Helping People Who Are Out of Work Because of Ill-health Return to Work

A Literature and Programme Review for the Improving Health, Increasing Employment in Birmingham and Solihull Project Board

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REPORT 460

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Executive Summary

Introduction

Incapacity Benefit (IB) claimants

Nearly 61,000 people in Birmingham and Solihull – over one in 12 of the working age population – are out of work because of ill-health, and are claiming incapacity benefits (IB)[1] (Department for Work and Pensions, November 2007). This compares with one in 14 of the working age population nationally. Approximately three-quarters[2] of those claiming IB in Birmingham and Solihull have been doing so for over two years (Department for Work and Pensions, November 2007). Helping this large number of people, many of whom are distant from the labour market, back to work is a challenge for national and regional authorities.

Improving Health, Increasing Employment Project Board's aims

The Improving Health, Increasing Employment Project Board of Birmingham and Solihull (IHIE) is working to draw together the various strands of national and regional Government interventions. IHIE is a partnership of the three Birmingham Primary Care Trusts (PCTs), the Solihull Care Trust, the Birmingham and Solihull Mental Health Foundation Trust, University Hospital Birmingham Foundation Trust, Jobcentre Plus (JCP), the Learning and Skills Council (LSC), Birmingham Voluntary Service Council, Birmingham Chamber of Commerce, Birmingham City Council and Solihull Metropolitan Borough Council. These organisations are collaborating to create a coherent approach to worklessness and ill-health in Birmingham and Solihull, via a five-pronged approach:

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[1] Incapacity Benefit or Severe Disablement Allowance.

[2] Over 46,000 people.

- retention (helping people who are off work through illness to retain their employment)
- recovery (helping recent IB claimants back to work through Jobcentre Plus' Pathways to Work scheme)
- rehabilitation (developing referral pathways and support programmes to help long-term IB claimants move back towards employment)
- return (encouraging employers to take a positive attitude to recruiting people who have been out of work because of ill-health)
- GPs/primary care (developing various links between GP/primary care staff and employment services).

Literature and programme review's aims

This literature and programme review aims to inform IHIE's commissioning of support programmes to help longer-term IB claimants. It contributes primarily to the rehabilitation strand of the IHIE work plan, although some of its findings will also have relevance to other aspects of the work plan.

This research will also contribute to the broader fund of knowledge about what works in employment and skills, against the backdrop of the Government initiatives detailed above.

Methodology

Literature review

There has been little research on how best to support people with health problems who have been out of work long term in returning to employment; although this review aims to redress this, the evidence base is very limited.

The first phase of this research was a literature review. The Institute of Employment Studies (IES) carried out a desk review of published research to identify the main client groups of long-term IB claimants and their needs. IES also consulted evaluation literature to identify what types of programmes have been most effective in addressing the needs of long-term IB claimants. There is a lack of literature that specifically pertains to long-term IB claimants. For example, in assessing the routes to IB-claiming this literature review relies on data relating to recent IB claimants – no such data is available for those claiming long term. Similarly, the vast majority of findings from the Pathways evaluations also relate to recent and repeat IB claimants, rather than to longer-term claimants, and should therefore be treated with caution.

Programme review

The second phase of this research was a programme review. IES conducted Internet searches to identify programmes that support disabled people or those on health-related benefits in their return to work, conducted lengthy interviews with programme staff using pro forma questions to generate standardised information, and analysed the programmes it had identified according to the following criteria:

- how programmes engage with this client group
- how programmes engage with employers
- what services the programmes provide – and which services are less commonly available
- how programmes are designed and delivered and the implications this may have for future commissioning.

Data limitations

The programme review does not show definitively whether specific approaches work better in some circumstances than in others. However, the review illustrates the diverse range of programmes that exist to address the needs of different localities, the problems that different programmes models have encountered, and some of the factors that have made them successful.

Both the literature review and programme review findings highlight the current lack of tailored support for existing IB claimants that IHIE is seeking to address.

Characteristics of client group

IB claimants' characteristics — the national picture

The picture of the IB population in Birmingham and Solihull is broadly in line with national trends, and the following salient characteristics will need to guide programme design:

- Two of every five IB recipients have mental health conditions: the majority have mild to moderate mental health problems, such as anxiety, depression, or stress. There is a general consensus that rehabilitation principles for severe mental health problems should also apply to mild and moderate mental health conditions, but little evidence exists in support of this view. Other than the Pathways evaluation, there is also little evidence on ways of helping people with mental health problems claiming IB. The vast majority of studies report effects on mental health outcomes but do not record the impact on employment status. Employer discrimination and stigma may be a particular problem for IB claimants with a mental health condition

as their primary diagnosis. Mental ill-health, as a cause of stigma, is considered to be second only to HIV/AIDS.

- One in five has musculoskeletal conditions: the majority of these have non-specific back/leg/neck/arm pain. A review of the available evidence on the clinical and occupational management of common health problems found support for a biopsychosocial approach to rehabilitation for this group. The reviewers concluded that there was limited evidence available on effective interventions for people with long-term health conditions, or in receipt of disability benefits, who had been out of work for more than a year.

- One in ten IB claimants has a circulatory or respiratory condition, such as high blood pressure, angina or chronic bronchitis; a small number of IB claimants have heart or lung disease that is severely and permanently limiting. Waddell et al. (forthcoming) suggests that there is little evidence of work outcomes for studies of interventions for these types of conditions.

- Older men are the largest single group of IB claimants.

- Research has consistently identified the proportion of IB claimants who want to work as around 30 per cent. However, it is estimated that only three per cent of existing claimants return to work over an 18 month period without assistance. When Pathways was extended to existing customers it succeeded in doubling the return rate; this provides an indication of the potential employment impact of programmes designed to help long-term IB claimants back to work.

IB claimants' characteristics –local picture

In addition, there are some specific issues which should inform programme design in Birmingham and Solihull:

- Some areas of Birmingham and Solihull have a particularly high proportion of IB claimants with mental health conditions: more than half the Birmingham wards have rates higher than the average for England, Scotland and Wales (41 per cent) and in one in four Birmingham wards the proportion of IB claimants with mental health conditions exceeds 45 per cent.[3] In Solihull, eight out of 17 wards have rates higher than the national average, but these exceed 45 per cent in only three wards.[4]

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[3] Billesley (46.9 per cent), Bournville (52.0 per cent), Brandwood (45.2 per cent), Edgbaston (50.4 per cent), Harborne (45.6 per cent), King's Norton (49.1 per cent), Ladywood (53.4 per cent), Longbridge (49.7 per cent) Moseley and Kings Heath (53.3 per cent), Northfield (50.0 per cent), Selly Oak (48.1 per cent), Stockland Green (45.1 per cent) (Department for Work and Pensions (May 2007b).

[4] Knowle (50.0 per cent), Olton (46.9 per cent), Shirley East (50.0 per cent) (Department for Work and Pensions, May 2007b).

Mental health conditions are therefore likely to be one of the main areas of concern for IHIE in future programme design.

- Over 76 per cent of all IB and SDA claims, nationally and regionally, are between two years and over five years duration. The overall profile of IB claims in Birmingham and Solihull's wards is broadly similar. However, in several Birmingham and Solihull wards there is a significantly higher proportion of IB claims where the claim period exceeds five years. In some wards, over 60 per cent of IB claimants have been claiming for over five years.[5] Programme design will need to take into account the longevity of the claim period and therefore the potentially greater difficulty in moving people from entrenched habits of worklessness closer to employment.
- Birmingham has a higher than the national average proportion of younger age IB claimants, while in Solihull, the age profile of IB claimants is older than the national average.
- There are no definite statistics on the ethnicity of IB claimants but sample surveys suggest that claim rates for minority ethnic groups are in line with their numbers in the population as a whole. However, as ethnic minority groups make up 30 per cent of the total population of Birmingham, considerably higher than the UK average of nine per cent (2001 Census), this may create specific requirements, for instance in respect of ESOL[6] needs and culturally sensitive provision. People from ethnic minority groups are likely to constitute a significant proportion of IB claimants in some parts of Birmingham and Solihull.
- In Birmingham and Solihull, areas with high levels of unemployment often (but not always) have a substantial proportion of the population claiming IB.

Policy context

Government focus on economically inactive

Provision for long-term IB claimants, a previously somewhat neglected group, is the focus of rapidly evolving national Government policy. Meeting the 80 per cent employment target and the child poverty targets implies a renewed focus on people who are economically inactive due to ill-health, including those who are claiming IB and those who are not.

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[5] Birmingham wards: Billesley (61.6 per cent), Brandwood (62.2 per cent), Kingstanding (61.2 per cent), Moseley and Kings Heath (64.4 per cent). Solihull wards: Knowle (67.5 per cent), Shirley South (60.6 per cent), Shirley West (62.9 per cent), Silhill (62.3 per cent) (Department for Work and Pensions (May 2007b).

[6] English to Speakers of Other Languages

Government support for existing IB claimants

Nationally, the Government's 2008 welfare reform Green Paper sets out the Government's aims to help longer-term IB claimants find and retain work through personalised support. In return, people will be expected to take a job if it is available, whilst the Government will recognise that there are some people with complex and multiple problems who need additional support to meet their responsibilities (Department for Work and Pensions, July 2008a). The Government is unlikely to roll out the new personalised support programmes for existing IB claimants in Birmingham and Solihull until 2011 at the earliest. There is consequently a need to develop programmes to support this client group during the 2008–2011 period.

New programmes that affect IB claimants

The Government is also introducing a regional pilot of an integrated skills and employment system in the West Midlands that will potentially include region-wide commissioning for programmes that help longer-term IB claimants. The nationwide roll out of the Increasing Access to Psychological Therapies Programme and the Adult Advancement and Careers Service, and the development of a National Strategy for Mental Health and Employment will also have implications for provision for long-term IB claimants.

These far-reaching changes give IHIE commissioners the opportunity to benefit from synergy created by the various partner organisations working together.

Consensus on work and health

There is also an emerging consensus that work can be good for health, and that health professionals need to be involved in helping people out of work due to ill-health back into employment.

Barriers to work and how these can be addressed

IB claimants' barriers to work

IB claimants are a heterogeneous group with a wide variety of complex needs. It is clear that existing IB claimants face significant challenges in returning to work, and in many cases contend with multiple barriers. This review has identified a range of barriers which may be faced by those who are long-term workless because of health problems. Some will apply to almost everyone: health, low skills, lack of recent work experience, and attitudinal barriers such as lack of confidence and anxiety about finding and sustaining work. Others, such as non-white ethnicity, caring or financial issues, affect specific groups and may require specialist provision; niche providers can provide an important contribution in these instances. Developing programmes for

long-term IB claimants that are sensitive to the needs of specific ethnic groups is particularly important in Birmingham where Pakistani, Black Caribbean, Black African and Bangladeshi groups have levels of unemployment between two and a half, and three and a half times the city average.

'What works' for specific health conditions

Mental health

In terms of 'what works' for specific health conditions, the evidence base for employment and mental health is mainly concerned with the more serious conditions. Cognitive Behavioural Therapy (CBT), supported employment, and the integration of health and employment advice have all been identified as having a potential role here.

Musculoskeletal and cardio-vascular conditions

The available evidence supports a biopsychosocial model for musculoskeletal disorders, but while this is assumed to apply to those with cardio-vascular problems there is almost no evidence on employment outcomes for cardiac rehabilitation programmes.

Client engagement

This review found few health-led programmes, but those that had successfully engaged with local health services found them to be highly effective in generating client referrals, provided that proper training of primary care staff and lead-in time is provided. The use of primary care-led client engagement could be usefully explored by IHIE commissioners. More generally, programmes adopted a variety of means to engage clients and traditional approaches such as door-knocking and leafleting remain among the most effective. A good staff–client relationship is also vitally important in helping clients move towards employment.

Employer engagement

Employers' attitudes towards hiring long-term IB claimants are a problematic matter. This area has been dominated by labour supply initiatives, but labour demand is a key issue, as is indicated by the long-standing relationship between unemployment rates and IB claim rates. Employers in areas of high unemployment have a greater degree of choice about whom they recruit, and may be reluctant to take on individuals with long-term health conditions or those receiving benefits.

Areas lacking support

When IES compared the barriers identified with the scope of services on offer (both in programmes in the programme review, and in other separately evaluated programmes), there were some areas where support is less commonly available than others:

Health

Health is perceived by unemployed individuals with health conditions as their main barrier to work. Despite this, health advice is generally not provided directly by programmes, except those dealing with mental health problems or substance misuse issues. Programmes' lack of focus on health issues is further discussed in Chapter 6's appraisal of funding, targets and outcomes (Section 6.6). Conversely, healthcare services have a lack of occupational focus, a shortcoming that was picked up by the Black Review (Health Work Wellbeing, March 2008).

Employer engagement

A need to engage with employers is widely acknowledged by programmes. Engagement needs to address two issues: employers' often negative attitudes towards people with health problems, and the value of in-work support after a long-term IB claimant has started work. Employers' negative attitudes towards taking on longer-term IB claimants were highlighted both in the literature review findings and by programme review respondents. This is a particular problem in areas of low labour demand where employers have a wide choice of candidates. However, few programmes in the programme review undertook work in this area, and there appears to be a gap in provision. Government is taking steps to address this shortcoming. Wider availability of in-work support for employers and employees, job-broking, and supported employment for people with mental health problems could also be useful.

Skills shortfall

Lack of recent employment experience, and in some cases the older age profile of IB claimants, means that many people on long-term IB do not have up-to-date skills for the workplace. However, few of the programmes in this review have developed projects to address the skills shortfall for existing IB claimants. This is one area that may be addressed as the integrated employment and skills system is rolled-out, regionally and nationally. Lack of recent employment experience can also mean that some existing IB claimants can benefit from volunteering or work placement schemes as stepping stones towards employment.

Self-employment

None of the programmes reviewed provide support in the area of self-employment. Given the over-representation of self-employed people among IB claimants and the prevalence of self-employment among both disabled people and minority ethnic groups, this may be a worthwhile area for pilot initiatives in Birmingham and Solihull, but there is a limited evidence base to guide design, due to low levels of existing provision.

Programme design and delivery

Programmes' main client groups

Programmes in this programme review covered four main client groups: all those on benefit; specific groups of benefit claimants; people with general health conditions; people with specific health conditions.

Programmes' mixed caseloads

Programmes do not tend to specialise in helping long-term IB claimants back to work: existing IB claimants are supported as part of a mixed caseload of unemployed people in general. IHIE may wish to explore in more depth (and directly with Want2Work, a programme that has been particularly successful in securing employment outcomes for those who have been claiming IB for extended periods) the advantages and disadvantages of programmes that specialise in helping long-term IB claimants, as opposed to programmes that manage a more mixed caseload.

The Government is proposing to introduce back-to-work support programmes over the next few years, but given the current lack of programmes that support long-term IB claimants, IHIE commissioners may need to innovate in creating new provision in Birmingham and Solihull.

Effect of primary care involvement

There were almost no health-led programmes featured in this programme review, and secondary data also point to a lack of health-led programmes to assist long-term IB claimants (including those with mental health conditions) back to work. However, programmes outside the scope of this review have shown that when primary care staff *are* fully engaged with the employment agenda, this can have a dramatic effect on referrals.

Primary care providers' current lack of knowledge of employment needs and preconceptions about the impact of employment on health will need to be explicitly addressed in any future programmes that make primary care the focus for joint

employment-health initiatives. Work on awareness and capacity in primary care is already part of the IHIE programme.

Programmes that help ethnic minority clients

Programmes that specialise in helping ethnic minority long-term IB claimants have found that being based in the heart of that ethnic community is important to the success of their programmes. This includes employing advisers from the local community who speak community languages, using female advisers where there are cultural sensitivities around gender, and engaging the clients' families through outreach. This may have implications for programme design in Birmingham and Solihull, where substantial numbers of ethnic minority IB claimants are likely to be concentrated in certain areas.

Programmes that help older people

The programme review did not identify any programmes that deal specifically with long-term IB claimants in older age groups – a fact that will be particularly relevant for Solihull which has a higher proportion of IB claimants in older age groups, compared with the national average. IHIE will wish to consider the advantages and disadvantages of programmes that have a more narrow focus on particular age groups.

Programmes' relationships with other agencies

The review highlighted the importance of strong external relationships to ensure quality referrals, avoid duplication and create a good strategic fit locally, regionally and nationally. There is mixed evidence on the potential role of health services – and GPs in particular – as a source of referrals and this is an area that is likely to require a certain amount of lead-in time and preparation, as discussed above.

Joint caseload management

Joint caseload management is an approach that tends to be widespread in and understood by people working in health-led services, particularly mental health. It does not tend to be used in employment-led services. The value of extending this approach more widely is an area that might usefully be explored, perhaps via a pilot scheme.

Programmes' staffing

Programmes in the review employed a mixture of health and employment staff, generalists and specialists, depending on the requirements of the service delivered, but all were agreed that the personal qualities and aptitudes of staff – such as

empathy, and willingness to work in a client-centred way – were at least as important as qualifications.

Programmes' funding, targets and outcomes

Programmes tend to have employment targets, not health targets. There are tensions between hard employment-led targets (especially those of major funders) and the complex needs of clients who have long-term health conditions. In setting programme targets and outcomes, programme commissioners and funders will need to take into account what is realistically achievable given the complex needs of this client group. It may be important to broaden outcome measures to include work-related activities and health outcomes, particularly given that people in this client group perceive their health problems to be the main barrier to employment. In setting targets for new programmes, commissioners will also need to decide whether to engage with a large number of people but aim for a fairly low percentage of employment outcomes, or to seek a high proportion of employment outcomes, but be more selective about who is allowed onto the programme.

Programme size and replicability

Programme size, and conclusions about economies of scale and replicability, is something that should be handled with care.

Programme branding

Attention to programme branding can also be important in encouraging take-up of services.

Conclusion

By seeking an overview of existing provision, in its local area, and elsewhere, IHIE has taken an important first step in design of future provision in Birmingham and Solihull.

1 Introduction

1.1 Overview

This literature and programme review has been conducted against the background of rapidly evolving national and regional policy that is changing the way that people with long-term illness and disability are supported back to work.

In this context, this review aims to contribute on two fronts: firstly, by adding to the national debate on the needs of people who are off work because of long-term sickness or disability and, secondly, by providing a detailed appraisal of existing programmes to enable commissioners in Birmingham and Solihull to plan programmes to benefit local residents.

This chapter sets out the background to and purpose of the study.

1.2 Background to the study

Nearly 61,000 people in Birmingham and Solihull – over one in 12 of the working age population[7] – are out of work because of a health condition, and are claiming incapacity benefits (IB)[8] (Department for Work and Pensions, November 2007). The national target is to reduce the total number of IB claimants by one million[9] by 2016 (Department for Work and Pensions, 2006b). Approximately three-quarters[10] of those claiming IB in Birmingham and Solihull have been doing so for over two years (Department for Work and Pensions, November 2007). The challenge for Birmingham and Solihull is to meet the national target for reduction in the number of IB claimants, by bringing IB claimants, and in particular the large subset of people whose health

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7 Compared with one in 14 nationally (Department for Work and Pensions, November 2007).

8 Incapacity Benefit or Severe Disablement Allowance.

9 From 2.6 million to 1.6 million.

10 Over 46,000 people.

condition has kept them out of the workforce for extended periods, back into employment.

The Improving Health, Increasing Employment of Birmingham and Solihull (IHIE) project board is seeking to address this challenge, building on work already initiated by its constituent organisations. IHIE is a partnership of the three Birmingham Primary Care Trusts (PCTs), the Solihull Care Trust, the Birmingham and Solihull Mental Health Foundation Trust, University Hospital Birmingham Foundation Trust, Jobcentre Plus (JCP), the Learning and Skills Council (LSC), Birmingham Voluntary Service Council, Birmingham Chamber of Commerce, Birmingham City Council and Solihull Metropolitan Borough Council. These organisations are working together to create a coherent approach to worklessness and ill-health in Birmingham and Solihull. IHIE intends to address the barriers that stop people with health problems being in employment; it also contends that employment will, in turn, improve the health of people in Birmingham and Solihull, building on Dame Carol Black's findings that employment can, in the right circumstances, be beneficial to health (Health, Work, Wellbeing, March 2008).

To achieve this, IHIE is utilising a five-pronged approach of:

- **retention** (helping people who are off work through illness to retain their employment)
- **recovery** (helping recent IB claimants back to work through Jobcentre Plus' Pathways to Work scheme)
- **rehabilitation** (developing referral pathways and support programmes to help long-term IB claimants move back towards employment)
- **return** (encouraging employers to take a positive attitude to recruiting people who have been out of work because of ill-health)
- **GPs/primary care** (developing various links between GP/primary care staff and employment services).

In a recent Green Paper, the Government has announced its intention to move existing (longer-term) IB claimants who are judged capable of work onto programmes to support them back to work over the next few years (Department for Work and Pensions, July 2008a). Birmingham and Solihull's provision for this client group is likely to develop accordingly, but national changes are unlikely to take effect until 2011. Consequently, IHIE is exploring how best to support this heterogeneous client group back to employment in Birmingham and Solihull during the 2008–2011 period. Examples of successful provision will also have considerable potential to inform future models of commissioning and delivery in this area.

1.3 Purpose of the study

This literature and programme review contributes primarily to the rehabilitation strand of the IHIE work plan, and focuses on people who have been out of work for long periods because of their health, and in particular long-term IB claimants, but some of its findings will also have relevance to other aspects of the work plan, such as GPs/primary care, and retention.

The aim of the literature and programme review is threefold:

- to identify the main characteristics of this client group (people who are long-term sick or disabled and existing IB claimants in particular), both nationally and in Birmingham and Solihull
- to identify the barriers to work that this client group faces and the ways in which they can be addressed
- to identify main features of programme design and delivery using existing evaluation literature and data from the programme review.

The review will inform IHIE in its commissioning of referral pathways and support programmes to help long-term IB claimants in Birmingham and Solihull to move back towards employment. It will also contribute to the fund of knowledge about what works in employment and skills, against the backdrop of the new, integrated employment and skills system which will shortly be piloted in the West Midlands, and the unveiling, locally and nationally, of the new Adult Advancement and Careers Service, and the Increasing Access to Psychological Therapies programme.

1.4 Structure of the study

The report is set out as follows:

- Executive Summary.
- Chapter 1: Introduction (sets out the background to and purpose of this study).
- Chapter 2: Methodology (explains the literature and programme reviews' methodology and data limitations).
- Chapter 3: Characteristics of Client Group (sets out the numbers and characteristics of IB claimants, both regionally and nationally, the links between a prevalence of IB claimants and unemployment, the typical duration of IB claims, the age, gender and ethnic profile of IB claimants and the main medical conditions that affect this client group).
- Chapter 4: Policy Context (explains the current approach to disability, ill-health and employment and discusses existing and proposed national Government programmes for IB claimants).

- Chapter 5: Barriers to Work and How These Can Be Addressed (examines the barriers to returning to work for people with long-term health conditions and reviews the evidence on employment interventions; it then discusses how the programmes that featured in the programme review had sought to address these barriers).
- Chapter 6: Programme Design and Delivery (looks at the detailed aspects of programme design and delivery to inform IHIE's commissioning of new programmes in Birmingham and Solihull).

2 Methodology

2.1 Introduction

This study was conducted in two phases: a literature review and a programme review, in order to provide both breadth in terms of an appraisal of 'what works' as evidenced in the literature, and depth in terms of an appraisal of 'what works' as evidenced in the practical, day-to-day running of existing programmes.

2.2 Literature review

The first phase of this study was a literature review. IES carried out a desk review of published research[11] to identify the characteristics of this client group: people with long-term health conditions in general, and IB claimants in particular, nationally and regionally (Chapter 3). The literature review then identified this client group's barriers to employment and the ways in which these barriers have been successfully tackled in the past (Chapter 5). This was not a 'systematic literature review' per se, but a systematic approach was adopted to gather as much relevant literature as possible, and to maintain an 'audit trail' of searches.[12]

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[11] The main literature review publications were identified from systematic searches of the following main sources: ASSIA (Applied Social Sciences Index of Abstracts); British Journal of Occupational Therapy; Department of Health publications; Department for Innovation, Universities and Skills publications; Department for Work and Pensions publications; European Foundation for the Improvement of Living and Working Conditions; Joseph Rowntree Foundation; NICE systematic review of the management of long-term absence; programme literature and supplementary reports relating to long-term incapacity benefits identified in the Carol Black review (Health, Work, Wellbeing, March 2008); programme literature relating to long-term incapacity benefits identified in earlier IES studies.

[12] The following is a brief list of example search terms used to trawl the main literature sources: incapacity and work; ill-health and worklessness; support and work and incapacity benefit; ethnicity; health and work; disadvantage and health; worklessness; Neighbourhood Renewal Fund; European Social Fund.

2.3 Programme review

The second phase of this research was a programme review. IES collected standardised, comparable information about exemplars of current programmes in English cities that support people with long-term health conditions or disabilities back to work. The programme review had two aims:

- to provide a detailed analysis of the main features of existing programmes for this client group, in cities that are similar to Birmingham and Solihull, to help commissioners plan new and complementary provision for longer-term IB claimants (Chapter 6)
- to add to the literature review's findings on how best to tackle this client group's barriers to work (Chapter 5).

The programme review focused on programmes in cities in the metropolitan area surrounding Birmingham and Solihull, and cities that have a similar demographic and economic profile to Birmingham and Solihull's most deprived wards.[13] IES identified programmes using Internet searches[14] and conducted telephone interviews with programme managers and staff using a pro forma of 29 questions to generate standardised information on each programme (see Appendix 1). The resultant programme data is recorded in full in a separate spreadsheet, available electronically from IES.

In addition to the primary data gathered by telephone interviews, IES also reviewed secondary information about several evaluated and other programmes:

- The Northern Way (ECOTEC, November 2007), including:
  - Aim High Routeback (AHRB) (Frontline, April 2008)
  - Furness Enterprise (Foster and Lyons, June 2008)
- Routes to Health (Craig, Lambert, Simpson, 2008)

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[13] Birmingham and Solihull's most deprived wards were identified in the regional *City Strategy* document (Birmingham, Coventry and Black Country City Region, June 2007). These are wards that have a high proportion of: long-term IB claimants, unemployment, income deprivation, children living in poverty, ethnic minority groups (especially Pakistani, Indian, Black Caribbean, White Irish, Bangladeshi), people with no qualifications, low annual earnings, people in poor health, disabled people, and drug and alcohol misuse. IES compiled a list of cities with similar patterns of deprivation to Birmingham and Solihull from previous IES evaluations of city-based programmes (for example, Tackey et al., 2006 and Atkinson et al., May 2005): Bradford, Bristol, Coventry, Dudley, Leeds, Liverpool, Inner London, Leicester, Greater Manchester, Nottingham, Sandwell, Sheffield, Telford, Walsall, Wolverhampton.

[14] The main websites used were: City Councils, PCTs and Strategic Health Authorities, Government Offices and the Economic Development Agencies for each area. Google searches were also conducted, using terms such as: 'disability + work', 'incapacity + employment'.

- Stepping Stones (ECOTEC, July 2006)
- Want2Work (Want2Work and Merthyr Tydfil CBC, June 2008)
- Getting London Working (Tank Consulting, 2006).

These evaluations helped draw out some of the key issues for designing services to help those out of work because of their health condition. The evaluations are summarised in the appendices.

IES analysed the programmes in its review according to the following criteria:

- how programmes engage with this client group (Section 5.14.1)
- how programmes engage with employers (Section 5.14.2)
- what services the programmes provide – and which services are less commonly available (Section 5.15)
- how programmes are designed and delivered and the implications this may have for future commissioning (Chapter 6).

2.4 Data limitations

Both the literature review and the programme review have some data limitations.

The literature review revealed a lack of literature specifically relating to long-term IB claimants. For example:

- There is no literature available on the routes that longer-term IB claimants took to becoming IB-claimants; in assessing the routes onto IB; this literature review relies on data relating to recent IB claimants (Kemp and Davidson, 2008), as discussed in Section 3.3.
- Findings from the Pathways evaluations referred to in Sections 3.3 and 3.4 also relate to recent and repeat IB claimants, rather than to longer-term claimants (Bewley et al., 2007), and should therefore be treated with caution.

The conclusions that can be drawn from this programme review are limited by some weaknesses in the programme review data:

- IES had originally aimed to obtain information on 50 programmes. However, it proved difficult to persuade busy programme managers to participate in such a lengthy interview. In addition, the interviews themselves were extremely time-consuming. IES conducted full interviews with 27 respondents.
- IES did not identify many programmes to support people off work that specifically focused solely on longer-term IB claimants: although the programmes included long-term IB claimants amongst their client groups, they were not their main focus.

- During the programme review's Internet search, no health-led employment programmes were found on PCT websites, which instead directed the user to employment projects delivered by third-sector organisations. Additional Internet searches also did not reveal any health-led programmes. Consequently, the programme review relies on health-led programmes reviewed as part of the secondary data for its information (see Section 2.3 above).
- It has also not been possible to show definitively whether specific approaches work better in some circumstances than in others. Further research would be required in order to explore what approaches are most effective in particular circumstances.
- Very few of the programmes in the review had been subject to formal evaluations.[15]

2.5 Conclusions

There has been little research on how best to support people with health problems who have been out of work long-term in returning to employment; although this review aims to redress this, the evidence base is very limited. As noted in Section 5.5, Waddell et al. (forthcoming) concludes that there is no high quality evidence on effective and cost-effective vocational rehabilitation interventions for long-term IB claimants.

The literature review used published research to identify the characteristics of people with long-term health conditions in general, and IB claimants in particular, nationally and regionally, identifying this client group's barriers to employment and the implications for programme design.

The programme review looked at the day-to-day organisation of programmes, as reported by programme managers and staff, to evaluate how programmes engage with this client group and with employers, which services the programmes provide – and which services are less commonly available, and how programmes are designed and delivered.

The data limitation issues are noteworthy: the lack of literature on longer-term IB claimants, and the relative absence of programmes that specifically help this client group highlight the current lack of tailored support for existing IB claimants.

It has not been possible to show definitively whether specific approaches work better in some circumstances than in others. Further research would be required in order to explore what approaches are most effective in particular circumstances. However, it has been possible to illustrate the diverse range of programmes that have developed to address the needs of different localities, the problems that different programmes models have encountered, and some of the factors that have made them successful.

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[15] Those that had were: Access to Employment (LSC audit), Employment and Training Programme (OFSTED inspection, LSC audit), Industrial Services Group (ALI inspection), The Meadows One Stop Shop (Matrix and Investors in People) and W9 (IiP).

3 Characteristics of the Client Group

3.1 Introduction

This chapter presents the statistical picture of the numbers of people who are out of work because of long-term health conditions or disabilities and, of those, the numbers who are on incapacity benefits. It then discusses the findings from the literature review on the characteristics of IB claimants, both regionally and nationally, including the links between IB and unemployment, the duration of IB claims, the age, gender and ethnic profile of IB claimants and the main medical conditions that affect IB claimants.

3.2 Characteristics of people of working age with long-term health conditions or disabilities

3.2.1 Population with long-term health condition or disability

According to the 2001 census, of the 32,727,494 working age people surveyed, 4,635,500 reported having a limiting long-term illness that limits daily activities or work; approximately 14 per cent of the working age population[16]. In total, 47 per cent of people reporting a health problem are in paid employment, three per cent are unemployed and 49 per cent (2.27 million) are reported as being economically inactive.

Table 3.1 highlights the increasing prevalence of illness or disability as people age. It would appear that there are no significant differences in the overall prevalence of illness or disability by gender across age groups. The prevalence of limiting long-term illness is slightly higher in males in younger age groups, with this trend reversing with age, apart from in the oldest age group. However, note that women in this group were no longer considered to be of working age at the time of the 2001 Census.

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[16] Source: UK Statistics Authority website: www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI) – *All people in households Part 1: Census 2001, National Report for England and Wales Part 2* – using search 'Limiting Long-term Illness'.

Table 1: Number of people reporting a limiting long-term illness, by age and gender

	All people	People with a limiting long-term illness	%*	Males	%*	Females	%*
All people	51,107,639	9,019,242	18	4,214,655		4,804,587	
Working age total	32,727,494	4,635,500	14	2,307,257		2,328,243	
0–15	10,488,736	451,161	4	265,122	5	186,039	4
16–49	24,142,336	2,327,268	10	1,167,153	10	1,160,115	10
50–64	9,098,070	2,421,527	27	1,212,335	27	1,209,192	26
65 or older	8,312,774	4,284,900	52	1,728,378	49	2,556,522	53

Source: ONS, 2001, Census, National Report for England and Wales Part 2, UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI).

Tables 3.2 and 3.3 show the variation in limiting long-term illness rates by ethnic group and age in Birmingham and Solihull. Limiting long-term illness becomes more prevalent as people age, regardless of ethnic group. However, these rates vary considerably, across individual wards, and across ethnic groups. Of Birmingham's working age population, in the 16 to 49 age group the ethnic groups with the highest proportion of people with a limiting long-term illness were: White Irish, Mixed Other, Pakistani, and Mixed White and Asian. In the 50 to 64 age group, the ethnic groups with the highest proportion of people with a limiting long-term illness in Birmingham were: Bangladeshi, Pakistani, Indian and Mixed White and Black Caribbean.

Table 2: Limiting long-term illness rates, by ethnic group and age: Birmingham, 2001

	All ages	0–15	16–49	50–64	65 or older
All groups	19.7	5.3	11.5	33.2	55.9
White British	21.0	5.2	11.2	30.3	55.5
White Irish	33.6	5.0	15.6	37.4	52.5
Other White	16.7	4.9	8.7	30.8	55.7
Mixed White & Black Caribbean	9.9	6.5	12.3	43.1	51.1
Mixed White & Black African	8.9	4.3	10.4	31.8	50.0
Mixed White & Asian	11.0	5.8	12.9	42.6	60.7
Mixed Other	11.5	6.4	13.5	40.8	53.1
Indian	16.2	3.6	10.8	43.6	65.0
Pakistani	15.0	5.5	13.2	52.4	63.2
Bangladeshi	13.8	4.9	11.8	54.5	64.2
Other Asian	15.2	4.9	11.9	42.7	58.0
Black Caribbean	20.3	6.3	12.6	40.5	58.2
Black African	9.2	3.5	6.4	28.7	57.8
Other Black	13.7	8.0	13.7	45.8	51.7
Chinese	11.1	3.3	4.5	30.0	60.1
Other Ethnic	11.2	5.0	8.4	38.3	61.2

Source: ONS, 2001, Census of Population (Standard Table 107), UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI).

Table 3: Limiting long-term illness rates, by ethnic group and age: Solihull, 2001

	All ages	0-15	16-49	50-64	65 or older
All groups	3.4	3.5	7.9	22.3	46.6
White British	3.4	3.6	8.0	21.9	46.6
White Irish	3.1	3.5	9.1	27.9	44.4
Other White	3.1	2.6	5.9	21.0	41.4
Mixed White & Black Caribbean	3.1	3.8	8.9	0.0	31.6
Mixed White & Black African	0.0	3.7	0.0	0.0	0.0
Mixed White & Asian	3.7	1.8	9.8	22.2	37.5
Mixed Other	3.0	4.2	8.6	39.1	56.3
Indian	4.0	4.0	6.9	33.9	54.9
Pakistani	3.8	2.1	6.9	33.3	54.3
Bangladeshi	6.5	28.6	11.1	100.0	66.7
Other Asian	4.6	0.0	8.6	25.8	45.5
Black Caribbean	5.2	4.7	9.4	35.6	48.2
Black African	2.8	5.2	5.0	36.0	78.6
Other Black	8.4	7.9	12.9	0.0	100.0
Chinese	1.8	2.0	3.1	24.2	43.3
Other Ethnic	3.4	0.0	5.4	16.1	100.0

Source: ONS, 2001, Census of Population (Standard Table 107), UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI).

Of Solihull's working age population, in the 16 to 49 age group, the ethnic groups with the highest proportion of people with a limiting long-term illness were: Other Black, Bangladeshi, Mixed White and Asian, and Black Caribbean. In the 50 to 64 age group, the ethnic groups with the highest proportion of people with a limiting long-term illness in Solihull were: Other Asian, Other Mixed, Black African and Black Caribbean. However, the statistics for Solihull in Table 3.3 should be treated with caution as the total numbers of individuals recorded in each ethnicity and age sub-group are often very low.

3.2.2 The incapacity benefits (IB) population

Data from *Neighbourhood Statistics* (ONS, May, 2007a) showed 2,358,525 Incapacity Benefit and Severe Disablement Allowance claimants in England and Wales (2,123,360 IB and 235,165 SDA). The Department for Work and Pensions (DWP) definition of incapacity benefits is broader than this, and makes it difficult to estimate the proportion of people out of work due to illness who are not claiming incapacity

benefits[17], which includes those who fail to meet the health criteria (who may claim Jobseeker's Allowance (JSA), subject to meeting the eligibility criteria); have insufficient contributions to qualify for a contributory benefit and are disallowed from income-tested benefits – such as IS or JSA, for instance – because they have a working partner, a pension or savings above the allowable threshold or are receiving an 'overlapping benefit' such as Invalid Care Allowance. There is, in any case, considerable movement between these various benefit statuses, particularly between JSA, IS and IB.

Table 3.4 compares the numbers of IB claimants as a percentage of the working age population for England and Wales, with the local situation in Birmingham and Solihull.

Table 4: Incapacity Benefit claimants

	Working age population*	Incapacity Benefit/ Severe Disablement Allowance claimants**	IB claimants as percentage of working age population***
Birmingham	623,678	53,880	8.7
Solihull	121,300	6,995	5.8
England, Wales and Scotland	36,445,500	2,685,320	7.4

** Source: ONS, 2008a, Annual Population Survey (October 2006–September 2007) UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI).*

*** Source: DWP Information Directorate (May 2007), © Crown Copyright*

**** Authors' calculations*

The headline IB figures for Birmingham and Solihull suggest that Birmingham fares somewhat worse than the national average, while Solihull is somewhat better than the national average. However, these figures obscure the fact that, in some individual wards in both Birmingham and Solihull, the ratio of IB claimants to working age population is far higher than the national average and the city average. At Super Output Area level, the proportion of IB claimants can exceed 20 per cent.

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[17] For the purposes of this report, 'incapacity benefits' includes people claiming any of the following: Incapacity Benefit (IB); Severe Disablement Allowance (SDA); Income Support (IS) which includes a Disability Premium; IS pending an appeal against disallowance from IB; Housing Benefit or Council Tax which includes a Disability Premium (unless working 16 or more hours or in receipt of Jobseeker's Allowance); Disability Living Allowance (unless working 16 or more hours or in receipt of Jobseeker's Allowance); War Pension with an Unemployability supplement; Industrial Injuries Disablement Benefit with an Unemployability supplement (IIB); National Insurance credits on the grounds of incapacity; equivalent benefits to Incapacity Benefit imported to Great Britain under European Community regulations or the European Economic Area Agreement.

This is the definition used by Jobcentre Plus, and which provides the basis for access to their disability and health-related provision; it is also a qualifying criterion for disability-related in-work benefits.

Link to areas of high unemployment

In Birmingham and Solihull, areas with high levels of unemployment often (but not always) have a substantial proportion of the population claiming IB. Appendix 2 shows the overlap between Birmingham and Solihull wards with a high proportion of people claiming IB, high proportions claiming Jobseeker's Allowance (the numbers of JSA claimants serves as a surrogate measure for the numbers of people unemployed, at ward level) and high levels of economic inactivity.[18]

Duration of incapacity benefits claims

Table 3.5 shows that three-quarters of claimants have been claiming for over two years. According to DWP, of the 40 per cent of new claimants who do not return to work within a year, only 22 per cent of those will leave within the next year and 29 per cent of them will still be receiving benefits after another eight years (DWP, 2006a).

Table 5: Length of Incapacity Benefit claim

Length of claim	N	%
Less than 6 months	216,830	9
6 months - 1 year	144,950	6
1-2 years	205,465	9
2-5 years	470,865	20
5 years and over	1,320,415	56

Source: DWP Information Directorate (May 2007), © Crown Copyright

The profile of IB claims in Birmingham and Solihull's wards is broadly similar to the national picture. However, in several Birmingham and Solihull wards there is a significantly higher proportion of IB claims where the claim period exceeds five years. In some wards, over 60 per cent of IB claimants have been claiming for over five years.[19] Programme design will need to take into account the longevity of the claim period and therefore the potentially greater difficulty in moving people from entrenched habits of worklessness closer to employment.

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[18] It should be noted, however, that City Strategy wards were identified by Super Output Area analysis and by Deprived Area Fund status, rather than by ward analysis (Birmingham, Coventry and Black Country City Region, June 2007).

[19] Birmingham wards: Billesley (61.6 per cent), Brandwood (62.2 per cent), Kingstanding (61.2 per cent), Moseley and Kings Heath (64.4 per cent). Solihull wards: Knowle (67.5 per cent), Shirley South (60.6 per cent), Shirley West (62.9 per cent), Silhill (62.3 per cent) (Department for Work and Pensions, May 2007b).

3.2.3 Age, gender and ethnicity

Age and gender

As at May 2007, 46 per cent of incapacity benefits claimants were aged 50 or over, 47 per cent were aged between 25 and 49, and six per cent were aged under 25 (DWP Information Directorate, May 2007, © Crown Copyright). The largest single group of IB claimants is older males.

The age profile of IB claimants in Birmingham and Solihull is similar to the national picture; however, Solihull, has a higher proportion of IB claimants in the oldest age group when compared with Birmingham. Conversely, Birmingham has a higher proportion of IB claimants in the youngest age group when compared with Solihull. Programme commissioners will need to take account of different age profiles when designing provision.

Ethnicity

Table 3.6 shows the ethnic breakdown for IB claimants. These figures are in line with the general population.

Table 6: Ethnic breakdown of Incapacity Benefit claimants

Sickness or disability benefit received	White	%	Mixed	%	Asian or Asian British	%	Black or Black British	%	Chinese	%	Other	%	Total
Incapacity benefit	1,245,766	94	8,661	1	38,790	3	22,442	2	1,721	0	14,964	1	1,332,344
Severe Disablement allowance	146,415	88	3,394	2	5,734	3	5,979	4	0	0	5,510	3	167,032
Industrial injury disablement allowance	68,573	98	0	0	0	0	673	1	0	0	840	1	70,086
Total IB benefits	1,460,754	93	12,055	1	44,524	3	29,094	2	1,721	0	21,314	1	1,569,462

Source: LFS data for Oct-Dec 07 working age adults, UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI)

The data in Table 3.6 is taken from the Labour Force Survey (LFS), as DWP does not provide data on the ethnicity of IB claimants on a routine basis. LFS does not break down these data to city level, so it is not possible to compare the national statistics shown in Table 3.6 with statistics for Birmingham and Solihull. However, based on Table 3.6, it is assumed that the ethnicity of IB claimants in Birmingham and Solihull will broadly match that of the general population.

Programme design will need to take account of the needs of different ethnic groups in areas where ethnic minority groups form a significant proportion of the local

population. Ethnic minority groups make up 30 per cent of the total population of Birmingham, considerably higher than the UK average of nine per cent, while at only five per cent, ethnic minority groups account for only a small proportion of the total population of Solihull (2001 Census). Assuming that the ethnicity of IB claimants matches that of the general population for smaller areas, the proportion of IB claimants with an ethnic minority background is likely to be high in certain parts of Birmingham and Solihull.

3.2.4 Main medical conditions affecting long-term IB claimants

Table 3.7 shows the main medical conditions of people claiming IB/SDA and this illustrates that people with mental disorders make up the majority of claimants. It is notable that the prevalence of different health conditions also varies across ages.

In addition, the causes of health conditions vary across the age groups. For example, older claimants are more likely than younger claimants to have work-related illnesses whereas younger claimants are more likely than younger claimants to have injuries due to traffic or sporting accidents (Kemp and Davidson, 2008).

Table 7: Main medical reasons for claiming IB or SDA

Medical reason for claiming IB	England, Scotland, Wales	%*	Birmingham	%*	Solihull	%*
Mental disorder	967,340	41	23,224	43	2,755	39
Musculoskeletal disease	419,420	18	9,305	17	1,335	19
Respiratory or circulatory disease	177,595	8	4,358	8	560	8
Diseases of the nervous system	145,930	6	2,850	5	445	6
Injury or poisoning	134,475	6	2,848	5	425	6
Other	513,765	22	11,356	21	1,475	21

Source: Incapacity Benefit/Severe Disablement Allowance Claimants, May 2007, UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI)

** Authors' calculations*

3.3 Routes onto Incapacity Benefit

The following section discusses the main routes onto Incapacity Benefit.

3.3.1 Main routes onto IB

The three main routes onto IB can be explained as:

- move from long period of work to IB
- move from long period of non-work to IB
- short transitions work/non-work/IB.

The routes onto IB have implications for programme design. Programme commissioners will need to bear in mind clients' proximity to the world of work when designing provision. Clients who have been away from the work place for a very long time as a result of moving from a long period of non-work to IB may require more assistance in updating their skills, or boosting their confidence. Those who have been cycling through short periods of work, non-work and IB, may also have underlying problems, such as a lack of skills, which are preventing them from securing long-term sustainable employment.

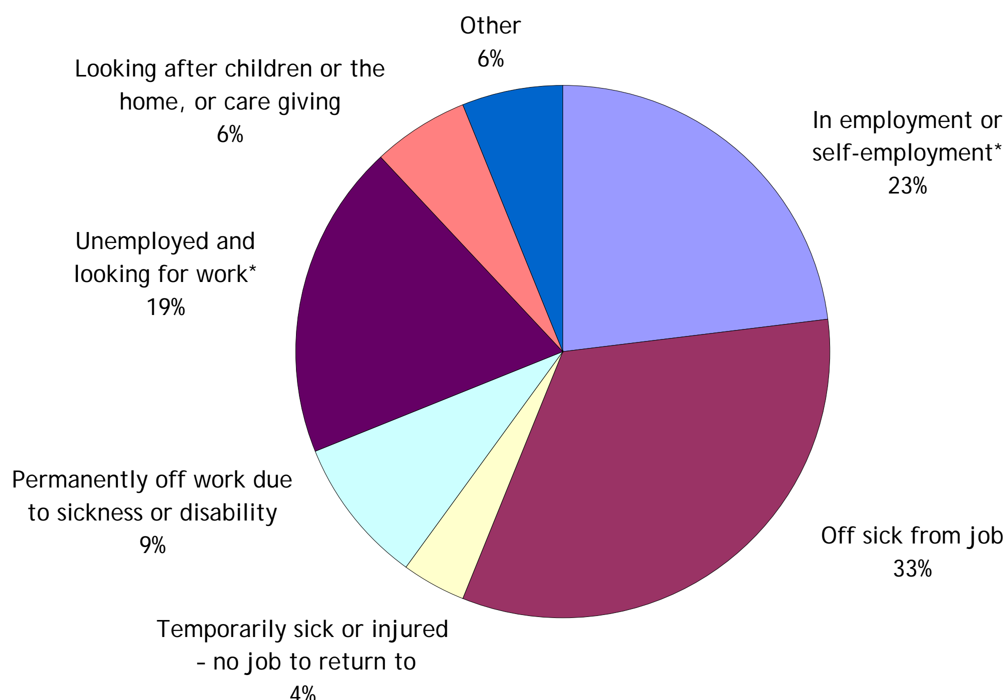
3.3.2 Data limitations

It is important to note that there is no data available on the routes that longer-term IB claimants took to becoming IB claimants. The following insights, from Kemp and Davidson's 2008 DWP report, relate to recent IB claimants only. This data was not routinely collected in the past, so unfortunately it is not possible to show comparable results for longer-term claimants. Nevertheless, some general lessons may be gleaned from the data on more recent claimants.

3.3.3 Pre-IB employment status of recent IB claimants

Detailed information about the routes onto Incapacity Benefit was gained from interviews with 1,843 recent claimants which expands on these three routes.

Figure 1: Employment situation immediately prior to claiming Incapacity Benefit



* Including those on a Government training scheme

Source: Kemp and Davidson (2008)

Figure 3.1 shows employment status prior to claiming IB for recent claimants in Kemp and Davidson's (2008) report. As previously stated, it is not possible to show comparable results for longer-term claimants.

- Just over half of recent claimants had some connection with paid work immediately prior to their claim: 23 per cent had been in work and 33 per cent had been off sick from their job.
- Of those who had been working, three-quarters were employees and a quarter were self-employed. The rate of self-employment among recent IB claimants is much higher than among the general population: in comparison, 14 per cent of all jobs recorded by the Labour Force Study were self-employment jobs (ONS, 2007b), 70 per cent had been in steady employment throughout their adult lives.
- Recent IB claimants were more likely to have been working for small or medium-sized enterprises: 40 per cent of recent IB claimants were employed by enterprises with less than 50 employees (compared with 26 per cent of UK employees employed by this size enterprise overall); 19 per cent of recent IB claimants were employed by employers with between 50 and 249 employees (compared with 12 per cent of UK employees employed by this size enterprise overall). Recent IB claimants were also less likely to have been working for large employers: 41 per cent of recent IB claimants were employed by employers with 250 or more employees, compared with 61 per cent of UK employees employed by this size enterprise overall (Kemp and Davidson, 2008).
- Two-thirds of the remainder had been getting Income Support (IS) or Jobseeker's Allowance (JSA) immediately prior to their claim for IB. One in ten *recent* claimants had not worked for over a decade.
- Of those people not in work before claiming IB, 62 per cent said they had left their last job because of their ill-health. Ten per cent of respondents had been off sick with no job to return to, 19 per cent were unemployed and looking for work.
- Nine per cent considered themselves to have been permanently off work due to sickness or disability, and six per cent had been looking after the home or care-giving, immediately prior to their recent claim.
- One in five of those working immediately prior to claiming had been on a temporary contract, and almost half (47 per cent) of all recent claimants were low-paid, earning less than £10,000 a year. Often IB claimants churned between benefits because they were in low-skilled temporary jobs where they would be more likely to be laid off than to get sick pay (see also Sainsbury and Davidson, 2006 – DWP ROIB qualitative findings).
- 34 per cent of recent IB claimants had no academic, vocational or professional qualifications, compared with only 14 per cent in the general population (Office for National Statistics (2007) *Social trends 2007*, cited in Kemp and Davidson, 2008).

- The majority of recent claimants (73 per cent) worked in the private sector, and just under a quarter (23 per cent) in the public sector. Almost two in five (37 per cent) worked in firms with fewer than 50 employees, and just over a quarter (27 per cent) in large organisations with over 1,000 employees.

3.3.4 Gender, ethnicity and age

Table 3.8 breaks down the routes onto IB for recent claimants by their personal characteristics:

- Women were significantly more likely to have moved onto IB via the non-work route and men more likely via the other two routes.
- Respondents who described themselves as being white were also very much more likely than people from other ethnic backgrounds to have moved onto IB from work.
- The oldest age group was most likely to claim IB directly from work (65 per cent among respondents aged 55 or more) showing how this can act as a transition to retirement, while this route was least common among young people aged 16–24, some of whom have a disability and are moving straight from education onto disability/ill-health benefits. These two groups will have very different needs in terms of support for a return to employment. Those claiming following a period of non-work obviously lack recent labour market experience, and this has implications for how quickly they are likely to leave benefit.

Table 8: Routes onto Incapacity Benefit, by personal characteristics

	Work[a]	Work to non-work[b]	Non-work[c]	Total	Base
Gender					
Men	54	28	18	100	1,085
Women	52	24	25	100	757
Age group					
16 to 24	33	41	26	100	265
25 to 34	48	30	22	100	285
35 to 44	51	25	24	100	391
45 to 54	58	21	21	100	472
55+	65	21	14	100	424
Ethnicity					
White	55	25	20	100	1,688
Other	33	32	36	100	155

[a] In work or off sick from work immediately prior to their claim for IB.
[b] Neither in work nor off sick from their job immediately prior to their recent claim but did have a job in the previous two years.
[c] Neither in work nor off sick from their job immediately prior to their recent claim, and had not had a job in the previous two years.

Row percentages. Totals may not sum to exactly 100 due to rounding.
Base: all respondents.

Source: Kemp and Davidson, 2008

3.3.5 Physical or mental health conditions

Routes onto IB also varied according to whether recent claimants' health condition was related to their mental or their physical health. Those whose main or only condition was their mental health were less likely than other people to have moved onto IB directly from work, while respondents who had only physical health conditions were more likely to have done so. Again, this has implications for employability and the likelihood of recent work experience.

3.4 Routes off Incapacity Benefit

The likely trajectories of long-term IB claimants have become widely rehearsed in recent policy documents: once someone has been claiming incapacity benefits for 12 months, the average duration of their claim is eight years, and after two years they are more likely to die or retire than return to work (HM Government, 2005). As discussed in Section 5.6, it is also likely that expectations about working will diminish over time. Kemp and Davidson found that, only six months after the original claim, 27 per cent of IB claimants perceived themselves as being permanently unable to work due to sickness or disability, compared with just nine per cent at initial interview (Kemp and Davidson, 2008). This figure is likely to be even higher for long-term IB claimants.

As previously discussed in Section 3.2.2, three-quarters of claimants have been claiming for over two years. According to DWP, of the 40 per cent of new claimants who do not return to work within a year, only 22 per cent of those will leave within the next year and 29 per cent of them will still be receiving benefits after another eight years (DWP, 2006).

Many people move from IB to another benefit, for instance if they reach retirement age and start claiming pension, or if they fail a medical and claim JSA.

There are a number of sources of data regarding the destinations of those who leave incapacity benefits, including routine statistical data on the whole claimant population, destination surveys which cover a representative sample of those leaving benefit, and impact analysis for groups of claimants who have been subject to a particular intervention, such as New Deal for Disabled People (NDDP) and Pathways to Work (Pathways). Differences in the sample population, the type (or absence) of intervention, and the ways in which the data was collected, mean that these provide quite widely varying estimates of the probability of return to work, moving to another benefit, and so on. As there are large amounts of data missing from administrative statistics, and there have been changes in benefit regulations since earlier studies were conducted, the most relevant findings are those from the evaluations of NDDP and Pathways. Findings from the Pathways evaluation suggest that in the absence of any intervention, around a third of new and repeat claimants but under three per cent of existing claimants (with claims of under two years' duration) would return to paid employment over an 18 month period (Bewley et al., 2008).

3.4.1 NDDP – the impact of a voluntary approach

NDDP is a voluntary programme, which means that those who take part tend to be those who are most motivated and work-ready; but levels of take-up have remained persistently low since its inception. Both of these factors are important in contextualising NDDP employment outcomes. Of those on qualifying benefits, only three per cent (260,330 people) registered for NDDP (over the period of July 2001 to November 2006). Of these, 43 per cent (110,950) had found jobs by November 2006. Of those who found work by August 2006, 57 per cent (59,080) achieved employment lasting 13 or more weeks. Kazimirski et al. (2005), however, noted that 50 per cent of NDDP registrants who started a job left it during the year following their registration with NDDP, highlighting issues about the sustainability of work. Surveys of NDDP participants showed that they were more likely to be male, younger, on benefits for a shorter period of time, less likely to have a mental health condition, and more likely to have musculoskeletal problems, more likely to state their health was fair, or (very) good and less likely to say it was (very) bad, and more likely to have an educational qualification than the incapacity-related benefit population as a whole. In addition, participants' attachment to the labour market appears to be stronger than that of members of the broader eligible population, since more participants than non-participants were in work or looking for work.

3.4.2 Pathways – results from a mandatory programme

Pathways, which is mandatory for new and repeat claimants, and voluntary for others, has increased employment rates among those claiming IB by around seven per cent in the areas where it has been introduced. Pathways provision will not be available to existing customers in Birmingham and Solihull before 2011; where they have been included in the Pathways pilots, the impact on their employment rates is an additional three to four per cent, which is double their 'natural' rate of return (Bewley et al., 2008).

Pathways, which is mandatory for new and repeat claimants, and voluntary for others, has increased employment rates for new claimants by around seven percentage points – from around 33 per cent to 40 percent. For existing claimants, Pathways has doubled rates of return from about three per cent to about six per cent. Pathways to Work became mandatory for new and repeat claimants in Birmingham and Solihull in December 2007; it is also available locally to existing claimants on a voluntary basis.

3.5 Proportion of IB claimants that want to work

IB claimants are deemed economically inactive because of their health and benefit status, but some people claiming IB are able and willing to work. This proportion has been estimated at a third – a figure that has gained much currency in recent policy

debate – but is worthy of closer examination in order to improve understanding of the scope and timescale for increasing employment rates among this group.

Loumidis et al. (2001) found that 78 per cent of people on disability and incapacity benefits did not expect to return to work, and only three per cent were actually looking for work, while seven per cent said they wanted work but were not looking for a job, and 12 per cent said they would need rehabilitation or training first. In another survey, 34 per cent of people on disability and incapacity benefits said they would like to work, but on a further question, only six per cent said they would actually be available for work at present (*Labour Force Survey Summer 2002*, cited in Waddell and Burton, 2004). Bailey et al. (2007) found that of 65 per cent of claimants in Pathways areas who had not returned to work within 14 months of their initial claim, just under one in three were actively seeking work, and a further nine per cent intended to do within a year, but over half of those not currently working had no idea when they might work again, or did not expect to do so.

As well as changes over time, and changes in policy, it is important to note that the population for these surveys differs significantly, since the Pathways study cited covers new and repeat claimants only; work intentions may be very different for long-term claimants.

The evidence suggests that while there is a reasonable proportion of IB claimants who would like to return to work, this may be lower than expected; many people are not ready to do so immediately, and some may require a considerable amount of prior assistance. Measuring intermediate or so-called 'soft' outcomes such as 'meaningful activity' – such as participation in training, voluntary work, and paid work under the 16 hours threshold – or changes in attitudes to job seeking, may therefore be an important element in programme design and in measuring programme impact (Lloyd and O' Sullivan, 2003; Hasluck and Green, 2007). Health outcomes may also be an important consideration, since they may be a prerequisite for a return to work – one evaluation of employment support for people on IB found that the project resulted in a number of positive health behaviours, including reduced (or complete cessation of) smoking, reduced consumption of alcohol, increased exercise, and improved diet (Frontline, 2008).

3.6 Cost-benefit analysis

Very little cost-benefit analysis has been carried out to determine the net value of delivering employment support programmes for people out of work due to ill-health. This is largely because of the methodological complications involved in doing so. The results are also highly sensitive to the assumptions about how long-lasting the impact of such interventions may be. Cost-benefit analysis has been carried out for Pathways (Adam et al., 2008), based on new and repeat claimants only, and found that the net return was £1.51 for every £1 if impact was assumed to last 70 weeks, rising to £3.06 if the programme was deemed to have an impact lasting 150 weeks.

3.7 Conclusions

This chapter has shown that, nationally, mental health problems account for the largest proportion of IB claimants (40 per cent). Older people make up almost half of those claiming IB. The situation in Birmingham and Solihull is similar to the national average, but Solihull has a higher than average proportion of older IB claimants, and Birmingham has higher than average proportions of IB claimants with mental health problems, and in some Birmingham and Solihull wards there are notably higher than average numbers of people with long claim periods (five years or more). Wards with high levels of unemployment are also often those with high levels of IB claimants. Birmingham also has a significantly higher ethnic minority population than in the UK as a whole, and this is likely to be reflected in its IB population. Programme commissioners will need to take into account this IB client group profile, nationally and regionally, when designing provision.

White men are more likely to enter IB from work, while women and ethnic minorities are more likely to move to IB following a period of economic inactivity or claiming another benefit. Again, this has implications for programme design. Clients who have been away from the work place for an extended length of time as a result of moving from a period of non-work to IB may need more help than those who moved from work to IB.

Research has consistently identified the proportion of IB claimants who want to work as around 30 per cent. However, a much smaller proportion will be immediately available, and many will need support and time to move back towards the labour market. In addition, return to work rates decline very rapidly with length of time on benefit, and it is estimated that only three per cent of existing claimants return to work over an 18 month period without assistance. In the areas where Pathways was extended to existing customers, this rate was doubled, and this may provide an indication of potential employment impact. Improved health outcomes have also been noted in some evaluations, and could form an additional basis for programme monitoring and evaluation.

4 Policy Context

4.1 Introduction

This chapter sets out the historical development of the current approach to disability, ill-health and employment, before discussing the existing and proposed national welfare-to-work programmes for those on incapacity benefits. It then reviews current Government policy in respect of supporting people with a health problem or disability into employment.

4.2 Current employment policy

The Department for Work and Pensions (DWP) and Jobcentre Plus (JCP) are working towards a target of an 80 per cent employment rate (Department for Work and Pensions, 2005a). Recent years have seen a reduction in the number of Job Seeker's Allowance (JSA) claimants, helping raise the employment rate to around 75 per cent. Achieving the target 80 per cent employment rate will require bringing key groups of economically inactive adults back into the workforce: people with long-term health conditions and disabilities are one such group. There is a growing recognition of the need to engage with IB claimants, to meet both the 80 per cent employment target and child poverty targets (Child Poverty Action Group, 2007; Child Poverty Unit, 2008; Barnes et al., 2008). In addition, the Government's aim of bringing one million more older people into the workforce (Department for Work and Pensions, 2005b), combined with the prevalence of ill-health and disability in the over 50s age group, has increased the necessity for tackling the issues of ill-health, disability and worklessness.

The national Government target is to reduce total number of IB claimants, which currently stands at 2.6 million, by one million by 2016 (Department for Work and Pensions, 2006b). Longer-term, DWP's projections show that the Government anticipates reducing expenditure on benefits for people with sickness or a disability and Disability Living Allowance from 1.7 per cent of Gross Domestic Product in 2006/2007 to 1.4 per cent by 2025 (Department for Work and Pensions, May 2008).

4.2.1 Existing provision in respect of disability and ill-health

Over the past 40 years, the UK has gradually moved away from the demand-led approach to disability, ill-health and employment established in the 1940s, and this development has gathered pace in the last decade. Following the 1997 election, concern about the growing numbers of people on IB led to the development of active labour market policies, which emphasise the development of human capital. Current Government policy operates from the view that there is: *'growing consensus that work is good for people's health'*. Government aims to help people to find and retain work through personalised support, while in return, expecting that people will take a job if it is available, but recognising that there are some people with complex and multiple problems who need additional support to: *'meet their responsibilities'* (Department for Work and Pensions, July 2008b). The main national employment programmes that resulted are delivered via Jobcentre Plus (JCP): the New Deal for Disabled People (NDDP), Pathways to Work, Workstep and Work Preparation (Workprep).

4.2.2 The New Deal for Disabled People (NDDP)

NDDP is a voluntary programme for people claiming incapacity benefits (an estimated 2.7 million people at the time of its instruction) and was implemented nationally in 2001. NDDP provides a single gateway to employment services via Jobcentre Plus for new incapacity benefit claimants. As a voluntary programme, NDDP has consistently suffered problems of low take-up. NDDP is available in Birmingham and Solihull.

4.2.3 Pathways to Work

Pathways to Work is a mandatory programme for new IB claimants and is available to existing IB claimants on a voluntary basis. It was introduced in late 2003 (DWP, 2002) and initially piloted in the seven areas of the country with the highest claim rates, and has recently been rolled out nationally. Pathways has been available in Birmingham and Solihull since December 2007 through local provider Work Directions, contracted to JCP. Work Directions plans to support 1,820 existing IB (voluntary) claimants and 3,200 recent IB claimants (mandatory participants) in 2008, and has pledged a 32 per cent job outcome during that period – although it is not clear whether this outcome applies to both existing and recent IB claimants (WorkDirections, 2008). The Government has recently announced that a personalised programme of back-to-work support based on Pathways to Work will be extended to all existing claimants judged capable of work (Department for Work and Pensions, July 2008a); the earliest this support for existing claimants could be available in Birmingham and Solihull is likely to be 2011.

4.2.4 Workstep

Workstep is a voluntary JCP Programme that provides job support to disabled people who face more complex barriers to getting and keeping a job, but who can work effectively with the right support. It enables eligible disabled people to realise their full potential to work within a commercial environment, giving them, whenever possible, an opportunity to progress into open employment. The programme also offers practical assistance to employers. Approximately 26,000 disabled people use this service. In Birmingham and Solihull, local authority-appointed providers administer Workstep.

4.2.5 Work Preparation (Workprep)

Workprep is a JCP-funded programme provided by outside agencies, to enable people with long-term health issues or a disability to look at returning to work, without risk to their benefits. There are two types of Workprep: the Personal Development Module which focuses on skills development (PDM) for up to 16 hours a week and a Work Placement Module (WPM) with an employer for up to 13 weeks. In Birmingham and Solihull, a mixture of voluntary, private and local authority providers administer Workprep.

4.2.6 Access to Work

Access to work is a DWP programme, run by Jobcentre Plus, which provides advice and practical support to disabled people and their employers to help overcome work-related obstacles arising from their disability. Financial help under Access to Work can pay for equipment necessary because of an individual's disability, adaptations to a vehicle if someone cannot use public transport, or a communicator for job interviews for people with hearing difficulties, and other types of practical support (Jobcentre Plus website, August 2008)

4.3 Imminent welfare reforms

In 2008, Dame Carol Black's review of the health of Britain's working age population: *Working for a healthier tomorrow* (Health Work Wellbeing, March 2008) made far-reaching recommendations to Government, around the premise that: *'work can be good for health'*. These recommendations include:

- a new '*Fit for Work*' service that adopts a case-managed, multidisciplinary approach to helping people who are off work because of sickness – referring them into services such as advice on finance and housing, as well as physiotherapy and talking therapies

- supporting health care professionals to provide *'fitness-for-work'* advice, and changing the focus from a sick note culture of what people cannot do, to a *'fit note'* culture emphasising what people can do at work
- fully integrating specialist mental health provision with employment support programmes
- integrating occupational health with mainstream healthcare provision
- improving employers' sickness absence management.

In its 2008 welfare reform Green Paper (Department for Work and Pensions, July 2008a), Government announced that it would invite successful City Strategies areas, such as Birmingham and Solihull's, to develop Fit for Work pilots. A working group has been established in Birmingham with a view to developing a Fit for Work pilot.

4.3.1 Employment and Support Allowance

Alongside providing these forms of employment support, and consistent with an emphasis on labour supply behaviour, the Government is also reforming entitlement criteria for incapacity benefits. From October 2008, Employment and Support Allowance (ESA) will replace both Incapacity Benefit and Income Support on grounds of incapacity or disability. As set out in the Government's 2008 Green Paper, the intention is that: *'for the vast majority, ESA will be a temporary benefit as people recover from, or adapt to, their condition and prepare for a return to work'* (Department for Work and Pensions, July 2008a). There is an increasing expectation that IB claimants will return to work, in return for: *'personalised back-to-work support for all new and existing claimants of incapacity benefits'* (Department for Work and Pensions, July 2008a). In addition to changes in the way benefit is calculated, ESA will replace the Personal Capability Assessment with a Work Capability Assessment, focusing on what people *can* do rather than what they *cannot* do. Initially focused on new and repeat claimants, the programme will move existing claimants onto the new system in phases between 2009 and 2013, and aims to provide '*a personalised programme of back-to-work support based on Pathways to Work*'. However, as already mentioned in Chapter 1, this programme is unlikely to be rolled-out in Birmingham and Solihull until 2011. IHIE is exploring how best to support this client group back to employment in Birmingham and Solihull during the 2008–2011 period.

4.3.2 Integrated employment and skills

In response to the Leitch Review, the Government is starting to bring together the commissioning of employment and skill services (Department for Innovation, Universities and Skills, 2007), and the West Midlands is one of several regions that will shortly be piloting the resultant integrated employment and skills system. Based on the City Strategy, it will look at more innovative ways to bring together an extended range of providers and local partners.

In 2007, the *City Strategy Business Plan* set out the local authorities' intention to work with priority groups in the 55 most deprived wards of the region, including IB claimants and other sick and disabled people (particularly those aged over 50 and those claiming for over three years) (Birmingham, Coventry and Black Country City Region, June 2007). The City Strategy's overriding targets were to halve the gap between the City Region's employment rate and that of the priority wards and reduce the numbers claiming the main worklessness benefits – including IB and Severe Disability Allowance.

There were no specific health targets within the City Strategy for people who are out of work because of ill-health, as the strategy focused on helping people into work, rather than addressing their health issues per se. However, it was envisaged that primary health care workers, including GPs, would play a key role in referring clients and facilitating client engagement. Over time, the health services' input to the strategy was intended to include:

- GPs and other support services referring individuals to the *'Caseload Tracking Team'* in order to engage clients
- some employment/skills services would be co-located in GP surgeries
- Pathways to Work would be integrated with the *City Strategy*
- employment and skills services would engage more closely with primary health care providers, for example, GPs and treatment agencies developing 'prescriptions for work' where diagnosis reveals work-related issues
- advisers would be positioned in surgeries and ensure GP's recommendations are supported by all agencies and voluntary sector organisation
- programmes for personal support for people in the *'target caseload'* would include *'ongoing support to sustain and progress in employment'* such as CBT, and condition-management
- City region-wide commissioning and procurement would be enacted to avoid gaps, fragmentation and duplication in service provision (Birmingham, Coventry and Black Country City Region, June 2007).

It remains to be seen to what extent the integrated employment and skills pilot in West Midlands will incorporate the above elements into its policy and programmes.

4.3.3 Increasing Access to Psychological Therapies

In February 2008, Government unveiled plans to roll out the Increasing Access to Psychological Therapies (IAPT) programme that will train an additional 3,600 psychological therapists over the next three years. The programme is designed to help people with anxiety and depression disorders through cognitive behavioural therapies. PSA 16 on socially excluded adults also makes commitments to ensure that

IAPT is aligned with Pathways, that those receiving treatment for mental health problems receive assistance to remain in or return to work, and that the IAPT programme will include employment support.

The Government has also recently announced that it will be building on developments in IAPT, by setting out a National Strategy for Mental Health and Employment to co-ordinate, across Government, a response to employment challenges faced by people with mental health conditions (Department for Work and Pensions, July 2008a).

4.3.4 Adult Advancement and Careers Service

The Government is also developing a new Adult Advancement and Careers Service, created from a merger of Nextsteps and learndirect, which will cover health issues where these are a barrier to gaining employment or skills.

4.4 Other relevant targets

4.4.1 Health

The main PSA target that relates to long-term IB claimants is PSA 18: *'to promote better health and wellbeing for all'* (HM Treasury, 2007). PSA 18 also includes other relevant targets: highlighting the need to support people in their aspirations for independence and wellbeing, and improving the wellbeing and inclusion of people with depression and/or anxiety disorders (HM Treasury, 2007).

As discussed above, PSA 16 deals with employment (and accommodation) issues for those in contact with secondary mental health services, and also covers those with learning disabilities.

In addition, PSA 17 on tackling poverty and promote independence and wellbeing in later life requires that older people: *'make a contribution to society, in particular through employment'*, thereby addressing the problem of material poverty amongst the over 50s, and reducing dependence.

4.4.2 Skills

The Government has adopted the Leitch Review ambition to become a: *'world leader in skills'* by the year 2020, setting ambitious targets for improved qualification attainment by individuals at all levels (DIUS, 2007 and HM Treasury, 2007). This skills target is significant for people with long-term health conditions and disabilities, given the prevalence of low/no qualifications amongst this group. As discussed in Section 3.3.3, 34 per cent of recent IB claimants have no qualifications, compared with 14 per cent in the general population (Office for National Statistics (2007) *Social trends 2007*, cited in Kemp and Davidson, 2008).

4.5 Local solutions to worklessness

There is a growing recognition that local areas vary widely in their social and economic circumstances and that programmes to tackle worklessness need to be tailored to these circumstances if they are to be effective (Meadows, 2008). DWP has been considering: *'a more decentralised approach to the delivery of interventions for customers'*, in which they envisage devolving greater powers to Jobcentre Plus District Managers and PAs: *'so that they could decide the appropriate type of provision needed to suit their customers and the local labour market'* (Department for Work and Pensions, 2007c). If this move takes place, there will be fewer rules on eligibility, programme mix and length, with more flexibility, variation and local innovation possible in the provision of support to long-term IB claimants through JCP. The Government has recently announced plans to run a number of pathfinder back-to-work support projects for existing IB claimants in various regions of the country.[20] Contracts with pathfinder providers are intended to have a new financing system that will allow Government to test new types of outcome-based contracts that encourage the provider to focus on those with more complex barriers to work and the achievement of sustained employment. This system would also allow Government to test the extent to which providers' innovations can improve employment outcomes for existing IB claimants, and the market price for supporting people into sustained employment (Department for Work and Pensions, July 2008a).

Partnerships approaches to welfare reform and area regeneration are seen to work most effectively where they build on established local partnerships, and are able to engender a sense of ownership and control at local level (North et al., 2007). Partnerships at the sub-regional level have been highlighted as being of particular importance, since these map most closely onto '*Travel to Work Areas*'[21] in which people tend to be seeking work (North et al., 2007). The City Strategy aims to facilitate successful partnership working of this type and IHIE is a partnership that brings together health as well as skills and employment agencies.

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[20] Initially, Greater Manchester, Norfolk and Lambeth, Southwark and Wandsworth (Department for Work and Pensions, July 2008a).

[21] The Office for National Statistics and Newcastle University have defined a set of 'Travel to Work Areas' (TTWAs). The fundamental criterion of a TTWA is that, of the resident economically active population, at least 75 per cent actually work in the area, and also, that of everyone working in the area, at least 75 per cent actually live in the area. 243 TTWAs were defined in 2007 using 2001 Census information on home and work addresses (ONS, 2008b, UK Statistics Authority website: www.statisticsauthority.gov.uk or www.statistics.gov.uk August 2008, Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI).

4.6 Conclusions

This is an area of rapidly evolving national Government policy. Meeting the 80 per cent employment target and the child poverty targets implies a renewed focus on people who are economically inactive due to ill-health, including those who are claiming IB and those who are not. The Government is proposing to introduce back-to-work support based on Pathways to Work for existing IB claimants, although the earliest this is likely to be introduced in Birmingham and Solihull will be 2011. At the same time Fit for Work pilots will be developed locally, an integrated skills and employment system will be rolled out, as will the Increased Access to Psychological Therapies Programme and the Adult Advancement and Careers Service. These far-reaching changes give IHIE commissioners the opportunity to benefit from some synergy created by the various partner organisations working together to help long-term IB claimants. There is a growing recognition that partnership working, as already embodied in City Strategy, is the best way of tackling local concentrations of worklessness and the multiple needs of long-term IB claimants.

There is also an emerging consensus that work can be good for health, and that health professionals need to be involved in helping people who are out of work due to ill-health back into employment. While new and repeat claimants have been the focus of return to work measures over the past five years, there is a growing emphasis on the need to deal with the large numbers of existing claimants who have not so far been included.

5 Barriers to Work and How These Can Be Addressed

5.1 Introduction

This chapter examines the barriers to returning to work for people with long-term health conditions, including both the issues that affect all those with a long-term health problem, specific issues for particular groups, and multiple barriers. It goes on to review the evidence on employment interventions to help people with long-term health problems, and then discusses how the programmes that featured in the programme review had sought to address these barriers.

5.2 Health

The majority of unemployed individuals with a long-term health condition perceive their health as the main barrier to a return to work (Grewal et al., 2002; Corden and Nice, 2006a, 2006b), and a health condition is also the most commonly cited reason by recent IB claimants as to why they lost their last job (Kemp and Davidson, 2008). Health conditions may restrict the work opportunities available or prevent a return to former types of employment, especially physically demanding or stressful work. Other health-related barriers to a return to work may include the demands of hospital appointments, the experience of chronic pain and fatigue, employer inflexibility, and particularly for some conditions, stigma and discrimination (Salway et al, 2007).

Mental health conditions are widely recognised as a major cause of ill-health and sickness absence in the UK (Layard, 2004, 2006; SEU, 2004) and people with mental health problems are over-represented among the workless, whether unemployed or economically inactive. In addition to those whose primary reason for claiming IB is a mental health condition, there are a large number of people who develop secondary mental health problems, such as reactive depression, following a prolonged period of ill-health or worklessness. For others, mental health problems are associated with issues such as problematic alcohol and drug use. Customers with mental health problems have a distinctive profile within Pathways, being further from work at the

outset, less likely to enter paid work, and much more likely than other customers to have a fluctuating health condition over the previous year (Bailey et al., 2007).

People with long-term health problems may have anxieties about their ability to sustain work or concerns about the impact of work on their health (Waddell and Burton, 2004; Casebourne and Britton, 2004, Corden and Nice, 2006a, 2006b). Those with mental health problems cite such concerns as a key barrier to work and they are noted as influencing advisers as well as claimants (Social Exclusion Unit, 2004). Any return to work by those with long-term health conditions or disabilities requires that the work be safe, flexible and sustainable.

With regard to healthcare services, delays and a lack of occupational focus may act as barriers to entering work, and it is believed that many health professionals provide inappropriately cautious advice regarding work capacity (Waddell and Burton, 2004). These issues are currently at the forefront of Government policy, with Dame Carol Black's review of the health of the working age population recommending a number of changes to enhance the ability of healthcare services to help people remain in and return to work.

5.3 Low skills

A study of recent IB claimants found that they were twice as likely compared to the general population to have no vocational or academic qualifications and to have a higher prevalence of literacy and numeracy problems (Kemp and Davidson, 2008, as discussed in Sections 3.3.3 and 4.4.2); a third of those surveyed for the Pathways evaluation had no qualifications (Bailey et al., 2007). This is reflected in the over-representation of recent IB claimants compared to the general population in unskilled manual and service occupations prior to their claim for IB. Employment in low-skilled, low-paid work creates a tendency for claimants to cycle between work and benefits, as in low-paid work they are more likely to be laid off than to receive sick pay (Sainsbury and Davidson, 2006). In addition to a lack of skills, many IB recipients lack recent contact with the labour market: just over a third of those surveyed for the Pathways evaluation had done paid work for 12 months or more during the two years preceding their claim, and 30 per cent had done no work at all during this period (Bailey et al., 2007). This may lead to skills becoming outdated as well as eroding confidence in the ability to find work.

5.4 Availability of employment

People with health conditions – particularly when they lack skills and are therefore competing for low-skilled work – are at a disadvantage in the labour market compared with people without health conditions, and this is particularly noticeable when labour demand is weak.

Although IB claimants as a whole cite health as the main barrier to work, those who are looking for work mention a lack of local jobs and a lack of confidence as obstacles to work more often than health, and this is a pattern that has persisted over time (Green et al., 2000; Bailey et al., 2007).

There is a longstanding association between high unemployment rates and the regional distribution of claims for incapacity benefit and this can be observed in the data for Birmingham and Solihull (Section 3.2.2): local unemployment rates are a strong predictor of prevalence of long-term IB claiming.

The availability of jobs influences both the possibility and probability of return to work for those with long-term health conditions and those receiving IB (Waddell et al., 2003; Waddell and Burton, 2004). People with health problems who are looking for work are at a disadvantage in areas of low labour demand where employers have a wide choice of candidates (Sanderson, 2006; Beatty et al., 2007, 2008).

This issue is exacerbated by the attitudes of some. Many employers believe that disabled people are less productive and more likely to be absent from work than non-disabled people (Needels and Schmitz, 2006). They may also hold similar views about individuals with long-term health conditions more widely. The Disability Discrimination Act (DDA), in common with other anti-discrimination legislation, has to date been more effective in protecting the rights of people already in work, rather than helping workless disabled people into employment (Hurstfield et al., 2004). Employer discrimination and stigma may be a particular problem for the approximately 40 per cent of IB claimants with a mental health condition as their primary diagnosis (Roeloffs et al., 2003, cited in Lelliott et al., 2008). The issue of employers' attitudes is discussed at greater length in Section 5.6 below.

5.5 Length of time since last employment

In assessing the likelihood of returning to work, the length of time since last employment is more significant than the length of benefit claim, since many people are out of work at the point of claiming IB (Kemp and Davidson, 2008; Waddell et al., forthcoming), and some people out of work due to ill-health are not receiving IB, and have 'cycled' between benefits. There is a very limited evidence base on the long-term inactive, because initiatives such as Pathways have tended to focus primarily on those closer to the labour market. Indeed a review of over 400 studies on vocational rehabilitation by Waddell et al. (forthcoming) concludes that: *'There is no high quality evidence on effective and cost-effective vocational rehabilitation interventions for people who have been on IB long term (more than one year on benefits)'.*

A widely cited view is that people tend to adjust to an out of work routine and find it difficult to contemplate change. However, Pathways advisers also report that it is important not to stereotype people on the basis of the time they have been claiming, since they have seen some notable successes with this group, and some of their most

motivated voluntary customers have been drawn from the pool of existing claimants (Knight et al., 2005; Barnes and Hudson, 2006a). Recent findings on the impact of Pathways in the seven pilot areas where it was extended on a mandatory basis to people who had been claiming for between one and three years show that it increased employment rates by three to four per cent among this group (Bewley et al., 2008).

5.6 Attitudinal barriers

Those with long-term health conditions who are detached from the labour market may experience a number of personal and/or psychological barriers to returning to work, and worklessness itself is widely acknowledged as a causal factor in the development of common mental health problems (Jahoda, 1982; Warr, 1987). Lack of confidence was cited as a barrier to work by roughly one in ten recent claimants, and by 30 per cent of recent claimants with a mental health problem (Kemp and Davidson, 2008); for all IB claimants in Pathways areas the rate is around a third, showing the extent to which this problem tends to become entrenched over time (Bailey et al., 2007).

As discussed in Section 3.4, the *Routes onto Incapacity Benefit* study also found that IB claimants' perceptions of their ability to work changed over time, often for the worse (Kemp and Davidson, 2008).

Employers' attitudes towards employing people with health conditions may also be problematic, as discussed in Section 5.4. The experience of stigma and discrimination can exacerbate the problems of low confidence and increase the personal and psychological barriers. In the expectation of their employer having a negative attitude towards employing someone with a health condition, individuals may be less likely to disclose their health condition to an employer, preventing them from receiving appropriate support to enter or retain a job, issues which have highlighted by the Equality and Human Rights Commission (Phillips, May 2008).

As noted above in Section 5.2, health beliefs may also constitute a barrier to employment for some people.

5.7 Age

Taking both recent and existing claimants into account, half of all claimants nationally are over the age of 50; the age distribution is slightly younger for Birmingham, and slightly older for Solihull (see Section 3.2.3). The majority of these claimants have been on IB for more than two years and are likely to be completely detached from the labour market. For older age claimants, incapacity benefit often provides a route to early retirement (Waddell and Burton, 2004; Corden and Nice, 2006b). Older IB claimants tend to claim benefits for longer and face a wide range of barriers to employment including outdated skills, health problems, employer discrimination and caring responsibilities (Ritchie et al., 2005). Older workers may also face access or motivational barriers to retraining (Atkinson et al., 2006; Newton et al., 2005). The

evaluation evidence from Pathways to Work has also found stronger employment effects on those aged under 50, for both new and existing customers (Bewley et al., 2007, 2008).

Older workers with health problems can face discrimination by employers, are often unfamiliar with job-seeking after many years in employment, and may have internalised beliefs that they are too old to seek work. The New Deal 50 plus shows that older workers with health problems who find work have good job retention rates, but also have low rates of progression and are often in low-paid employment (Atkinson et al., 2003). The evaluation of the intensive activity period for those aged 50 plus found that there is more demand for work placements than for work experience among people of this age, and that repeated experiences of unsuccessful job search can be seriously demoralising (Atkinson et al., 2006).

5.8 Ethnicity

All non-white groups except Chinese face an additional risk of unemployment, and this is borne out by the picture in Birmingham and Solihull. The unemployment rate in Birmingham overall is eight per cent but, as shown in Appendix 3, varies considerably by ethnic group. Chinese and Indian people in Birmingham have similar unemployment rates to white people, while some significant minority ethnic communities (Pakistani, Black Caribbean, Black African and Bangladeshi) have unemployment rates between two and a half and three times the city average. Those in 'other' ethnic categories have strikingly high rates of unemployment – two-thirds are jobless and many in this group are likely to be recent migrants (Birmingham Economic Information Centre, May 2008).

The evidence from national research is that the risk of unemployment is much greater for Bangladeshi and Pakistani than for Indian and Black Caribbean groups; the latter have higher rates of employment among women, and generally higher skills levels, although young Black Caribbean men experience particularly severe employment disadvantage. While this is partly due to lower levels of educational achievement, the evidence also suggests persistent employer discrimination (Clark and Drinkwater, 2007; Berthoud, 1999: Berthoud 2003; Carmichael and Woods, 2000; Heath et al., 1999). The Black African group has a very polarised distribution, with those who are highly educated doing very well in the labour market, while those with lower qualifications or extended education trajectories much more likely to be unemployed (Berthoud, 1999; Clark and Drinkwater, 2007).

Barriers to employment faced by Pakistani and Bangladeshi people in the UK have been categorised into five main groups: personal characteristics; households; human capital; area-based (ie willingness to travel outside the local area for work); and employer attitudes (Tackey et al., 2006). In terms of personal characteristics, age represents a significant barrier to work, especially for men in their 40s and 50s. Age was linked directly with health, and Pakistani and Bangladeshi men were likely to

suffer multiple health problems. Childcare and other caring responsibilities were identified as a barrier for Pakistani and Bangladeshi women. The report identified the biggest barrier as that of low levels of human capital, the root of which was felt to be a lack of facility with the English language. Willingness to travel for work was least among women caring for young children or elderly family members and those with health problems, who preferred to work locally, sometimes within walking distance of home. Some Bangladeshi and Pakistani women also faced cultural pressures to work in defined local areas, or were unconfident outside the area where they lived because of their lack of experience in travelling alone. In addition, although very few respondents reported experience of direct discrimination, most interviewees believed employers would discriminate against them because of their ethnicity, and increasingly because of their religion (Tackey et al., 2006). A separate study investigating Pakistani and Bangladeshi women's attitudes to work and family found that language barriers and poor health were the main barriers mentioned in terms of accessing employment (Aston et al., 2007).

Berthoud (2003) also notes marked differences in non-employment between different ethnic groups and emphasises that 'minority ethnic` is not appropriate as an all-embracing category when looking at employment. Nazroo (1998) makes similar observations in respect of health. For most outcomes, Bangladeshi and Pakistani people report the poorest health, followed by Caribbean people and then Indian people, with Chinese and White people having the best health. Nazroo concludes that socio-economic status explains a significant degree of variation in health both between and within minority ethnic groups.

5.9 Caring responsibilities

Caring for either a child, an elderly person or sick person may place an additional burden on an individual with a long-term health condition that may not be compatible with seeking and finding work (Corden and Nice, 2006a). The lack of provision of appropriate childcare or other support may be a key barrier to taking up work. Equally, a lack of appropriate flexible work options and lack of employer understanding of the needs of carers may prevent the balancing of work and caring responsibilities (Arksey et al., 2005). In addition, carers may be affected by a lack of skills and confidence, especially if they have spent years outside the formal labour market and have been isolated in the home. Carers may also face financial disincentives to work (Howard, 2002; Ritchie et al., 2005) and those involved in extensive amounts of care for children or elderly people tend to define themselves as not actively prioritising paid work, even where they are required to do so by Jobcentre Plus (Hudson et al., 2006).

5.10 Transport

Transport can be an important barrier for those on incapacity benefits. A survey of recent IB claimants found that they are less likely to own or drive a car than the general population and that lack of suitable transport was sometimes cited as a barrier to work (Kemp and Davidson, 2008; Bailey et al., 2007). More generally, area-based studies of worklessness have found that transport is increasingly problematic for some work journeys, owing to the growing use of hub and spoke bus routes, which require people to change buses in the town centre (Meadows, 2008). Conversely, providing assistance with transport can improve job retention rates (Stafford et al., 2007), although driving lessons have been found to be of limited value (ECOTEC, 2006).

5.11 Financial considerations

People who have been claiming benefits for a lengthy period often have concerns that they would be worse off financially if they were to find a job (Kemp and Davidson, 2008; Bailey et al., 2007). Some IB claimants have debt problems, especially if they have been on benefits for an extended period (Corden and Nice, 2006a); levels of debt are three times higher amongst those with mental health problems (ONS, 2002; Mind, 2008). People may also have financial concerns linked to uncertainty about their ability to cope with or sustain work. They may risk losing benefits and fear not being able to get back on to benefits should their employment come to an end. For many IB claimants this may be a realistic view of their labour market opportunities: as Section 3.3 showed, significant numbers cycle through periods of temporary and insecure employment. Equally, they may be concerned about how to cover any gap in finances between stopping benefits and receiving their first pay packet. They may also be uncertain about any financial gains to be had by finding work and may have limited knowledge of the benefits and tax credits systems (Corden and Sainsbury, 2001). There is evidence that a move into work can lead to greater financial difficulties. Kempson et al. (2004) point out that such financial difficulties may arise:

- due to failure to keep up with existing commitments during the transition to work, especially if the individual was financially worse off in work
- through falling behind with commitments that had previously been covered by benefit or payment protection insurance payments
- through borrowing more over the transition
- through creditors who had previously exercised forbearance wanting increases in payments.

5.12 Multiple barriers

Previous research into employment disadvantage has noted that some economically inactive groups face particular barriers to work – women who have never worked, older job changers, and those who have failed to establish themselves in a pattern of regular paid employment. The first group includes many Pakistani and Bangladeshi women, some of them widows, often with large families and with ESOL needs (Barnes et al., 2005; Tackey et al., 2006). Those in the 'older job changers' group are typically male, white, Pakistani, Caribbean or Bangladeshi and have often worked in unskilled manual jobs, leaving because of redundancy or ill-health and unable to return to their previous type of work either because it is no longer widely available or because it is now too physically demanding (Hudson et al., 2006). Some non-White people in this group have also been 'managing' ESOL needs by working in ethnic enclave employment, such as catering or the textile industry, and face barriers to the wider labour market as a result (Barnes et al., 2005; Tackey et al., 2006). Those who have failed to establish themselves in regular paid work encompass a variety of groups, including women who become lone parents at a young age, those with broken work records due to unemployment, recent migration to the UK or periods of ill-health, and those with more complex personal circumstances such as time in the care system, problematic drug use or involvement in crime (Hudson et al., 2006; Lakey et al., 2001; Hasluck and Green, 2007).

5.13 What works for specific health conditions?

This section reviews the available literature on employment interventions for people with the main health conditions that affect those claiming IB.

As shown in Section 3.2.4, two-thirds of IB claims are due to mental health, musculoskeletal disorders and cardio-respiratory conditions. Musculoskeletal disorders and common mental health problems are also the two main causes of days lost from work due to ill-health (HSC, 2007). It should be emphasised that the discussion below focuses on the available evidence, and that the majority of this does not cover effective work-focused rehabilitation interventions for people who have been out of work for more than a year, and are distanced from the labour market, since there are fewer initiatives which target this group. Many of the principles of successful interventions outlined below may also apply; however, the obstacles to a return to the labour market for these people are likely to be more complex, and interventions potentially more costly and less successful. Interventions to help these people return to work may require the development of new and innovative approaches.

In this context, it is also notable that while the original design of Pathways to Work envisaged that the Condition Management Programme element might be delivered in condition-specific formats, the majority of pilot areas have adopted a generic model

that is informed by the principles of Cognitive Behavioural Therapy (Barnes and Hudson, 2006b). The form of provision has emerged as important, however, with some older or long-term claimants, and those with mental health problems, often preferring one-to-one support, rather than group work (Barnes and Hudson, 2006a).

5.13.1 Mental health conditions

Long-term incapacity due to mental health problems is rising faster than any other common health problem, but a high proportion of unemployed people with mental health problems say they would like to work (Waddell and Burton, 2004). In addition, people with mental health problems do not always feel that a complete recovery is necessary before they can go back to work (although they often start new jobs rather than go back to old ones), and the right work can help the recovery process (Sainsbury et al., 2008a; Waddell et al., forthcoming).

Pathways has had little effect, in terms of either health improvements or employment outcomes, on customers with mental health problems (Adam et al., 2006; Bailey et al., 2007). The qualitative strand of the Pathways evaluation has provided some evidence on what was effective for those customers with mental health needs who did progress (Knight et al., 2005).[22] These include:

- an empathetic and understanding IBPA
- timely advice from experts (for example, work psychologists, CMP providers)
- Cognitive Behavioural Therapy (CBT) element of CMP
- customer motivation/willingness to move forward
- making use of appropriate referral options.

The vast majority of mental health interventions are directed towards the more severe end of the spectrum, such as psychosis and schizophrenia (Underwood et al., 2007; Greener and Guest, 2005; Waddell and Burton, 2004) despite the much greater prevalence of less severe mental health conditions, such as depression and anxiety. There is a general consensus that rehabilitation principles for severe mental health problems should also apply to mild and moderate mental health conditions, but little evidence exists in support of this view. Other than the Pathways evaluation, discussed above, there is also little evidence on people with mental health problems claiming IB. The vast majority of studies also do not record impact on employment status. Waddell et al. (forthcoming) find that while both pharmaceutical and psychological approaches to anxiety and depression can improve symptoms and quality of life, there is no reliable evidence on work outcomes. Of the eight studies which

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22 A specific study looking at the needs of people with mental health problems on Pathways is in progress (Hudson et al., forthcoming).

Underwood et al. examined in depth, only one was concerned with people with mental health problems who were workless; this was a 'job clinic' run in Northern Ireland in the early 1990s (McCrum et al., 1997). While 17 per cent of those who took part in this programme returned to full-time work, the absence of a control group means that it is impossible to estimate how many would have done so even in the absence of the project; however, it is notable that all those who took part entered some form of meaningful activity (education and training, supported work or voluntary work) on completion.

For more severe mental health problems, supported employment programmes appear more effective than pre-vocational training programmes in helping clients to secure competitive employment, and vocational services seem to be more effective at getting people into work when integrated with mental health teams (Crowther et al., 2004; Schneider et al., 2002; Schneider et al., 2003: all cited in Waddell and Burton, 2004).

Both anti-depressants (Greener and Guest, 2005) and CBT (Seymour and Grove, 2005) have been identified as having a key role in the retention of employment for people with common mental health problems; a study currently being conducted by DWP is looking at the effectiveness of CBT for incapacity benefit recipients: although not yet completed, interim results suggest significantly lower levels of depression/anxiety and higher levels of self-esteem for customers who completed their course of CBT (Winspear, 2007). Based on their evaluations, Thomas et al. (2003) and Grove and Seebohm (2005) make a range of recommendations for effective job retention programmes for people with mental heath problems, some of which may be equally applicable to services designed for those who are workless:

- access regardless of diagnosis
- providing both vocational and mental health counselling
- working with employers and health professionals
- tailored case management
- addressing family and relationship issues
- access to financial counselling and advice.

5.13.2 Musculoskeletal disorders

Musculoskeletal disorders (MSDs) are the second most common primary diagnosis of IB claimants. A review of the available evidence on the clinical and occupational management of common health problems found support for a biopsychosocial approach to rehabilitation for MSDs. The reviewers concluded that there was limited evidence available on effective interventions for people with long-term health conditions, or in receipt of disability benefits, who had been out of work for more than a year. The review identified an optimal window for intervention of between one

and six months, and acknowledged that beyond this time period incapacity can become entrenched, the obstacles to return to work greater, and rehabilitation more difficult. However, some of the evidence on effective interventions for back pain may still be relevant to this group, although as the authors point out, new and innovative approaches may be required and these would need to be subjected to rigorous testing to prove their effectiveness (Waddell and Burton, 2004).

Bearing in mind the above caveat, the review found that the suggested components of an intervention for back pain included a physical conditioning programme, cognitive-behavioural elements and a close association with work-related goals and outcomes (Schonstein et al., 2003a; Schonstein et al., 2003b: both cited in Waddell and Burton, 2004).The evidence reviewed also suggested the importance of good communication, co-operation and common agreed goals between all interested parties (Frank et al., 1996; Carter and Birrell, 2000; COST Action B13, 2003: all cited in Waddell and Burton, 2004). These factors may also be important for programmes and interventions aimed at individuals more distant from the labour market.

5.13.3 Cardio-vascular conditions

As for the other major common health problems, the broad consensus favours a biopsychosocial approach (Waddell and Burton, 2004). A recent review highlights the almost total neglect of vocational outcomes in UK cardiac rehabilitation programmes (Waddell et al., forthcoming).

5.14 How programmes address barriers

5.14.1 Introduction

This section discusses how programmes tackle the employment barriers faced by those with long-term health problems – as discussed in Sections 5.1 to 5.12 – and draws on both the 27 programmes reviewed by IES and on evaluations of relevant provision. It examines the programmes' overall approach to engaging clients and employers, and goes on to discuss specific support services offered (Section 5.15). The categories of support that programmes provided are shown in full at Appendix 1 (Q 13).

Programmes will need to address the principle barriers to work facing people with health conditions discussed in Sections 5.1 to 5.13, as summarised below:

- People with health conditions perceive their health as the main barrier to a return to work. This makes engagement with clients the first challenge for programmes.
- People with health conditions often have low skills and lack recent work experience, making it more difficult for them to compete for work. Skills

assessments and training, bridging activities, intermediate labour markets, in-work support and supported employment are therefore likely to be important.

- Older workers may face additional access or motivational barriers to work and may face discrimination by employers. Programmes will need to reflect the particular needs of older workers with health conditions.
- Programmes in areas with a high proportion of ethnic minority groups will need to vary their client engagement approach to address cultural differences.
- Programmes will also need to address the caring responsibilities, transport issues and financial concerns of many people with health conditions.
- Programmes will need to reflect the fact that, in many instances, people with health conditions face multiple barriers to work.
- Programmes for people with mental health conditions will need to draw on the limited evidence on what works, that includes empathetic advisors, advice from experts, Cognitive Behavioural Therapy, supported employment programmes, vocational services that are integrated with mental health teams, anti-depressants, and so on.
- Programmes for people with musculoskeletal disorders may benefit from a biopsychosocial approach to rehabilitation.
- There is limited evidence on what works for cardiac rehabilitation programmes, but in general, major common health problems favour a biopsychosocial approach.

However, even when programmes are successful in helping their clients to overcome these barriers, people with health conditions can still find it difficult to get work because of some employers' reluctance to employ people with health conditions, particularly during times of low labour demand. Engaging with employers, job-broking and in-work support for employers are likely to be important if programmes are to succeed in changing employers' perceptions, and this is discussed in detail at Section 5.15.

5.14.2 Engaging clients

Previous programme evaluations have highlighted the importance of outreach and community-based delivery in reaching those furthest from the labour market, who are unlikely to be in touch with employment services (Barnes et al., 2005). IES asked programme staff how and where programmes were delivered.

Most of the programmes in this review did not focus on health or IB, and therefore did not engage with clients through the intermediary of health services. However, earlier programmes, such as Aim High Routeback and Routes to Health, successfully used health services as the entry point for client engagement. Aim High Routeback employed a health professional engagement officer to visit GPs, dentists,

rehabilitation centres and groups, district nurses, health visitors and other health professionals and organisations to raise awareness of the benefits of employment, for patients' health and their lives as a whole. The project staff felt that having someone with a health background in this post was crucial to establishing effective relationships with health professionals and thereby improving client engagement (Frontline, April 2008). The Routes to Health project originated in the NHS and used an NHS case manager to refer clients on for treatment. Although some health staff were initially reluctant to engage clients for subsequent referral to employment services, this was overcome through training (Gibson, 2008).

The engagement methods of the 27 programmes in this review were fairly wide. Delivery was predominantly a combination of outreach, one-to-one work and, in some cases, group sessions. JCP providers, such as Access to Employment, Stepping Stones, Industrial Services Group and Ready4Work, often use group sessions.

Outreach was predominantly delivered in community centres, day centres, Jobcentre Plus Offices and other similar venues. Stepping Stones reported that it also targets doctors' surgeries, libraries, social housing offices, markets and shopping malls (ECOTEC, 2006), while ASHA (a small community organisation that works with Bangladeshi women) approaches people via door-knocking. The Camden Housing and Employment Project had adopted a very systematic approach to outreach, engaging clients by conducting campaigns based on individual housing estates: they select a ward to do a three-month intensive outreach campaign in the ward's estates, which includes leaflets through people's doors and talking to people on their doorsteps (in addition to word-of-mouth/Internet-generated self-referrals and JCP referrals). Clients are registered onto the project via a mini-survey conducted on their doorstep. They then have an initial one-to-one meeting of an hour or longer at which needs assessment and action planning take place, and subsequent follow-up meetings based on their need. Meetings are held in ward-based, community or estate settings such as community centres, libraries or people's own home.

Programmes in other evaluations[23] also emphasise the importance of outreach. The Northern Way Barrow-in-Furness pilot, in addition to locating services in community-based premises, also engaged in door-knocking, and encouraged people to pass on details of the initiative via their 'refer-a friend' scheme, while Routes to Health used text-messaging to stay in touch with clients, and highlighted the importance of using non-medical meeting places to retain a focus on employment rather than health. Conversely, the Aim High Routeback evaluation saw the use of familiar health settings for outreach as a vital element in providing a 'safe space' for clients (Frontline, 2008).

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[23] These programmes did not appear in the programme review, but were part of this study's secondary data sources.

The staff–client relationship is vitally important in building a strong, effective relationship that supports the client in improving their health and moving towards employment. Evaluation findings suggest that this is the primary factor in success and considerably outweighs other aspects of provision, such as financial incentives (Frontline, 2008). Programme review examples show the very high value that clients place on being listened to, and of feeling that the person supporting them is accessible. Text messages, phone calls and out of hours contact were sometimes important in facilitating and maintaining engagement, as was encouraging people (or providing practical support) to take up referral options (Craig, Lambert, Simpson, 2008).

5.14.3 Information, advice and guidance

Information, advice and guidance (IAG) was the one universal feature of all 27 programmes in the programme review[24].

Previous research on IAG has highlighted the importance to successful IAG of an holistic, multi-issue approach that allows the advisor to address a broad range of the clients' concerns, including childcare, finance, transport, and so on (Page et al., 2007). ASHA (a community organisation working with Bangladeshi women) found it important for their advisers to address any issues that the clients have, not just about employment, but also housing, education and support for young people. In-depth IAG has also been found to be particularly powerful in effecting change: the Department for Education and Skills found, in its assessment of the net added value of IAG for adults, that people who received more in-depth support had the most positive learning and work outcomes (Department for Education and Schools, 2007).

As with programme staff more generally, it is important that IAG advisers are enthusiastic, motivated and committed (DWP, 2007c); a flexible, personalised approach to the client is also effective. Previous research has indicated that those clients whose IAG is prescribed by others (for example, if their participation in IAG is part of a mandatory JCP programme) are least likely to feel any ownership of the IAG process (Department for Education and Skills, 2003).

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[24] IAG is defined by the Learning and Skills Council (LSC) as:

'Information: data on learning and work opportunities conveyed through printed matter, audio-visual materials or computer software, or through information officer.

Advice: providing an immediate response to the needs of clients who present an enquiry or reveal a need that requires more than a straightforward information response. It is usually limited to helping with the interpretation of information and with meeting needs already clearly understood by the client and may include signposting to a guidance interview where a more in-depth response can be provided.

Guidance: an in-depth interview or other activity conducted by a trained adviser which helps clients to explore a range of options, to relate information to their own needs and circumstances and to make decisions about their career IAG appears to be an indispensable support for individuals with long-term health conditions making the difficult transition to employment.' (Learning and Skills Council, August 2008)

5.14.4 Health advice, counselling and therapies

As discussed above in Section 5.2, the literature review evidence suggests that unemployed individuals with a long-term health conditions perceive their health as the main barrier to their return to work. It is therefore essential that programmes tackle their clients' underlying health condition, in order to have any chance of successfully moving them closer to employment. However, programmes, even when they are integrated health and employment programmes, are generally led by employment targets, rather than by health targets, and relatively few of the programmes provide health advice, counselling and therapies themselves.

Health advice may either be provided in-house, or the client may be referred to an external organisation, such as occupational health, mental health teams, GPs, NHS walk-in services, local day centres and so on. With the exception of mental health programmes, and services for drug and alcohol addiction, few programmes directly provide health advice.[25] However, health advice was provided by the Want2Work programme in Merthyr Tydfil (Appendix 5), and by the Northern Way Easington pilot (Appendix 7).

Few of the programmes provide counselling or therapies as part of their core services.[26] Mental health programmes and programmes that help people with addictions are exceptions, in that both these types of programmes typically do provide health advice, counselling and therapies as a matter of course. In addition, some programmes for people with mental health conditions also refer on to JCP's Condition Management Programme (as does the Work and Wellbeing programme in Sheffield).

Programmes that help people with addictions normally provide health advice and therapies in-house. Both New Start and the Meadows One Stop Shop stated that drug and alcohol addiction or misuse, and criminal convictions, were the primary barriers for their clients when returning to work. This is supported by a great deal of research evidence on both the practical issues and stigma faced by those with such problems (Fletcher et al., 2001; Kemp et al., 2005). The programmes operate at different points along a person's journey away from addiction and into work. The New Start provision is a health programme that supports people with addictions with health advice, confidence building, and counselling and therapies. They refer on to other organisations to obtain support for their clients' job searches. The Meadows One Stop Shop and Foot in the Door take referrals from drug addiction support groups or drug and alcohol teams.

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[25] Programmes that provide health advice in-house (and are not mental health or drug service programmes) included: Access to Employment, Apna, ASHA, Links to Work and W9.

[26] Programmes that provide counselling or therapies in-house included: Foot in the Door (mental health specialists), Enable (for people with learning disabilities and mental health clients), New Start (drugs specialist), Westminster Employment (clients with sensory impairments).

5.14.5 Confidence building

The literature review discussed the importance of addressing clients' attitudinal barriers and overcoming considerable anxieties (Section 5.6). The majority of programmes include some provision for confidence building and personal development, demonstrating its importance to this client group. Asked to identify important features of their work, Blind in Business responded: *'confidence building and encouraging people to make independent decisions about what they want and what they don't want.'* Confidence building may be provided through IAG, health advice, therapies, counselling, outreach, group sessions, and general contact with programme advisers.

5.14.6 Bridging activities

For groups furthest from the labour market, breaking down social isolation and increasing the range of activities undertaken outside the home may be a necessary first step towards being able to seek and find paid employment.

Several programmes in the programme review provided work experience or work placements.[27] Routeways to Employment for Disabled People pointed out the benefits that work placements, in particular, can bring: *'work placements are good for building confidence, they start with manageable hours to get them used to work hours. They maintain good relationships with supervisors'.* However, the Camden Housing and Employment Project pointed out that a shortage of work placements was a problem for its clients[28]:

> *'(there is) no access to a good, broad offering of work placements, tasters, work experience or work shadowing. They should have a one size fits all opportunity to offer to disabled people and those with no work experience at all and the long-term unemployed'.*

Ideal for All reported the same problem as a barrier for its clients, and ascribed the lack of work placements to poor access or lack of specialist equipment. Another important consideration is whether the work placements and work experience will contribute to outcomes and targets. One organisation, Bridge Employment, reported that, in their case, work placements *did* count as jobs for the purposes of its targets (for further discussion of targets, see Section 6.6).

Voluntary work is also widely regarded as having the potential to improve employability by providing the opportunity to try out employment in a safe environment, and offering evidence of recent work experience for CV purposes,

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[27] Programmes that provided work experience or work placements included: Access to Employment, Aldwych Enterprises and Portugal Prints, Apna, Enterprise and Training Programme, Industrial Services Group, W9, Work Able.

[28] Two programmes are currently developing work placement schemes which may be of interest: CITE is running with the Ambulance Service to guarantee work placements in Camden, while Transport for London is also developing a work placement scheme.

although progress from volunteering into paid employment is rarely monitored. Volunteering can also offer health benefits by reducing social isolation and providing meaningful occupation. Several organisations reviewed provide opportunities for voluntary work.[29] Employment Link, for example, refers its clients to volunteer bureaux. Voluntary work may be particularly relevant to clients with learning disabilities. Enable's Learning Disability Employment Team reported that their clients more commonly want voluntary work than paid employment.

5.14.7 Skills training

Vocational training was less common among the projects reviewed[30], and the programme review did not glean a great deal of information about this issue. However, Access to Employment said that their sector-specific training had been successful: *'in building momentum and providing continuity for clients'* and may merit further investigation. Blind in Business received industry-specific support for City-based financial careers.

Vocational skills cover help with writing CVs and completing application forms. This was an area of support provided by the majority of programmes. NVQs or other accredited learning are provided by a limited number of programmes in this programme review, most of them employment-led.[31] The Employment and Training Programme, for example, provides NVQs courses and accredited basic skills courses and prides itself on offering training flexibly, rather than in traditional forms.

Lack of accredited learning was cited as one of the main barriers to employment for clients with learning difficulties, by both Access to Employment and the W9 project. Both organisations attempt to address this: the W9 project refers on to other organisations that offer accredited learning; Access to Employment offers accredited learning themselves. An initial assessment stage, where a skills profiling is done using pictures, continues with skills profiling sustained over the six week period that they are on the programme, moving at a pace to suit the individual. The programme aims to tackle the main barriers that they have identified for this client group, including lack of accredited training and lack of in-work support.

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[29] Programmes that provided opportunities for voluntary work included, Aldwych Enterprises and Portugal Prints, ASHA, Employment Link, Enable, Ideal for All, Stepping Stones, W9.

[30] Programmes that provided vocational training included, Access to Employment, Aldwych Enterprises and Portugal Prints, ASHA, Ideal for All, Industrial Services Group.

[31] Programmes that provided NVQs or other accredited learning included: Access to Employment, Employment and Training Programme, Foot in the Door and STEPS, Ideal for All, Industrial Services Group.

5.14.8 Intermediate labour markets

Intermediate labour markets (ILMs) are social enterprises that produce socially useful goods and services while employing those with multiple disadvantages. Their main emphasis is on providing experiences of work routine and the work environment, although some provide job search and basic training.

The social enterprise approach is commonly used amongst programmes that support people with learning difficulties. For example, Apna runs gardening projects for their ethnic minority clients with learning difficulties and disabilities, while Employment and Training Programme has its own canteen and shop for training purposes. However, most of the programmes that featured in this programme review did not appear to have a social enterprise approach.

5.14.9 Supported employment

Only two programmes identified themselves as providing supported employment: the Bridge and Enable. The Bridge described quite an intensive approach, with weekly meetings with clients prior to them obtaining work, and daily contact once they are in work. Enable have a similar approach, with fortnightly meetings, and regular contact once the client is in work, but note that many of their clients with learning disabilities are under-confident about taking paid work and tend to opt for volunteering positions as a safer option. Both Bridge and Enable employ job coaches to teach people placed in work the tasks involved in their job.

Wider Internet searches revealed that supported employment for people with learning disabilities is a widespread form of provision. From the limited evidence we have gathered, supported employment appears to be less common for other types of health condition or disability, although it appears to have considerable potential to meet the needs of those with mental health problems.

5.14.10 Financial support

For those who return to work, Tax Credits are available to those in low-paid work, and additional support is available via Pathways in the form of discretionary awards to help with return to work expenses and a Return to Work Credit. These forms of support may be important in addressing the financial issues identified in Section 5.11. Few of the programmes interviewed in the programme review offered any form of financial support.[32]

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[32] These programmes provided financial help: CHEP, Springboard, The Meadows One Stop Shop, Work and Wellbeing.

5.14.11 Self-employment

None of the programmes reviewed provide support in the area of self-employment, although Employment Link noted that they could provide referrals to Business Link for clients who wish to become self-employed. This is an important absence, given the importance of self-employment for IB claimants (see Section 3.3.3).

5.15 Engaging employers

5.15.1 Lack of employer engagement

Engaging with employers is an important but often neglected area in working with people who are long-term workless through ill-health or disability, apart from the specialised role played by NDDP job brokers.

Time after time, the organisations interviewed as part of this programme review cited employers' negative attitudes towards employing people who have ill-health or disability as a major barrier to their clients obtaining employment. One respondent described: *'…the stigma of being unemployed and disabled. Getting employers to give people opportunities – they have the perception that disability means a wheelchair'*, while another drew attention to employers' lack of awareness of mental health conditions. Another respondent expressed the view that employers had good intentions but were nervous about the unknown, did not know how to make adjustments to the work environment and did not always have the 'skills' to employ people from these groups.

IES asked programme managers whether they worked with employers, particularly in the area of raising employer awareness of the needs of people with long-term health conditions or disabilities. Despite the fact that most programme respondents knew employers' attitudes were a problem, the majority of programmes do not work with employers to address this issue.[33]

The following sections set out the types of employer engagement provided by programmes in this review, and in other evaluated programmes.

5.15.2 Job-broking

Over half of the organisations in this programme review provide a job-broking service.[34] For example, Blind in Business has some links to the banking industry (via

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[33] Those that did included: Access to Employment, Blind in Business, W9, Westminster Employment.

[34] Programmes that provide job-broking included: Access to Employment, ASHA, Breakthrough UK Liverpool, Bridge Employment, CHEP, Employment and Training Programme, Enable, Ideal for All, Links to Work, Springboard, Meadows One Stop Shop, Routeways to Employment for Disabled People, Work and Wellbeing, Westminster Employment.

its funding), and is able to help people access openings in this area; they also offer a more generalised job brokerage via an external organisation. Access to Employment, who serve people with learning disabilities, also have two dedicated job brokerage staff.

5.15.3 In-work support

In-work support was only provided by a limited number of programmes in this programme review[35], but was identified by Access to Work (Access to Work provides in-work support for both their clients and employers) in particular, as an important factor in that programme's success.

In other programme evaluations, the Getting London Working Programme (see case study in Appendix 7) had a dedicated employer-facing team, and engaged in capacity-building training to address employer issues. This programme was unusual in providing support for both employees and employers for up to a year after starting work. In-work support was also provided to employers by some of the Northern Way pilots (ECOTEC, 2007).

NDDP and, more specifically, Pathways to Work, are intended to provide in-work support, but access can be patchy, and take-up is sometimes low. Many people are extremely reluctant for their employer to know that they are accessing support of this kind, but such support can be valuable in managing expectations on both sides, preventing the breakdown of employment relationship and enabling any 'teething problems' to be overcome, particularly where people have mental health problems (Section 5.2) or have not worked for a very long period (Section 5.5).

5.15.4 Other forms of employer engagement

Other forms of employer support included:

- Blind in Business held several big employment events a year to publicise their visually-impaired graduate clients to financial employers.
- The Northern Way Barrow pilot also attracted employers by paying a wage subsidy for the first six months of employment (Foster N and Lyons J, 2008).

5.15.5 National employer-led campaign

The Government plans to establish an employer-led campaign to increase the diversity of the workforce to include people with disabilities and those with long-term health conditions (Department for Work and Pensions, July 2008a). This may go some way to addressing the problems with employer engagement.

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[35] These included: Access to Work, Camden Housing and Employment Project, Industrial Services Group, Ready4Work.

5.16 Conclusions

IB claimants are a heterogeneous group with a wide variety of complex needs. It is clear that existing IB claimants face significant challenges in returning to work, and in many cases contend with multiple barriers. This chapter has identified a range of barriers which may be faced by those who are long-term workless because of health problems. Some will apply to almost everyone: health, low skills, lack of recent work experience, and attitudinal barriers, such as lack of confidence and anxiety about finding and sustaining work. Others, such as non-white ethnicity, caring or financial issues, affect specific groups and may require specialist provision. Developing programmes for long-term IB claimants that are sensitive to the needs of specific ethnic groups is particularly important in Birmingham, where Pakistani, Black Caribbean, Black African and Bangladeshi groups have levels of unemployment between two and a half, and three and a half times the city average.

In terms of ‘what works’ for specific health conditions, the evidence base for employment and mental health is mainly concerned with the more serious conditions. CBT, supported employment, and the integration of health and employment advice have all been identified as having a potential role here. The available evidence supports a biopsychosocial model for musculoskeletal disorders, but while this is assumed to apply to those with cardio-vascular problems there is almost no evidence on employment outcomes for cardiac rehabilitation programmes.

Although the programmes adopted a variety of means to engage clients, traditional approaches such as door-knocking and leafleting remain effective. However, data from the Aim High Routeback and Routes to Health evaluations also show that health-led programmes that had used local health services to initiate client engagement can be very successful, provided that proper training and lead-in time is provided. The use of primary care-led client engagement could be usefully explored by IHIE commissioners.

A good staff-client relationship is also vitally important in helping clients move towards employment.

When IES compared the barriers identified with the scope of services on offer (both in programmes in the programme review, and in other separately evaluated programmes), there were some areas where support is less commonly available than others:

- Health is perceived by unemployed individuals with health conditions as their main barrier to work. Despite this, health advice was generally not provided directly by most of the programmes reviewed, except those dealing with mental health problems or substance misuse issues. Programmes’ lack of focus on health issues is further discussed in Chapter 6’s appraisal of funding, targets and outcomes (Section 6.6). Conversely, healthcare services have a lack of occupational focus, a shortcoming that was picked up by the Black Review (Health Work

Wellbeing, March 2008). The implications of capacity in mainstream healthcare services are discussed further in the next chapter (Section 6.5.2).

- Lack of recent employment experience, and in some cases the older age profile of IB claimants, means that many people on long-term IB do not have up-to-date skills for the workplace. However, few of the programmes in this review have developed projects to address the skills shortfall for existing IB claimants. This is one area that may be addressed as the integrated employment and skills system is rolled out, regionally and nationally. In addition, bridging activities, such as work placements and volunteering, can help some people move gradually towards the labour market.

- None of the programmes reviewed provide support in the area of self-employment. Given the over-representation of both disabled people and minority ethnic groups in self-employment, this may be a worthwhile area for pilot initiatives in Birmingham and Solihull, but there is a limited evidence base to guide design, due to low levels of existing provision.

- A need to engage with employers is widely acknowledged by programmes. Firstly, employers' negative attitudes towards taking on longer-term IB claimants were highlighted both in the literature review findings and by programme review respondents. This is a particular problem in areas of low labour demand where employers have a wide choice of candidates. However, few programmes in the programme review undertook work in this area, and there appears to be a gap in provision. As previously noted in Chapter 4, Government is taking steps to address this shortcoming. Secondly, wider availability of in-work support for employers and employees, job-broking, and supported employment for people with mental health problems could also be useful.

6 Programme Design and Delivery

6.1 Introduction

As discussed in Chapter 1, IHIE had asked IES to review existing regional and local programmes across England that provide back-to-work support for longer-term IB claimants, and identify key features. IHIE is planning to commission new and complementary provision for longer-term IB claimants in Birmingham and Solihull, and needs a benchmark of what provision looks like elsewhere in the country, in order to help it identify what types of programme would be most suitable in Birmingham and Solihull. In addition to the contact details of relevant programmes (available electronically from IES, on request), IHIE had developed with IES an extensive list of questions to ask programme managers and staff and these are reproduced in full at Appendix 1. This chapter looks at the detailed aspects of programme delivery and how these influenced what projects were able to achieve.

6.2 Programmes' coverage

The programme review revealed that, broadly speaking, programmes covered four main client groups:

- unemployed people or benefit claimants in general (including IB claimants)
- specific groups of unemployed people or benefit claimants (including IB claimants)
- people with health conditions in general
- people with a specific health condition.

The following sections review the main features of these four types of programmes.

6.2.1 Unemployed people or benefit claimants in general

At the outset, it is important to make the point that the programme review did not identify specific programmes that work *solely* with *longer-term IB claimants*. The

programmes that featured in the programme review all deal with long-term IB claimants alongside other client types. For example, Bridge Employment provides programmes for long-term IB claimants, but also for short-term IB claimants, in addition to people with general and specific health conditions or disabilities. The programme review's pro forma questions did not ask programme respondents to reflect on whether a different approach was required in order to meet the needs of their long-term IB clients alongside the needs of more recent clients.

Examples of programmes that particularly dealt with long-term IB claimants were only found through these separately-evaluated programmes:

- Want2Work (Merthyr Tydfil; see case study in Appendix 4; Owen, Williams, 2008)
- Northern Way programmes (areas in north of England; see case studies in Appendices 5 and 6; ECOTEC, 2007 and Frontline, April 2008)
- Routes to Health (North Lanarkshire, Scotland; see case study at Appendix 7; (Gibson, 2008).

Want2Work has been particularly successful in securing employment outcomes for those who have been claiming IB for extended periods; a third of its employment outcomes have been achieved with people claiming IB for six years or more. Those who have been out of work may require additional help to leave benefits and settle into a work routine. Want2Work provides both cash help with the costs of entering work, and ongoing advice in the form of in-work support for those who have started employment. Routes to Health has achieved meaningful activity outcomes (employment, training or volunteering) for 30 per cent of its clients.

IHIE may wish to explore in more depth (and directly with Want2Work) the advantages and disadvantages of programmes that specialise in helping long-term IB claimants, as opposed to programmes that manage a more mixed caseload. Mixed caseloads may be easier to manage; more recent IB claimants may be more positive about a move into employment than longer-term claimants (see Section 3.5), and therefore it may be easier to achieve employment targets with this group. IHIE may wish to consider the advantages and disadvantages of programmes that have a more narrow focus on particular claimant groups.

The programmes identified in the programme review predominantly have a broad remit and help unemployed people or benefit claimants in general.[36] Not all clients on such programmes will have health problems or disabilities, but many do. Clients who have health issues typically contend with other, multiple disadvantages. An example

[36] For example, Bridge Employment, Camden Housing and Employment Project (CHEP); The Meadows One Stop Shop. The following separately-evaluated programmes also provide a service to a broad range of clients: Want2Work, The Northern Way programmes, Routes to Health, Stepping Stones, Getting London Working.

is provided by Camden Housing and Employment Project (CHEP) which targets clients who live in Camden and who are tenants or lease holders, including people in temporary accommodation and those housed temporarily outside of the borough, whilst still on the Camden housing list. CHEP uses information from the local authority to identify and target groups on estates and filter out ineligible residents. Many of CHEP's clients are long-term unemployed and from a background of inter-generational worklessness. They lack formal qualifications, have little work experience, and low skills. Some also have language barriers. Many also have disabilities, and health conditions, including poor mental health.

6.2.2 Specific groups of unemployed people or benefit claimants

As detailed in the preceding section, IES did not identify any programmes that work solely with longer-term IB claimants. However, IES did identify programmes that work with unemployed people or benefit claimants in general from ethnic minorities – one of the key areas of interest for IHIE, given the ethnic profile of Birmingham (see Section 5.8).

Ethnic minority IB claimants

In order to adapt its provision to the needs of ethnic minority IB claimants in Birmingham and Solihull, IHIE requires information on what approaches have been successful for programmes that specialise in working with ethnic minority groups.

The following programmes were identified from the programme review as working with IB claimants from specific ethnic groups: Apna Group (works with ethnic groups generally), ASHA (works with Bangladeshi women) and Work and Wellbeing (works with ethnic groups and other communities). Another programme, Ideal for All, stated that it works in close partnership with the Bangladeshi Forum (Smethwick Bangladeshi Youth Forum in the West Midlands).

The above three programmes are all smaller, community-based programmes. None of these programmes had employment as their sole focus: the services provided by the Apna Group and ASHA both developed from other services that were already offered to the ethnic groups they serve. The Apna Group offered general advice and advocacy, and ASHA was a social project for people with disabilities. As previously discussed, for people that have been out of the job market for some time, tackling work issues first can be seen as threatening, and may be better introduced via another point of access. Where clients have multiple problems, there is also a hierarchy of needs to be tackled, and other issues may need resolving before employment can be considered.

Understanding the needs of the ethnic communities that they focused on was at the heart of their successes for the Apna Group and ASHA. ASHA is a small employment programme for women in the local community, and run by a local Bangladeshi Women's Association near Dudley. The programme has only been in operation since

April 2008, and evolved from more general support and advice services. The programme is based in a community centre, at the heart of the local community. It offers health and exercise programmes that programme workers use to engage with local residents. They also conduct door knocking to ensure that their services are known about. Both ASHA and the Apna Group had advisers who were from the local community and spoke community languages, and in the case of the Apna Group employed a female adviser so that cultural sensitivities could be respected. Both these programmes were based within the community and conducted outreach to homes. The Apna Group and Work and Wellbeing both emphasised the importance of the community and family around the client as vitally important, since a potential barrier to engagement is the fact that disability is often managed within families in ethnic communities.

Older IB claimants

As previously discussed, as people age, ill-health and disability become more prevalent. Solihull has a higher proportion of IB claimants in older age groups (50–59 years and 60+ years) compared with the national average. Locating programmes that help older IB claimants is therefore an important issue for IHIE. However, the programme review did not identify any programmes that specialise in helping older longer-term IB claimants return to work, although Camden Housing and Employment (CHEP) has some links with Help the Aged. In part, this may be because helping people in the 50+ age group with long-term health conditions or disabilities return to work is relatively uncharted territory; New Deal 50 plus targets those who are unemployed, while Pathways has mostly addressed the needs of new and repeat claimants and has enjoyed only limited success in helping those aged 50+. Programmes also find it harder to achieve targets with this group and (as with longer-term IB claimants generally) may prefer to run a mixed caseload. The striking successes achieved by the Northern Way Knowsley pilot may partly be attributed to the mixed client group with which it worked, which included lone parents, older people, those with health problems and those with low skills levels (Knowsley Council, June 2008). Stepping Stones also widened its target population, from only serving those on IB to lone parents and other workless groups, over the lifetime of the programme (ECOTEC, 2006). IHIE may wish to consider the advantages and disadvantages of programmes that have a more narrow focus on particular age groups.

6.2.3 Health conditions in general

The third type of programme was those which focused on helping clients with health conditions in general. Examples of these include the Springboard Project, Ideal for All, The Industrial Services Group (which runs the Jobcentre Plus (JCP) Workstep programme in Bradford), and Ready4Work Supported Employment (a Workstep programme in Nottingham).

As with programmes that help unemployed people and benefit claimants more generally, people on these programmes have to contend with multiple disadvantages, compounded by their health condition or disability. However, as the programmes are specifically aimed at those with a health condition, the staff qualifications and approach have more of a health focus and the organisations that they link to are also predominantly those with a health focus.

6.2.4 Programmes for particular health conditions

Some programmes specialise in helping people with particular health conditions. The most common ones that were identified were: programmes to help people with mental health conditions (which are discussed in more detail below); programmes addressing the needs of people with learning disabilities and learning difficulties[37] and programmes for people who are drug and alcohol dependent.[38]

The programme review did not identify any programmes that deal specifically with musculoskeletal conditions which, as noted in the literature review, are (with mental health conditions) one of the main causes of days lost from work due to ill-health.

Mental health conditions

Mental health is the most important cause of ill-health and sickness absence in the UK (and the proportion of IB claimants with mental health conditions is particularly high in Birmingham– as shown in Section 3.2.4). However, as discussed in Chapter 5, although a high proportion of unemployed people with mental health problems say that they *would* like to work, mental health conditions often fluctuate, and people with mental health problems also face very high levels of stigma and labour market discrimination. IHIE is keen to explore the programme design of programmes that specialise in helping this group of IB claimants.

Just over a third of programmes in the review cited people with mental health needs as one of their main client groups.[39] Many other programmes had links to mental health teams or other mental health services, including employment services. These

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[37] Programmes that help people with learning disabilities and learning difficulties included: W9 Project, Apna Group; in addition, Access to Employment had previously aimed its services at those with learning disabilities and learning difficulties but have now extended their scope to become a pan-disability organisation.

[38] New Start; The Meadows One Stop Shop and Foot in the Door also include people who are drug and alcohol dependent amongst their target client groups.

[39] Programmes that help people with mental health conditions included: Aldwych Enterprise and Portugal Prints (for people with long-term and enduring mental health conditions), Bridge Employment, Employment and Training Programme, Employment Link, Enable, Foot in the Door and STEPS, Islington Mind, Work and Wellbeing.

links include general partnership working and integrating services, and outreach located in Community Mental Health Team locations.

When programmes link closely to external mental health service provision, by far the majority implement a joint caseload management system. This perhaps reflects the origin of this approach as a health care management plan that is used within mental health services. The Islington Mind Employment Project offers a wide range of employment services, health advice and counselling, and takes a joint-caseload management approach with healthcare professionals. The joint caseload management approach is discussed in more detail in Section 6.4 below.

In addition to adopting a joint caseload management approach, programmes that specialise in helping people with mental health conditions require particular types of job functions and specialist staff. For example, Aldwych Enterprises and Portugal Prints' key workers and session workers have a variety of qualifications and include psychoanalysts, staff with diplomas in group work, art therapists, psychologists; staff also receive ongoing training in Cognitive Remediation Therapy (CRT).

In some instances, mental health services may also employ former clients, or provide work experience in the form of volunteering opportunities.

Lack of confidence and resultant attitudinal barriers (manifested by both the clients and those with whom they come into contact), are endemic amongst IB clients generally (see Section 5.6) and are particularly pronounced amongst mental health clients of these programmes. Work and Wellbeing programme in Sheffield reported their clients with mental health conditions as having a lack of confidence from being out of work for some time and said that the client themselves sometimes have an attitude of 'I can't…'

The attitudes of the support networks, friends and family of clients with mental health conditions were also felt to discourage people to engage with services. This was particularly noted in black and minority ethnic (BME) communities where disability was managed within families. There was a lack of support groups for clients with mental health conditions and this made it difficult for the programme to engage with potential clients.

The programme review also found a lack of employment focus in health services. One respondent commented that:

> *'employment in mental health services is seen as a secondary area; talking treatments and medication are primary... employment is undervalued'.*

Another reported that their programme's mental health clients had often been told by GPs that they would never or should never work again. The Aim High Routeback programme (evaluated by Frontline, April 2008) found that for clients with complex mental health problems and other mental health problems, employment was not an option until they had their condition more under control. The opportunity to talk to a

health case worker and undertake condition management before embarking on employment was an important feature of this programme for this group. All clients received condition management of some kind through Aim High Routeback (AHRB).

6.3 Staffing

IHIE was interested in the staffing of programmes aimed at helping people with health conditions move into employment, to help develop its future commissioning plans in Birmingham and Solihull. The programme review asked programme managers and staff to supply details of the job functions of programme, any specialists employed by the programme and any other qualifications or experience that staff may have.

6.3.1 Job functions

Programme staff's job functions vary enormously. Some programmes employ staff whose job functions are dictated by the types of support the programme provides. For example, drug workers are employed by the New Start programme for drug users, while, at Blind in Business, all employees are specialists in working with visually impaired people. Other programmes employ a wide range of different job functions in order to fulfil the extensive services the programme provides. Employment and Training Programme, for example, employs an NVQ co-ordinator, an employment development worker, a basic skills tutor, an IT tutor, and a programme manager in order to deliver its wide range of services. Conversely, small, community-based organisations report that they still provide an equally wide range of services using only a small number of job functions. The Bangladeshi women's programme, ASHA, for example, offers a wide range of different support services, provided solely by a combination of employment advisers and volunteers.

In general, integrated health and employment programmes are more likely than employment-led services to say that they employed a mixture of health and employment staff. For example, Bridge Employment reported that its staff come from: '*a range of backgrounds, some from employment, some from support and care*'.

Another approach adopted in both integrated health and employment services, and in employment-led services is to employ specific health professional engagement staff to link in to primary health care, as has been used by the Aim High Routeback project (part of the Northern Way initiatives), as previously discussed in Section 5.14.2. ECOTEC found that Northern Way programmes that used specialised staff with a health background, in addition to staff with employment experience, and combined their work and expertise closely: *'can have a range of advantages in terms of delivery'* (ECOTEC, November 2007). IHIE will wish to consider the strengths and weaknesses of the combined health and employment staff approach.

6.3.2 Qualifications and experience

Looking across the spectrum of programmes in the review, there was a variety of levels of qualification. Most staff had relevant experience, but relevant qualifications were not always required and many people had: *'learnt on the job'*. There appears to be a degree of informal acquisition of knowledge in programmes that help people who are workless because of ill-health to return to employment.

There were some exceptions to this overall picture. All of the programmes that work with people with learning disabilities, for example, appear to employ staff with experience or qualifications in learning disabilities, ranging from a basic LDAF qualification (Learning Disability Awards Framework), staff with a background in learning disabilities who are about to start doing an NVQ Level 2 Advice and Guidance, and staff who are trained to work with learning disability who are taking an NVQ 3 in Care.

Health care workers are another exception: as explained above, staff for integrated health and employment programmes often have health qualifications, such as drug worker qualifications. Another exception is tutors and trainers, who normally have some form of teaching qualification. The area of advice and guidance also appears to be becoming more professionalised. Several organisations mentioned that their staff had, or were acquiring, the NVQ Level 2, 3 or 4 in Advice and Guidance.[40]

6.3.3 Personal qualities

The quality of staffing was identified by the majority of programme managers and staff that IES interviewed as among the most important factors in determining the success of the programme.

Firstly, programme managers felt it was vitally important that staff were empathetic and adopted a client-centred approach. Foot in the Door and STEPS summed up the feelings of many programme respondents:

> *'They (programme staff) accept people for who they are and don't think of people in terms of their diagnosis. They make people feel at ease and valued, and are able to relate to people due to their own varied experience of life and work.'*

In some instances, this client-centred approach included the organisation being directed or staffed by the clients or disabled people, as is the case with Ideal for All's board and Westminster Employment's advisers. Some programmes, sensitive to their clients' culture, disposition and gender, have tailored their approach accordingly. For example, Apna Group supports its women clients with female staff, while ASHA's advisers (to work with its Bangladeshi clients) are from the local community and

[40] Such programmes included: Access to Employment, Camden Housing and Employment project, The Meadows, One Stop Shop, Westminster Employment.

speak the community language. The client-centred approach may also require organisations to make physical adjustments to the work environment to accommodate people's particular conditions: at Industrial Services Group, for example, the programme has *'regular inclusive update meetings with signing and Braille'*.

Secondly, working with the right people is also about training staff to work with this client group. For example, the Industrial Services Group runs deafness awareness sessions with training provided by deaf staff. Ready4Work Supported Employment Team also highlighted the importance of ensuring ongoing training and development.

6.4 Lead agency and case management

IHIE asked IES to reflect on whether programmes were 'integrated' health and employment programmes, or whether they were employment-led or health-led, to give IHIE a benchmark with which to assess the existing and planned programmes in Birmingham and Solihull. Looking at the 27 programmes interviewed, the overwhelming majority categorised themselves either as an integrated health and employment service, or as an employment-led service; 11 out of 27 programmes reported that they provide an integrated health and employment service[41], while half reported that they are employment-led.[42] Only one service was 'health-led'.[43]

Organisations that offer an integrated health and employment service were more likely than those that are employment- or health-led to state that they use a joint caseload management system. In the programme review's pro forma questions to programme respondents, IES had defined joint caseload management system as: *'a cross-disciplinary team of professionals working in a co-ordinated way to address the needs of the client'*. The joint caseload management approach is most commonly used when

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41 Examples of integrated health and employment services were: Access to Employment, Aldwych Enterprises and Portugal Prints, ASHA, Bridge Employment, Foot in the Door and STEPS, Islington Mind Employment Project, Ready4Work Supported Employment Team, Springboard Project, W9 Project, Westminster Employment, Work and Wellbeing.

42 Employment-led services included: Blind in Business, Breakthrough UK Liverpool, Camden Housing And Employment Project (CHEP), Employment and Training Programme, Employment Link, Enable (Learning Disability Employment Team and Mental Health Employment Team), Ideal for All, Industrial Services Group, Links to Work, Routeways to Employment for Disabled People, The Meadows One Stop Shop, SKILL (National Bureau for Students with Disabilities), Stepping Stones, Work-Able. In addition, other programmes that fell outside this programme review, but have been subject to useful evaluations, were also employment-led, for example: most of the Northern Way pilots were led by employment services (such as the Northern Way pilot led by the Blackpool Employment and Skills Consortium; ECOTEC, November 2007), Stepping Stones (ECOTEC, 2006), Want2Work (Owen, Williams, June 2008).

43 The only health-led programme was New Start. One additional programme, Apna Group, did not define itself as an employment-led, an integrated health and employment service or a health-led service, but as an 'advocacy service'.

programmes link to external mental health services. IHIE will wish to consider to what extent a joint caseload management approach is a familiar and appropriate approach for the client group and professional background of programme staff. This may imply piloting joint case management before seeking to adopt this more widely.

6.5 Relationships with other agencies

6.5.1 Initial scoping and needs analysis

Evaluation evidence[44] suggests that broad consultation in designing programmes, to ensure that it complements existing provision, is an important feature in their success – while this may mean delays in start-up, it reduces problems in delivery and implementation (ECOTEC, 2007). The Northern Way Knowsley pilot considerably exceeded its targets for engagement and employment outcomes, and attributed its success both to a careful prior analysis of local needs and existing provision, and to a flexible engagement strategy (Knowsley Council, June 2008). The Aim High Routeback evaluation noted that because Pathways was rolled out in the area during the life of the project, there had been some duplication of services and competition for clients, highlighting the importance of designing provision which is a good strategic fit with that being offered by other providers (Frontline, 2008). By seeking an overview of existing provision, in its local area, and elsewhere, IHIE have taken an important first step in design of future provision in Birmingham and Solihull.

6.5.2 Referrals to programmes

Programmes in the programme review provided a range of services, as discussed in Section 5.15. All the organisations that IES interviewed link to a wide variety of other organisations, both for referrals in, and for onwards referrals to other services. The fact that a programme has an 'integrated' health and employment approach does not make it more self-sufficient – integrated health and employment programmes are still heavily dependent on their links with external organisations.

Organisations that support those who are long-term workless highlight the importance of receiving and accepting referrals from a wide variety of sources, an approach sometimes referred to as 'first door, right door' access. This maximises the chances of reaching an individual, since each person may only be in touch with a single service that can act as a point of contact. While many programmes operate on a referral only basis, Employment Link (an employment-led, local authority-funded programme in Telford) had decided, having consulted its clients, that it would only take self-

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[44] From programmes evaluated in earlier studies.

referrals, as its clients had reported that they: *'were sick of being referred to places and wanted the autonomy of applying themselves'*.[45]

In an 'integrated' health and employment programme, primary care staff that have been fully engaged with the employment agenda can have a galvanising effect on referrals. In the Aim High Routeback pilot (ECOTEC, November 2007) evaluators found that, where GPs are brought on board, it can be highly effective in generating client referrals, for example, by GPs handing clients leaflets about the Northern Way pilot. AHRB went a stage further by persuading GPs to send out letters to people on their register who are claiming IB. Again, this was effective in getting referrals, although the evaluators make the point that it is important to ensure that GPs have the final say over who is a suitable recipient of such letters and the approach used. Having AHRB run by the PCT, as opposed to an employment agency or organisation was also seen as beneficial in persuading health professionals to become involved.

The Routes to Health project discussed in Section 5.14.2 found that training primary care staff and improving referral systems were instrumental in increasing take-up – to the extent that local primary health care services now routinely ask questions about employment status and plans when carrying out health assessments (Gibson, June 2008). Similarly, a 2008 evaluation of a pilot placing employment advisers in GP surgeries also suggests that GPs' attitudes about the feasibility of employment can be altered over a relatively short period, by seeing positive outcomes for patients. This pilot also showed that GPs were the main users of the advisers – and the biggest influence on patients, reinforcing the need identified in Section 5.14.2 to work with primary care services (Sainsbury et al., 2008b).

IHIE will need to consider the extent to which primary care in Birmingham and Solihull is in a position to provide a jumping-off point into employment services. Work to develop the capacity of primary care services in Birmingham and Solihull is an integral part of IHIE's programme. The Black Review (Health Work Wellbeing, March 2008) recommended that GPs' confidence and ability to provide meaningful advice about job-readiness should be strengthened. The finding from the limited scope of this research is that health-led programmes that provide people with long-term health conditions and disabilities are few and far between. If this is to change, and primary care is to become a route by which people with long-term health conditions and disabilities are directed to employment services, major developments will have to take place in the expectations and training of GPs and other primary care providers.

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[45] Another organisation, SKILL (National Bureau for Students with Disabilities), commenting on the difficulties of referrals in terms of managing clients' emotion, echoed this view: *'Sometimes …(clients) have to be referred on, which can be stressful for people going from pillar to post.'*

6.5.3 Onward referrals to other provision

All the programmes that IES interviewed as part of the programme review appear to be heavily reliant on referral to and from, and working in partnership with, external health, skills and employment organisations, such as:

- PCTs (for example, Foot in the Door and STEPS)
- other public sector health organisations (for example, ASHA works with local community health networks; several programmes work with occupational therapy services)
- third sector health organisations (for example, Westminster Employment refers to RNID and RNIB)
- further education services (for example, Aldwych Enterprises and Portugal Prints work with Westminster Adult Education Service)
- Jobcentre Plus Disability Employment Advisors (for example, Ready4Work Supported Employment Team).

Bridge Employment in Sheffield is an example of an integrated health and employment service that works in partnership with a wide variety of other employment and health services. Bridge Employment links to Job Net in Sheffield which has a shop front in deprived areas. Bridge Employment also works in partnership with a voluntary and community consortium, a health and wellbeing consortium and JCP and Workprep contract providers. Bridge Employment employs an individual specifically to make referrals to other organisations, such as volunteering organisations and social firms.

Managing referrals and client handover can also be important to reduce drop-out. The Aim High Routeback pilot not only ensured that the first assessment was made within a week of the initial contact, but also provided transport to this appointment. Springboard Project also pointed out the importance of following up referrals:

> *'They follow up referrals and let clients know exactly what to expect from each organisation.'*

Programmes that refer on to other organisations, or receive referrals from other organisations will need to address data sharing issues, as was reported in the Aim High Routeback evaluation (Frontline, April 2008). The programme's evaluators found that data sharing across health and employment caseworkers created governance difficulties, and programme staff had to operate within a strict governance framework in order to safeguard clients' information. However, the evaluators concluded that:

> *'ironing out those governance issues has been worth it, enabling a genuinely integrated approach to supporting the client back to work'.*

It will be important for IHIE to consider how any planned new programmes in Birmingham and Solihull will relate to existing local service provision at the design stage.

6.6 Funding, targets and outcomes

6.6.1 Funding

The programmes in the review are funded in a variety of ways. Some programmes are funded by and accountable to national and regional government departments: the Department for Work and Pensions (via Jobcentre Plus), the Learning and Skills Council, local authorities, and PCTs in particular. Others are voluntary and community programmes that are reliant upon fundraising and grant-making. Yet others operate through a combination of many different funding sources. For example, SKILL (which assists disabled students) receives charitable funding, membership fees, various grants and other income generated by fundraising. The Meadows One Stop Shop is funded by Neighbourhood Renewal Fund (NRF) (sub-contracted from Nextstep Into Work); in addition one staff member is funded by Nottingham City Council; LSC funding has also been secured.

The insecurity and paucity of funding was felt to be a major shortcoming, widely identified by programme managers and staff across all programme types, and is also evident from the fact that some successful programmes reported in evaluations have subsequently closed due to lack of funding. W9, a small London charity, reported that:

> *'(we) need more money. We get funding from the local authority but a one and a half to two per cent annual increase isn't enough to cover staff wages. This is a small company which is completely dependent on the borough.'*

One programme manager thought that the split between large, Government-funded programmes, and the rest, had had a detrimental effect on smaller organisations and blamed a lack of sustained funding for the community and voluntary sector. Another respondent pointed out that DWP and JCP have moved to funding on a regional or district-wide basis, which requires smaller organisations to form partnerships, or sub-contract.

Fluctuations in funding affect the range and quality of services that can be provided from one funding period to the next, and can limit the potential of the programme to expand. SKILL reported that its Information Service grows and shrinks according to the amount of funding available. Foot in the Door and Steps said:

> *'The main shortcoming on STEPS is that the potential demand is greater than (we) are funded to cope with, so the programme only covers a small geographical area but we have no funding to open it out.'*

However, one organisation, Ideal for All, said that it had evolved over time to better fit the funding on offer: its programme was: *'always evolving'*, having started under European Social Fund (ESF) funding, it had moved to Neighbourhood Renewal Fund (NRF) funding and had subsequently become more involved in employment and skills rather than just employment.

6.6.2 Measuring success – targets and outcomes

IES asked programmes to explain how they have defined and measured targets, outcomes and other benefits – both in terms of health, and in terms of employment.

The vast majority of programmes reported employment targets and outcomes, rather than health targets.

Some programmes reported what could be described as 'hard' outcomes: in particular, moving a certain number of programme participants into employment (and, in some instances, employment was defined as employment of a certain number of hours a week, to meet funding criteria). Other programmes had softer outcomes: for example, to register a certain number of members. Other programmes had a combination of hard and soft outcomes. Hard outcomes tend to be set by the main funders: the Department for Work and Pensions (via JCP), LSC, local authorities and the PCTs. More demanding employment outcomes set by the Department for Work and Pensions (DWP) for Jobcentre Plus' contractors may be difficult for organisations that meet the needs of people with long-term health problems whose health condition may fluctuate. For example, Access to Employment, a JCP contractor in Camden, London has DWP funding linked to job outcomes: DWP will only accept as measurable outcomes jobs of 16+ hours, which may be problematic for disabled people for whom part-time work may be more attainable than full-time work.

A similar problem was reported by the Employment and Training Programme. The programme's targets were to engage with 32 individuals, all of whom should achieve qualifications and, under a horticulture programme, to engage ten people, of which eight should be moved into work. However, the programme did not meet these targets and the shortfall was ascribed to the complex needs of their client group: people with mental health problems, substance abuse problems, people with multiple needs and homeless people. The respondent commented that these groups struggle with retention due to clients taking time out because of health problems: *'this client group takes longer to get back to paid employment as they have to take it in stages, ie voluntary work first'*.

This highlights the point made earlier in Chapter 3 that although a reasonable proportion of IB claimants would like to return to work, some of this group will require a considerable amount of prior assistance, and others will never return to paid work. It also points to the necessity to measure intermediate or 'soft' outcomes, such

as participation in training, voluntary work and paid work under the 16 hours threshold.

Health outcomes may also be important, and are less commonly used by programmes. The feasibility of measuring health outcomes can be seen in the experience of the Aim High Routeback programme. Evaluators found that AHRB had had a positive impact on the healthy lifestyle choices of clients, in terms of reducing smoking and alcohol consumption, and improving diet and exercise (Frontline, April 2008).

Difficulties in meeting targets may result in programmes ceasing to deliver services. Camden Housing and Employment Project reported that it had previously provided Information, Advice and Guidance (IAG) in liaison with JCP, but had stopped doing so, as they had found the target of moving large numbers of people off means-tested benefits and into employment too challenging.

Programme commissioners and funders will also need to decide what targets and outcomes are realistically achievable with this client group. For example, Camden Housing and Employment Project (CHEP) planned to deliver outreach to 3,000 tenants, but only expected 25 to 30 to go into paid employment; the remainder will receive one-to-one IAG and an action plan, and have undertaken some kind of activity. These levels may sound low, but are comparable with the rate achieved by Pathways for existing clients. In this context the results for Access to Employment, which they had viewed as problematic (45 out of 186 registrations last year went into 'sustainable work') appear impressive.

Programme commissioners will also need to determine whether to engage with a large number of people but aim for a fairly low percentage of employment outcomes, or to seek a high proportion of employment outcomes, but be more selective about who is allowed onto the programme. Broadening the outcome measures to include other work-related outcomes is another alternative. For instance, ASHA has a six month target to work with 50 individuals, 40 of whom they plan to progress into training, employment, and other activities.

Funders' targets may also limit the time that programmes have to engage with their clients. Those projects that are limited to specific time periods often struggle to make sufficient progress in the time allowed. The programmes reviewed that did not report to the major funders typically were able to engage with their clients more flexibly and over a longer period than programmes operating under JCP programmes, such as Pathways to Work or New Deal for Disabled People which have to meet standardised criteria. In the Northern Way evaluations, flexibility on timing was noted as an important feature of the programmes' success (ECOTEC, 2007). On the other hand, the Bridge programme had found it necessary to impose an upper limit of six months on service received, in order to focus the minds of both staff and clients on the intended employment outcome, and referred onto alternative provision at this point.

Some organisations – even those funded by large public bodies – may have the option to apply softer targets to people with complex needs. Voluntary organisations that are not tied to the targets set by large public funders have more flexibility to apply soft outcomes, for instance Aldwych Enterprises and Portugal Prints have targets of the client becoming used to being in a work environment, the client becoming socially aware and the client gaining greater insight into mental health issues. Within the limited scope of the programme review, the only programmes that had slighter softer (but still stretching) targets were those funded by organisations with a health emphasis. For example, Foot in the Door and STEPS have a Service Level Agreement with the local PCT that requires 80 per cent of their courses to be made available to PCT clients. They thought that this Service Level Agreement was:

> *'sensitive to the fact that people are a long way from being work ready (so) they record positive progression to voluntary work, education, employment and independent living (re-establishing people in their own homes, coping with their family or re-engaging with the caring process).'*

The targets set can be an important driver for projects and may lead to change in the client profile, and at worst, a dilution of the intention to help those with the greatest needs, over time. IHIE will need to be aware of the tensions between hard employment targets and the complex needs of people in this group.

The Government has recently announced plans to run a number of pathfinder back-to-work support projects for existing IB claimants in various regions of the country.[46] Contracts with pathfinder providers are intended to have a new financing system that will allow Government to test new types of outcome-based contracts that encourage provider to focus on those with more complex barriers to work and the achievement of sustained employment. This system would also allow Government to test the extent to which providers' innovations can improve employment outcomes for existing IB claimants, and the market price for supporting people into sustained employment (Department for Work and Pensions, July 2008a). IHIE could consider commissioning pilot programmes by way of preparing for this development.

6.7 Programme branding

Programme branding can affect the relationship of trust between staff and clients, and influence programmes' efficacy. Foot in the Door and STEPS, for instance, highlighted the fact that the programme was separate from traditional health or employment services, and was delivered in a fun way:

> *'they are set apart from the traditional Health Authority and so not seen as just another form of treatment…they make their courses fun and inject humour'.*

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[46] Initially, Greater Manchester, Norfolk and Lambeth, Southwark and Wandsworth (Department for Work and Pensions, July 2008a).

This was also important for the Aim High Routeback programme, which was PCT-branded, rather than JCP-branded; evaluators thought that this '*seems to have helped engagement with those unlikely to engage with mainstream employment support*' (Frontline, 2008). The Stepping Stones project also branded themselves differently to JCP with different name badges, even though programme staff were mainly JCP staff (ECOTEC, 2006).

IHIE will wish to consider whether future programmes in Birmingham and Solihull are branded separately from mainstream employment, health or skills services.

6.8 Programme size and replicability

Programme size and replicability is an issue that needs careful handling. As the following example demonstrates, small size can belie an organisation's efficacy in addressing the niche needs of a particular group; and small organisations that prove effective can subsequently grow in capability and stature. Apna group is a charity working in advocacy for BME groups in Dudley. The programme receives short-term funding from the British Institute of Learning Disabilities, and only aims to register 15 clients per year. However, Apna pointed out that they have grown five-fold since they started operating six years ago, and said that they have developed from being a social group to a more focused, professional advocacy organisation, that is now regionally recognised. However, they also said that they have had difficulties moving away from their original purpose: some carers still perceive them as a drop-in respite care centre, rather than a place in which people can develop skills and self-confidence.

In commissioning additional programmes in Birmingham and Solihull, IHIE will need to take into account the value of such small, niche organisations.

6.9 Conclusions

Programmes in this programme review covered four main client groups: all those on benefit; specific groups of benefit claimants; people with general health conditions; people with specific health conditions.

Programmes do not tend to specialise in helping long-term IB claimants back to work: existing IB claimants are supported as part of a mixed caseload of unemployed people in general. IHIE may wish to explore in more depth (and directly with Want2Work, a programme that has been particularly successful in securing employment outcomes for those who have been claiming IB for extended periods) the advantages and disadvantages of programmes that specialise in helping long-term IB claimants, as opposed to programmes that manage a more mixed caseload.

There were almost no health-led programmes featured in this programme review, and secondary data also point to a lack of health-led programmes to assist long-term IB claimants (including those with mental health conditions) back to work. However,

programmes outside the scope of this review have shown that when primary care staff *are* fully engaged with the employment agenda it can have a dramatic effect on referrals. Primary care providers' current lack of knowledge of employment needs and preconceptions about the impact of employment on health will need to be explicitly addressed in any future programmes that make primary care the focus for joint employment-health initiatives. IHIE is already working to develop awareness and capacity in primary care.

Programmes that specialise in helping ethnic minority long-term IB claimants have found that being based in the heart of that ethnic community is important to the success of their programmes. This includes employing advisers from the local community who speak community languages, using female advisers where there are cultural sensitivities around gender, and engaging the clients' families through outreach. This may have implications for programme design in Birmingham and Solihull, where substantial numbers of ethnic minority IB claimants are likely to be concentrated in certain areas.

The programme review did not identify any programmes that deal specifically with long-term IB claimants in older age groups – a fact that will be particularly relevant for Solihull which has a higher proportion of IB claimants in older age groups, compared with the national average. IHIE will wish to consider the advantages and disadvantages of programmes that have a narrower focus on particular age groups.

The review highlighted the importance of strong external relationships to ensure quality referrals, avoid duplication and create a good strategic fit locally, regionally and nationally. There is mixed evidence on the potential role of health services, GPs in particular, as a source of referrals, and this is an area that is likely to require a certain amount of lead-in time and preparation, as discussed above.

Joint caseload management is an approach that tends to be widespread in and understood by people working in health-led services, particularly mental health. It does not tend to be used in employment-led services. The value of extending this approach more widely is an area that might usefully be explored, perhaps via a pilot scheme.

Programmes in the review employed a mixture of health and employment staff, generalists and specialists, depending on the requirements of the service delivered, but all were agreed that the personal qualities and aptitudes of staff – such as empathy, and willingness to work in a client-centred way – were at least as important as qualifications.

Programmes tend to have employment targets, not health targets. There are tensions between hard employment-led targets (especially those of major funders) and the complex needs of clients who have long-term health conditions. In setting programme targets and outcomes, programme commissioners and funders will need to take into account what is realistically achievable given the complex needs of this client group. It

may be important to broaden outcome measures to include work-related activities and health outcomes, particularly given the point made in Chapter 5 that people in this client group perceive their health problems to be the main barrier to employment. In setting targets for new programmes, commissioners will also need to decide whether to engage with a large number of people but aim for a fairly low percentage of employment outcomes, or to seek a high proportion of employment outcomes, but be more selective about who is allowed onto the programme.

Programme size, and conclusions about economies of scale and replicability, is something that should be handled with care. Attention to programme branding can also be important in encouraging take-up of services.

By seeking an overview of existing provision, in its local area, and elsewhere, IHIE has taken an important first step in design of future provision in Birmingham and Solihull.

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Appendix 1: List of Programme Questions

1. What is the programme name?
2. Who is main programme contact? (*name, job title, e-mail, phone number)*
3. What is provider name?
4. What is the provider type? *(public, private, voluntary; national, regional, local)*
5. What is geographical area covered by programme? *(region, city, area)*
6. When did programme start? *(month, year)* and when will/did programme finish? *(month, year)*
7. Is the programme an integrated health/employment service, or does it offer a mainly health or mainly employment service?
8. Does the programme link into other health/employment services?
9. If yes, which ones? *(Please say – if it isn't clear from the service name – whether they are health or employment)*
10. What are your main client groups? *(What health conditions/disabilities do they have? Are they long-term (2 years and over) or short-term Incapacity Benefit claimants? Are they sick or disabled but not claiming benefits?)*
    - Any unemployed
    - JSA
    - IB long-term/higher rate
    - IB short-term/lower rate
    - DLA
    - Economically inactive
    - Any health condition/disability
    - Specific health condition/disability

a. Mental health
b. Disease of nervous system
c. Respiratory/circulatory system
d. Musculoskeletal
e. Injury/poisoning
f. Learning difficulties
g. Drug/alcohol
h. Other (specify)

11. What are the barriers to employment that your clients face?
12. What are the eligibility criteria for the programme's clients?
13. What type of support is offered? *(eg work placements, skills assessments)*

- IAG
- Counselling/Therapies
- Health advice
- Confidence building/personal development
- Vocational Training
- Vocational skills (ie CV and application support)
- NVQ or accredited training
- Job broking
- Jobcentre Plus Programmes
  a. Workprep
  b. Workstep
  c. Job Introduction Scheme (JIS)
  d. New Deal for Disabled People
  e. Other
- Work experience/placement
- Supported employment
- In-work support
- Self employment
- Voluntary work
- Employer services (ie awareness training)

- Financial support
- Other (specify)

14. How do you first engage with your clients? *(eg advertising, outreach workers in community settings)*

15. How are clients assessed initially?

16. How do you subsequently deliver support to your clients? *(eg outreach, one to one, group sessions)*

    - Outreach (specify type of location)
    - One to one
    - Group sessions
    - Gender – specific sessions
    - Other

17. In what venues is the support delivered? (*eg community centres, GP surgeries)*

18. Does the programme use a joint caseload management system? *ie a cross-disciplinary team of professionals working in a co-ordinated way to address the needs of the client.*

19. What are the job functions of the staff working on the programme? (*eg are they specialist health advisors, employment advisors?)*

20. Do you employ specialists to work with (a) particular ethnic groups (b) with older people (c) with long-term incapacity benefit claimants?

21. Do the staff working on the programme have any other qualifications or experience that informs what they do? (*eg are they ex-clients? Do they have prior experience in primary health care? Are they qualified in a particular specialism, eg psychologist, etc?)*

22. What organisations refer clients to this programme? (*Are there any formal protocols or agreements covering referrals?*)

23. To which organisations does this programme refer its clients? (*Are there any formal protocols or agreements covering referrals?)*

24. Are there any other organisations that this programme works with, and in what capacity? (*eg through partnerships, local authorities/city strategy involvement, employers' involvement)*

25. What are the programme's targets, and how are those targets measured? *(numbers helped, numbers moved into employment/sustainable employment).*

26. What, in your personal opinion, have been the most important factor(s) in your success?

27. What have been some of the programme's shortcomings?

28. Have any changes been made during the life of the programme? What were these and why were they made?

29. Are there other people we should speak to, or other interesting/innovative programmes that you think we should include in our study?

Appendix 2: Birmingham and Solihull IB Claimants and JSA Claimants

Table A2.1: Birmingham wards: IB claimants, JSA claimants and economic inactivity

Ward Name	Working age population*	People on IB**	People on IB as % of working age population	People on JSA**[47]	People on JSA as % of working age population	Economically inactive as % of working age population*
Kingsbury***	9,150	1,320	14.4	560	6.1	29.3
Sparkbrook***	15,916	2,230	14.0	1,740	10.9	51.8
Shard End***	12,669	1,695	13.4	795	6.3	30.0
Washwood Heath***	15,491	2,000	12.9	1,655	10.7	44.3
Kingstanding***	14,353	1,845	12.9	995	6.9	31.3
Aston***	15,528	1,920	12.4	2,035	13.1	45.7
Ladywood***	16,308	1,985	12.2	1,635	10.0	35.9
Stockland Green	14,297	1,735	12.1	1,020	7.1	29.7
Soho***	15,554	1,765	11.3	1,555	10.0	41.1
Handsworth***	15,242	1,665	10.9	1,510	9.9	46.3
King's Norton	12,105	1,310	10.8	730	6.0	28.4
Nechells***	16,707	1,745	10.4	1,570	9.4	51.3
Weoley***	12,604	1,275	10.1	760	6.0	31.4
Longbridge	18,490	1,870	10.1	915	4.9	26.0
Sparkhill	17,980	1,815	10.1	1,335	7.4	43.9
Fox Hollies	13,744	1,360	9.9	735	5.3	30.1
Billesley	15,444	1,525	9.9	680	4.4	27.1
Brandwood	14,392	1,420	9.9	755	5.2	25.8
Erdington	14,523	1,430	9.8	740	5.1	25.4
Small Heath***	19,455	1,915	9.8	1,430	7.4	47.8
Yardley	13,288	1,295	9.7	815	6.1	26.2
Bartley Green***	13,136	1,275	9.7	730	5.6	26.3
Acock's Green	15,951	1,470	9.2	855	5.4	24.1
Hodge Hill	14,341	1,310	9.1	725	5.1	26.9
Sheldon	11,352	940	8.3	420	3.7	21.6
Northfield	13,817	1,140	8.3	565	4.1	21.3
Sandwell***	17,023	1,400	8.2	995	5.8	33.3
Moseley***	14,293	1,115	7.8	600	4.2	28.0

[47] Jobseeker's Allowance is payable to people under pensionable age who are available for, and actively seeking, work of at least 40 hours a week.

Ward Name	Working age population*	People on IB**	People on IB as % of working age population	People on JSA**[47]	People on JSA as % of working age population	Economically inactive as % of working age population*
Quinton	11,757	890	7.6	450	3.8	23.9
Harborne	13,810	1,000	7.2	580	4.2	26.8
Bournville	14,772	1,055	7.1	555	3.8	22.5
Oscott	12,508	880	7.0	390	3.1	21.5
Hall Green	15,523	955	6.2	430	2.8	23.0
Edgbaston	17,081	975	5.7	645	3.8	41.2
Sutton New Hall	19,504	1,060	5.4	395	2.0	17.3
Perry Barr	14,260	710	5.0	405	2.8	22.9
Sutton Four Oaks	16,361	665	4.1	225	1.4	18.8
Selly Oak	18,778	710	3.8	420	2.2	45.0
Sutton Vesey	17,128	640	3.7	230	1.3	17.5

** Source: ONS (2001), UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI)[48]*

*** Source: Department for Work and Pensions Information Directorate (May 2007), © Crown Copyright*

**** City Strategy target ward*

48 Figures for working age population by ward are only available in 2001 Census, not in Annual Population Survey.

Table A2.2: Solihull wards: IB claimants, JSA claimants and economic inactivity

Ward Name	Working age population*	People claiming IB and SDA**	People on IB/SDA as % of working age population	People on Jobseeker's Allowance (JSA)**	People on JSA as % of working age population	People who are economically inactive as % of working age population*
Fordbridge***	5,212	675	13.0	270	5.2	29.3
Chelmsley Wood***	6,515	840	12.9	380	5.8	29.0
Smith's Wood***	6,661	810	12.2	360	5.4	21.1
Kingshurst***	4,564	460	10.1	220	4.8	27.3
Bickenhill	8,726	595	6.8	185	2.1	20.9
Elmdon	5,535	320	5.8	95	1.7	18.6
Lyndon	5,878	315	5.4	95	1.6	17.9
Castle Bromwich	7,304	380	5.2	110	1.5	17.2
Shirley East	6,641	320	4.8	95	1.4	23.9
Olton	6,611	315	4.8	95	1.4	18.5
Shirley West	7,090	335	4.7	100	1.4	23.6
Silhill	7,124	325	4.6	95	1.3	16.6
Shirley South	10,276	370	3.6	130	1.3	11.9
Meriden	7,237	235	3.2	55	0.8	18.7
Packwood	8,763	255	2.9	55	0.6	16.5
Knowle	6,486	185	2.9	40	0.6	20.2
St. Alphege	8,323	165	2.0	55	0.7	23.2

** Source: Source: ONS (2001), UK Statistics Authority website www.statisticsauthority.gov.uk or www.statistics.gov.uk Crown Copyright material is reproduced with the permission of the Controller, Office of Public Sector Information (OPSI)*

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**** City Strategy target ward*

Appendix 3: Birmingham JSA Claimants by Ethnic Group

Table A3.1: Birmingham quarterly JSA claimant data by ethnic group

	1st quarter 2008	JSA claimant rate for all people in ethnic group
White – British	13,900	4.7%
White – Irish	398	3.1%
White – Other	287	4.4%
All White	14,582	4.7%
Mixed – White & Black Caribbean	655	16.4%
Mixed – White & Black African	108	22.2%
Mixed – White & Asian	138	8.2%
Mixed – Other	203	16.7%
All Mixed	1,105	15.0%
Asian – Indian	1,222	4.9%
Asian – Pakistani	4,283	16.0%
Asian – Bangladeshi	983	20.3%
Asian – Other	370	11.4%
All Asian	6,858	11.5%
Black – Black Caribbean	3,030	13.4%
Black – Black African	1,338	53.2%
Black – Other	410	17.5%
All Black	4,777	17.4%
Chinese	78	4.1%
Other Ethnic Group	1,250	63.2%
All Other	1,328	34.1%
Did Not State/Unknown	4,290	
Total	32,942	8.0%

Source: Birmingham Economic Information Centre (July 2008) Quarterly Unemployment by Ethnic Group and Gender, www.birminghameconomy.org.uk

Appendix 4: Want2Work, Merthyr Tydfil

Merthyr has the highest IB claim rates in the UK and the highest economic activity rates in Wales; 30 per cent of the population has a limiting long-term illness.

This programme is funded by the EU and is part of a wider strategic approach to joblessness in this area of Wales, informed by the Merthyr Works strategic employability partnership, a cluster of local authorities which mirrors JCP delivery areas, and the Heads of the Valleys employment consortia. It provided community based advisers, support from health professionals, funding for training, Return to Work bursaries, and In-Work Support.

The programme is specifically targeted at those claiming IB. It aimed to engage 1,667 people, and has in fact engaged 2,367. It was also very successful in achieving its employment targets – aiming for 334 job entries and achieving 698 (to March 2008); 40 of these went into self-employment. While around half of those making use of the programme had short-term claims (under two years), 22 per cent had been claiming for six years or more, and one in ten for over a decade.

An evaluation by Sheffield Hallam University estimates the increase in employment rate from taking part at between five and six per cent.

Want2Work closes in 2008 and a funding bid for a further phase is currently under consideration (Owen, Williams, June 2008).

Appendix 5: Northern Way – Case Study 1

The Northern Way is a collaboration of regions and cities across the north of England led by three regional development agencies. One of their investment priorities is to bring more people into employment, and one of the ways that they intend to do this is by focusing on long-term IB claimants. Their aim is to create pilot projects in areas with the highest concentrations of IB claimants and then to evaluate these in order to have a strong evidence base with which to influence government policy.

One scheme that has already been running with support from Northern Way is Routes to Work Barrow, run by Furness Enterprise. Barrow has the third highest concentration of IB claimants in the country, with over 80 per cent of the IB claimants having claimed for more than two years. They took a community-based outreach approach, that was flexible and client-led. In line with the national picture, they had low levels of qualifications, confidence issues and needed financial guidance to ease a return to work. To address the skills issues they trained 220 individuals on flexible short courses. They had three different schemes to address confidence issues and they conducted Better Off calculations and signposted to other services to tackle the financial concerns of the clients. In order to engage with the clients, they were based in the community and undertook door-knocking exercises, had a refer-a-friend scheme and worked in partnership with Jobcentre Plus. They also worked with small local employers and provided wage subsidies. They have so far engaged with 1,311 clients and 98 have gone into employment.

Appendix 6: Northern Way – Case Study 2

The Aim High Routeback programme in Easington is another initiative supported by Northern Way, funded by One NorthEast and housed within the Primary Care Trust which started in November 2005. This project was particularly successful in helping those with mental health problems and those who had been on IB for more than five years, both key customer groups for Birmingham and Solihull, so its findings are of particular relevance.

Staff comprised 12 multidisciplinary health and employment professionals and was delivered from community-based premises to people living in the district and claiming incapacity benefits. The aims of the programme were to encourage 500 people to work through condition management and employment advice; 250 people were to be placed into work with 13 weeks of in-work support. They were also working towards other outcomes such as training and volunteering opportunities.

Referrals came from GPs, health professionals or community advisors. Clients would then have an initial assessment and action planning meeting with a health caseworker. The option available to the clients on the programme included: money management, condition management, travel training, and careers and job searching advice. Condition management and a focus on health was an integral part of this programme, with advice given about managing symptoms, healthy living and identifying obstacles using cognitive-based therapy techniques.

The results to February 2008 were: 373 starts on the programme with 151 people into work. They also measured outcomes, including: a 55 per cent decrease in GP visits by their clients, a 41 per cent reduction in their medication, and 38 per cent increased their exercise. They found that joint working between the health and employment specialist caseworkers was essential and in fact access to a healthcare worker was very important for this client group. They note that it is unrealistic to expect GPs to be able to offer this level of input. They found that the branding of the pilot as a scheme run by the PCT had fewer negative consequences than one run by Jobcentre Plus, which helped with engagement. As a partnership between health and non-health professionals data-sharing issues caused initial delays, even with clients' informed

consent. Once the challenges had been overcome, the sharing of information contributed to the success of the pilot and they recommend that future models emulate this success. One other recommendation for future projects is to ensure a strategic fit with mainstream provision by developing a working agreement to define boundaries and avoid duplication and competition.

A cost–benefit analysis has been conducted for the project, using two calculations: a pessimistic assumption and an optimistic assumption. The cost benefits are based on the fiscal benefit of people moving into work (reduction in benefit, etc) and economic outputs of those in work. The cost benefit they have achieved is between £948,033 to £12,651,058, with qualitative interviews with clients showing the figure is more likely to be towards the higher end of the range. Based on the total expected jobs by the end of 2008, the cost per job is likely to be £5,705.09. As a small-scale pilot, they did encounter a number of factors that contributed to a higher cost per job rate, such as high start-up costs and administration costs.

Appendix 7: Routes to Health: North Lanarkshire

This project began in 2005 with three years of funding from Community Regeneration and Workforce Plus Funds, and is part of a larger organisation, Routes to Work Ltd. Routes to Health aimed to target people on Incapacity Benefits and raise the issue of employability with both workless clients and with health professionals. In addition to its intention to contribute to reduce worklessness, it also aimed to improve health. It provided a single point of contact for agencies in the areas working with people who were jobless and had health problems. Following an initial screening interview, an NHS case manager developed an action plan with the client, which was monitored over time, and made referrals to the appropriate services. Frequent contact was made by phone and text, and regular meetings were held.

This project measured soft outcomes including voluntary work and training, as well as job entries – and these are formally included in its measure of success. Based on this, the project has achieved a 30 per cent employment-related outcomes target for the 365 people it has assisted; the actual employment rate is a more modest 16 per cent. The project is also counting numbers of health intervention referrals (eg CBT, physiotherapy) and fitness referrals (eg gym membership, weight loss, smoking cessation). The vast majority of those seen have been referred for one or more services of this kind.

In addition to the outcomes it achieved for individual clients, the project was also seen to have had success in moving employability onto health agendas, both at a service delivery levels (eg questions about employment intentions as part of medical assessments) but also at a strategic level, where employment issues are addressed in local health forums.

Initial barriers faced by the project were the preconceptions of medical and health staff, and persistent myths about benefits and employment. A training pack for primary care staff is now being produced to address these issues and concerns.

The project noted that those who were already educated to FE/HE level had better outcomes than those with few qualifications, highlighting the importance of skills issues for employability. IT also noted that the extended periods over which it was able to work with clients (eight to 30 weeks, with many at the upper end of this spectrum) was important to tackling deep-rooted problems. Those who were referred via Pathways, and limited to 13 weeks, did less well. It was also seen as important to let claimants disengage and return later if they had issues which were preventing them from benefiting from the programme.

Appendix 8: Getting London Working

The Getting London Working (GLW) programme, funded by the Single Regeneration Budget (SRB), started delivery in January 2000 and finished in March 2006. It focused on unemployed people of working age in four deprived London boroughs. In terms of client profile, 57 per cent of participants had been unemployed for six months or longer; 31 per cent were considered economically inactive; and 15 per cent were receiving some form of disability benefit. In terms of job outcomes, 47 per cent were achieved by those who had been unemployed for six months or more; 14 per cent were achieved by those receiving disability benefits. The programme effectively targeted individuals from BME groups, with 64 per cent of clients and 63 per cent of job outcomes being achieved by individuals from BME groups. No information is provided on the health status of participants, health status by ethnicity, or the exact nature of health conditions. The evaluation report states that no data was available on the assessed needs of participants, although the authors suggest that the participants would have been likely to have had a range of needs associated with deprived areas. Key elements of this programme were:

- outreach activity designed to engage clients with employment activity in non-traditional settings
- one-to-one support provided by trained advisors covering both motivational aspects and the brokering of any specific training required
- targeted support through the provision of both seminars on such things as CV development, as well as more intensive support where required a focus on the needs of employers as well as clients through a dedicated employer team
- aftercare provided to both client and employer for up to a year after starting work
- employer capacity building offers a range of support to employers aimed at changing employers' perceptions and attitudes to clients
- programmes enabling clients to enter voluntary work where appropriate.

The programme monitored not only jobs gained, but also referrals to, and starts on, training and take-up of voluntary work. It also measured the number of businesses advised, the number of employer volunteer schemes created and the number of employers who took part in capacity-building exercises or agreed to provide some degree of preferential opportunity for GLW clients.

The outreach activity referred to above included placing employment advisors in GP surgeries. An evaluation of the placement of an employment advisor in one such surgery found some positive outcomes, including return to employment, although the numbers involved were small.