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Central London Works: First process evaluation report

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1 Background

1.1 The Central London Works programme

Central London Works (CLW) is a £51 million employment programme, launched in March 2018 and being delivered across twelve Central London boroughs[1]. The programme has been partially funded by the Department for Work and Pensions, through a devolution agreement through which CLW will operate instead of the national Work and Health Programme for residents of these twelve boroughs. Similar agreements are in place for other parts of London and for the Greater Manchester Combined Authority. The programme is also funded through the European Social Fund.

CLW is specifically designed to provide personalised, intensive employment support to disabled people, those with long-term health conditions and the long-term unemployed. Referrals to the programme are predominantly from Jobcentre Plus (JCP), although they can also be made by other partners with eligibility determined by JCP.

The programme has a number of distinctive features:

- It combines both specialist employment and health support, delivered by health care professionals – with funding set to allow for small caseloads, specialist employment advisers and in-house health support
- The close involvement of Central London Boroughs is intended to allow for co-ordination and integration of CLW support with wider local services – including skills, welfare, social services and local employability support
- It is an entirely voluntary programme – with no mandatory referrals to participate in the programme or any aspects of support, and no sanctions for non-participation
- It has a 'payment by results' model that supports the achievement both of non-employment outcomes and of earnings progression
- Like the national Work and Health Programme, it is being operated as a randomised control trial – with participants randomly allocated either to the CLW intervention or to a 'business as usual' control group, so that the impacts of the programme can be rigorously evaluated

Delivery of the programme is being led by Ingeus Limited, working with a supply chain of subcontracted providers. Overall, it is anticipated that up to 21,000 residents will be

[1] Camden, City of London, Hackney, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth and Westminster

supported through the programme – with participants supported for up to 15 months out of work and up to a further six months when in work.

1.2 Aims and objectives of the research

CLF has commissioned an independent evaluation both to complement the national and London evaluations and to provide insights on the design, implementation and effectiveness of central London Works. This is intended to inform future programme design and to support performance improvements during programme delivery. The evaluation is focused in particular on understanding:

A. The characteristics of those joining the programme and how are they being supported by the provider and local services
B. The effectiveness of integration in improving access to support for participants
C. The effectiveness of health support in improving health and wellbeing outcomes for participants
D. The effectiveness of the payment-by-results approach in driving positive outcomes for all participants
E. The impact of CLW on job finding rates, hours, earnings, and benefit receipt – compared both with 'business as usual' services and the national Work and Health Programme

This report summarises findings from qualitative research conducted in the first year of evaluation (to December 2019), so in particular focusing on the design, implementation and early experiences of CLW. Therefore this research pre-dates the impacts of the Covid-19 pandemic. A second report, drawing together findings from programme management information and a participant survey, is being published separately alongside this report.

1.3 Structure of the report

Chapter 2 below describes the methodology used for this stage – including an initial scoping review, immersive research in delivery sites, and in-depth interviews.

Chapter 3 then looks in depth at the one-to-one sessions observed, while chapter 4 turns to focus on the group session taking place at the time of the visits.

Chapters 5 and 6 combine observation and follow-up interview notes to describe and analyse both the approaches taken by CLW advisers and participant responses.

Chapter 7 then draws together findings from the qualitative work under the relevant themes of the programme set out in 1.2 above (focusing particularly on themes A, B and C).

Finally, Chapter 8 draws together key conclusions and recommendations.

2 Methodology

This report draws together findings from an initial scoping phase, immersive visits, and depth interviews. These are taken in turn below.

2.1 Scoping

During the scoping phase, interviews were carried out with a lead contact in each of the 12 London Boroughs delivering CLW. These were conducted in Summer 2019. Interviews explored with Boroughs their views on the key targets groups for CLW, the programme's design and early implementation, its governance and the effectiveness of partnership working.

Findings from this stage were used to inform the design of materials for the subsequent immersive visits and depth interviews, and are integrated into the report chapters below where appropriate.

2.2 Immersive visits

The evaluation team carried out observation and shadowing visits to fifteen sites – comprising 11 out of the 12 London Boroughs involved in CLW, three supply chain providers and one Jobcentre Plus office where support was co-located[2]. Visits were conducted between October and December 2019.

The immersive visits included observations of 53 sessions, of which 39 were one-to-one sessions and 14 were group sessions. As part of the visits, we also interviewed delivery staff including provider managers and advisers, Employment Adviser Managers (EAMs), Hub Guides and health care professionals involved in delivering on-site health support.

Observation method

The aim of the observation visits was to examine the 'real world' interactions between advisers/ staff and participants, in order to gather data about:

- What is delivered in the intervention, how it is delivered, and how it is tailored to the individuals' circumstances;
- The participant's engagement, attitudes, behaviours and support needs; and
- The approaches used by the adviser/staff.

[2] A visit was not made to the City of London due its small size and the low number of referrals being made.

We were particularly interested in the language used in, framing and context of discussions as such issues cannot be easily self-reported during qualitative interviews. The aim was to uncover the nuance and 'added value' provided through a model where support is tailored to individual needs, through:

- One-to-one support delivered by advisers with participants – including initial action planning/ enrolment meetings; follow-up meetings; job-search support; delivery of employability support (e.g. mock interviews, CV writing);
- Group support delivered by advisers/ peers with participants; and/ or
- Support delivered by partners with participants – for example condition management, physiotherapy, other therapies, budgeting support, digital support, training, skills, in-work support.

The table below describes the types of activities we were hoping to observe:

Table 2.1 Activities being observed

Activity	Description
Introducing/promoting Central London Works	Meeting a potential participant, explaining who they are and making them aware of the project, initial relationship building, establishing eligibility
Enrolling an individual	Completing the referral/ enrolment process, familiarisation with the participant's work/employment history and circumstances
Completing an action plan	Identifying participant objectives/ job goals, any barriers and support needs, possible solutions and agreeing actions
Support activity	Including for example: • Coaching sessions, e.g. writing a CV, careers research, signposting, facilitating access to support (financial or service) • Support with managing a health condition • Training/ learning sessions • Mentoring sessions • Advice/ support sessions on wider issues (e.g. budgeting, digital, family) • Employer activity: employment intro to work, mock interview, work experience, employment taster, in-work support • Group work, which may be facilitated by an adviser or by peers
Review an action plan	Review progress towards agreed actions, identify any additional barriers, agree any further actions
Follow-up contact	Phone/email participant to confirm employment, sustained employment.
Any other support provided	

Types of sessions observed

Of all the observations, 23 were of general, one-to-one catch-ups between participants and advisers that covered a wide range of topics. These formed the majority of the observations. The sessions varied in length, with some lasting only 15 or 20 minutes and others more than one hour. A smaller proportion of the observations were of initial diagnostic meetings that tended to be longer, lasting 30 minutes or more. Finally, a small segment of the one-to-one observations had a more specific employment focus: these

included mock interviews, supported job search, interview skills or a review and rewriting of CVs. Like diagnostic meetings, they also tended to be longer (30 or more minutes).

Where possible, short follow-up interviews were conducted with participants to get their perspectives on the support received. It should be noted however that not all participants agreed to be interviewed afterwards, and those that did so were generally those that had a higher observed level of engagement with the programme. There did not seem to be any specific pattern to whether people agreed to a follow-up interview or not, with those who declined mostly saying they did not have time.

The immersive visits included observations of 14 group workshops: four on health and ten on employment. The health workshops were on back care, mood management and motivational strategies; one session observed was an introductory Pilates lesson. There were ten employment workshops observed. These sessions covered various topics: confidence in interviews, time management, interview skills and barriers to employment. The group sessions were typically longer than the one-to-one meetings, lasting one to two hours.

Demographics of advisers and participants

The table below presents the demographic details of advisers and participants observed by gender, ethnicity, age and disability. While these figures are based on qualitative research and cannot be taken to represent the overall demographics of the programme, it is notable that advisers were more likely to be female while participants tended to be male. It is also important to note that these data are from observations alone and participants were not asked for this information directly. The figures on disability in particular should be treated with caution as they are a combined figure from observations and where a participant or adviser disclosed a condition.

Table 2.2 Demographics of participants and advisers

Gender	**Female**	**Male**
Adviser	27	14
Participant	16	22
Ethnicity	**White**	**BAME**
Adviser	10	27
Participant	13	25
Age	**Over-50**	**Under-50**
Adviser	9	28
Participant	17	21
Disability/health condition	**Disability/hc**	**No disability/hc**
Adviser	9	29
Participant	16	22

Source: IES qualitative research

Most of the advisers we observed or spoke to had experience of working with this participant group, and in some cases had previously been participants on CLW themselves.

The AEIOU Framework

As Central London Works includes a wide range of support, there was potential for observations to cover a variety of activities. An AEIOU framework is a simple approach to organising ethnographic data around five elements: Activity, Environment, Interaction, Object, and User. This allows researchers to identify and compare features across a range of different activities and identify common or key findings. [3]

- **Activities** are goal-directed sets of actions—paths towards things people want to accomplish. What are the modes people work in, and the specific activities and processes they go through?
- **Environments** include the entire arena where activities take place. What is the character and function of the space overall (eg a private room, a community centre, the persons home), of each individual's spaces (eg. spacing for group work), and of shared spaces?
- **Interactions** are between a person and someone or something else; they are the building blocks of activities. What is the nature of routine and special interactions between people, between people and objects in their environment, and across distances?
- **Objects** are building blocks of the environment. What are the objects and devices people have in their environments and how do they relate to their activities (eg action plans, visual refs, documents, information sheets)?
- **Users** are the people whose behaviours, preferences, and needs are being observed. Who is there? What are their roles and relationships? What are their values and prejudices?

This approach allows researchers to identify and compare features across a range of different activities and identify common or key findings. The research team used this framework flexibly in the observations and focused on elements that were most relevant to each situation. Observers recorded the:

- Time devoted to particular activities;
- Adviser style – for example challenging, directive, responsive, flexible, engaged, process- or claimant-led;
- Participant's response – for example whether they were passive, active, engaged or disengaged; and

[3] Description of framework elements quoted from: https://help.ethnohub.com/guide/aeiou-framework

- Use of tools and other objects such as screening tools, vacancy print-outs or leaflets, and how these are introduced.

Prior to the visit we provided information sheets and consent forms to use with individuals or groups who were being observed. We also provided verbal assurance to participants on how findings and any data collected would be used.

2.3 Follow-up depth interviews

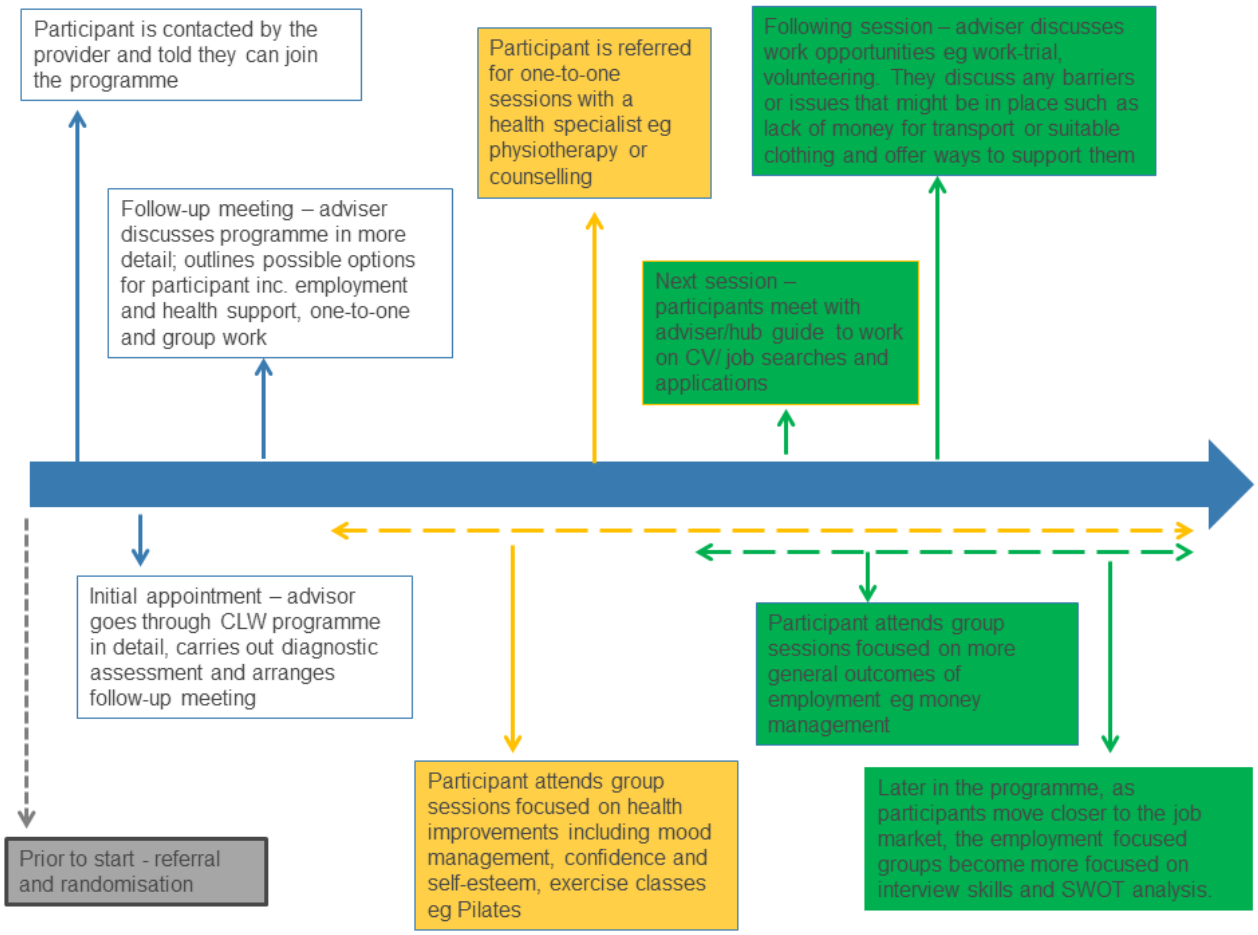
Follow-up telephone interviews were conducted with a small number (three) of health care professionals involved in the delivery and management of support by telephone. These gathered feedback on referrals made to them, the nature of support offered in one-to-one meetings with health workers, attendance, participant outcomes and suggested improvements. The follow-up telephone interviews also enabled us to collect information on the content of individual health sessions as we were not able to observe these during immersive visits (either due to timing issues or the sensitivities of the support delivered). Due to the small numbers of interviews conducted, the findings from these health care professionals should be treated as indicative.

Telephone interviews were also carried out with three Jobcentre Plus staff, including work coaches local to CLW hubs where observations took place. The interviews gathered additional data on the referral process, JCP involvement with participants on the programme, participant outcomes and suggested improvements. Again, due to the small numbers these findings should be considered indicative only.

3 One-to-one sessions

The diagram below shows a typical participant journey through CLW support, from referral to employment outcome. This chapter summarises findings from one-to-one sessions from the initial appointment onwards, while Chapter 4 summarises findings from group sessions.

Figure 3.1 CLW – typical participant journey



Source: IES qualitative research

3.1 Initial appointments

The participant's first appointment on the programme was normally a diagnostic meeting at the CLW hub offices. The one exception to this in our observations was a hub that was co-located at the JCP on the day of the visit. Here, an adviser for CLW explained the programme to the participants and took down contact details. The second appointment was then set at the hub location for the diagnostic to take place.

This diagnostic meeting involved the adviser going through a questionnaire covering health and wellbeing, skills and education, and work experience. Typically, filling in the questionnaire sparked a wider conversation about the participant's barriers, and any immediate concerns such as housing needs. Advisers then talked through the support offer: including case workers, health workers, workshops, and that the programme offers a combination of group-based and 121 support. Some but not all advisers said that this would be tailored to the individual's needs. Participant also received an information package and signed a participant pledge.

The box below outlines an example of an Initial appointment at a prime provider office:

Case study – initial appointment

- Adviser asks what participant knows about the programme. She says it's to help you get work and training. He explains that it's the Work and Health Programme and that they help people with physical and mental health condition. He details the provision: case workers, health workers, workshops. Programme focuses on "health, life, skills and work".
- Participant receives the information package and signs the participant pledge.
- The adviser asks about the participant's background. She details various jobs, housing issues (in temporary accommodation), her current volunteering work, and depression. This gets written into a form. Adviser says they can help her with her health and with the housing.
- She is asked about what she wants to do. She says she is interested in counselling. He said they can look into that but it may be too long a course for 15 months on the programme. She expresses unwillingness to do anything else.
- Her following appointment with the case worker is arranged in two weeks.

3.2 General appointments

The majority of the observations were of general catch-up meetings that participants had with their adviser, normally conducted on a bi-weekly basis. Advisers described the aims of these sessions in varied ways, reflecting the heterogeneity of the participant group. A common aim for these sessions was keeping in touch, so advisers could check on how their participants were doing.

Action plans were discussed in seven of the sessions we observed, with advisors tracking and recording progress in these documents. In another two cases, advisers said they would discuss the action plan at the next appointment. Sometimes, if the participant was at risk of disengagement from CLW or if they were close to achieving employment, advisers saw the goal of the regular catch-ups as keeping participants focused, motivated and moving forward.

One-to-one meetings were typically booked in at the end of a session. Advisers would also book participants onto upcoming group sessions during catch-ups. The majority of one-to-one meetings appeared to take place face-to-face but advisers would sometimes offer to do these over the phone (for example if the participant was too ill to attend in person).

Advisers typically had general catch-up meetings with their participants bi-weekly. Some of the smaller, supply-chain providers had weekly meetings with participants. Advisers across

all providers were also flexible and depending on the participant's needs would see some more frequently. Examples of these cases included where participants:

- Had a high level of need in terms of their motivation or health condition and they were at risk of disengaging from the programme; or
- Were close to the labour market and needed extra support to keep their motivation up when applying for jobs and attending interviews.

In some cases, especially early on in the participant's journey, the focus of the one-to-one session tended to be on finding out about the participant's current barriers to employment and seeking to address any immediate ones such as the lack of a CV or documents proving their right to work in the UK. Later on, the focus might shift to more difficult issues such as ill health, low confidence or lack of motivation. If participants were further along in their journey, these sessions were used to discuss career options, help participants discover their skills, gain work experience and ultimately look for and apply for jobs.

The general catch-up sessions were less structured than other types of sessions, often covering a wide range of topics. The flexibility of these sessions was seen positively by participants as they generally covered their specific needs at that time. Sometimes the focus of the meeting was on job search, other times on health, but in most cases it was a combination of both. In meetings where employment was the main focus, the advisers asked about the participant's health and general wellbeing. If the participant had recent or on-going health concerns, these would be discussed but often with some reference to future job search, such as what type of work the participant would like to do.

Wider issues were also often covered, such as housing, debt, finances and budgeting, welfare rights, winter fuel allowance and employment status. It was notable that some participants had very significant barriers outside of health or long-term employment, such as homelessness. In such cases the meetings focused on seeking to help individuals to address these, rather than to talk about employment.

The observation notes from a general one-to-one meeting at a prime provider's office below highlights the wide variety of topics covered in such meetings:

Case study – general appointment

- The adviser and participant spent a few minutes talking about the emails received on job applications – some confusion over the one to XX (a global fast-food outlet) and a worry they might not have the right email address – no real solution was given to this
- Then they spent a few minutes discussing applications the respondent has sent – the advisor tried to encourage the participant, saying it's good she's applying, but that most of them are clearly unsuitable such as an area manager for a large company despite having no relevant experience for that. The adviser tried to explain that she needs to apply for relevant opportunities
- Next they went through the CV and the adviser suggested some changes – then a subsequent appointment was set up to go through the changes
- They spent a considerable time (20 minutes) then talking about computer courses – but the advisor felt these wouldn't be appropriate timings with the school run the participant had to do. The advisor tried to phone the person running the course but couldn't get through so he

suggested booking in for weekly sessions for computer skills support (shortly after, the participant received a call from the person running the computer classes but the advisor had to step in and make it clear to her that the timings for the course would not be appropriate)

- The adviser asked whether the previous session on particular vacancies highlighted any of interest, but this discussion didn't really go anywhere
- Finally, the advisor ended the meeting and suggested handing physical CVs to various local shops she knows are recruiting at the moment.

In some meetings, the job discussion focused on the participant's recent experiences with applying and interviewing for jobs. Examples included the adviser presenting the participant with new vacancies or work placement opportunities; discussion of a participant's experience of a recent interview, with the adviser sometimes giving news about the outcome of an interview in person and sharing feedback from the hiring manager; and discussion around job applications a participant had sent and whether they had heard back about an interview. The advisers typically tried to resolve participant queries during the session: for example, they would call the hiring manager to find out about an outcome of an interview or to get feedback; or call a recruiter about a job posting the participant had seen to find out about more information about the role or the interviews.

There were also broader discussions around employment in the catch-up meetings. For example, advisers discussed types of employment their participants wanted to do; past employment and transferable skills that can be applied for another type of work; and how health or other barriers influence their current ability to work or their choices about types of work. Advisers would also discuss and re-work CVs with participants in dedicated, employment-focused sessions (see section 3.3 below).

Sometimes there was discussion about training courses and skills. In some cases, participants were referred to IT courses that were organised externally by local partners. Participants also made their own suggestions about training opportunities to their advisers. In one case the participant had found a training course on car mechanics. The adviser encouraged them to do this because it would allow the participant to update their skillset and also help him to network (and so help with his job search). In another case, the participant needed help from their adviser to apply for an MBA course. On this occasion, the adviser discouraged the participant from doing this due to their low income and precarious housing, and encouraged the participant to look for jobs instead.

Examples of health discussions within general appointments included discussion about the participant's current health and wellbeing (their own view of their health and information that they have from the health team or their GP/ health professional) and the support they needed. Sometimes advisers would encourage the participant to seek more help from their GP/ health professional, or they made a referral to the hub's internal health team for further support. Advisers also discussed the possibility of future employment with participants. If their health condition meant that employment was not a realistic immediate option, job search was put on hold but the participants would still attend their general catch-ups to stay motivated and engaged. Meetings were also re-arranged for over the phone where a participant was too ill to attend in person.

JCP and CLW staff told us that on some occasions, three-way meetings would be held with participants. One such meeting was observed during the immersive visit to a JCP

office, where a CLW adviser was co-located. The participant had been referred onto CLW about three months prior and had initially engaged with the health practitioner. However, there had been a change in staff and the participant had not attended any appointments or answered calls or texts since. Due to the flexibility of CLW, the JCP Work Coach and the adviser were able to talk to the participant together during an appointment at JCP and find out the reasons for their non-attendance. During the session, it became apparent that the participant has an anxiety condition which has been a barrier to attendance and communication. During this meeting, the adviser agreed that they would make a referral to a health practitioner for one-to-one counselling:

"X (the participant) is always 'closed' and reluctant, it did seem to get a bit better for a while but now it has got worse again. X has mental health issues, anxiety and depression and there have been some issues with their parents, some possible trauma…and lack of family support. It has become difficult to get hold of X on the phone recently and they have been avoiding speaking to someone. The participant is very capable, has a degree and has worked in the past so is very capable but stuck in a cycle of anxiety, and has little support from family members."

Prime provider - adviser

3.3 Employment-related appointments

Some of the one-to-one sessions had an explicit employment focus and involved, for example, mock interviews, supported job search and CV writing. In one case a hub guide did a mock interview with a candidate, followed by providing some constructive feedback.

"The session was really helpful. It was what I needed because I feel out of practice. I thought the advisor was helpful and nice. The next session is already booked and it will be another mock interview"

Prime provider - participant

In another session, the participant was keen to get voluntary experience in a homeless centre, having himself experienced homelessness in the past. In the session, the participant applied for an opportunity at a homeless charity with support from the adviser. The adviser also advised them to apply for a warehouse position while continuing to apply for positions in the homelessness sector, so that they could gain work experience and increase their income.

Another specifically employment-related session involved an adviser helping the participant to tweak their CV to make it suitable for applying for customer service roles. The participant had a DBS record and their current CV only reflected his past experience in security. The adviser supported him to add in more relevant detail from his previous roles, and in the same session worked with him to conduct the National Careers Service (NCS) skills assessment online that laid out different career paths. The participant had not considered many of the suggestions before, but through the assessment he realised how many transferable skills he had from his previous roles.

Self-employment was only discussed in one session observed during our visits. In this case, the participant had a background in the music industry but was not able to work in

the industry due to their health barriers. The participant was now looking to set up a community-based studio for young people. The participant already had a business unit in mind where they could set up the studio, and the adviser primarily helped them with funding applications as well as encouraging the participant to find out more about self-employment.

> *"It was brilliant today, a big step forwards. The adviser spent lots of time with me and I found out more about the work that will need to be done to make things happen…JCP just want me to get back to work and off UC. Here they look at what you really want to do and help you with that.*
> *I'm really pleased with the support I'm getting from my advisor. I feel like people are trying to help me here."*
>
> Prime provider – participant

In some cases, meetings were less productive – often because of a lack of information or sufficient specialism to meet that individual's needs. So for example in one case, a participant had been 'handed over' to a new adviser who did not have access to their case notes. Most of the meeting was then spent reviewing jobs that the participant was not able to do because of their health conditions. In another case, language barriers meant that the discussion had to be translated by a colleague – with again an apparent lack of understanding about the specific limitations that the participant's health barriers placed on their ability to do certain jobs.

3.4 The office environment

It was notable that across different sites and providers there was typically not much privacy for one-to one meetings to be conducted. The vast majority of the observations took place in an open plan office, with other caseworkers and participants often nearby.

This was not always an issue, and in general catch-up meetings participants appeared happy to share about their progress with job search, health or general wellbeing. However, in some meeting participants needed to share information about issues that were sensitive in nature (for example about their mental health) and in these cases the open-plan setting appeared to be unsuitable, and potentially a barrier to the participant's ability to talk openly and freely with their adviser. The open-plan setting felt particularly inappropriate for the initial appointments, where participants are asked to disclose a lot of personal details.

Private rooms were available in some hub sites, and where this was the case they were used particularly where the participant had requested more privacy. One participant interviewed during the visits had an anxiety condition, and they felt uncomfortable in anything but a one-to-one setting in a private room. The participant said that having the private space had been important to their progress because it had allowed them to build a trusting relationship with their adviser, allowing them to make gradual progress in the programme.

> *Having private space here has been very valuable. It has always been available to me. I need to talk about sensitive issues (with the advisor) and I don't want to do that in the open office. I wouldn't want everyone to know about my personal issues.*

Participant – provider office

However, seven of the offices visited did not appear to be a dedicated private room and so meetings could only be conducted in open plan spaces, or in areas like office kitchens that offered a little more privacy.

It was also noteworthy that many of the open-plan offices had noticeboards where the job targets of different advisers were visible to visitors, including programme participants during their one-to-one meetings.

3.5 Health-related appointments

As noted in section 2.3, it was not possible to directly observe health appointments (due to timings and/or sensitivity of the topic) and so these findings are from interviews conducted with staff employed by the prime provider to deliver health support.

The majority of participants have at least one physical or mental health condition, and so are encouraged to attend health workshops run by the provider. Some also attend private meetings with health workers outside of these group sessions. Participants who are flagged as having more complex or specific health needs in the diagnostic meeting are referred to the health team, and the participant is assigned a health worker with relevant expertise – for example in mental health, muscular pain, arthritis, back pain, post-stroke fatigue or respiratory issues.

Referrals were generally made during a participant's first few appointments, but can be made at any point during the programme. Once a participant has been referred and assigned to a health worker, the health worker calls the participant to book in the first appointment. Generally there is not a long lead-in time between the referral and the first contact (it was described as happening "within days").

In the initial sessions, health workers find out more detail about the participant's health condition, how it affects them day-to-day and why it is a barrier to work. They then create a tailored plan of support that includes short- and long-term goals. The goals vary but in the long-term may be about engaging with the healthcare system or managing pain; or in the short-term about joining a walking group or attending workshops.

Health workers interviewed saw their role as supporting people to better understand and manage their condition. They do not provide treatment – instead, the appointments provide a time to explore the participant's health holistically in a way that is not usually possible in a GP appointment. One health worker summarised the approach in the following way:

We make them more independent. We want people to go away with things they can do to help themselves, so that they are in charge of managing their own health, and making sure that they have the tools to manage their health when they go into work, too.

Provider – health worker

It was reported that sometimes, individuals had not reported one or more of their health conditions to their GP or other health professional. In these cases, a key aim is to get the individual to access the right support through the healthcare system and so take more

ownership of their health. Health workers are not able to refer participants directly to NHS services, but they can write to the individual's GP explaining the need for a particular therapy (for example, physiotherapy or a specialist appointment). They will sometimes write the letter during a session with the participant, which can also help them feel more actively involved in managing their health.

It was reported that the content of health conversations varied, but might include discussion about pain management and types of work that the individual may be able to do while learning to manage their pain; or ways that participants can manage their mental health while they wait for an NHS appointment (which were reported as taking up to six months depending on the local authority). Health workers reported that many of the delivery offices lack suitable space for private conversations, and that this was a challenge for delivery.

Attendance at health sessions was reported to be high, particularly with those participants with mental health conditions. Health workers reported that participant feedback is positive and that attendees find the sessions helpful. Health workers said that once a participant has attended an initial appointment with them, they are generally keen to attend more one-to-one sessions.

The health staff we spoke to reported that one of the biggest issues they faced was participants not answering their phones after the initial referral from the caseworker. The health practitioner team manager told us, *"Once we've seen them, we've got them (engaged)"* Given that these people do not engage with the service, it is difficult to be sure of the reasons behind this issue. The physical health practitioners we interviewed did say that in some cases there was a mismatch between what they offer (support to self-manage their conditions) and what participants expect (physiotherapy/ treatment/ massage etc). Other possible explanations might be that participants were disengaged after an unsatisfactory initial appointment or the complexity of their needs which, being severe and often multiple, may act as a barrier to engagement.

Health staff reported that if people drop out, there is typically a reason for that – for example substance abuse making their lives unstable, or withdrawal from the programme itself. Sometimes participants stopped attending so as to focus on finding employment. The small number of interviews with these staff mean that we have to treat these findings with caution at this point. However, these issues will be explored in more detail in the next stage of the evaluation when depth interviews will be carried out with participants and a larger number of health care professionals.

People generally have two to five private sessions with health workers. Participants are given resources to work through between sessions, and participation is encouraged in the health workshops (described in Chapter 4 below). Health workers reported that participants attending one-to-one sessions often have multiple health conditions, and in these cases, each condition is discussed in a different session.

Health workers can also refer participants to other services to support exercise, diet, finance and budgeting, social activity and so on however, we did not observe this at this stage of the research. Each borough has a different range of services available, but it was reported that in general there was a lot of provision that could be referred to – including for

example from Age UK, food banks and Citizens Advice Bureau. This suggests that health workers – much like employment advisers – are able to attend to participants' broader needs outside of work and health.

3.6 Tools and resources

As part of one-to-one meetings, advisers mostly used laptops or PCs to carry out various tasks including making notes, filling in action plans, making changes to the participants' CVs, supporting job searches and finding out information and contact details. Occasionally advisers used online tools such as the National Careers Service skills assessment, a budget calculator and a CV builder.

Initial meetings had paperwork for the participant to sign, as well as leaflets and an information pack about the programme. In one session (a mock interview), the adviser had a pre-prepared form with typical interview questions that she used to also note down the participant's answers. Offices also had folders with local jobs and volunteering opportunities, and advisers handed out print-outs of upcoming workshops.

3.7 Adviser delivery

Advisers on the whole delivered one-to-one sessions very well. It was clear that many were experienced working with individuals who were out of work and with similar disadvantages, often from delivering other contracted employment programmes. Many had a warm, down-to-earth style that participants responded well to and that made them relax (often after an initial nervousness or reluctance to engage). It was clear that many had cultivated a good personal rapport with individuals on their caseload – for example talking about family life and personal interests as part of wider conversations. Most advisers also appeared to take genuine interest in the wellbeing and employment prospects of their participants.

Advisers varied their style depending on the individual. If the participant's main barrier was a lack of self-confidence, the advisers offered support and encouragement and noted the positive progress that had been made since joining CLW. As one put it:

> *"I knew you had it in you. You just had to believe in yourself like we believe in you"*
>
> Prime provider - adviser

If participants appeared distressed or upset, advisers adopted a gentler tone. In some cases participants were closer to gaining employment, and in these meetings advisers tended to offer participants more space to speak and to self-direct the activities that they did together.

Some meetings were more challenging for advisers to manage – for example where participants were evasive and reluctant to answer questions about their job search, or where they tried to change the topic or engage other people around them. In these situations, advisers typically took a firm line with the participant and brought the discussion back to their personal situation and support needs.

There were a handful of meetings however where the advisers' approach appeared ill-judged because it caused a negative reaction in the participant. In a couple of meetings, the advisers appeared to dictate the meeting, not involving the participant as much as they could have. The participants reacted by becoming withdrawn and disengaged from the activity. In one session, the adviser directly challenged the participant about their ability to manage a work placement. It appeared as if the participant had not been expecting this from the meeting and was shocked and affronted by being told they were not ready for work experience. The adviser later explained that this approach was aimed at preserving the participant's confidence in the long-term by not placing them with an employer until they were work ready. However, the approach caused a strong emotional response in the participant and the meeting may have dented their self-confidence in the short-term.

3.8 Participant responses

The vast majority of participants appeared to be engaged with their advisers in the one-to-one meetings, based on their responses and body language. In most cases, participants listened to and appeared to take on board their advisers' suggestions, had a good rapport with them, and were open to receiving support and undertaking activities. Participants were also usually willing to share details about their personal circumstances, including disclosing difficult experiences or barriers. Sometimes, although less commonly, participants made proactive suggestions and led the conversation.

Participant feedback after meetings was generally very positive, although as noted this may reflect the fact that those who took part in post-meeting interviews with the researcher were generally more engaged with the programme. Participants felt like the adviser understood them and treated them as an individual, that support was personalised to their needs, and that it was better than other employment support that they had received in the past.

[The adviser] has helped me to identify what I really want to do. That's why I love this place, they look at me as an individual.

The programme is going swimmingly well for me. I have been in for a month. They have got my CV sorted which needed a lot of work. It needed to be more focused. I work well with my adviser. It's great!

The support I am getting from here is very different to the job centre. I wasn't sure initially whether I would want to do it but after chatting with [the adviser] about the programme and what was on offer I decided to give it a go, and I am getting quite a bit out of it.

I thought it was good. I'm pleased that at least some people care about me. [The adviser] is very friendly and helpful.

When I came to the first appointment I thought it'd be like the job centre, another let-down. But I liked the atmosphere here so I decided to come back and give it a go.

I'm all happy with this. The main thing was to start getting the support as JCP felt it would be useful. I am hoping I can get the support now that the centre is familiar with the situation. The main thing to get out of today was advice on when to disclose the health condition and I managed to get that.

Participant feedback

In cases where the participant had been helped with CVs and job application or where it was an initial assessment, they sometimes withheld judgement until they could see anything coming out of the meeting. One participant we interviewed was pessimistic about the likely success of the programme, especially given how long they had been unemployed for and their experiences of programmes in the past. They were also concerned about the potential impacts on their benefits and housing as there had been problems the last time they had taken part in an employment programme.

The appointment was ok but I've been in the system for 20 years and I just feel it'll be the same thing all over again. They'll probably get me on the computer, working on my CV….
I can't go through getting work for 2 days, losing my job and then losing my benefits and getting into rent arrears again.

Participant

There were however sessions where the participants were disengaged: for example their body language was closed, they appeared passive or distracted, and/ or were not constructively engaging with the adviser. There appeared to be different underlying reasons for this disengagement. Some expressed negativity and doubt about their potential to achieve employment, particularly if they had been out of the labour market for a long time. Others had many different health or other barriers and appeared to be overwhelmed, or dejected when prompted to think about taking steps towards employment.

In a few cases where the participant was withdrawn and not engaging, it appeared that there may be underlying health conditions or impairments that may be contributing to this but had not been disclosed. In one follow-up meeting for example, where a young woman reported that she had not followed up on any of the work-trial opportunities previously suggested, it was only towards the end of the session that she disclosed that she suffered from anxiety and so had difficulty travelling on public transport. It was not clear whether this had been recorded previously, but once the adviser was made aware he offered to travel with her for the first time.

Engagement was more challenging if the participant had not been on the programme for a long time and therefore had not yet developed a relationship with their adviser. For example, there tended to be more disengagement during the initial diagnostic meetings, where participants were noticeably more likely to appear distracted and passive. As noted in Chapter 4, these meetings generally took place in an open plan office and included often quite sensitive questions – which likely further undermined their level of engagement.

Language barriers also made participant engagement difficult on occasion, as referenced in Chapter 3. In some cases the adviser or one of their colleagues could speak the same language as the participant but in most sessions this was not a possibility. The advisers then either tried to communicate in English or they called an external translation service.

3.9 Key strengths and areas for improvement

To summarise, a range of activities were observed and being delivered across sites, with many examples of high quality delivery and support. Key strengths included:

- Advisers were welcoming and put participants at ease, were flexible in their approach and often built a good personal rapport with participants – while adopting a firm but fair approach when needed
- Relevant, timely and personalised information and advice was given, based on the goals and needs of the participants and with a clear focus on taking steps towards employment
- Advisers were aware of the needs of the participant and showed sensitivity to their situation and experience – including health conditions, confidence, skill levels and wider circumstances
- Appropriate referrals were being made to health and employment provision and to wider services (internally and externally), with advisers often able to offer a choice of options
- Next steps were clear and future sessions were booked in

Four key areas for improvement were identified:

- The lack of private meetings rooms and visual display of job targets likely affected some participants' ability and willingness to engage in the programme
- While support was personalised to the participant, in some cases the complex nature of individuals' needs made it hard for advisers to effectively work with and support them – for example where they had been unemployed for a very long time, had multiple and complex health conditions, or had language difficulties
- Linked to this, it was apparent that in cases where individuals had higher or more complex needs, there was generally less provision available to refer to, either from within the programme or among external partners – however it was not clear whether this was due to the provision not being available, or due to the programme not having access to it
- In a minority of cases, advisers were not fully prepared for meetings and did not have sufficient background on previous discussions and/ or work limitations, or did not have access to additional specialist expertise like language translation

4 Group sessions

Fourteen group sessions were observed – four of which were health-related, and ten employment-related.

4.1 Health-related groups

The focus of the health-related groups run by the providers is incredibly varied and covers both physical and mental health issues. The group sessions we observed as part of the immersive visits covered:

- Pilates
- Back care
- Mood management
- Motivational strategies

There were smaller and larger health workshops, and they took different formats. The large groups were more structured around themes that the facilitator wanted to cover. The smaller groups were less structured and, naturally, required more participation on the part of the participants. These small groups also allowed for a more tailored approach. For example, in a Pilates session both participants mentioned having back pain at the start of the session, and the health worker focused the session on exercises addressing it.

As mentioned, the larger groups tended to have a more structured format set in advance by the health worker. The health worker typically gave an introduction to the topic and delivered key pieces of information, and then typically they would encourage conversation about the topic in the group. In the groups that worked most effectively, the health worker would also share something from their own life that warmed up the conversation between participants. A conversation between participants and the health worker would flow from that, sometimes with the help of props (for example PowerPoint presentations, or in one case a model of a human skeleton).

Health workshop facilitators described the goals of the workshops to be confidence-building to break down barriers and support job search. Some also mentioned re-socialisation as a goal: getting participants to actively take part in activities outside of their home and to speak to others who are in a similar position. Health workers typically introduced their session as a “relaxed, safe, open space” where everyone was allowed to contribute and where there were no wrong answers. When health workers were asked what they thought had gone well in the session, they mentioned in particular participants discussing and sharing ideas with one another. This helped to address issues that many participants had around social isolation and a lack of confidence.

4.2 Employment-related groups

The employment-related group sessions were in most cases run by advisers, or in some cases by employer account managers. Flipcharts, PowerPoint presentations and hand-outs were often used, but not other props or aides. Examples of hand-outs include: 'unhelpful thoughts' in interviews; common interview questions; good and bad questions to ask at the end of an interview; and a list of local employers known to be supportive towards employing disabled people.

There was a wide range of different activities that took place in the employment workshops we observed, including:

- Barriers to employment
- Interview preparation and skills
- Employability workshop
- Time management

Typically sessions began with the adviser explaining the purpose of the session and what would be covered. Then the adviser would either deliver key points of information about the topic; or they would go round the room asking everyone to talk about their situation in relation to the theme. At the end of the session, some advisers asked participants what their key takeaways had been and if they have gained a better understanding of the topic. They would also advertise other upcoming workshops.

Some activities were based on team work: in one case, the group was split into pairs and the pairs asked each other questions that might come up in interviews. In another group participants were asked to do a 'meet the employer' role-play where they would simulate meeting an employer and introducing themselves. There were also a variety of different activities led by the adviser: including for example asking challenging interview questions and asking the group to work on answering them together; or asking participants to reflect on their strengths and weaknesses in front of an employer.

In one hub, participants were split into two strands for the delivery of group support:

- One that worked with those further from employment and focused on topics around general labour market orientation and finances (for example how much money they would like after paying their bills and what they would need to earn to make that a reality); and
- One working with those closer to work, and focused on providing support to apply for jobs – including for example SWOT analysis, interview skills and presentations.

This innovative approach appeared to be successful in ensuring that group discussions were pitched at an appropriate level for attendees, and could better support them to make progress.

When asked about the goal of the sessions, many of the facilitators of employment sessions said it was to the help participant with their mind-set to work as opposed to having a particular employment-related goal. In particular, these facilitators said that lack

of confidence and shyness were major barriers for the participants, and that workshops were designed to help with that.

4.3 Session delivery

Most advisers and health workers delivered group sessions to a very high standard, which was reflected in participant responses and levels of engagement. The advisers and health workers were skilled facilitators – with a demeanour that was positive, friendly and supportive, and using techniques to encourage participation from everyone in the group. On the whole, those workshops that had clearly defined aims were the ones that participants appeared to gain the most from.

Group conversation was an important part of successful workshops. To encourage this, some facilitators shared their personal stories to create a connection with participants and to stimulate conversation. Some participants lacked confidence to answer interview questions, or they were reluctant to work in pairs or small teams. In these situations the facilitator would offer extra support to work on interview questions in a one-to-one session, and help small teams and pairs work together.

Facilitators asked questions of the participants, including challenging ones, but in a style that was motivating and encouraging as opposed to putting individuals on the spot. Sometimes, individuals in the health groups shared personal details and facilitators managed these situations sensitively – acknowledging the response and then directing the conversation in a more general direction to avoid a group discussion of any one individual's circumstances.

The group sessions appeared to work particularly well when there was a connection between the adviser and participants from previous workshops or from one-to-one meetings. This pre-existing relationship gave the advisers more opportunities to encourage participation from quieter attendees.

Nonetheless, there were aspects of facilitators' approaches that were less successful in engaging participants. In some groups, there was too much focus on the delivery of information and not enough on group discussion. Usually this was because the facilitator simply had too much information that they wanted to deliver in too short space of time. This was more common in health workshops than in the employment groups. In some other cases, it was because facilitators relied too much on the pre-prepared material and broke up successful discussions in order to move on to the next piece of information.

Lastly, in a small number of cases it appeared that the content of the group session would have been better suited to a one-to-one meeting. For example one session focused on identifying job roles that participants felt would be relevant to them, and then discussing their barriers to employment – but in practice, participants were often reluctant to share this with the group and the benefits of discussing this as a group rather than in confidence with an adviser appeared to be limited.

4.4 Participant responses

Participants were generally well engaged with group sessions and took part in and responded to the activities and content presented. Participants mostly described their facilitators as friendly and engaging, and some favourably compared the employment groups to the support that they had received from Jobcentre Plus. It was reported that advisers were genuinely interested in helping them, and some participants mentioned advisers that had sought their input despite their initial reluctance and shyness. The quotes below highlight the feedback from participants.

Participant feedback was different in groups where the focus was on group discussion as opposed to information. Attendees in the first type of workshop commonly said that the sessions were useful and interesting. Many felt that they had learnt something new or gained a new perspective. Others mentioned the social aspect of the group as a positive takeaway, and the fact that the advisers are encouraging and the sessions help build their confidence.

By contrast, participants who had attended workshops that were focused on information did not say the knowledge gained was their favourite part of the workshop; instead they mentioned enjoying the workshops in general, or that they like the facilitator. In these groups, some participants felt slightly overwhelmed by the amount of information that was provided and didn't rate the materials used.

> *There was a lot of information for just 1 hour.*
>
> *I didn't like the video she showed in the middle of the session – it's a bit of a cop-out and it did not present any information she would not have been able to present herself.*
>
> Participant feedback

The group conversation elements were particularly affected by the extent to which participants were familiar with other people in the room and so comfortable to share their experiences or personal situations. Those groups where people did talk openly about their personal history tended to be ones where attendees knew each other and the group was well established. For example in one hub, an adviser held a weekly group session for 8-10 of her participants where attendees talked openly about their current barriers and worked together to offer advice and encouragement. This worked well because the participants worked with each other regularly and felt comfortable sharing and challenging each other.

In other cases though, where groups did not know each other, there could be limited engagement and individuals appeared uncomfortable sharing details about their employment and health histories. To address this, ice-breakers were sometimes used at the start of the session to help to ease attendees into speaking to each other in a group (for example, chair-based exercises for back pain).

4.1 Settings

The group sessions typically took place in a meeting room adjunct to the hub office space, although in one case the meeting was held in a local church hall close to the hub due to space constraints on-site. In some cases, the main hub meeting room was also a computer room for programme participants and in these cases other participants could be using this equipment while the session was on-going.

In some group meetings, staff had the use of a whiteboard and if not, a flipchart. A few advisors had the use of a laptop but this was not always linked up to a large screen or projector. In one case, there was a projector in the room but this did not work on the day.

4.2 Key strengths and areas for improvement

As with one-to-one activities, there was a wide variety of activities delivered in group sessions and a range of good practices observed. These included:

- The expertise of CLW staff – both in delivering and facilitating sessions in a way that was supportive and inclusive, and specific expertise in the subjects being covered
- Rapport – sessions worked best where advisers and participants had built up a relationship over a number of weeks and months, as was often the case
- Flexibility – with sessions delivered at different times and locations, of different sizes and in different ways – which appeared to be effective in supporting participation and engagement in support
- The focus of sessions themselves – which were well tailored to the objectives of the programme and the capabilities and needs of participants, with a good variety and choice of sessions to take part in, and with clearly defined purposes and goals

There were four key areas for improvement identified:

- The availability of suitable space – with health workers in particular reporting that the lack of suitable space for group sessions meant that in some cases sessions could not be run even where there was demand for them
- Planning and preparation – in some cases, advisers were rushing or focusing too much on delivery of information, which could have been addressed with more focus on planning and timing the workshop in advance
- Meeting individuals' needs – in most cases, groups had participants with diverse needs and sometimes the pace of delivery or the nature of the content appeared to be at the wrong level for all of those taking part
- Resources to support delivery – again reflecting the available facilities, in some workshops information was projected onto screens that were too small to read, and/ or there were insufficient laptops/ IT resources to enable participants to participate fully

5 Thematic findings

In this section, we draw together findings from the immersive visits, wider interviews and scoping stage and summarise these against three of the five key objectives for the research, namely to understand:

- The characteristics of those joining the programme and how are they being supported
- The effectiveness of integration in improving access to support for participants
- The effectiveness of health support in improving health and wellbeing outcomes for participants

5.1 Participant characteristics and support received

Most of the participants we observed as part of the visits had complex and often multiple needs – including significant health conditions or impairments; social isolation and/ or low confidence; caring responsibilities or wider personal circumstances such as homelessness that limited their ability to work; poor qualifications; and/ or a lack of recent work experience and work skills.

As Chapters 3 and 4 set out, advisers were generally very responsive to individuals' needs and tailored their support appropriately. Three examples of participants' needs and the personalisation of support are set out below.

Case study one

Participant has a problem with her back/leg that means she can't sit down for a long time. Adviser needs to be sensitive to that when looking for retail jobs. Part-time might be a good start for the participant. Participant had a difficult time early in the programme because a family member in their [home country] died so she had to fly back which caused lots of issues with the JCP that the adviser helped her resolve. Now her personal life is back on track and they are on a good roll with the interviews. (One to one)

Case study two

The participant had a significant problem with his eyes at the they have had to put the job search on hold until they get more news about it in the new year. The adviser told him to focus on his health for now but still engage in the programme via the health team and weekly catch-ups with the adviser. (One to one)

Case study three

This participant, like many others, felt socially isolated and lacked confidence. The goal of the health workshop observed was for participants to leave the house and talk to other participants, and ask questions and contribute. Coming to the meetings helps build up their confidence to

help with job search. The adviser hopes participants will also be encouraged to take up exercise classes near to their home and incorporate it to their routine. (Group health)

The referral process

A number of issues and concerns were raised in interviews about the referral process from Jobcentre Plus. These were particularly related to the low volume of referrals and to concerns that those referred had a higher level of labour market disadvantage than had been anticipated. In a number of cases, it appeared that the providers and Jobcentre Plus had been working together to address this, for example by allowing provider staff to attend appointments within Jobcentre Plus offices. Unsurprisingly, the referral process worked better in locations where there were close working relationships between the provider and Jobcentre Plus – most notably through co-location of support.

Co-location makes a massive difference to getting people signed up, as JCP staff are less confident about talking to participants than the provider's advisers themselves are. They can sell it more effectively.

JCP staff

At the time of the scoping interviews, all of the Borough leads pointed out that referrals to the programme were low, and did not meet the targets set out for their areas. In particular, the number of people with health conditions and disabilities coming onto the programme was lower than planned. Given that the Boroughs wanted support to be targeted at these groups in their local communities because of a lack of provision for them, these leads were concerned.

Currently, JCP referral to a potential programme start can take four weeks and involves a PRP gatekeeper at DWP. It's an unwieldy process, too long and complicated and it's not working in terms of converting people referred into starts. Currently its easier for potential referral partners to refer elsewhere – people will stand a better chance of getting the support they need that way.

Borough lead

Jobcentre Plus staff interviewed said that the referral time was now around two weeks, but that it could take longer. Staff described the referral process as "long-winded" because the DWP have to say yes or no to every referral and then individuals had to be randomly assigned either to the programme or a 'business as usual' (control) group.

The referral process itself is too long-winded because first DWP have to say yes/no to a referral and whether they go onto the programme or into the control group. It takes about 2 weeks from referral to first appointment, and it used to take longer. I know we need a control group but it needs to be done in another way, people should be assessed before we sell the programme to the customer

JCP staff

Jobcentre Plus staff and Borough leads expressed dissatisfaction with the randomisation process. There was frustration particularly around the fact that if an individual has been put

into the control group, there is nothing they can refer the customer to for two years. One member of staff interviewed suggested that those randomised into the control group were in fact then referred on to alternative and shorter support, which could have implications for the impact assessment of the programme.

More broadly, interviews with Jobcentre Plus Work Coaches suggested that they were supportive of the programme and the services that it offered, and that they were actively selling the programme as way of addressing health conditions and getting back to work. Relations with provider staff were viewed as being very positive, and they particularly value the flexibility with their time, their local knowledge and the health-related aspects of the programme.

> *We know that it is hard to find work if you have a health condition. People are often not very confident and tend to focus a lot on their health. The focus on health barriers on CLW, and the support from the provider's in-house healthcare specialists is what seems to make it work well.*
>
> JCP staff

Work coaches reported that claimants were generally positive, although those who were long-term unemployed tended to be more negative about the offer – especially if they had previously received support through the Work Programme. Since the programme is voluntary, Work Coaches are not able to mandate individuals to attend if they do not want to. The Work Coaches we interviewed said that they did not state that the programme was voluntary unless they were directly asked this, because they had found that if they did then this could lead to some claimants losing interest. Similarly, follow-up interviews with participants suggested that in some cases individuals were not clear about whether their attendance was mandatory or voluntary. Again, this will be an issue explored in more depth in the participant survey and reported in the summer.

Work Coaches suggested that they identified and referred in particular those who said that they were willing to work but were unable to do so because of ill health. They reported that they particularly valued the fact that the programme is open to all, including those who do not have a diagnosed condition, and that it works well for people with all physical and mental health conditions.

Referrals from outside of JCP appeared to be very uncommon. Borough leads suggested that this reflected the restrictions of the RCT design, the requirement for all referrals to be routed via JCP and/ or simply confusion as to whether referrals from other organisations were permitted. Moving forwards, boroughs were working on developing other referral routes and some were planning on investing in this aspect of the service and planning to use the extra money from CLF to fund their outreach work.

> *There have been a few referrals from external organisations but not many, despite promoting the offer across their networks, e.g. the social prescribing team. We hope to raise the profile of CLW in the coming months. CLF is releasing funds for outreach work in each borough and in this borough, it will be used to fund our outreach worker.*
>
> Borough Lead

Finally, the use of information sessions, run by providers at JCP offices, appeared to have been effective in keeping staff updated about the programme and encouraging them to refer to the programme.

> *We received a lot of information about CLW around the time it started, and this has continued. We get regular emails about it, speakers from the provider came to here; we've had about four provider speakers so far this year reminding us of the programme – who it's for and what they do.*
>
> JCP staff

Key strengths and areas for improvement

Key strengths

- As set out in Chapters 3 and 4, participants have often complex needs, and adviser support appears to be being personalised well to meet these – delivering support that addresses both health and employment, as well as wider support needs
- Referral processes appear to have improved, underpinned by good communications and sharing of information locally
- Referrals appear to work best where there is regular communication, 'warm handovers' to reduce risks of drop-out, and where possible the co-location of services and use of three-way meetings

Areas for improvement

- As Chapters 3 and 4 set out, in some cases participants had levels of labour market disadvantage that required more intensive or specialist support than the programme appeared to be able to provide
- Communications and joint working with Jobcentre Plus could be improved in some Boroughs, and made more consistent across the programme so as to reflect what is working well elsewhere
- The centralisation of the referral process has inhibited other services and partners from referring on to CLW, which in turn likely affects their appetite to work together more broadly
- Referral timescales still appear to be longer than would be ideal, although this appears to mainly be a consequence of the randomisation process

5.2 The effectiveness of integration

Following on from the above, co-location with Jobcentre Plus also supported on-going engagement with participants – both by the Work Coach and the CLW adviser. From the Work Coach perspective, it meant that they could catch-up with participants more easily and ask their customers about their progress when they see them. This is often a virtuous

circle, as participants generally give good feedback which encourages Work Coaches to make more referrals.

At a wider Borough level, the extent of service integration and alignment varied widely both at the time of scoping interviews and immersive visits. This reflected the differences in services across Boroughs, but also different levels of engagement. In some cases, provider staff are able to co-locate in Council buildings, and it was reported that this offered the scope to build a more personalised and integrated offer.

> *Case workers are co-located in council offices and they offer general 1:1 support here including advice and job searches plus health support which takes place at [the providers] premises. The offer is unique in terms of what else is available in the area because of the holistic nature of the support and in all of this, the relationship between participant and caseworker is key.*
>
> Borough lead

Borough leads also felt that providers were well set-up for sign-posting to other services in the local community.

> *Referring to specialist partners and services in the borough is a key part of [the providers] support – they have good links to IAPT, referrals to exercise sessions, Adult and Community Learning, CAB, the local law centre amongst others.*
>
> Borough lead

However during the immersive visits, it appeared that the large majority of services and support received by participants were being delivered by the prime provider, their supply chain offices and the health care professionals employed as part of the programme. There was only limited evidence of direct referral to other services. While referrals to NHS services were mentioned, this was generally in the context that these can take many months to lead to an appointment. As a consequence, advisers and programme health care professionals tended to rely on in-house provision.

Key strengths and areas for improvement

Key strengths

- There appear to be good examples of co-location with Council services, although these vary across the twelve Boroughs
- CLW advisers were generally able to signpost individuals to relevant local services to meet wider needs, including money advice, wellbeing, exercise and social inclusion

Areas for improvement

- Meaningful integration with mainstream health services appears to still be patchy – meaning that there appears to be an absence of access to more specialist and intensive health support

- Immersive visits found little evidence of extensive integration and co-ordination of wider employment, skills and social services – although this may come out more strongly in subsequent rounds of research

5.3 The effectiveness of health support

The findings on the delivery and effectiveness of within-programme health support were generally very positive. As Chapters 3 and 4 set out, we observed good engagement with health group sessions and positive feedback on the support received. The facilitators of health workshops felt that the sessions have had a positive impact on individuals' confidence and wider wellbeing, and as a consequence they would be more effective in their job search and self-management.

Similarly, interviews with health workers suggested that one-to-one sessions led to improvements in participant confidence, engagement, understanding of their condition and themselves, and self-management. This meant that individuals could become more active and independent in managing their health, and in turn better engage with other elements of the programme. These findings will be tested and explored in more detail in the second evaluation report, which will include quantitative findings on participants' experiences of health support and on their self-efficacy and wellbeing.

The holistic approach to wellbeing was also mentioned by JCP staff as being particularly important elements of CLW support. One Work Coach said they have seen individuals with low confidence "totally transformed", and that they no longer see health as a major barrier to employment. Work Coaches have also noticed that the more people engage with the health programme, the less they brought up health issues in meetings at the JCP office. Another aspect of the health offer highlighted by Work Coaches was the support from in-house mental health specialists – which was particularly valued given the long lead-in times for accessing this support through the NHS.

Borough leads were also positive about the difference the health provision was making to their residents.

A number of people have been taking part in the health offer. We don't have any data on the outcomes from this yet, but anecdotal feedback suggests that people like the support and find it useful.

Borough lead

The health provision is very welcome as it's really different from other offers. It includes group work and 1:1 support such as physiotherapy, occupational therapy, counselling etc. There seems to be a good range of support available, and they are also linking in with other services.

Borough lead

Key strengths and areas for improvement

Key strengths

- In-house health support appeared to be high quality, specialised and effectively meeting gaps in available provision
- In-house support was reported to be contributing to improvements in confidence, self-management and participants' ability to prepare for work

Areas for improvement

- There appeared to be very little ability to join up with mainstream (NHS) health support

6 Conclusions and recommendations

Chapters 3 to 5 set out a range of positive findings from the first eighteen months of Central London Works. In particular, the evaluation found that the delivery of one-to-one support through the programme was of a high quality; that advisers delivered personalised and flexible support, that was positive and focused on employment and health; that in-house health provision was of a high quality; and that participants were able to access wider support to meet their employment, health and wider needs. Relationships with Jobcentre Plus had improved over the year, and in many places had let to improvements in referrals and the engagement of participants.

A number of areas for improvement were also identified, often related to meeting the needs of those with more significant levels of disadvantage; access to appropriate and more specialist provision; and the resourcing of provision (including the availability of space to deliver services). We would suggest that there are four key areas where recommendations for improvement could be made.

6.1 The participant journey through support

While the flexibility and personalisation of support was identified as a key strength in the fieldwork, there were a number of aspects of the participant journey through the programme where there appeared to be scope for specific improvements. We would recommend that:

1. The initial process from referral to attachment is reviewed, so as to apply the learning from areas where this was working most effectively. In particular, there appears to be scope to share good practice on co-locating with Jobcentre Plus, warm handovers, and rapid engagement with the service. (The accompanying on report on quantitative findings also identifies issues around the length of time between referral and programme attachment.)
2. The structure and delivery of the initial diagnostic interview is reviewed. This stage was often delivered in an open plan environment with participants asked for a lot of personal and sensitive information, and participants often appeared to be disengaged. It was not clear of the extent to which this information was all necessary for programme management or monitoring, or that it all needed to be asked for in the first meeting. This may in turn be contributing to the relatively high drop-out rates on the programme. There would be value in reviewing this model, so that the initial intervention can focus to a greater extent on goal setting and action planning, with (more of) the personal and sensitive information collected at later stages (where it is necessary to do so).
3. Ingeus explore further whether there is a clear enough organising model for the stages of support delivery, that this is understood by advisers, and that this is adaptable to the needs of different groups. While support was very flexible and personalised, it was not always clear that interventions were part of a clearly structured and goal-directed action

plan, or that there was a clear operating model being applied (or different models for those with different needs). This is reiterated by the quantitative research in the accompanying report, which found that just half of participants reported having an action plan and clear goals.

6.2 Meeting additional needs

Participants had a range of support needs, and this report has identified that the in-house employment and health support was of a high quality and generally effective in meeting these. However, in some cases the complexity of participants' needs made it hard for advisers to provide meaningful support or refer them on to appropriate provision, while in other cases there were relatively less complex barriers that nonetheless made it difficult to deliver effective support. We would make three specific recommendations, that:

1. Ingeus review the support offer and participant journey for those with more complex health and/ or employment needs, with a view to providing more specialist and tailored support. This could mean for example having a clearer segmentation of participants so that those with greater levels of need can be supported by more experienced or specialist advisers with smaller caseloads; and/ or identifying specialist referral partners who could delivery third-party support.
2. The content, composition and delivery of group sessions is reviewed, to ensure that these are useful for all participants. Participants in group sessions often had diverse needs, and so again there would be value in exploring whether participation in sessions could be better segmented so as to ensure that all participants can benefit. If this is not possible, then an alternative approach could be to have additional facilitation or support within group sessions.
3. Ingeus look to improve access for those who do not speak English as a first language. In areas with significant numbers of first-generation migrants from specific countries or regions, then this is often most effectively achieved in employment and social services by recruiting staff from those communities. Where this is not possible, then access to translation services should be available where it is needed.

6.3 Programme resources

A recurring theme in the evaluation has been the availability of physical space for service delivery. However there were also other signs that programme resourcing was stretched at times. We make two specific recommendations, that:

1. Ingeus and boroughs try to identify and secure additional premises for the delivery of private or group-based work. The lack of availability of appropriate space for this appeared to be a significant impediment to participation and to engagement with the programme. This included both rooms for one-to-one sessions where privacy was needed, but also to having group sessions in appropriate and well equipped facilities. Clearly, this will need to be reviewed when social distancing restrictions from the Covid-19 pandemic are removed.
2. Ingeus ensure that advisers have sufficient time to prepare for meetings or sessions. This again applied both to group work – where some sessions observed were rushed

or focused too much on delivery of information; and on occasion to one-to-one meetings where advisers may not have had time to prepare or did not have sufficient background on previous discussions. These issues are not unusual in service delivery, but nonetheless there would be value in looking to address them.

6.4 Partnership working

Finally, there appeared to be scope to improve the extent and breadth of partnership working within boroughs and with wider non-statutory services. This was most notable in the relative dearth of specialist provision for onward referral of those with complex needs, where it was not clear whether this was due to its non-availability or it not being aligned with Central London Works.

We would recommend therefore that Central London Forward, the boroughs and Ingeus look to identify key gaps in provision, based on the data and experience of delivering Central London Works so far; map the availability of provision that could meet these identified needs; and work to bring together the right partners within and across boroughs who could help to deliver this support.