interviews or to a workplace
4. The cost involved in getting to interviews or to a workplace
5. Lack of vacancies/too much competition for jobs respondent's interested in
6. Lack of jobs in local area
7. Lack of jobs for people with respondent's health issues/disabilities
8. Lack of jobs for people with caring responsibilities
9. Not having right skills for jobs interested in
10. Not interested in working/don't want a paid job
11. Financially worse off in paid work
12. Lack of work experience
13. Drug or alcohol problems
14. Criminal record
15. Housing problems
16. Transport/travel difficulties
17. Something else (Please specify)
18. None of these

{DEmp =4 to 8, not in work <u>and not</u> 1 or 2} OR {DEmp =3 AND DStJob =No, don't know, refused} (2nd part of routing trumps the 1st part)

DEver

Do you think you will get paid work at some point in the future?

INTERVIEWER: If respondent gives a vague that is not 'Yes' or 'No', read out the list of codes including 'Don't know' to clarify which is most appropriate.

1. Yes

2. No

{Ask if DEmp = 3 to 8, not in work and DEver =1, yes}

DWhen

From now, how many months do you think it will take you to find work?

INTERVIEWER: ENTER NUMBER OF MONTHS

{IF DEmp = 1 or 2 employed or self-employed or DStJob =Yes}

DWkAttb

Please could you tell me how much you agree or disagree with this statement…?:

I am a happier person now [TEXTFILL DEmp =employed or self-employed: “I am in work” / DStJb =yes: “I am about to start working”]

Do you… READ OUT…

INTERVIEWER ADD IF NECESSARY: Please answer based on how you are feeling at the present time.

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{IF DEmp = NOT 1 or 2 employed or self-employed or DStJob =No}

DWkAttc

Please could you tell me how much you agree or disagree with this statement…?:

I would be a happier person if I was in work.

Do you… READ OUT…

INTERVIEWER ADD IF NECESSARY: Please answer based on how you are feeling at the present time.

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

{IF DEmp = NOT 1 or 2 employed or self-employed or DStJob =No}

DWkAttd

Please could you tell me how much you agree or disagree with this statement…?:

The thought of being in paid work makes me nervous

Do you… READ OUT…

INTERVIEWER ADD IF NECESSARY: Please answer based on how you are feeling at the present time.

1. Strongly agree,
2. Agree,
3. Neither agree or disagree,
4. Disagree,
5. Or strongly disagree?

SECTION E: Background info

AIMS

This section collects background information on, for example:

- health conditions and disabilities and the extent to which these impact on daily life
- Qualifications
- Interaction with family and friends
- Tenure
- How well the respondent feels generally these days

{Ask all}

IntroE

ADD IF NECESSARY: We are now very close to the end of the interview. In this final section I would like to collect some background information as we realise your circumstances may have changed since we last spoke to you.

{Ask all}

EBen

I will now read out a list of benefits that you might be receiving currently. Some of these benefits may not be relevant to you, but we need to read out the same list to everyone.

So, apart from ESA, do you receive any of the following benefits or tax credits at the moment?

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

MULTICODE.

INTERVIEWER: READ OUT ACRONYMS. CODE ‘Housing or Council Tax Benefit’ OR ‘Child Benefit’ IF EITHER RESPONDENT OR PARTNER RECEIVES THEM.

FOR OTHER BENEFITS ONLY CODE WHERE RESPONDENT IS THE RECIPIENT.

INTERVIEWER: IF RESPONDENT CANNOT REMEMBER THE NAME OF A BENEFIT, CODE AS 15. ‘Another benefit or tax credit not already mentioned’.

1. Housing or Council Tax Benefit (you or your partner)
2. Child Benefit (you or your partner)
3. Disability Living Allowance (DLA)
4. Statutory Sick Pay (SSP)
5. Incapacity Benefit
6. Income Support
7. Job Seekers Allowance (JSA)
8. National Insurance Credits for Incapacity
9. Carer’s Allowance
11. Working Tax Credit
12. Child Tax Credit
13. Universal Credit (UC)
14. Personal Independence Payment (PIP)
15. Another benefit or tax credit not already mentioned (Please specify)
16. None (DO NOT READ OUT)

{Ask all}

EMar

Are you currently ... ?

READ OUT. CODE FIRST THAT APPLIES.

1. Married
2. In a civil partnership
3. Living with partner
4. Single (or engaged but not living with a partner as a couple)
5. Widowed
6. Divorced
7. Separated

{Ask all}

EChild

And can I just check do you currently have any dependent children aged under 16?

INTERVIEWER IF YES: How many? IF NO, CODE 0.

0..19

{Ask all}

EDisE

I now have some questions about any health conditions, illnesses or impairments you may currently have, which have lasted for 12 months or more.

Do you currently have any of the following?

ADD IF NECESSARY: We want to understand what may have changed for you since we last spoke to you.

READ OUT AND CODE EACH IN TURN BEFORE READING THE NEXT.

MULTICODE.

1. Depression
2. Stress or anxiety
3. Fatigue or problems with concentration or memory
4. Pain or discomfort
5. Dizziness or balance problems
6. Problems due to alcohol or drug addiction
7. Problems with arms or hands
8. Problems with legs or feet
9. Problems with neck or back
10. Arthritis
11. Difficulty with seeing
12. Difficulty with hearing
13. Speech problems
14. Skin conditions or allergies
15. Chest or breathing problems
16. Heart or blood pressure problems
17. Problems with bowels, stomach, liver, kidneys or digestion
18. Mental health condition (other than depression/stress)
19. Learning difficulties
20. Progressive illness not covered above
21. Other health or disability issue (Please specify)

{Ask all}

ESever

To what extent does your health condition(s) or disability(ies) limit your ability to carry out everyday activities…?

READ OUT.

INTERVIEWER: CODE FOR EFFECT OF ALL DISABILITIES

IF HEALTH CONDITION FLUCTUATES, ASK FOR GENERAL EFFECT

1. A great deal
2. To some extent
3. A little
4. Not at all

{Ask all}

Equal

What is the highest level of education qualification that you currently have?

INTERVIEWER: PROBE TO CODE.

1. Degree or higher degree or equivalent; NVQ or SVQ levels 4 or 5
2. Higher educational qualification below degree level
3. A levels or Highers; NVQ or SVQ level 3
4. GCSE equiv (grades A-C); CSE grade 1; NVQ or SVQ level 2
5. GCSE grades D-G; CSE grade 2-5; NVQ or SVQ level 1
6. Other quals (inc vocational and foreign quals below degree level)
7. No formal qualifications

INTERVIEWER HELP SCREEN:

Degree or Degree equivalent, and above

- Higher degree and postgraduate qualifications

- First degree (including B.Ed.)

- Postgraduate Diplomas and Certificates (including PGCE)

- Professional qualifications at degree level e.g. graduate member of professional institute, chartered accountant or surveyor

- NVQ or SVQ level 4 or 5

Other Higher Education below degree level

- Diplomas in higher education & other higher education qualifications

- HNC, HND, Higher level BTEC

- Teaching qualifications for schools or further education (below Degree level standard)

- Nursing, or other medical qualifications not covered above (below Degree level standard)

- RSA higher diploma

A levels or equivalent

- A level or equivalent

- GCE ‘A’-level

- AS level

- SCE Higher, Scottish Certificate Sixth Year Studies or equivalent

- NVQ or SVQ level 3

- GNVQ Advanced or GSVQ level 3

- OND, ONC, BTEC National, SCOTVEC National Certificate

- City & Guilds advanced craft, Part III (& other names)

- RSA advanced diploma 122

GCSE/O Level grade A*-C, vocational level 2 and equivalents

- GCE ‘O’-level passes

- NVQ or SVQ level 2

- GNVQ intermediate or GSVQ level 2

- RSA Diploma

- City & Guilds Craft or Part II (& other names)

- BTEC, SCOTVEC first or general diploma

- O level or GCSE grade A-C, SCE Standard or Ordinary grades 1-3

Qualifications at level 1 and below

- NVQ or SVQ level 1

- GNVQ Foundation level, GSVQ level 1

- GCSE or O level below grade C, SCE Standard or Ordinary below grade 3

- CSE below grade 1

- BTEC, SCOTVEC first or general certificate

- SCOTVEC modules

- RSA Stage I, II, or III

- City and Guilds part 1

- Junior certificate

{Ask all}

EUMeetFam

How often are you currently in touch with family, relatives or friends, either face-to-face, by phone or text or electronically (Skype/email, social media) or any other means?

INTERVIEWER: Exclude getting together with family for professional reasons such as work.

READ OUT.

1. Never
2. At least once a year
3. Every couple of months
4. Once a month
5. Several times a month
6. Every week (not every day)
7. Daily

{Ask all}

EWell1

I have a few questions on how you are generally feeling these days.

For each of the following four statements I would like you to give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’.

Overall, to what extent do you feel the things you do in your life are worthwhile?:

0..10

{Ask all}

EWell2

Overall, how satisfied are you with your life nowadays? 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{Ask all}

EWell3

Overall, how anxious did you feel yesterday?: 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{Ask all}

EWell4

Overall, how happy did you feel yesterday?; 0..10

(ADD IF NECESSARY: Please give me a score on a scale of 0 to 10 with nought being ‘not at all’ and ten being ‘completely’)

{Ask all}

ETenure

And, thinking about where you live, do you (or your household) currently own or rent your accommodation?

INTERVIEWER: PROMPT TO CODE

1. Own it outright
2. Buying it with the help of a mortgage or loan
3. Part own and part rent (shared ownership)
4. Rent it
5. Live there rent-free (including living with parents)
6. Squatting

{Ask all}

ILink

The information we've collected from you today is really important in helping the Department for Work and Pensions, the DWP, to understand how well help and support for ESA claimants is working. The DWP would like to add information they hold on your benefits and tax records to your answers to this interview. This will give them a better picture of how well ESA is working for different kinds of people.

If you agree, we will pass DWP a code that links your answers in this interview to your government records. They would only do this for research and statistical purposes. Your answers would only be seen by a small number of specialist researchers within the DWP and no-one else, and would be kept confidential to that research team. So any dealings you might have with the DWP, Jobcentre Plus, or any other government agencies will not be affected at all, in any way.

Would it be ok for us to let DWP match the answers that you give during this interview to your records?

[ADD IF NECESSARY: We asked you this question when we last spoke to you, but we only asked it in relation to your answers at the last survey, *not* this survey. We need separate permission to link your answers at this survey.]

1. Yes,
2. No

Permission to recontact

{Ask all}

Qual

We are hoping to speak to a small number of participants to get more detailed feedback about the services and support provided to them as part of their Employment and Support Allowance (ESA) claim. This would take up to one hour, either on the phone or in person, depending on your preference. Taking part is completely voluntary, you do not have to take part if you do not want to.

If you are selected, we will contact you with further information and to confirm you are still happy to take part.

Are you happy to be contacted about taking part?

1. Yes,
2. No

{Ask if Qual = 1, Yes}

Phone

We would like to confirm your contact information now. We have the following phone number for you, could I please check that this is the best number to contact you on?

Phone number: (FEEDFORWARD PhoneNumber)

1. Yes
2. No

{Ask if Phone = 2, No}

PhoneNew

INTERVIEW: ENTER PHONE NUMBER

{Ask if Qual = 1, Yes}

Postal

We have the following postal address for you, could I please check that it is correct?

Postal address: (FEEDFORWARD Address1, Address2, Address3, Address4, Address5, PostCode)

1. Yes
2. No

{Ask if Postal = 2, No}

PostalNew

INTERVIEWER: ENTER POSTAL ADDRESS

{Ask all}

ISupport

Thank you for talking to us. We know it's not always easy to talk about personal issues like this. If you have any concerns or questions about your existing ESA claim you can contact Jobcentre Plus on 0345 608 8545. There is also information on ESA at https://www.gov.uk/employment-support-allowance.

{Ask all}

IThank

That is the end of the interview, thank you very much for your time.

C.2 Qualitative topic guides

Wave 1: Manager topic guide

ESA WRAG 18-24 pilot

Manager Topic Guide

Research Aims:

- provide details on the support delivered under each pilot and gather feedback on claimant experiences;
- explore why the pilot interventions did or didn't have an impact on benefit and employment outcomes; and
- provide lessons learnt from service delivery to inform the design of any national roll-out.

Overview of topics to be covered in interviews:

- Why support has been designed in the way it has
- What is being delivered and by whom
- How are claimants responding to the support
- Implementation challenges

Interviewer notes:

- This document is a guide to the principal themes and issues to be covered.
- Questions can be modified and followed up in more detail where necessary.
- Not all questions will be relevant to all stakeholders; focus on only those questions relating to professional role of interviewee

1 INTRODUCTION TO RESEARCH

- Introduction to researcher. Thank you for agreeing to take part
- Introduction to Inclusion – research organisation, independent of all Government Departments
- Explanation of research:
  - The research is to test the effectiveness of two years of enhanced support for ESA claimants in the Work Related Activity Group who have been given an 18-24 month prognosis period.
  - We want to understand what support is being delivered and how effective it is.
  - We are interviewing both staff and claimants across the three pilot programmes that are taking place in three areas of England.
  - We are also measuring claimant outcomes and comparing these to a control group not receiving the additional support.
- Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue.

- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included.
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted and files are stored in secure folders which only the research team can access. The recording will be deleted at the end of the research. Is that OK?
- The interview will last about 1 hour.
- Questions?
- Ask for permission to start recording

START RECORDING

2 BACKGROUND

- Please could you briefly describe your role and responsibilities?

For HCP/WP pilots only:

- And can you tell me briefly about your organisation …
    - What type of support does it provide? Who does it work with? Do they have other Work Programme contracts (as prime/subcontractor)?
- What is the organisation's role in delivering the ESA WRAG 18-24 pilot?
    - Probe on prime/subcontractor structure.
    - Contract management or delivery (or both)?
    - For subcontractors: Do they focus on particular groups or work with all? Do they cover a specific geographical area?

For JCP pilot

- And can you tell me a bit about this office?
    - Size (e.g. no of staff, staff specialisms, structure)
    - In a cluster?
    - Characteristics of caseload, local labour market (broadly)

Ask All:

- And what is your role in relation to this pilot?

3 PROJECT AIMS AND OBJECTIVES

- What do you see as the overall aim of this pilot?
- How will you define if the pilot has been successful?

4 DESIGN OF SUPPORT MODEL

- I want to start by getting an overview of the delivery model you are using for this pilot …
- *WP only:* Firstly, do you identify the pilot customers (i.e. ESA WRAG claimants with 18-24 mth prognosis) and treat them any differently from other ESA customers?

If yes, the following questions refer to pilot provision, if no they refer to provision for ESA claimants generally

- What are the key elements of provision? e.g.
    - Assessment
    - Action/activity plans
    - Review meetings
    - Support to manage health condition / disability – what, delivered by whom?
    - Support to prepare claimants for work – what, delivered by whom? E.g.
        - Helping claimants access voluntary work or work experience placements
        - Helping claimants with training courses or qualifications
    - Support to find work – what, delivered by whom?
    - Any follow-up support to help claimants stay in work – what, delivered by whom?
    - Anything else?
- Why has the support been designed in this way?
    - probe on how much leeway they had in designing the support
    - How helpful were the products and guidance developed for the pilot? (JCP only)
    - how much leeway do advisers have in deciding elements of support to deliver?
- Do (pilot) claimants have a key adviser/caseworker (establish the term they use) who they work with over time?
- How does the adviser provide support e.g.
    - Face-to-face
    - Telephone (under what circumstances)
    - By email/online (when and why)
- Frequency and length of appointments
    - How often do advisers see claimants? How is frequency determined?
    - How long are appointments? What determines appointment length?
    - Does this vary over time? (i.e. frequency or duration of meetings). Why?
- How do you decide what support claimants will receive? e.g.
    - Claimant led (claimants identify their own needs)
    - Provider assessment of claimant needs
    - Provider knowledge/judgment of likely outcomes from support
    - Costs of support
- Are any elements of the support mandatory for claimants?

[NB For JCP and WP pilots, customers can be mandated to undertake work-related activity between appointments. However, HCP are not allowed to mandate activities between appointments.]

    - Probe on appointments and activity/support between appointments

    - What is the Fail to Attend rate like (for appointments or other mandatory activities)?
    - Have any of the claimants on this pilot been sanctioned? For what reasons?
- What do you see as the main barriers and challenges in moving closer to work for this group?
    - Are there variations by age, gender, employment history, health condition or disability, caring responsibilities, offending history, local area characteristics, etc.?
- How does what you offer meet the needs of the pilot claimants?
    - Are there variations by age, gender, employment history, health condition or disability, caring responsibilities, offending history, local area characteristics, etc.?
- Are there any barriers that prevent claimants from engaging with the support?
    - E.g how accessible is the support?
    - Include barriers to attending adviser appointments and to attending other provision
    - What have you done to try and overcome these barriers?
    - Explore what support is provided to other groups of ESA claimants
- Have you made any changes to the delivery model since the start of the pilot?
    - How and why?
    - How effective were they?

For JCP:

- How does the delivery model for pilot customers in the 'treatment group' differ from those 18-24 ESA WRAG customers allocated to the control group?

For WP:

- How does the delivery model you've described compare to how you work with other ESA claimants?
    - Probe on how they stream ESA claimants (if at all) and how this pilot group fits within the streams.

5 IMPLEMENTING SUPPORT MODEL

- Which staff members are involved in delivering the pilot?
    - roles, numbers, locations, specialisms
- How did you decide which staff would be involved in delivery?
    - What skills/abilities/experience do you think are important for this pilot?
- What support is provided to staff delivering the pilot?
    - Was any training provided? By whom?
    - How useful was it?
    - Any additional training needed?
- How easy was it to start delivering this pilot?
    - Anything else you would have liked to help prepare you to do this?

- What do you think has worked well so far in delivering this pilot?
- And what have been the key challenges in delivering the pilot?
    - How have they been addressed?
- Are there any other organisational (or other) priorities that have impacted on delivery of this pilot?

6 WORKING WITH PARTNERS

- Which organisations do you work with to support claimants?
    - Where are claimants referred? Explore who, why, etc.
    - Where are claimants signposted?
- How effective have these partnerships been?
    - What has worked well?
    - What have been the main challenges?
    - Could anything be improved?
- Any additional kinds of support needed to refer/signpost claimants to?
    - Any gaps in support available locally?
- Do you work with employers? e.g.
    - To arrange work experience / mentoring / work visits for claimants
    - Employers deliver training/awareness sessions to claimants
    - To find work for claimants (job broker model)?
    - To support claimants into and in work?

7 CLAIMANT OUTCOMES

- How have claimants responded to the support offered?
- How effective do you think the pilot has been in helping claimants manage their health condition/disability?
    - Does this vary for different claimant groups? How?
- How effective do you think the pilot has been in moving claimants closer to work?
    - Does this vary for different claimant groups? How?
- What kind of changes have you seen in claimants?
    - probe: behaviour, attitudes, motivation, confidence
- How effective has the pilot been in helping customers stay in work?
- What did you expect to achieve in this pilot?
    - Probe on different type of outcomes (job entry/outcome, movement towards work (‘distance travelled’), etc.)
- How do claimant outcomes so far compare to these expectations?
- Have there been any unexpected outcomes?
- Which elements of support do you think have been most/least effective?
    - Are there variations by age, gender, employment history, health condition or disability, caring responsibilities, offending history, local area characteristics, etc.?

- How do you assess the effectiveness of the support provided?
- Is there any other support that might be more effective (for groups/individuals that have not been helped)?

8 RESOURCING AND PAYMENT MODEL

- How are you monitored on programme performance?
    - Do you / caseworkers have any targets?
    - How do you feel about this?
- Can you describe the funding model for this pilot? (HCP/WP only)

  [NB The WP providers are paid by results, while the HCP provider is paid for delivering appointments.]
    - Has this funding model affected your delivery of the pilot? Explore any effects on support they are able to offer to claimants
    - Do you feel that the funding model offers sufficient resource to progress this claimant group?

9 LESSONS TO DATE

- Overall, how well do you think the pilot has been going so far?
    - To what extent do you think the pilot is meeting its aims (refer back to what they said the aims were previously)?
    - How could it better meet these aims?
- If it were down to you, would you roll this pilot out nationally?
    - What would you change about it if it were being rolled out nationally?
- Anything else to add?

STOP RECORDING

- Any questions?

Thanks and close

Wave 1 Frontline staff topic guide

ESA WRAG 18-24 pilot

Frontline Staff Topic Guide

Research Aims:

- provide details on the support delivered under each pilot and gather feedback on claimant experiences;
- explore why the pilot interventions did or didn't have an impact on benefit and employment outcomes; and
- provide lessons learnt from service delivery to inform the design of any national roll-out.

Overview of topics to be covered in interviews:

- Implementation
- Referrals
- Supporting claimants
- Working with partners
- How claimants are responding to the support
- Challenges and lessons to date.

Interviewer notes:

- This document is a guide to the principal themes and issues to be covered.
- Questions can be modified and followed up in more detail where necessary.
- Not all questions will be relevant to all; focus on only those questions relating to professional role of interviewee.

1 INTRODUCTION TO RESEARCH

- Introduction to researcher. Thank you for agreeing to take part
- Introduction to Inclusion – research organisation, independent of all Government Departments
- Explanation of research:
  - The research is to test the effectiveness of two years of enhanced support for ESA claimants in the Work Related Activity Group who have been given an 18-24 month prognosis period.
  - We want to understand what support is being delivered and how effective it is.
  - We are interviewing both staff and claimants across the three pilot programmes that are taking place in three areas of England.
  - We are also measuring claimant outcomes and comparing these to a control group not receiving the additional support.
  - N.B. In these interviews we are interested in staff's *experience* of delivering the programme – rather than in numbers of those achieving particular outcomes etc.
  - Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue.

- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included.
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted and files are stored in secure folders which only the research team can access. The recording will be deleted at the end of the research. Is that OK?
- The interview will last about 1 hour.
- Questions?
- Ask for permission to start recording

START RECORDING

2 BACKGROUND

- Please tell me about your role, and what you are doing in relation to this pilot?
    - What / to whom do you deliver?
    - How long have you been involved in this type of delivery?
    - Any specialisms re claimants, types of support, etc.?
    - *WP only*: Do you distinguish pilot claimants (ie ESA WRAG with 18-24 month prognosis) from other ESA claimants? *(If no, refer to 'ESA customers' from now on)*
- What do you see as the overall aims of this pilot? *(if recognise as a pilot)*
- Have you worked with this claimant group before? *(ie ESA 18-24 mth prognosis)*
    - How prepared did you feel to work with this claimant group?
- What support have you and your colleagues had to help you deliver this pilot?
    - Was any training provided to work with this claimant group? By whom?
    - How useful was it?
    - Any additional training needed?

3 REFERRALS

[N.B. HCP/WP pilots will receive referral from JCP. JCP staff will be following guidance that all customers in the ESA 18-24 prognosis group are recruited to the pilot and randomly allocated to treatment or control.]

- How are claimants referred / signposted to you? *[HCP/WP pilots only]*
    - How does the process work – electronically, forms sent, telephone, warm handover, etc.
- What information do you receive about claimants at referral?
    - How useful is this information?
    - What other information would you have liked?
- What do you see as the main barriers and challenges in moving closer to work for this group?
    - Are there variations by age, gender, employment history, health condition or disability, caring responsibilities, offending history, local area characteristics, etc.?

4 SUPPORT MODEL

N.B. In JCP staff interviews, some advisers may work with treatment customers only but in many cases they will have a mix of treatment and control customers.

Ask JCP staff only:

- Would you have a mix of 'treatment' and 'control' group pilot customers on your caseload? *[establish correct terminology to use]*
- Does the support you provide to the two groups vary? How?
- *Clarify that next set of questions relate to treatment customers only*

Ask all:

- Do claimants have a key adviser/caseworker (establish the term they use) who they work with over time?
    - How many pilot claimants/treatment customers *(JCP)* would be on your caseload? Proportion of total caseload?
- How do you / the caseworker provide support, e.g.
    - Face-to-face (*JCP only:* probe for whether first three meetings were face-to-face)
    - Telephone (under what circumstances)
    - By email/online (when and why)
- Frequency and length of appointments …
    - How often do you see claimants? How do you determine frequency?
    - How many appointments would claimants have in total?
    - How long are appointments? What determines appointment length?
    - Does this vary over time? (i.e. frequency or duration of meetings). Why?

5 WORKING WITH CLAIMANTS

Assessment

- How do you decide what support claimants will receive? e.g.
    - Claimant led (claimants identify their own needs)
    - Provider assessment of claimant needs
    - Provider knowledge/judgment of likely outcomes from support
    - Costs of support
- How is the assessment conducted?
    - By whom, i.e. respondent, specialist assessor, other?
        - *For JCP/WP*: Do you discuss claimant support needs with specialist health staff (e.g. DEA for JCP staff or other health professionals for WP staff)
    - Methods used e.g. conversation only, diagnostic tools, distance travelled metrics

    - What is assessed, e.g. work history, skills, soft skills (e.g. confidence, motivation to work), health and health support needs, mental health issues, addictions?
- Do you draw up action or activity plans for claimants? Explore how they do this.
    - Do all claimants get a set package of support? What is this?
    - Do you do anything differently for certain types of claimants, e.g. particular health conditions or disabilities, caring responsibilities, work history, skills, qualifications etc.?
    - Is the claimant involved in devising/agreeing the action/activity plan?

Support offered & provided

N.B. Most important section – ask all questions here

- What kinds of activities might be included on plans / provided to claimants? e.g.
    - Support related to health condition / disability e.g. drug and alcohol support, condition management, physiotherapy, counselling
        - What type of support is provided?
        - Is any of this support provided in-house?
        - What other agencies/organisations are involved?
    - Referral/sign-posting to self-help/support groups for particular conditions
        - Examples
    - Attendance at exercise/gym sessions
    - Group social activities (e.g. walking groups)
    - Mentoring, confidence, motivation, etc.
    - Support with training / courses
        - Examples
    - Voluntary work or work experience placements
    - Support with job search e.g. careers advice, reviewing CV, support to apply for specific jobs / work experience
    - Better off Calculations
    - Other
- How is support sequenced?
    - Importance of addressing certain needs first?
- What is the balance of time spent on the various activities?
- To what extent can you tailor provision, and sequencing, to individual needs?
    - How much freedom do you have to decide what to deliver and to whom?
    - Any additional flexibility needed? Why?

Ask JCP staff only:

- Do you refer clients to Disability Employment Advisers? Explore if, when and why.

Ask all:

- What methods or approach have you used to develop claimants' motivation / willingness to consider work as an option?
- How do you review claimants' progress over time?
    - Are action/activity plans revised periodically? How, and why?
- Overall, how well does what you provide meet the needs of your pilot claimants? *[refer back to main barriers/challenges for this group mentioned earlier]*
- Have you made any changes to the support offered/provided since the start of the pilot?
    - How and why?
    - What effect have these changes had? Have they been successful?

Mandation

N.B. JCP and WP customers can be mandated to undertake work-related activity between appointments. But for HCP participants, attendance of appointments is the only mandatory activity.

- Are there any mandatory elements of the support you provide? (i.e. that the customer has to take part in)
    - Do you mandate customers to undertake activity between appointments?
    - Please provide examples of the activities that are mandatory for customers.
- How have customers responded to this mandation?
- What is the Fail to Attend rate like?
- Have any of the claimants on this pilot been sanctioned? For what reasons?
- Are there any barriers that prevent claimants from engaging with your support?
- What have you done to try and overcome these?
    - And how successful have you been in overcoming these barriers?
    - What else do you think could be done to encourage claimants to engage with your support?

6 PARTNERS

Less important section - If not discussed already, cover the following briefly:

- Which organisations do you work with to support claimants?
    - Where are claimants referred? Explore who, why, etc.
    - Where are claimants signposted?
- How effective have these partnerships been?
    - What has worked well?
    - What have been the main challenges? How addressed?
- Are there any gaps in the support available locally?
- Do you work with employers? e.g.
    - To arrange work experience / mentoring / work visits for claimants
    - Employers deliver training/awareness sessions to claimants

- To find work for claimants (job broker model)?
- To support claimants into and in work?

7 CLAIMANT OUTCOMES

- How have claimants responded to the support you've offered?
  - Examples of positive and negative feedback
- What kind of changes have you seen in claimants?
  - E.g. changes in claimants' attitude, behaviour, skills, motivation
- How effective do you think the pilot has been in helping customers manage their health condition or disability?
- How effective do you think the pilot has been in moving claimants closer to work?
  - Does this vary for different claimant groups (age, gender, employment history, health condition or disability, caring responsibilities, offending history, local area characteristics, etc.)?
- Has the support you've delivered had any other impacts on customers?
- Which elements of support have been most/least effective in helping claimants?
  - I.e. in moving closer to work or other impacts stated previously?
- What other types of support would have helped you in moving customers forward?
  - Were there any gaps in the support you could offer claimants that might have made the difference?

8 MONITORING & RESOURCES

- How are you monitored on your performance for this pilot?
  - Do you have any targets?
  - How do you feel about this?
- Are there any other priorities/pressures that have impacted on your delivery of the pilot?

9 LESSONS TO DATE

- Overall, how well do you think the pilot has been going so far?
  - To what extent do you think the pilot is meeting its aims?
  - How could it better meet these aims?
- What have been the key challenges in delivering this pilot so far? How have they been (or are they being) addressed?
- If it were down to you, would you roll this pilot out nationally?
  - What would you change about it if it were being rolled out nationally?
- What advice would you give to other providers who were about to start delivering on this pilot?
- Anything else to add?

STOP RECORDING

- Any questions?

Thanks and close

Wave 1 Claimant topic guide

ESA WRAG 18-24 pilot

Claimant Topic Guide

Research aims:

- Explore the experiences of support received
- Explore claimants' views on support and its impact on bringing them closer to work
- Gather views on how support could be improved

Overview of topics to be covered in interviews:

- Overview of how they have been supported, including initial assessment and content of sessions with advisers
- Views on support and whether it is providing the right support to look for work
- Views on how the support could be improved

NOTE ON THE TOPIC GUIDE: The following guide lists the discussion phases, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like Why? When? How? as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. This guide is to be used openly and flexibly, to maximise both ease of flow of the interview and the content being captured. The time periods given in each section work as rough guidance for interviewers but may vary in practice.

1 Introduction to Research

- Introduction to researcher
- Thank you for agreeing to take part
- Introduction to NatCen – research organisation, independent of all Government Departments
- Explanation of research:
  - This research study is about the experiences of people that have been part of a pilot programme which aims to help people get ready for work.
  - We want to understand your experiences of the support received
  - As part of this research study we are interviewing 72 people who have taken part in one of three pilot programmes that are taking place in three areas of England.
  - We are also speaking to staff who delivered the programme.
- Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue and to have a break or stop the interview at any time

- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included
- Disclosure: if you say something which indicates that you or someone else might be at risk of significant harm, we might have to tell someone else but we will try to discuss this with you first
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted which means if someone found the recorder they wouldn't be able to listen to the recording. Files are stored in secure folders which only the research team can access. Is that ok?
- The interview will last about 1 hour
- We will send you £20 in vouchers
- Questions?
- Ask for permission to start recording

START RECORDING

2 Contextual information

This section aims to get an overview of the participant's work and benefits history and life context, particularly details of their health condition.

- What they do on a day-to-day basis e.g. working, caring etc.
- Housing situation, who they live with and roughly where
- Education/skills background
- Overview of recent employment history
  - Description of recent jobs and timescales for when employed
  - When / why they left last job
  - If in work, details of job e.g. – role, hours
- Overview of benefit history including length of current claim
- Health conditions and disabilities
  - Description of the health condition they are claiming Employment and Support Allowance for
  - Onset, medical treatment sought for it
  - How it affects their day-to-day life and ability to work
  - Any other health conditions which impact on ability to work
- Their main barriers to work and views on impact of finding work
- If not in work, feelings about returning to work
  - How ready
  - How motivated
  - How confident
- What type of work they feel ready / able to pursue. If in work details of job:
  - Hours
  - Type of role
- Longer term career goals

3 Referral and initial interview

This section aims to understand the referral process and what happens at the initial interview stages, including what support, if any, they are given.

Referral to support

For JCP claimants: please refer to the pilot as 'extra support from Jobcentre Plus'.

For HCP claimants: please use provider name – 'Ingeus'.

For WP claimants: please try and establish the provider name and then use during this section.

- *For WP claimants only*: Can you tell me which organisation you have been receiving support from? *[cross-check against list provided and/or use list to prompt if necessary]*
- Experience of being referred to [name of WP/HCP provider] / being told about extra JCP support:
  - How and when first informed about support and by who
  - Information given at this stage
    - Aim of the support, how it is intended to help
    - Length/duration of support, number and frequency of meetings
    - Mandatory elements – what did they understand about this?
    - Nature of the support
    - Who the support would be delivered by
- Feelings about referral at the time
  - Concerns
  - Expectations
  - Feelings about work
  - Whether clear about next steps
- Length of time between referral and having first appointment

Initial interview

I would like to ask you about your first appointment with [JCP/ name of HCP provider / name of WP provider], what you recall and how you felt about the early sessions you were involved in.

Please prompt the customer with the date of the first interview (if this information is available – JCP claimants only).

Note to interviewer: some participants may not remember the first interview in detail. If memory is vague, ask what they recall and how they felt about the early sessions of the pilots covering the prompts below

- Format of first appointment
  - Face-to-face or telephone (any choice in this?)
  - Length
  - Location
- Content of discussion

    - Work history and work aspirations
    - Health condition / disability
    - Other barriers to work
    - Current skills and / or work experience and gaps
    - Support needs
- Types of advice and support offered during initial interview
    - Support related to health condition / disability e.g. drug and alcohol support, condition management, counselling
    - Mentoring, confidence, motivation, etc.
    - Support with training / courses
    - Support with job search e.g. careers advice, reviewing CV, support to apply for specific jobs / work experience
    - Better off Calculations
    - Other?
- Format of support offered? e.g.
    - In-house/external
    - Self-help guides
    - Peer support groups
- Action plan
    - Whether action plan developed
    - Views of the action plan
        - How compiled / agreed, how much input they had
        - Whether achievable (within timeframe)
        - Whether they feel it met their needs around improving their health/ health management and preparing for work
- Views of initial interview
    - Likes
    - Dislikes
    - Whether met expectations / what else would they have liked?

This section aims to gather evidence on the types of ongoing support claimants are receiving from the pilot programmes.

Ongoing contact with provider

- In total how many appointments they have had so far (with the adviser/caseworker)
- How often
- Average appointment length
- Format of contact, i.e. face-to-face / phone, do they have any choice about format? (**JCP only:** probe for whether first three meetings were face-to-face)
- Location of appointments
- Continuity of adviser i.e. whether same adviser each time
- Nature of any contact with adviser outside of appointments, i.e. mode, discussion

- How appointments and contact with adviser has changed over time

Content of ongoing adviser meetings

- Discussion during subsequent meetings:
  - Review of action plan
  - Discussion of health condition/disability
  - Discussion about other barriers to work
  - Discussion about courses or qualifications
  - Discussion about potential careers/jobs
  - Discussion about job search, employability, skills
  - Discussion of work experience or voluntary opportunities
  - Discussion about in-work support and what is available
  - Discussion of ongoing support needs and how these can be met
- How discussion has changed over time
- Views of ongoing meetings, likes and dislikes, what else they would have liked.

Referrals to other support

Cover other support provided in addition to adviser appointments – either in-house or externally. (E.g. participants may be referred to workshops on Interview Skills, Effective Job Searching, Confidence and Motivation, LearnDirect courses or other skills, physiotherapy, counselling or other health support, or to group activities such as a walking group)

- Any referrals to other support services so far
- Point at which referral/s made
- Purpose of referral/s
  - Treatment for health condition
  - Health condition management
  - Support groups for health condition (on-line or in person)
  - Drug and alcohol support
  - Job search
  - Skills development
  - Voluntary work or work experience
  - Activity/social groups e.g. walking group
  - Confidence/motivation/attitude
  - Other (e.g. debt management, housing etc.)
- Clarify (for each) whether delivered in-house or externally
- Views on support received
  - Whether useful and met / meeting their needs
  - Appropriateness of timing of referral
  - Any other support they think they need
  - If other support not taken up, why not

Work-related activity

- Work-related activity completed so far
  - Researching possible jobs/careers
  - Training
  - volunteering
  - Working experience/shadowing
  - Help with CV, applications, mock interviews
  - Job applications completed
  - Attended interviews
- Whether initiated voluntarily or by adviser
- Views on work-related activity
  - Useful/ not useful
  - Ability to undertake activities
- Any plans for work-related activity in the future

Failure to attend and sanctions

- Whether missed any appointments so far
  - Why and how many
  - Barriers to attending appointments
  - What could enable their attendance
  - Consequences of non-attendance
  - Feelings about this
- Whether experienced any sanctions so far
  - Why
  - How many / for how long
  - Feelings about this

5 Perceived impact of the support

This section aims to explore the impact claimants feel the support has had on their ability to find work

Overall views on support so far

- What they like about the support
- What they dislike
- Extent to which it is meeting expectations / needs
- How accessible they found the support they needed
- Views about frequency, format and location of support
- Nature of any perceived gaps in support provided

Views on adviser so far

- How helpful, supportive, knowledgeable, available
- Whether offered right type of support

- Whether provided right level of support (e.g. too much or too little)
- Overall, what they like / dislike about adviser support

Views on impact of support so far

- How the support has affected (if at all) their:
  - Health condition management
  - Confidence, motivation
  - Skills e.g. job searching, job applications, vocational skills, etc.
  - Work-related activity e.g. whether they have engaged in voluntary work, training, job searching as a result of the support (aside from mandatory WRA)
  - Views about work
  - Readiness for work
  - If in work or worked since being on pilot – influence on finding and entering work
- Which specific elements of the support have caused these changes

  –

6 Suggestions for improvement

This section aims to explore claimant's suggestions on how the support could be improved

- Suggestions on how support could be improved, including:
  - Timing of support i.e. is it the right time for them personally to receive it
  - Frequency of support
  - Format of support (e.g. face-to-face or telephone)
  - Type of support given
  - Location of support
  - Overall adviser approach
  - Signposting and referrals to other organisations
  - Other
- Views on what second year of support should look like

7 Overall thoughts

- Feelings about support received so far
- Views on what would help them move closer to work
- Views on whether support currently receiving is likely to help them move closer to work

STOP RECORDING

- Reassure regarding confidentiality and anonymity
- Check to see if participant has any further questions
- If telephone interview: remind participant that we will post them their £20 voucher and leaflet. Check address and explain it will be sent via recorded delivery so we can ensure it gets to them safely

- Ask about re-contact for Wave 2 interview
- Thank for their time and ensure they have research team contact details

Wave 2 Manager topic guide

ESA WRAG 18-24 pilot evaluation

Manager topic guide

Research Aims:
- provide details on the support delivered under each pilot and gather feedback on claimant experiences;
- explore why the pilot interventions did or didn't have an impact on benefit and employment outcomes; and
- provide lessons learnt from service delivery to inform the design of any national roll-out.

Overview of topics to be covered in interviews:
- Any changes in the support model or delivery since the previous interview
- How they work with partner organisations in the delivery of pilot support
- What types and features of support have been effective in helping claimants to progress

Interviewer notes:
- This document is a guide to the principal themes and issues to be covered.
- Questions can be modified and followed up in more detail where necessary.
- Not all questions will be relevant to all stakeholders; focus on only those questions relating to professional role of interviewee

1 INTRODUCTION TO RESEARCH

- Introduction to researcher. Thank you for agreeing to take part
- Introduction to L&W/NatCen – research organisation, independent of all Government Departments
- Explanation of research:
  - The research is to test the effectiveness of two years of enhanced support for ESA claimants in the Work Related Activity Group who have been given an 18-24 month prognosis period.
  - We want to understand what support is being delivered and how effective it is.
  - We are interviewing both staff and claimants across the three pilot programmes that are taking place in three areas of England.
  - We are also measuring claimant outcomes and comparing these to a control group not receiving the additional support.
- Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue.

- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included.
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted and files are stored in secure folders which only the research team can access. The recording will be deleted at the end of the research. Is that OK?
- The interview will last about 1 hour (individual interview) or 1.5 hours (group interview).
- Questions?
- Ask for permission to start recording

START RECORDING

2 BACKGROUND

If interviewed at Wave 1, recap briefly and ask:

- Has your role changed since we last spoke?

OR

- Please tell me about your role, and what you are doing in relation to this pilot?
- Has the organisation's role in delivering the ESA WRAG 18-24 pilot changed at all since we last spoke/ over the last year?
    - How/why?
- What is the size of your current pilot caseload (in this office/provider)?

[Check if this differs to Wave 1 – we would expect the caseload to be smaller as the pilot draws to a close.]

    - (If relevant:) Has the reduced caseload size affected your delivery of support to pilot customers at all? How?

3 DESIGN AND DELIVERY OF SUPPORT

- Has the support that you offer to claimants on this pilot changed at all since we last spoke/ over the last year? How/why?
    - Personal adviser model
    - Frequency and length of appointments
    - Provision
        - Has any new provision been put in place? Explore
        - Has anything previously offered been discontinued? Why?
    - Staffing changes, e.g. roles, numbers, locations, specialisms
        - What effect has this had?
    - Any other changes?

4 EFFECTIVENESS OF SUPPORT

- Overall, how well does what you provide meet the needs of your pilot claimants?

- What do you think has worked well in delivering this pilot?
    - Have you found particular *ways of delivering* support to be effective?
        - Probe on e.g. timing, location, mode of delivery, flexibility, etc.
        - Ask for examples
    - Does this vary by customer characteristics?
        - Probe on age, gender, employment history, type of health condition or disability
        - Ask for examples
- How are customers made aware of the mandatory aspects of the programme?
    - Do you tell them about the possibility of sanctions?
- How helpful is conditionality / mandation:
    - as a tool for engaging claimants with the programme?
    - for achieving claimant outcomes?
- How have claimants responded to the support offered through the pilot?
    - What have fail to attend rates been like?
    - What has the level of engagement in work-related activity been like?
- What kind of changes have you seen in claimants as a result of the pilot?
    - probe: behaviour, attitudes, motivation, confidence
    - ask for examples
- What do you think works best in changing claimants minds about work?
    - How and why does this make them more willing to consider work as an option?
    - Does this vary for different claimant groups?
- Which elements of support have been most effective in helping claimants manage their health condition?
    - Ask for examples
    - Does this vary for different claimant groups? e.g. based on health condition, employment history, levels of motivation, etc.)
- Which elements of support have been most effective in moving claimants closer to work?
    - Ask for examples
    - Does this vary for different claimant groups? (e.g. based on health condition, employment history, levels of motivation, etc.)
- What would have made the intervention more successful in moving claimants towards work? *Prompt on:*
    - Frequency of appointments
    - Staff training
    - Health input (expertise of in-house staff / external provision)
    - Access to training, other support

5 LESSONS TO DATE

- Reflecting back on the two years of the pilot, overall how successful do you think the pilot has been?
    - To what extent do you think the pilot has met its aims?
- What would you say have been the key strengths of the pilot?
- What would you say have been the key challenges in delivering the pilot?
    - How have they been addressed?
- Have there been any organisational (or other) priorities that have impacted on the delivery of this pilot?
- How well equipped were staff delivering the pilot? (expertise, training, support)
- If it were down to you, would you roll this pilot out nationally?
    - What would you change about it if it were being rolled out nationally?

[For HCP/WP staff only:]

- How well did the pilot financial model facilitate the delivery of effective support to this claimant group?
    - Any suggested changes /improvements to ensure the delivery of successful support for this group in future?
    - What would an appropriate funding model for this claimant group look like?
        - e.g. balance between outcome payment and service fee
        - what outcomes should be rewarded

6 WORKING WITH PARTNERS

NB It is not necessary to accurately distinguish between referral or signposting for each delivery partner, but in general we would like to know which of these mechanisms works better, what the pros and cons of each are.

Which other organisations do you work with to support claimants on this pilot?

- *WP only*: Are any of these subcontracted provision?
- How effective have these partnerships been?
    - What has worked well?
    - What have been the main challenges?
    - Could anything be improved?
- How do you ensure that the provision you refer to is effectively progressing customers?
    - Do they get feedback from partners about claimants' progress?
    - Is there any monitoring of partners' delivery/outcomes?
- Have any of these providers developed provision/support specifically for the pilot/ this customer group?
- Is there any provision that seems particularly effective for this pilot group?
- Are there any barriers to effectively sourcing support for this pilot group?
- Are there any gaps in the support available for this pilot group?

- Anything else to add?

STOP RECORDING

- Any questions?

Thanks and close

Wave 2 Frontline staff topic guide

ESA WRAG 18-24 pilot evaluation

Frontline staff topic guide

Research Aims:

- provide details on the support delivered under each pilot and gather feedback on claimant experiences;
- explore why the pilot interventions did or didn't have an impact on benefit and employment outcomes; and
- provide lessons learnt from service delivery to inform the design of any national roll-out.

Overview of topics to be covered in interviews:

- Any changes in the support model or delivery since the previous interview
- How they work with partner organisations in the delivery of pilot support
- What types and features of support have been effective in helping claimants to progress

Interviewer notes:

- This document is a guide to the principal themes and issues to be covered.
- Questions can be modified and followed up in more detail where necessary.
- Not all questions will be relevant to all; focus on only those questions relating to professional role of interviewee.

1 INTRODUCTION TO RESEARCH

- Introduction to researcher. Thank you for agreeing to take part
- Introduction to L&W/NatCen – research organisation, independent of all Government Departments
- Explanation of research:
  - The research is to test the effectiveness of two years of enhanced support for ESA claimants in the Work Related Activity Group who have been given an 18-24 month prognosis period.
  - We want to understand what support is being delivered and how effective it is. In this second round of interviews we are particularly focusing on effectiveness, what works and lessons learned.
  - We are interviewing both staff and claimants across the three pilot programmes that are taking place in three areas of England.

- We are also measuring claimant outcomes and comparing these to a control group not receiving the additional support.
- Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue.
- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included.
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted and files are stored in secure folders which only the research team can access. The recording will be deleted at the end of the research. Is that OK?
- The interview will last about 1 hour (individual interview) or 1.5 hours (group interview).
- Questions?
- Ask for permission to start recording

START RECORDING

2 BACKGROUND (cover briefly)

If interviewed at Wave 1, recap briefly and ask:

- Has your role changed since we last spoke?

OR

- Please tell me about your role, and what you are doing in relation to this pilot?
    - What / to whom do you deliver?
    - Any specialisms re claimants, types of support, etc.?

3 SUPPORT MODEL AND PILOT DELIVERY (cover briefly)

- Since we last spoke/ over the last year, have there been any changes to the support model for this pilot? For example:
    - Personal adviser model
    - Frequency and length of appointments
    - Changes to assessment process
    - Changes to provision
        - any new provision in place?
        - Has any previous provision stopped?
- How many pilot claimants/treatment customers *(JCP)* are currently on your caseload?
    - Proportion of total caseload?
    - Approximately what proportion of those people are in work? *(does not need to be accurate)*
    - *If relevant*: Has the reduced caseload size affected your delivery of support to pilot claimants at all? How?

Ask JCP staff only:

- Since we last spoke/ over the last year, have there been any changes to the support you provide to the 'control' group claimants on your caseload?
    - Probe how/why.

4 WORKING WITH CLAIMANTS – EFFECTIVENESS OF SUPPORT

Key section

- Overall, how well does what you provide meet the needs of your pilot claimants?
- What do you think has worked well in delivering this pilot?
    - Have you found particular *ways of delivering* support to be effective?
        - Probe on e.g. timing, location, mode of delivery, flexibility, etc.
        - Ask for examples
    - Does this vary by customer characteristics?
        - Probe on age, gender, employment history, type of health condition or disability
        - Ask for examples
- How are customers made aware of the mandatory aspects of the programme?
    - Do you tell them about the possibility of sanctions?
- How helpful is conditionality / mandation:
    - as a tool for engaging claimants with the programme?
    - for achieving claimant outcomes?
- Overall, how have claimants responded to the support you've offered?
    - Examples of positive and negative feedback
    - How does this differ between individuals?
- What kind of changes have you seen among claimants on the pilot?
    - E.g. prompt on soft skills – changes in attitude, behaviour, skills, motivation
- What do you think works best in changing claimants minds about work?
    - How and why does this make them more willing to consider work as an option?
    - Does this vary for different claimant groups?
- Which elements of support have been most effective in helping claimants manage their health condition?
    - Ask for examples
    - Does this vary for different claimant groups? e.g. based on health condition, employment history, levels of motivation, etc.)
- Which elements of support have been most effective in moving claimants closer to work?
    - Ask for examples

    - Does this vary for different claimant groups? (e.g. based on health condition, employment history, levels of motivation, etc.)
- What would have made the intervention more successful in moving claimants towards work? *Prompt on:*
    - Frequency of appointments
    - Staff training
    - Health input (expertise of in-house staff / external provision)
    - Access to training, other support

5 LESSONS TO DATE

Key section – important to cover in every interview

- Reflecting back on the two years of the pilot, overall how successful do you think the pilot has been?
- What would you say have been the key strengths of the pilot?
- What would you say have been the key challenges in delivering the pilot?
    - How have they been addressed?
- Have there been any organisational factors that have impacted on the delivery of this pilot?
- *For JCP staff:* Have there been any changes to resourcing (e.g. a move from delivery by DEAs/specialist staff to delivery by non-specialist staff) that have impacted on the pilot?
- How supported have you felt in delivering this pilot?
    - Which aspects of support helped you most?
    - How could support have been improved?

6 PARTNERS (cover briefly / omit if time is short)

NB It is not necessary to accurately distinguish between referral or signposting for each delivery partner, but in general we would like to know which of these mechanisms works better, what the pros and cons of each are.

- Can you tell me about which other organisations you work with to support claimants on this pilot?
    - What type of support do they provide?
    - Have any of these providers developed provision/support specifically for the pilot/ this customer group?
- How effective have these partnerships been?
    - What has worked well?
    - What have been the main challenges?
    - Could anything be improved?
- How do you ensure that the provision you refer to is effectively progressing customers?
    - Do you get feedback from partners about claimants' progress?

- Is there any provision that seems particularly effective for this pilot group? Examples
- Are there any barriers to sourcing support for this pilot group?
- Are there any gaps in the support available for this pilot group?
- Any lessons learnt or good practice on working with partners you'd like to be shared?
- Anything else to add?

STOP RECORDING

- Any questions?

Thanks and close

Wave 2 Claimant topic guide

ESA WRAG 18-24 pilot

Claimant Topic Guide

Wave 2

Research aims:

- Explore the experiences of support received
- Explore claimants' views on support and its impact on bringing them closer to work
- Explore which aspects of support helped claimants in moving closer to work
- Gather views on how support could be improved

Overview of topics to be covered in interviews:

- Overview of how they have been supported, including content of sessions with advisers, type of support received, customer journey, and perceived impact of the pilot
- Views on support and whether it is effective
- Views on how the support could be improved

NOTE ON THE TOPIC GUIDE: The following guide lists the discussion areas, key themes, sub-themes and the prompts and probes to be used for each interview. It does not include many follow-up questions like Why? When? How? as it is assumed that participants' contributions will be fully explored throughout in order to understand how and why views are held. This guide is to be used openly and flexibly, to maximise both ease of flow of the interview and the content being captured.

1 Introduction to Research

- Introduction to researcher
- Thank you for agreeing to take part
- Introduction to NatCen/L&W – research organisations, both independent of all Government Departments

- Explanation of research:
  - This research study is about the experiences of people that have been part of a pilot programme for ESA claimants which aims to help people get ready for work.
  - We want to understand your experiences of the support received
  - As part of this research study we are interviewing people who have taken part in one of three pilot programmes that are taking place in three areas of England.
  - We are also speaking to staff who delivered the programme.
- Participation is voluntary – there are no right or wrong answers, you can choose not to discuss any issue and to have a break or stop the interview at any time
- What you say is confidential, we will be writing a report of our findings but individuals' names will not be included
- Disclosure: if you say something which indicates that you or someone else might be at risk of significant harm, we might have to tell someone else but we will discuss this with you first
- We'd like to record the interview so we have an accurate record of what is said. The recorder is encrypted which means if someone found the recorder they wouldn't be able to listen to the recording. Files are stored in secure folders which only the research team can access. Is that ok?
- The interview will last about 1 hour
- We will send you £20 in vouchers
- Questions?
- Ask for permission to start recording

START RECORDING

2 Contextual information (5 mins)

This section aims to get an overview of the participant's work and benefits history and life context, particularly details of their health condition.

*For the **longitudinal respondents** – recap on previous responses from the last interview and explore if there have been any changes.*

*For the **boost sample**, explore all.*

- What they do on a day-to-day basis e.g. working, caring etc.
- Housing situation, who they live with and roughly where
- Education/skills background
- Overview of benefit history including length of current claim
- Overview of recent employment history and when/why they left last job
- Health conditions and disabilities
  - Description of the health condition they are claiming Employment and Support Allowance for
  - Any other health conditions
  - Has condition(s) changed over period of claim
  - Onset, medical treatment sought

    - How condition(s) affects their day-to-day life and ability to work
- Their main barriers to work and views on finding work
- If not in work, feelings about returning to work
    - How ready
    - How motivated
    - How confident
- What type of work they feel ready / able to pursue.
- If in work details of job:
    - Hours
    - Type of role
- Longer term career goals

3 Support received (10 mins)

This section aims to gather description of the types of support claimants received from the pilot programmes and whether and how it helped them.

Note to interviewer: We need to first clarify with respondents the period that they were on the pilot to ensure that they are answering questions in relation to this period. This is straightforward for HCP and WP respondents because they were with a specific provider for the duration of the pilot. For JCP, it is trickier because they would continue meetings at JCP after the pilot.

Use the prompts below flexibly at your discretion to ensure that respondents can identify the pilot period.

For JCP respondents still on pilot ask:

- We are interested in the support you have received from Jobcentre Plus as part of a pilot programme. According to our records, this started [insert start date].
- Do you recall having more frequent meetings at Jobcentre Plus over this period?
- This is the period we are interested in.

For JCP respondents who have finished pilot ask:

- We are interested in the support you received from Jobcentre Plus as part of a pilot programme. According to our records, this started [insert start date] and finished [insert pilot end date]
- Do you recall having more frequent meetings at Jobcentre Plus over this period?
- Are you still having meetings at Jobcentre Plus now?
    - Are you seeing a different adviser?
- The pilot period [refer to dates] is what we are interested in.

If respondent is unable to identify the pilot period distinctly, then ask the following questions about Jobcentre Plus support in general.

Some participants may not remember the following in detail. If memory is vague, ask what they recall approximately.

*For **longitudinal sample,** recap on previous responses and ask if any changes since previous interview*

- Overview of contact with provider during pilot
  - Frequency of appointments and length
  - Format of contact, i.e. face-to-face / phone (in and outside of appointments)
  - Continuity of adviser i.e. whether same adviser throughout support
  - Nature of any change to the above over the course of pilot
- Content of adviser meetings
  - Discussion of an action plan
  - Discussion of health condition/disability
  - Discussion about other barriers to work
  - Discussion about steps towards work/work preparation
  - How discussion changed over time
- Referrals to other support
  - Nature of support
  - Point at which referral/s made
  - Whether delivered in-house or externally
- Work-related activity
  - Help with CV, applications, mock interviews
  - Training / volunteering / Working experience/shadowing
  - Exploring possible jobs/careers / Job applications completed / Attended interviews
  - Whether initiated voluntarily or by adviser
  - Changes to type and/or frequency of WRA throughout the pilot?
- Nature of any support received from elsewhere for preparing for work?
- [If no longer on the programme] Nature of support currently received

Views on adviser

- How helpful, supportive, knowledgeable, available?
- Whether offered right type of support
- Whether provided right level of support (e.g. too much or too little)
- Overall, what they liked / disliked about adviser support

4 Perceived impact of the support (20 mins)

This section aims to explore the impact claimants feel the support has had on their ability to find work

- Do you think you have moved forward while receiving support from [WP/HCP/JCP] adviser/caseworker?
    - In what ways?
    - Probe on changes in:
      - Health condition or its management
      - Confidence, motivation
      - Views about work / readiness for work
      - Skills e.g. job searching, job applications, vocational skills, etc.

        - Work-related activity (e.g. whether they have engaged in voluntary work, training, job searching as a result of the support)
            - As part of the activities recommended by the work coach
            - Self-initiated activities
- Ask respondent to talk through when and in what order these changes occurred.

    [Use timeline in face-to-face interviews]

- [If have seen changes] What has contributed to this progress?
    - For each step mentioned above, probe on which specific elements of support helped them, e.g.
        - Aspects of support - conversations with adviser, referrals to external support, WRA etc.
        - The way in which the support was delivered e.g. more frequent meetings
        - Other factors such as changes in health condition, other changes in circumstances, etc
        - Other support outside of the pilot
    - Of the support on the pilot, what has been most helpful in helping them to move forward?
        - How/ Why?
        - What effect did it have?
    - What has been least helpful in helping them move forward?
        - How/ Why?
        - What effect did it have?
- Any gaps in support provided
- Where haven't made progress, why?
    - What are the specific barriers?
    - What would have helped them to make progress? e.g.
        - Longer time period
        - Different type of support? What would this look like?
        - Other?
- What do they see as the next steps for them now?
- Is there any additional support they need now?

Overall and concluding thoughts

- Feelings about support received so far
- Views on what would help them move closer to work now
- Views on whether support currently received (if any) is likely to help them move closer to work
- [If still on programme] Have they talked with their adviser/work coach about the end of the programme
- Will they continue with any of the support or activities mentioned previously (if relevant)?

5 Suggestions for improvement (5 mins)

This section aims to explore claimant's suggestions on how the support could be improved

- Suggestions on how support could be improved, including:
  - Timing of support i.e. was it the right time for them personally to receive it?
    - Whether thoughts on timing have changed since start of pilot
  - Frequency of support
  - Format of support (e.g. face-to-face or telephone)
  - Type of support given
  - Location of support
  - Overall adviser approach
  - Signposting and referrals to other organisations
  - Other

STOP RECORDING

- Reassure regarding confidentiality and anonymity
- Check to see if participant has any further questions
- If telephone interview: remind participant that we will post them their £20 voucher and leaflet. Check address and explain it will be sent via recorded delivery so we can ensure it gets to them safely
- Thank for their time and ensure they have research team contact details

Appendix D: Additional Tables

Appendix Table 4.1 Demographics of sample: age (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Banded age at time of interview			
<25	6	5	8
25-34	13	13	12
35-44	25	23	25
45-54	34	38	35
55+	23	22	20
Base[1]	363	202	500

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.2 Demographics of sample: gender (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Gender			
Female	51	50	45
Male	49	50	55
Base[1]	363	202	500

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.3 Demographics of sample: ethnicity (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
To which of these groups do you consider you belong…			
White	89	95	95
Black	2	1	1
Asian	5	0	1
Another group	1	1	2
Prefer not to say	2	2	0
Base[1]	363	201	497

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.4 Demographics of sample: marital status (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Marital Status			
Married	17	16	13
In a civil partnership	0	0	1
Living with partner	6	6	7
Single (or engaged but not living with a partner as a couple)	50	46	52
Widowed	3	4	3
Divorced	18	23	19
Separated	5	5	6
Base[1]	362	201	497

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.5 Demographics of sample: dependent children (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Do you have any dependent children aged under 16?			
0	79	79	79
1	11	11	10
2	5	7	6
3	3	1	4
4	1	1	1
5	1	1	-
6	-	-	
9	-	1	-
14	-	-	-
Base[1]	362	201	499

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.6 Demographics of sample: Housing status (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Do you (or your household) own or rent your accommodation?			
Own it outright	10	8	8
Buying it with the help of a mortgage or loan	6	4	5
Part own and part rent (shared ownership)	1	1	0
Rent it	75	81	79
Live there rent-free (including living with parents)	8	6	7
Squatting	0	1	1
Base[1]	362	200	497

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.7 Demographics of sample: highest educational qualification (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
What is the highest level of education qualification that you have?			
Degree or higher or equivalent	6	4	11
Higher educational qualification below degree	5	6	6
A levels or Highers; NVQ or SVQ level 3	10	8	13
GCSE equivalent grades A-C	21	22	22
GCSE equivalent grades D-G	10	12	11
Other qualifications	5	4	8
No formal qualifications	43	45	30
Base[1]	357	197	491

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.8 Demographics of sample: Frequency of contact with family, relatives and friends (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
How often are you in touch with family, relatives or friends?			
Never	3	3	2
At least once a year	1	2	2
Every couple of months	3	3	4
Once a month	3	2	4
Several times a month	5	3	5
Every week (not every day)	21	15	26
Daily	63	72	57
Base[1]	361	200	497

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.9 Demographics of sample: Paid employment history (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Ever had a paid job			
Yes	89	91	88
No	11	9	12
Base[1]	*357*	*193*	*451*

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.10 Demographics of sample: Whether ever worked (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Ever worked			
Yes	89	91	89
No	11	9	11
Base[1]	*363*	*201*	*499*

[1] Base: all Wave 1 pilot respondents

Appendix Table 4.11 Demographics of sample: Benefits received at Wave 1 (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Benefits received at Wave 1			
Housing or Council Tax Benefit (you or your partner)	76	75	76
Child Benefit (you or your partner)	20	15	19
Disability Living Allowance (DLA) (Please include mentions of mobility allowance / mobility when back coding)	41	46	50
Statutory Sick Pay (SSP)	3	5	0
Incapacity Benefit	9	9	6
Income Support	8	12	10
Job Seekers Allowance (JSA)	2	3	3
National Insurance Credits for Incapacity	4	5	5
Employment and Support Allowance (ESA)	88	85	84
Carer's Allowance	5	12	7
Working Tax Credit (includes mentions of disabled tax credit / payment, severe disability payment / premium)	1	4	3
Child Tax Credit	17	13	15
Universal Credit (UC)	-	-	0
Personal Independence Payment (PIP)	22	16	16
State pension	1	-	-
Pension credit	1	1	1
Widows pension	0	1	0
Industrial Injuries Disablement Benefit (IIDB)	1	0	0
Tax credit (not specified)	-	-	0
Pension (not specified)	1	0	0
Disablement pension	-	-	-
Other specific answer:	1	-	0
Vague / irrelevant answer	-	-	1
None	2	1	2
Don't know	-	1	-
Prefer not to answer	-	1	0
Base[1]	*363*	*202*	*500*

[1] Base: all Wave 1 pilot respondents

Appendix Table 5.1 Number of appointments by health (percentages)

		Column Percentages	
		JCP Pilot	JCP Control
Extent to which health problems limit activities	**Number of appointments**		
Refused/ not answered	1-3	-	[100]
	4-6	-	-
	11-20	-	-
	Base[1]		*[…]*
Don't know	1-3	[48]	-
	4-6	[52]	[100]
	Base[1]	*[…]*	*[…]*
Great deal	1-3	13	54
	4-6	18	34
	7-10	21	7
	11-20	39	4
	21+	10	1
	Base[1]	*291*	*400*
Less great deal	1-3	11	51
	4-6	16	30
	7-10	24	10
	11-20	38	5
	21+	11	3
	Base[1]	*173*	*197*
Base[1]		*466*	*599*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.2 Number of appointments by highest educational qualification

				Column percentages	
				WP Pilot	WP Control
Highest educational qualification	At least one GCSE grade A-C or equivalent	Number of appointments	1-3	9	50
			4-6	10	34
			7-10	19	11
			11-20	33	5
			21+	28	-
	Low / no / other qualifications	Number of appointments	1-3	14	45
			4-6	20	36
			7-10	13	11
			11-20	28	7
			21+	26	1
Base[1]	*Highest educational qualification*	*At least one GCSE grade A-C or equivalent*		*68*	*183*
		Low / no / other qualifications		*103*	*231*
	Base[1]			*174*	*418*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 5.3 Frequency of appointments (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Frequency of appointments			
Once a week	1	9	2
Once a fortnight	3	55	9
Once a month	13	28	56
Once every two months	36	5	18
Less than every two months	48	3	15
Base[1]	*328*	*165*	*446*

[1] Base: all respondents on pilot programme

Appendix Table 5.4 Whether frequency of appointments has changed (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Frequency of appointments changed			
Has remained the same	53	58	63
Appointments were more frequent at the start	35	17	19
Appointments have been more frequent recently	5	19	12
Other	7	5	5
Base[1]	*331*	*165*	*443*

[1] Base: all respondents on pilot programme

Appendix Table 5.5 Whether respondent felt there was always someone available to help (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Was someone always available to help			
Yes	68	76	78
No	32	24	22
Base[1]	*359*	*201*	*494*

[1] Base: all respondents on pilot programme

Appendix table 5.6 How well respondent felt advisers understood personal situation (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
How well adviser understood your situation			
Very well	61	55	58
Fairly well	26	22	28
Not very well	7	11	6
Not at all well	5	13	8
Base[1]	*362*	*202*	*495*

[1] Base: all respondents on pilot programme

Appendix Table 5.7 Whether respondent made aware of sanctions (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Made aware of sanctions		
Yes	92	84
No	8	16
Base[1]	*360*	*448*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.8 Whether respondent made aware of sanctions (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Made aware of sanctions		
Yes	87	78
No	13	22
Base[1]	*494*	*616*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.9 Whether practical help to manage your condition/disability (in relation to work) was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	35	22
Discussed and received but not as a result of discussion	8	6
Discussed and not received	54	66
Not discussed	3	6
Base[1]	*348*	*436*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.10 Whether practical help to manage your condition/disability (in general) was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	37	19
Discussed and received but not as a result of discussion	5	5
Discussed and not received	53	60
Not discussed	5	16
Base[1]	*348*	*430*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.11 Whether voluntary work was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	7	13
Discussed and received but not as a result of discussion	7	4
Discussed and not received	41	49
Not discussed	46	34
Base[1]	*357*	*444*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.12 Whether work experience was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	1	6
Discussed and received but not as a result of discussion	0	1
Discussed and not received	27	37
Not discussed	71	56
Base[1]	*348*	*431*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.13 Whether physiotherapy sessions were discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	10	4
Discussed and received but not as a result of discussion	8	6
Discussed and not received	18	14
Not discussed	64	75
Base[1]	*351*	*437*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.14 Whether exercise was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	28	7
Discussed and received but not as a result of discussion	9	6
Discussed and not received	29	11
Not discussed	34	76
Base[1]	*358*	*439*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.15 Whether pain management or relief training was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	14	4
Discussed and received but not as a result of discussion	4	4
Discussed and not received	23	10
Not discussed	58	82
Base[1]	*347*	*439*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.16 Whether confidence building and assertiveness training was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	11	6
Discussed and received but not as a result of discussion	3	2
Discussed and not received	44	27
Not discussed	42	64
Base[1]	*345*	*426*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.17 Whether support for specific health conditions was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	11	7
Discussed and received but not as a result of discussion	3	4
Discussed and not received	39	26
Not discussed	47	64
Base[1]	*339*	*428*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.18 Whether support to look for jobs was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	9	14
Discussed and received but not as a result of discussion	1	1
Discussed and not received	45	53
Not discussed	45	31
Base[1]	*357*	*443*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.19 Whether support to write a CV was discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	5	15
Discussed and received but not as a result of discussion	1	1
Discussed and not received	14	21
Not discussed	80	63
Base[1]	*357*	*446*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.20 Whether training or college courses were discussed and received (percentages)

	Column Percentages	
	HCP Pilot	HCP Control
Discussed/received		
Discussed and received as a result of discussion	3	8
Discussed and received but not as a result of discussion	2	2
Discussed and not received	24	25
Not discussed	72	66
Base[1]	*353*	*441*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 5.21 Whether practical help to manage your condition/disability (in relation to work) was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	31	23
Discussed and received but not as a result of discussion	7	6
Discussed and not received	56	62
Not discussed	6	8
Base[1]	*476*	*597*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.22 Whether practical help to manage your condition/disability (in general) was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	26	20
Discussed and received but not as a result of discussion	7	7
Discussed and not received	52	55
Not discussed	15	19
Base[1]	*476*	*591*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.23 Whether voluntary work was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	22	12
Discussed and received but not as a result of discussion	7	8
Discussed and not received	43	47
Not discussed	28	33
Base[1]	*491*	*605*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.24 Whether work experience was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	9	5
Discussed and received but not as a result of discussion	1	1
Discussed and not received	36	32
Not discussed	54	62
Base[1]	*482*	*588*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.25 Whether exercise was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	13	9
Discussed and received but not as a result of discussion	6	6
Discussed and not received	14	13
Not discussed	67	72
Base[1]	*492*	*599*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.26 Whether confidence building and assertiveness sessions were discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	13	9
Discussed and received but not as a result of discussion	3	2
Discussed and not received	31	21
Not discussed	54	68
Base[1]	*474*	*595*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.27 Whether social or group sessions were discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	11	6
Discussed and received but not as a result of discussion	3	3
Discussed and not received	23	20
Not discussed	63	71
Base[1]	*479*	*596*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.28 Whether support to look for jobs was discussed or received (percentages)

	Column percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	32	21
Discussed and received but not as a result of discussion	2	2
Discussed and not received	38	47
Not discussed	28	30
Base[1]	*490*	*610*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.29 Whether practical help with managing money, debt or benefits was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	13	6
Discussed and received but not as a result of discussion	1	1
Discussed and not received	37	33
Not discussed	50	59
Base[1]	478	598

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.30 Whether support to write a CV was discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	31	18
Discussed and received but not as a result of discussion	2	3
Discussed and not received	19	21
Not discussed	48	59
Base[1]	*491*	*614*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.31 Whether training or college courses were discussed or received (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Discussed/received		
Discussed and received as a result of discussion	21	13
Discussed and received but not as a result of discussion	3	3
Discussed and not received	30	26
Not discussed	45	57
Base[1]	*490*	*615*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.32 Whether confidence and assertiveness training was discussed or received (percentages)

	Column Percentages	
	WP Pilot	WP Control
Discussed/received		
Discussed and received as a result of discussion	16	9
Discussed and received but not as a result of discussion	3	3
Discussed and not received	24	21
Not discussed	57	67
Base[1]	*192*	*409*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 5.33 Whether social or group activity was discussed or received (percentages)

	Column Percentages	
	WP Pilot	WP Control
Discussed/received		
Discussed and received as a result of discussion	15	8
Discussed and received but not as a result of discussion	2	2
Discussed and not received	20	21
Not discussed	63	69
Base[1]	*193*	*410*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 5.34 Whether practical help managing debt and money was discussed or received (percentages)

	Column Percentages	
	WP Pilot	WP Control
Discussed/received		
Discussed and received as a result of discussion	11	6
Discussed and received but not as a result of discussion	1	1
Discussed and not received	31	32
Not discussed	56	61
Base[1]	*198*	*417*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 5.35 Whether support to write a CV was discussed or received (percentages)

	Column Percentages	
	WP Pilot	WP Control
Discussed/received		
Discussed and received as a result of discussion	44	13
Discussed and received but not as a result of discussion	1	2
Discussed and not received	22	18
Not discussed	33	68
Base[1]	*195*	*428*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 5.36 Number of training or college courses attended (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Number of training or college courses			
0 courses	97	86	79
1 course	2	6	10
2 courses	1	2	7
3+ courses	1	7	4
Base[1]	*353*	*194*	*488*

[1]Base: all respondents on pilot programmes

Appendix Table 5.37 Type of training or college courses attended (numbers)

	Multiple Responses (numbers)		
	HC Provider	WP Provider	Jobcentre Plus
Type of training or college courses			
Computing	[6]	15	51
English	[4]	4	18
Maths	[4]	5	15
Combined maths and English course	[0]	1	1
Hairdressing / beauty	[0]	0	3
Book keeping	[0]	2	6
Self-employment	[0]	0	1
Business / marketing	[0]	0	2
Health and safety / first aid	[0]	5	7
Employability	[1]	7	4
Interview techniques	[0]	3	0
CV writing	[0]	1	1
Confidence building	[0]	4	9
Financial management	[0]	0	0
Gardening	[0]	0	3
Customer services	[0]	3	1
Manual handling	[0]	0	1

	Multiple Responses (numbers)		
Counselling Service	[0]	0	1
Retail	[0]	0	1
European Driving	[0]	0	0
Graphic design	[0]	0	2
Security	[1]	0	1
Sign Language	[1]	0	1
Problem solving	[0]	1	0
Typing	[0]	1	0
Coaching	[0]	0	1
Social skills	[0]	3	1
Healthcare	[0]	2	5
Science and technology	[0]	0	1
Photo editing	[0]	0	1
Construction	[0]	0	3
Catering	[0]	0	1
Marketing	[0]	1	0
Stewarding	[0]	0	1
Bereavement counsellor	[0]	0	1
Drawing	[0]	0	1
Interpersonal skills	[0]	0	1
Leadership & Sport	[0]	1	0
Publishing	[0]	0	1
Childcare	[0]	0	1
Other specific answer	[0]	1	3
Vague / irrelevant answer	[1]	5	10
Base[1]	*[…]*	*65*	*161*

[1]Base: all respondents on pilot programme who took part in training courses

Appendix Table 5.38 Number of training courses attended (percentages)

	Column percentages		
	HC Provider	WP Provider	Jobcentre Plus
Number of training or college courses			
0 courses	97	86	79
1 course	2	6	10
2 courses	1	2	7
3+ course	1	7	4
Base[1]	353	194	488

[1]Base: all respondents on pilot programme

Appendix Table 5.39 Whether received other support: Referred to doctor / other health specialist (JCP and JCPC)

	Column Percentages	
	JCP Pilot	JCP Control
Referred to doctor/other specialist		
Yes	3	0
No	97	100
Base[1]	*490*	*569*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.40 Whether received other support: Advice about benefits/ administrative help (JCP and JCPC)

	Column Percentages	
	JCP Pilot	JCP Control
Advice about benefits/administrative help		
Yes	6	3
No	94	97
Base[1]	*490*	*569*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 5.41 Whether received other support: No – nothing else (numbers)

	Numbers		
	HC Provider	WP Provider	Jobcentre Plus
No – nothing else			
No	102	47	150
Yes	254	152	340
Base[1]	*356*	*199*	*490*

[1] Base: all respondents on pilot programme

Appendix Table 5.42 Whether received other support (percentages)

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Other support			
No – nothing else	71	76	68
Received help with arranging work / voluntary work	2	2	5
Referred to community support services	-	-	-
Referred to doctor / other health specialist	6	2	3
Adviser arranged for provision of medical equipment	-	-	-
Advice about benefits / administrative help	6	2	5
General support and encouragement from adviser	7	2	5
Assistance / financial assistance with travel arrangements	1	-	1
Family issues	-	-	-
Understanding re health issues	-	-	-
Discussed returning to previous work	-	-	-
Mental health issues	-	-	-
Advice about returning to education/training	-	-	-
Self employment information/help	-	-	-
Larger print on correspondence	-	-	-
Help with accommodation	-	-	-
Other specific answer		-	1
Vague / irrelevant answer	10	17	13
Base[1]	*221*	*127*	*299*

[1] Base: all respondents on pilot programme

Appendix Table 5.43 Whether received other support (numbers)

	Multiple responses (numbers)		
	HC Provider	WP Provider	Jobcentre Plus
Other support			
No – nothing else	254	152	340
Received help with arranging work / voluntary work	5	5	25
Referred to community support services	0	0	2
Referred to doctor / other health specialist	21	4	13
Adviser arranged for provision of medical equipment	0	0	0
Advice about benefits / administrative help	20	5	28
General support and encouragement from adviser	23	8	24
Assistance / financial assistance with travel arrangements	4	0	5
Family issues	0	0	0
Understanding re health issues	0	0	0
Discussed returning to previous work	0	0	0
Mental health issues	0	0	0
Advice about returning to education/training	0	0	0
Self-employment information/help	0	0	0
Larger print on correspondence	0	0	0
Help with accommodation	0	0	0
Other specific answer	2	0	3
Vague / irrelevant answer	33	26	57
Base[1]	*362*	*200*	*497*

[1] Base: all respondents on pilot programme

Appendix Table 5.44 Whether had any dislikes about support received

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Any dislikes			
Yes	22	32	30
No	78	68	70
Base[1]	*358*	*199*	*499*

[1] Base: all respondents on pilot programme

Appendix Table 5.45 Anything respondent did not like about support received

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
What dislikes			
Adviser not listening	1	-	5
Disinterested adviser	3	1	1
Multiple advisers / did not see the same adviser consistently	19	6	6
Adviser lacking empathy and understanding of health condition / disability	9	19	22
Unhelpful adviser	5	5	7
Inconvenient appointments	4	3	4
Appointments changing / being cancelled	2	1	2
Unreasonable expectations regarding work	8	7	2
Administrative issues / adviser not understanding the system	-	-	3
Lack of funding for courses	1	-	1
Felt under pressure / support was pushy	6	10	14
Stressful attending appointments	12	9	3
Prompted anxiety about benefits being stopped	6	8	1
Did not get the right support / a waste of time	16	11	7
Being sanctioned / the threat of sanctions	-	5	3
Communication issues	1	-	6
Travelling to/from	14	8	3
Just didn’t like going there	-	-	1
Didn’t like intrusion	-	-	1
Unwilling to put forward for training	1	-	2
Rude adviser	3	1	3
Privacy	1	2	3
Errors made by advisers	-	6	2
Facilities at provider	2	2	1
Selection of courses	-	-	1
No support	-	-	1
Being forced to work or threat of benefits being stopped when not ready due to illness	-	-	2
Other specific answer:	3	3	2
Vague / irrelevant answer	5	3	8

	Column Percentages		
Base[1]	*79*	*63*	*147*

[1] Base: all respondents on pilot programme who had a dislike about support received

Appendix Table 5.46 Whether have received in-work support

	Column Percentages		
	HC Provider	WP Provider	Jobcentre Plus
Received in-work support			
Yes	-	[40]	[21]
No	[100]	[60]	[79]
Base[1]	*[...]*	*[...]*	*[...]*

[1] Base: all respondents on pilot programme

Appendix Table 5.47 Rating of support by all treatment groups (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Rating of support by all treatment groups			
Very good	49	43	44
Good	40	45	40
Fair	6	6	9
Poor	4	2	5
Very poor	1	4	2
Base[1]	*259*	*113*	*345*

[1] Base: all respondents on pilot programme

Appendix Table 5.48 Rating of support (percentages)

	Column Percentages	
	HCP pilot	HCP control
Rating of support by HCP pilot and control groups		
Very good	49	40
Good	40	37
Fair	6	13
Poor	4	7
Very poor	1	3
Base[1]	*259*	*291*

[1] Base: all respondents on HCP pilot programme

Appendix Table 6.1 Why support received did not help with health condition (percentages)

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Why support not helped with health			
You needed medical help that they could not give you	63	74	72
The timing of the support was wrong	15	21	18
The appointments were too far apart	14	11	5
The appointments were too close together	1	7	8
Adviser did not understand your needs	20	26	25
Adviser did not have the right skills / expertise	19	23	21
You did not need help to manage your condition / disability	20	22	19
Appointments were too long	-	2	-
Travel / accessibility issues around getting to appointments	2	2	1
Adviser was too focused on job seeking and not condition / disability	1	4	1
Already undertaking the activities suggested	1	-	1
Needed more face-to-face appointments	-	1	0
Multiple advisers / did not see the same adviser consistently	1	2	0
Help from GP / other professionals not related to appointments	4	-	1

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Too ill / condition cannot be managed in this way	5	4	5
Waste of time/Couldn't help/Useless	5	1	2
Cancelled appointment	-	-	0
Made me too stressed/depressed/anxious	1	-	0
Waiting for appointment/Not had appointment yet	-	-	0
Unable to work	-	2	-
Didn't discuss it/inadequate correspondence	1	-	0
Too old	1	-	0
Put in wrong group	1	-	1
Didn't do any activities	1	-	-
They expected too much	-	-	0
Lack of power	-	-	0
Due to disability unable to hold down job	-	-	0
I have only just started seeing this adviser	-	-	0
Agoraphobia/too frightened	3	1	1
Wrong type of support	1	2	-
Did not help with finding work	1	-	-
Want to be left alone	-	1	-
Not given funding	1	-	-
Other specific answer	-	-	1
Vague / irrelevant answer	6	1	3
Don't know	5	1	2
Prefer not to answer	-	-	0
Base[1]	*142*	*122*	*266*

[1] Base: all respondents on pilot programme who said support didn't help with health

Appendix Table 6.2 Reasons support has not helped with work (percentages)

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Why support not helped with work			
You needed medical help that they could not give you	73	66	68
The timing of the support was wrong	28	37	25
The appointments were too far apart	17	13	5
The appointments were too close together	-	9	9
Adviser did not understand your needs	19	32	25
Adviser did not have the right skills / expertise	20	27	25
You did not need help to manage your condition / disability	15	29	10
You received your pension, instead of moving into work	-	-	1
Your medication prevents you from working	2	3	1
No help or appointments given	2	-	-
Other specific answer	2	-	3
Vague / irrelevant answer	-	-	3
Don't know	3	7	9
Prefer not to answer	1	-	2
Base[1]	*113*	*52*	*129*

[1] Base: all respondents on pilot programme who said support didn't help with work

Appendix Table 6.3 Reasons support has not helped with barriers to work (percentages)

	Multiple responses (%)		
	HC sprovider	WP provider	Jobcentre Plus
Why support not helped with barriers to work			
You needed medical help that they could not give you	74	86	75
The timing of the support was wrong	17	17	13
The appointments were too far apart	12	7	4
The appointments were too close together	1	9	6
Adviser did not understand your needs	16	21	22
Adviser did not have the right skills / expertise	17	23	22
You did not need help to manage your condition / disability	16	10	8
Multiple advisers / did not see the same adviser consistently	1	1	1
Confidence issues not addressed	0	-	1
Transport issues not addressed	3	-	1
Support received was not relevant	2	4	1
Poor relationship with adviser / did not trust adviser	-	-	1
Support was pushy / rushed	1	-	0
Health not addressed / Nothing adviser could do – feels too unwell to work	12	3	10
Lack of training	-	-	0
Age	1	1	0
No support / options given	-	-	2
Caring responsibilities	-	-	0
Just can’t work	-	-	1
Get support elsewhere/manage myself	-	-	0
Not looking for work	1	-	-
Criminal record	-	1	-
Doesn’t like Jobcentre	-	-	0
Other specific answer	4	2	4
Vague / irrelevant answer	3	1	2
Don’t know	2	2	2
Prefer not to answer	-	-	-

			Multiple responses (%)
Base[1]	*182*	*113*	*239*

[1] Base: all respondents on pilot programme who said support didn't help with barriers to work

Appendix Table 6.4 Most helpful element of support (percentages)

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Most helpful element of support			
Practical help to manage your condition/disability (in relation to work)	6	4	4
Practical help to manage your condition/disability (in general)	13	8	5
Voluntary work	1	6	9
Work experience	1	-	1
Physiotherapy sessions	1	-	-
Exercise	7	-	1
Pain management or relief training	5	-	1
Counselling or cognitive behavioural therapy	4	-	4
Confidence building or assertiveness sessions	6	9	8
Support groups for specific health conditions	4	-	2
Social or group activities	2	2	1
Addiction services	-	-	1
Support to produce a CV or apply for jobs	1	14	9
Practical help with managing money, debt or benefits	1	5	3
Training or college courses	1	10	16
One-to-one discussions with an adviser	1	-	4
Support to look for jobs	-	-	-
Practical help with managing money, debt or benefits	-	-	-
Collaborative working between advisers and other service providers	0	-	1
Other specific answer	-	-	-
Vague / irrelevant answer	-	-	0
Other	17	14	10
Can't say which is most effective	15	21	12
None of these	13	8	9
Base[1]	*166*	*51*	*207*

[1] Base: all respondents on pilot programme who said support helped

Appendix Table 6.5 Number of jobs applied for (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Number of jobs applied for			
1	[25]	[15]	26
2-5	[33]	[17]	18
6-10	[8]	[23]	17
11-20	[8]	[11]	10
21+	[26]	[33]	29
Base[1]	*[...]*	*[…]*	*92*

[1] Base: all respondents on pilot programme who had applied for a job since last interview

Appendix Table 6.6 Type of jobs applied for (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Type of jobs applied for			
Full-time - over 30 hours a week	[35]	[57]	44
Part-time - 30 hours a week or less	[88]	[86]	76
Working from home	-	-	1
Seasonal work	-	-	-
Other specific answer	-	-	1
Vague/ Irrelevant answer	[3]	-	1
Don't know	-	[5]	2
Base[1]	*[…]*	*[…]*	*97*

[1] Base: all respondents on pilot programme who had applied for a job since last interview

Appendix Table 6.7 Whether attended any job interviews (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Attended any job interviews			
Yes	[59]	[67]	[62]
No	[16]	[24]	[9]
No - when asked at Wave 1 only	[25]	[9]	[29]
Base[1]	*[…]*	*[…]*	*97*

[1] Base: all respondents on pilot programme who had applied for a job since last interview

Appendix Table 6.8 Number of interviews attended (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Number of interviews attended - banded			
1	[46]	[58]	38
2 to 5	[38]	[32]	38
6+	[16]	[10]	24
Base[1]	*[…]*	*[…]*	*62*

[1] Base: all respondents on pilot programme who had applied for a job and been invited to interview

Appendix Table 6.9 Whether anyone suggested they apply for a job (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Whether anyone suggested they apply			
Yes	[24]	[100]	[41]
No	[76]	-	[59]
Base[1]	*[…]*	*[…]*	*[…]*

[1] Base: all respondents on pilot programme who applied for jobs

Appendix Table 6.10 Current activities at Wave 1 (percentages)

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Current activities at Wave 1			
In paid work as an employee	2	4	8
Working as self-employed	0	-	2
Unemployed and actively looking for work	5	4	11
In education or training	2	5	8
Not working because of sickness or disability	91	88	78
Looking after the home or family	14	12	13
Doing voluntary or other unpaid work (full-time or part-time)	6	7	15
Something else	4	3	3
Base[1]	*363*	*202*	*500*

[1] Base: all respondents on pilot programme

Appendix Table 6.11 Whether in work at Wave 1 (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Whether in work at time of interview at Wave 1		
Yes	10	6
No	90	94
Base[1]	*500*	*623*

[1] Base: all respondents on JCP pilot programme

Appendix Table 6.12 Main activity at Wave 1 (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Main activity at Wave 1			
In paid work as an employee	2	4	7
Working as self-employed	-	-	2
Unemployed and actively looking for work	1	3	6
In education or training	1	2	4
Not working because of sickness or disability	87	81	69
Looking after the home or family	4	4	3
Doing voluntary or other unpaid work (full-time or part-time)	3	3	7
Something else	2	3	2
Base[1]	*359*	*201*	*495*

[1] Base: all respondents on pilot programme

Appendix Table 6.13 Whether work is permitted (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Permitted work			
Yes	[24]	[29]	[50]
No	[76]	[71]	[50]
Base[1]	[…]	[…]	[…]

[1] Base: all respondents on pilot programme who are were paid work or self-employed

Appendix Table 6.14 Standard Industrial Classification (SIC) of current employment (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Standard Industrial Classification			
Crop and animal production, hunting and related service activities	-	-	2
Manufacture of food products	-	-	4
Manufacture of textiles	-	-	5
Manufacture of leather and related products	-	-	-
Printing and reproduction of recorded media	-	-	2
Manufacture of chemicals and chemical products	-	-	-
Electricity, gas, steam and air conditioning supply	-	-	-
Waste collection, treatment and disposal activities; materials recovery	[9]	-	-
Construction of buildings	-	-	4
Specialised construction activities	-	-	-
Wholesale and retail trade and repair of motor vehicles and motorcycles	-	-	-
Wholesale trade, except of motor vehicles and motorcycles	-	-	-
Retail trade, except of motor vehicles and motorcycles	[10]	[12]	14
Land transport and transport via pipelines	[7]	-	-
Postal and courier activities	-	-	-
Accommodation	[10]	[24]	3
Food and beverage service activities	-	[8]	10
Telecommunications	-	-	2
Computer programming, consultancy and related activities	-	-	-
Financial service activities, except insurance and pension funding	-	-	3
Insurance, reinsurance and pension funding, except compulsory social security	-	-	-
Real estate activities	-	[11]	-
Veterinary activities	-	-	-
Rental and leasing activities	-	-	-
Employment activities	-	-	-
Security and investigation activities	[12]	-	-

	Column Percentages		
Services to buildings and landscape activities	-	-	-
Public administration and defence; compulsory social security	-	[12]	4
Education	[10]	-	11
Human health activities	-	-	9
Residential care activities	[8]	-	6
Social work activities without accommodation	[8]	[8]	3
Libraries, archives, museums and other cultural activities	-	-	2
Gambling and betting activities	-	[15]	-
Activities of households as employers of domestic personnel	-	-	4
Activities of membership organisations	-	-	-
Other personal service activities	-	-	2
Other	[26]	[10]	9
Base[1]	*[…]*	*[…]*	*52*

[1] Base: all respondents on pilot programme in paid work or self-employed

Appendix Table 6.15 Standard Occupational Classification (SOC) of current employment (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Standard Occupational Classification			
Chief executives and senior officials	-	-	2
Production managers and directors in manufacturing	-	-	-
Managers and directors in transport and distribution	-	-	-
Hotel and accommodation managers and proprietors	-	-	-
Shopkeepers and proprietors – wholesale and retail	-	-	-
Web design and development professionals	-	-	-
Further education teaching professionals	[8]	-	-
Teaching and other educational professionals n.e.c.	-	-	2
Electrical and electronics technicians	-	-	-
Welfare and housing associate professionals n.e.c.	-	-	-
Prison service officers (below principal officer)	-	-	2
Product, clothing and related designers	-	-	-
Business sales executives	-	-	2
Marketing associate professionals	-	[15]	-
Sales accounts and business development managers	-	-	-
National government administrative occupations	-	[12]	5
Officers of non-governmental organisations	-	-	-
Book-keepers, payroll managers and wages clerks	-	-	2
Pensions and insurance clerks and assistants	-	-	-
Library clerks and assistants	-	-	2
Other administrative occupations n.e.c.	-	-	2
Office managers	-	-	-
School secretaries	-	-	2
Receptionists	-	[10]	2
Gardeners and landscape gardeners	[8]	-	-
Metal working production and maintenance fitters	-	-	-

	Column Percentages		
Carpenters and joiners	-	-	-
Construction and building trades n.e.c.	-	[11]	-
Construction and building trades supervisors	-	-	2
Weavers and knitters	-	-	3
Pre-press technicians	-	-	2
Bakers and flour confectioners	-	-	2
Other skilled trades n.e.c.	-	-	2
Nursery nurses and assistants	-	-	2
Teaching assistants	-	-	-
Educational support assistants	-	-	2
Animal care services occupations n.e.c.	-	-	2
Ambulance staff (excluding paramedics)	-	-	-
Care workers and home carers	-	[8]	10
Leisure and travel service occupations n.e.c.	-	-	2
Hairdressers and barbers	-	-	2
Beauticians and related occupations	-	-	-
Housekeepers and related occupations	[10]	-	-
Sales and retail assistants	-	[12]	9
Retail cashiers and check-out operators	[9]	-	-
Sales supervisors	[10]	-	-
Call and contact centre occupations	-	-	-
Customer service managers and supervisors	-	-	2
Food, drink and tobacco process operatives	-	-	-
Textile process operatives	-	-	2
Construction operatives n.e.c.	-	-	-
Large goods vehicle drivers	-	-	-
Van drivers	-	-	7
Bus and coach drivers	[7]	-	-
Taxi and cab drivers and chauffeurs	-	-	-
Driving instructors	-	-	-
Mobile machine drivers and operatives n.e.c.	-	-	-
Elementary construction occupations	-	-	-
Packers, bottlers, canners and fillers	-	-	2
Elementary administration occupations n.e.c.	-	-	-

			Column Percentages
Cleaners and domestics	[10]	[22]	15
Refuse and salvage occupations	[9]	-	-
Security guards and related occupations	[12]	-	-
School midday and crossing patrol occupations	[10]	-	3
Kitchen and catering assistants	-	-	5
Waiters and waitresses	-	-	-
Bar staff	-	-	-
Leisure and theme park attendants	-	-	-
Don't Know	[7]	[10]	4
Base[1]	*[…]*	*[…]*	*52*

[1] Base: all respondents on pilot programme in paid work or self-employed

Appendix Table 6.16 Barriers to finding work (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Barriers to finding work			
Family or caring commitments	[9]	-	12
Health issues/disabilities limit the kind of work respondent can do	[74]	[80]	71
The time involved in getting to interviews or to a workplace	[4]	-	11
The cost involved in getting to interviews or to a workplace	[11]	[16]	4
Lack of vacancies/too much competition for jobs respondent's interested in	[27]	[27]	39
Lack of jobs in local area	[24]	[42]	38
Lack of jobs for people with respondent's health issues/disabilities	[40]	[32]	38
Lack of jobs for people with caring responsibilities	[9]	[7]	7
Not having right skills for jobs interested in	[18]	[23]	22
Not interested in working/don't want a paid job	[3]	-	1
Financially worse off in paid work	[7]	-	3
Lack of work experience	[19]	[26]	15
Drug or alcohol problems	-	-	3
Criminal record	[3]	-	2
Housing problems	-	-	-
Transport/travel difficulties	[23]	[26]	18
Lack of confidence	[11]	-	1
Anxieties / can't cope with crowds / difficulties interacting	-	-	4
Age is a disadvantage	[6]	[10]	3
Other specific answer	[4]	-	6
Vague / irrelevant answer	[7]	-	1
None of these	-	-	3
Don't know	-	-	-
Base[1]	*[…]*	*[…]*	*62*

[1] Base: all respondents on pilot programme who were not about to start work

Appendix Table 6.17 Barriers to finding work (percentages)

	Column Percentages	
	JCP Pilot	JCP Control
Barriers to finding work		
Not interested in working/don't want a paid job	1	-
Housing problems	-	4
Anxieties / can't cope with crowds / difficulties interacting	4	-
Age is a disadvantage	3	4
None of these	3	-
Don't know	-	1
Base[1]	*62*	*59*

[1] Base: all respondents on JCP pilot programme and control who are not about to start work

Appendix Table 6.18 Whether respondents think they will get a job in the near future, including those working (Wave 1) (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Will get a job in the near future			
Yes	55	56	64
No	45	44	36
Base[1]	*330*	*186*	*467*

[1] Base: all respondents on pilot programme who are not about to start work and are not in paid work or self-employed

Appendix Table 6.19 Whether respondents think they will get a job in the near future, including those working (Wave 2) (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Will get a job in the near future			
Yes	47	41	60
No	53	59	40
Base[1]	*182*	*97*	*248*

[1] Base: all respondents on pilot programme who are not about to start work and are not in paid work or self-employed

Appendix Table 6.20 Effect of support on motivation to leave Employment and Support Allowance (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Effect of support on motivation to leave Employment and Support Allowance			
Increased a lot	8	8	15
Increased a little	26	21	22
Decreased a little	2	6	2
Decreased a lot	2	4	3
No effect	62	61	58
Base[1]	*298*	*151*	*390*

[1] Base: all respondents on pilot programme

Appendix Table 6.21 Effect of support on motivation to leave Employment and Support Allowance (percentages)

	Column Percentages	
	HCP pilot	HCP control
Effect of support on motivation to leave Employment and Support Allowance		
Increased a lot	8	11
Increased a little	26	16
Decreased a little	2	5
Decreased a lot	2	5
No effect	62	64
Base[1]	*298*	*358*

[1] Base: all respondents on HCP pilot programme and control

Appendix Table 6.22 Effect of support on motivation to leave Employment and Support Allowance (JCP and JCPC) (percentages)

	Column Percentages	
	JCP pilot	JCP control
Effect of support on motivation to leave Employment and Support Allowance		
Increased a lot	15	11
Increased a little	22	17
Decreased a little	2	2
Decreased a lot	3	3
No effect	58	66
Base[1]	*390*	*495*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 6.23 Why motivation to leave ESA increased (percentages)

	Multiple responses (%)		
	HC provider	WP provider	Jobcentre Plus
Why motivation to leave ESA increased			
Increased confidence	48	[44]	49
Better health	12	[18]	9
Better management of condition	25	[14]	22
Support / encouragement from adviser	45	[38]	54
Gained new work-related skills	6	[13]	19
Thought people in work are always better off financially	17	[20]	16
Didn't want to stay on the scheme	12	[5]	15
Didn't want to go to the appointments	4	-	2
Didn't want to have to keep going to the Jobcentre	5	[4]	6
Didn't want to do the activities asked of me	4	[3]	1
Want to work / get a job	39	[39]	41
Increased desire to be in control / independent	2	-	0
Information from scheme helped	-	-	1
Change of personal circumstances	3	-	0
Wants more money / worried about money/ benefits / Doesn't want to be on benefits	1	[2]	-
Getting out of the house / meeting people	-	[7]	1
Found different job options / becoming self-employed / voluntary work	1	-	2
Scheme was enjoyable/stimulating	-	-	-
Found a job	1	-	0
Don't know	2	[4]	2
Prefer not to answer	-	-	-
Other specific answer	1	-	1
Vague / irrelevant answer	5	[11]	3
Base[1]	*103*	*[…]*	*155*

[1] Base: all respondents on pilot programme who said motivation to leave ESA increased

Appendix Table 6.24 Whether support has had impact on participants view of work (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Whether support has had impact on participants view of work			
Yes	35	34	47
No	65	66	53
Base[1]	*296*	*157*	*403*

[1] Base: all respondents on pilot programme

Appendix Table 6.25 Whether support has had impact on participants view of work (percentages)

	Column Percentages	
	JCP pilot	JCP control
Whether support has had impact on participants view of work		
Yes	47	37
No	53	63
Base[1]	*403*	*502*

[1] Base: all respondents on JCP pilot programme and control

Appendix Table 6.26 Whether respondents view work more positively or negatively since beginning of support (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Whether view work more positively or negatively since beginning of support			
More positively	63	48	63
More negatively	7	14	13
Neither more positively nor more negatively	30	38	23
Base[1]	*107*	*55*	*195*

[1] Base: all respondents on pilot programme where support has had an impact

Appendix Table 6.27 Whether respondents view work more positively or negatively since beginning of support (percentages)

	Column Percentages	
	WP pilot	WP control
Whether view work more positively or negatively since beginning of support		
More positively	48	65
More negatively	14	13
Neither more positively nor more negatively	38	21
Base[1]	*55*	*129*

[1] Base: all respondents on WP pilot programme and control where support has had an impact

Appendix Table 6.28 Whether support received has changed motivation to find work (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Whether support received has changed motivation to find work			
Increased it a lot	10	6	17
Increased it a little	22	17	21
Decreased it a lot	2	8	4
Decreased it a little	3	6	4
No change	63	63	54
Base[1]	*302*	*156*	*406*

[1] Base: all respondents on pilot programme not in paid employment

Appendix Table 6.29 Whether support received has changed motivation to find work (percentages)

	Column Percentages	
	HCP pilot	HCP control
Whether support received has changed motivation to find work		
Increased it a lot	10	11
Increased it a little	22	15
Decreased it a lot	2	5
Decreased it a little	3	9
No change	63	60
Base[1]	*302*	*362*

[1] Base: all respondents on HCP pilot programme and control not in paid employment

Appendix Table 6.30 Whether support received has changed motivation to find work (percentages)

	Column Percentages	
	JCP pilot	JCP control
Whether support received has changed motivation to find work		
Increased it a lot	17	11
Increased it a little	21	16
Decreased it a lot	4	3
Decreased it a little	4	4
No change	54	65
Base[1]	*406*	*503*

[1] Base: all respondents on JCP pilot programme and control not in paid employment

Appendix Table 6.31 Whether support received has changed motivation to find work (percentages)

	Column Percentages	
	WP pilot	WP control
Whether support received has changed motivation to find work		
Increased it a lot	6	10
Increased it a little	17	18
Decreased it a lot	8	3
Decreased it a little	6	4
No change	63	64
Base[1]	*156*	*341*

[1] Base: all respondents on WP pilot programme and control not in paid employment

Appendix Table 6.32 Reason support increased motivation to find work (percentages)

	Multiple responses (%)	
	JCP Pilot	JCP Control
Reason support increased motivation to find work		
Increased confidence	51	40
Better health	13	10
Better management of condition	21	16
Realised what I am capable of doing	24	27
Support / encouragement from adviser	49	48
Gained new work-related skills	20	12
Didn't want to stay on the scheme	9	15
Didn't want to go to the appointments	1	5
Didn't want to have to keep going to the Jobcentre	3	5
Want to work / get a job	36	39
Increased desire to be more in control / independent	1	2
More aware of / interested in the options available	4	2
Want to be better off financially	1	2
Want to improve life generally	-	1
Doing courses / going to college	1	2
Doing voluntary work	1	-
Currently working	1	-
Currently bored / fed up with circumstances	1	1
Getting out of the house / being more social	1	1
Financial advice / help	-	-
Don't like being on benefits / stigma / feels guilty	1	-
Have more positive mindset / I need to make an effort	2	1
Don't know	2	-
Prefer not to answer	-	-
Other specific answer	2	1
Vague / irrelevant answer	2	6
Base[1]	*158*	*142*

[1] Base: all respondents on JCP pilot programme and control who said motivation to find work increased

Appendix Table 6.33 Why support has increased motivation to find work: Gained new work-related skills (JCP and JCPC) (percentages)

	Column Percentages	
	JCP pilot	JCP control
Gained new work-related skills		
Yes	80	88
No	20	12
Base[1]		

[1] Base: all respondents on JCP pilot programme and control who said motivation to find work increased

Appendix Table 6.34 Why support has increased motivation to find work: Didn't want to go to appointments (JCP and JCPC) (percentages)

	Column Percentages	
	JCP pilot	JCP control
Didn't want to go to appointments		
Yes	99	95
No	1	5
Base[1]		

[1] Base: all respondents on JCP pilot programme and control who said motivation to find work increased

Table 6.35 What more respondents have done to find work (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
What participants done to find work			
Doing/considering other voluntary work	21	[25]	25
Doing/considering training courses	19	[28]	33
Doing/considering getting qualifications or certificates	14	[12]	15
Applying for more jobs	13	[15]	26
Applying for different types of jobs	10	[12]	14
Revising CV	8	[23]	20
Focusing on managing my health	27	[21]	20
No change - not done anything more	35	[30]	18
Signed up to job websites / with employment agencies	2	[5]	3
Doing / considering work experience	-	-	0
Exploring self-employment as an option	1	-	2
Currently in work	1	[3]	4
Looking for jobs	3	-	1
Looking for jobs - general	3	-	1
Joined support groups / clubs	-	[2]	-
Thinking about getting into work	1	-	-
Taking up careers advice / receiving help with job search / improving skills	-	-	1
Pushing myself to do more / getting out more / working on social skills	-	-	-
Don't know	1	-	-
Prefer not to answer	-	-	-
Other specific answer	1	[2]	1
Vague / irrelevant answer	3	-	2
Base[1]	*97*	*[…]*	*158*

[1] Base: all respondents on pilot programme who said motivation to find work had increased and were not already in paid employment

Table 6.36 What more respondents have done to find work (percentages)

	Column Percentages	
	JCP pilot	JCP control
What participants done to find work		
Doing/considering other voluntary work	25	29
Doing/considering training courses	33	24
Doing/considering getting qualifications or certificates	15	14
Applying for more jobs	26	19
Applying for different types of jobs	14	15
Revising CV	20	23
Focusing on managing my health	20	34
No change - not done anything more	18	17
Signed up to job websites / with employment agencies	3	-
Doing / considering work experience	0	1
Exploring self-employment as an option	2	1
Currently in work	4	5
Looking for jobs	1	2
Looking for jobs - general	1	3
Joined support groups / clubs	-	-
Thinking about getting into work	-	-
Taking up careers advice / receiving help with job search / improving skills	1	1
Pushing myself to do more / getting out more / working on social skills	-	1
Don't know	-	0
Prefer not to answer	-	-
Other specific answer	1	1
Vague / irrelevant answer	2	3
Base[1]	*158*	*143*

[1] Base: all respondents on JCP pilot programme and control who said motivation to find work had increased and were not already in paid employment

Appendix Table 6.37 Participants' current feelings about work (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Current feelings about work			
My health condition/disability rules out work as an option	80	82	63
On some days I could consider a return to work	14	11	21
I could return to work now if the right job was available	6	8	16
Base[1]	*358*	*198*	*487*

[1] Base: all respondents on pilot programme not in paid employment

Appendix Table 6.38 Participants' current feelings about work (percentages)

	Column Percentages	
	JCP pilot	JCP control
Current feelings about work		
My health condition/disability rules out work as an option	63	71
On some days I could consider a return to work	21	18
I could return to work now if the right job was available	16	11
Base[1]	*487*	*608*

[1] Base: all respondents on JCP pilot programme and control not in paid employment

Appendix Table 6.39 Participants' views on statement "Having any kind of paid work is better than not working" (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
Any paid work is better than not working			
Strongly agree	16	19	22
Agree	49	54	47
Neither agree nor disagree	18	13	14
Disagree	14	11	13
Strongly disagree	3	3	4
Base[1]	*348*	*197*	*486*

[1] Base: all respondents on pilot programme

Appendix Table 6.40 Participants' views on statement "People are put under too much pressure to find work" (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
People are put under too much pressure to find work			
Strongly agree	20	24	19
Agree	32	37	35
Neither agree nor disagree	21	13	17
Disagree	23	21	26
Strongly disagree	4	5	4
Base[1]	*352*	*196*	*482*

[1] Base: all respondents on pilot programme

Appendix Table 6.41 Participants' views on statement "People are put under too much pressure to find work" (percentages)

	Column Percentages	
	WP pilot	WP control
"People are put under too much pressure to find work"		
Strongly agree	24	18
Agree	37	34
Neither agree nor disagree	13	21
Disagree	21	21
Strongly disagree	5	7
Base[1]	*196*	*419*

[1] Base: all respondents on WP pilot programme and control

Appendix Table 6.42 Participants' views on statement "I am a happier person now" (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
"I am a happier person now"			
Strongly agree	[50]	[58]	38
Agree	[17]	[32]	44
Neither agree nor disagree	[21]	-	12
Disagree	[12]	[10]	4
Strongly disagree	-	-	2
Base[1]	*[…]*	*[...]*	*54*

[1] Base: all respondents on pilot programme in paid work, self-employed or about to start work

Appendix Table 6.43 Participants' views on statement "I would be a happier person if I was in work" (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
"I would be a happier person if I was in work"			
Strongly agree	24	21	26
Agree	36	38	41
Neither agree nor disagree	20	17	18
Disagree	15	14	9
Strongly disagree	5	10	5
Base[1]	*342*	*188*	*435*

[1] Base: all respondents in pilot programme not in paid employment and not about to start work

Appendix Table 6.44 Participants' views on statement "I would be a happier person if I was in work" (percentages)

	Column Percentages	
	HCP pilot	HCP control
"I would be a happier person if I was in work"		
Strongly agree	24	24
Agree	36	44
Neither agree nor disagree	20	14
Disagree	15	12
Strongly disagree	5	5
Base[1]	*342*	*422*

[1] Base: all respondents in HCP pilot programme and control not in paid employment and not about to start work

Appendix Table 6.45 Participants' views on statement "I would be a happier person if I was in work" (percentages)

	Column Percentages	
	WP pilot	WP control
"I would be a happier person if I was in work"		
Strongly agree	21	22
Agree	38	44
Neither agree nor disagree	17	18
Disagree	14	10
Strongly disagree	10	5
Base[1]	*188*	*409*

[1] Base: all respondents in WP pilot programme and control not in paid employment and not about to start work

Appendix Table 6.46 Participants' views on statement "The thought of being in paid work makes me nervous" (percentages)

	Column Percentages		
	HC provider	WP provider	Jobcentre Plus
"The thought of being in paid work makes me nervous"			
Strongly agree	23	24	21
Agree	29	26	28
Neither agree nor disagree	11	14	13
Disagree	28	26	27
Strongly disagree	9	10	9
Base[1]	*352*	*189*	*440*

[1] Base: all respondents in pilot programme not in paid employment and not about to start work