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## **A review of health-related support provision within the UK Work**

### **Programme: what's on the menu?**

Jenny Ceolta- Smith, Sarah Salway and Angela Mary Tod

#### **Abstract**

In common with other European welfare states, a large proportion of those who are out of work and claiming welfare benefits in the UK have long-term health conditions. The need to reduce the number of people who are claiming sickness related unemployment benefits by supporting them into paid work has been highlighted as a priority across the political spectrum since the late 1990's. However, recent years have seen a significant shift in UK welfare-to-work policy, with the introduction of the Work Programme in 2011. This unified programme diverges from earlier approaches in several important respects. The shift includes a move towards so-called 'black box' commissioning through which contracted organizations are given far greater freedom to design and deliver their interventions. Therefore, important questions arise regarding whether and how support for claimants with health conditions will be provided across Work Programme areas and the implications for claimant outcomes. This article begins to address these questions by reviewing

Prime Work Programme providers' (Primes) proposed interventional approaches as set out in their bids. Using a structured, interpretive analytical framework, bid documents prepared by the 18 Primes were reviewed and synthesized. The findings showed that individuals facing similar health-related obstacles to employment can expect to receive very different levels and types of support depending on which Primes' programme they are assigned to join. This review suggests that policy needs to ensure that claimants' health-related barriers to employment are addressed. Research to explore how claimants' health-related needs are being met in practice is also recommended.

**Keywords:** Work Programme; welfare reform; condition management; sickness benefits; welfare-to-work; return to work.

## **Introduction**

In common with other European welfare states, reducing the number of working age welfare benefits claimants with health-related needs by supporting them into paid employment has been a prominent policy focus for UK government since the late 1990s (Department for Work and Pensions (DWP) 2002). Initially, in 1998 the then New Labour government introduced voluntary programmes to encourage Incapacity Benefit claimants to move into paid work via the New Deal for Disabled People (DWP 2002). This programme offered varied forms of support which were across the UK and later revised in 2001 (Stafford 2012). These interventions were delivered

by organizations (private, public and voluntary) termed Job Brokers, who had been awarded contracts by Jobcentre Plus (a government agency that delivers back to work services for working age people in receipt of benefits) (Stafford 2012). However, these initiatives did not achieve the government's target reduction in the number of Incapacity Benefit claimants (DWP 2002).

## **Pathways to Work**

In 2003, Pathways to Work (PtW) was introduced; a relatively structured programme aimed at those claiming sickness benefits which included an explicit focus on addressing health-related barriers to employment. The first seven pilot PtW programmes were led by Jobcentre Plus. By April 2008, PtW programmes were available across the UK with 60 percent being delivered by private and voluntary sector organizations that were contracted by DWP. The PtW policy prescribed the Personal Adviser role - a front line worker who conducted a series of mandatory one-to-one Work Focused Interviews with claimants - and included provision of a health-focused intervention, referred to as the Condition Management Programme (CMP). The CMP was part of the 'Choices' menu that offered a range of voluntary support elements (Lindsay and Dutton 2012).

## **The Pathways to Work Condition Management Programme**

The CMP was developed by a Joint DWP-Department of Health Ministerial Group and was designed for claimants with non-severe mental health, cardiovascular and musculoskeletal conditions (Randall 2012). A range of interventions commonly based on cognitive behavioural approaches were generally provided by healthcare professionals (Lindsay and Dutton 2010). These interventions aimed to help participants manage their health conditions in order to progress into work (Lindsay and Dutton 2012). The CMP was delivered either by National Health Service (NHS) organizations, working in partnership with Jobcentre Plus or by private contractors who had been awarded DWP contracts (Lindsay and Dutton 2012). Funding for the NHS-led CMPs was provided by DWP and was not linked to any targets for claimant course completions or movement into work (Lindsay and Dutton 2010).

Following the expansion of the PtW programme, the responsibility for the design and delivery of CMPs moved away from the NHS. This move encouraged further heterogeneity of CMPs under DWP's 'black box' commissioning approach which allowed contracted providers to deliver PtW and fund a CMP within this. Many of these non-NHS led CMP interventions could be selected at the discretion of the provider. However, there was a requirement to consider the three groups of health conditions described above, local Incapacity Benefit claimant population needs, gaps in existing provision and adhere to NHS clinical governance standards (Jobcentre Plus 2006).

There have been mixed reports concerning the original aims and contribution of CMP, particularly regarding job outcomes (see Lindsay and Dutton 2013; Beatty *et al.* 2013). The DWPs' commissioned PtW evaluations and other empirical research have highlighted a number of benefits and drawbacks of CMP (Lindsay and Dutton 2013). Overall, the CMPs were found to support improvements in participants' self-

reported health (see Kellet *et al.* 2011). Additionally, two key CMP benefits that related to Personal Advisers' practice were: i) being assisted by CMP practitioners to help claimants who had complex health issues (Barnes and Hudson 2006; Nice and Davidson 2010), and (ii) improved interactions with claimants during Work Focused Interviews (Dickens *et al.* 2004). However, CMP was found to be limited in a number of ways, for instance, in not fully supporting some claimants with physical health conditions nor in offering longer term support (Lindsay and Dutton 2013). Some of the identified gaps in the PtW CMPs delivery appear to have been considered by the then Labour government as shown in their final reform paper: '*Building bridges to work: new approaches to tackling long-term worklessness*' (DWP 2010a). This paper set out proposals to develop a new expanded health-related support provision which would be accessible on a voluntary basis to a wider group of claimants including those who received Jobseeker's Allowance (a government benefit for working age people who are actively seeking work) (DWP 2010a). However, this proposed health-related support did not materialize following the change in government in 2010, being supplanted by proposals for the Work Programme, as described in the next section.

## **The Work Programme**

Pathways to Work ended shortly before the Work Programme was launched by the current Coalition government in June 2011. This new single programme replaced most of the existing provision implemented under the Labour government, and aims to meet the needs of nine claimant groups who are either longer term unemployed or

at risk of becoming so (DWP 2011a). The DWP (2011b) maintain that the Work Programme is designed to ' *avoid many of the failings of previous employment programmes which were inflexible, short term, too expensive, and failed to support the hardest to reach customers*' (: 140).

The Work Programme is split into 18 Contract Package Areas across the UK. Following a two-stage tendering process, the DWP awarded 40 contracts to 18 so-called 'Prime' provider organizations in April 2011 (subsequently referred to here as "Primes") (National Audit Office 2012) . The majority of these contracts were awarded to private organizations, bids having been assessed in relation to price and quality. Quality factors included: '*service delivery, resources, stakeholder engagement, and implementation*' (House of Commons Work and Pensions Committee 2011a: 18). Each Contract Package Area has at least two, but sometimes three, Primes. Primes hold the contracts with DWP, but may deliver their interventions directly and/or via one or more sub-contracted organizations. Contracts were awarded for five years until March 2016, with an additional two years to complete delivery by 2018 (DWP 2011a).

The Work Programme marks a departure from PtW in several important respects. In particular, there has been a further shift towards so-called 'black box' commissioning through which contracted organizations are given far greater freedom to design and deliver their interventional approach (Rees *et al.* 2014). Furthermore, commentators have noted that ill-health has considerably less prominence in the Work Programme than in PtW. This raises concerns regarding the extent to which health-related obstacles to employment are adequately highlighted in current policy (Lindsay and Dutton 2013; Beatty *et al.* 2013; Warren *et al.* 2011). The importance of addressing claimants' health-related barriers to employment alongside other employability

factors has also been demonstrated in evaluations of PtW and other research (Davidson and Kemp 2010; Beatty and Fothergill 2011; Black and Frost 2011; Lindsay and Dutton 2012). Given there is a lack of prescription within current contracts, important questions arise regarding whether and how support for claimants with health conditions will be provided across Work Programme areas and the implications for claimant outcomes.

This paper begins to address these questions by examining how the Work Programme policy objectives have been responded to by Primes. This is achieved via an exploration of whether and how health-related support was described in the successful bid documents submitted to DWP through the competitive tendering process for government contracts.

## **Methods**

This paper draws on findings from a multi-method study that was guided by the Canadian National Collaborating Centre for Healthy Public Policy (NCCHPP) method for synthesizing knowledge about public policies (Morestin et al. 2010). The study employed an interpretive documentary analysis alongside other methods. It is the findings of this documentary analysis that are reported on here.

Documents are written records that are considered to be sources of information that, if obtainable, can be subjected to a quality appraisal and selected as evidence for analysis (Scott 1990). Prior (2008) presents a useful typology for analysing documents that explains how documents can be studied in relation to their content or



use and function. As such documents can be considered as both topics (e.g. in terms of content- by focusing on how a document came '*into being*') and resources (e.g. in terms of use and function- by focusing on how a document is used by various actors) (Prior 2008: 825). Varied methodological approaches, quantitative and qualitative, and a range of methods can be adopted when conducting documentary analysis (Shaw *et al.* 2004). For example, a researcher may use a quantitative positivist methodology and method such as content analysis. Alternatively a qualitative interpretative approach can be used that incorporates policy discourse and identifies themes, and is adopted in this study. The NCCHPP's analysis framework, as discussed below, was selected because it offered a flexible but systematic analytical approach. This method also permitted the selected documents to be viewed as both topics and resources. Therefore, there were opportunities to not only explore how the Work Programme delivery models had evolved, but how policy and other evidence sources were used by actors (i.e. Primes) to formulate these.

### *Documentary sources*

In order to understand in more detail the Work Programme policy and its underlying theory and assumptions, the first stage of our documentary analysis involved the location and exploration of key policy papers, ministerial statements and supporting documents such as the tender specification and supporting information. These documents were found through web based searches which included the DWP and

related government websites, such as the House of Commons Work and Pensions Committee.

Next we identified and accessed documents that could provide insight into how the national-level Work Programme policy was responded to by the Primes delivering interventions on the ground. The bid documents that were prepared and submitted to DWP within this competitive tendering process, titled: '*Employment related support services framework agreement mini competitions for the provision of the Work Programme*', form the primary data for the present study (DWP 2010c). These documents were retrieved from the Government's Contracts Finder website. These included all of the 18 Primes, some of which operate in more than one area. These documents described the Primes' delivery models, customer journeys and minimum service levels. Minimum service levels are set by each Prime. Websites were also searched for all of the Primes, and where available, their sub-contractor organizations to identify any supporting information that could give further insight into the planned delivery, such as job descriptions for Personal Advisers and healthcare professionals employed by these organizations.

### *Review and synthesis approach*

Documentary analysis has been used widely within health and social policy research and is often utilized at the early stages of policy innovation when there is little by way of other evidence to analyse. The NCCHPP's analysis framework advocates the reviewing of documents as an essential component of any policy analysis. It also highlights the importance of unearthing the underlying logic of the policy, its

presumed intervention stages and associated assumptions. This process provides insights into the plausibility of the policy and highlights any areas that deserve scrutiny (Morestin *et al.* 2010). Thus, while recognising that public documents - including the Work Programme policy papers and the Primes' bid documents examined here - can only ever present a '*partial or superficial account*' (Shaw *et al.* 2004: 260), we nevertheless consider them to provide important insight into national policy and how it is being translated into organizational policy and operational plans. Following Shaw *et al.*'s lead (2004), we sought to go beyond the overt and explicit statements in the documents, to uncover both the rhetoric of the policy environment and indications of underpinning ideologies that shape the policy-into-practice process.

At the practical level, we followed the NCCHPP's recommendation by first reading and re-reading the retrieved documents several times prior to data extraction. An inclusive approach was taken when the documents were explored for any kind of reference to health. This included a wide variety of health conditions and other health-related issues such as drug addictions. Structured extraction templates were then developed on the basis of the emerging themes. Sections of text that concerned the identified dimensions were manually highlighted, coded, cut and pasted into the relevant sections in the extraction forms by the first author. It was necessary to reread the bid documents and extract further data as new questions emerged and preliminary analyses were challenged via a process of team reflection and validation. This process aimed to reduce researcher bias. Reading across the extraction templates, allowed both the explicit elements of the bid documents to be compared and contrasted and the more implicit elements to be flagged using

interpretive codes, before these were synthesized to produce the final findings as presented below.

## **Findings**

### **The Work Programme theory and assumptions**

Our analysis of the policy papers, ministerial statements and related documents allowed us to identify the key features of the Work Programme and its underlying assumptions that have a particular bearing on our focus of interest, namely whether and how the health-related needs of claimants will be met within this emergent provision. Overall, in common with other commentators (Lindsay and Dutton 2013; Beatty *et al.* 2013; Warren *et al.* 2011), we found that ill-health was not a prominent theme within the Work Programme policy material (see DWP 2011a). There tended to be a lack of detail in relation to health within the documents. For instance, while the policy documents stated that claimants who experience '*serious*' effects from their health condition will not be expected to engage in work-related activities or work (see the Work Programme specification, DWP 2010b: 37), there was no detail on what might constitute a 'serious' effect and no health conditions were specifically defined. Furthermore, the overall message within the policy papers and ministerial discourse was that ill-health does not represent a major barrier to employment for most people and that simple interventions can support claimants with 'common health conditions' (again, not defined) into work. For instance, Lord Freud (2011) was found to frequently cite Waddell and Burton's (2004) evidence stating that their findings showed: *'more than 90 per cent of people with common health problems*

*can be helped back to work by simple healthcare and workplace management measures'* (Freud 2011).

There was also a tendency to locate the cause of health-related unemployment with individuals' inability to manage their condition and thereby to ignore the role a hostile labour market can play in making securing and sustaining employment difficult for those with long-term health problems. Other considerations, such as the fact that poor quality work can exacerbate some health conditions, (Benach and Muntaner 2007), were also absent from the Work Programme documentation. A further key feature of the Work Programme that contrasts with its predecessor, PtW, has been its lack of prescription, for example, no health-related support provision such as CMP. Primes were given the freedom to design and deliver provision as they saw fit in order to meet claimants' needs. This approach is referred to as the 'black box' approach to commissioning (DWP 2011a). In relation to supporting claimants' health-related needs, DWP tender documents stated that bidders should describe their intentions to tailor support and the customer journey to meet the needs of any *'disabled customers or those with health conditions'* (DWP 2010b: 38). Primes were expected to determine the type of health-related support and intervention that could help claimants with health conditions move into and sustain work, as illustrated here: *'Providers will have considerable freedom to determine what activities each customer will undertake in order to help them into, and to sustain, employment. Specialist delivery partners from the public, private and voluntary sectors are best placed to identify the best ways of getting people back to work, and will be allowed the freedom to do so without detailed prescription from central government'* (DWP 2010b: 6).

This excerpt also conveys a further Work Programme principle closely linked to non-prescription, namely 'personalisation'. Work Programme policy documents conveyed the expectation for Primes to tailor the support provided to the needs and circumstances of individual claimants, including those with health-related barriers to employment: *'The new Work Programme will be an improvement on the current offer. It will deliver long-lasting tailored support. We are taking the first steps towards developing a package of support that includes a simplified benefits system that works alongside personalised back to work provision to support people into sustained employment'* (Grayling 2010).

In common with PtW, the Work Programme policy retained a core focus on the Personal Adviser role. There has also been the expectation that this individual will be central to assessing individual needs and ensuring an appropriately tailored package of support and required work-related activity (upon which benefits payments are conditional) for each claimant including those with long-term ill-health. *'The role of personal advisers in provider organisations will be crucial in the effective delivery of the Work Programme'* (House of Commons Work and Pensions Committee 2011b: 13). Furthermore, the differential payments made available for each of the nine claimant groups has been expected to discourage Primes from focusing on those claimants who are easier to get into work and neglecting the 'harder-to-help', so-called 'creaming and parking' (Rees *et al.* 2014). Policy documents have also suggested that this payment model will prompt innovative practice, including in-work support, to meet the needs of those experiencing health-related difficulties, as the following quote indicates:

*'What we will find, as the Work Programme progresses, is that providers will not only support claimants into employment but, in order to secure the larger*

*fees, will continue to deliver support for some time after people start work. (...). I believe this will lead to providers developing new ways to support people with health conditions at work' (Freud 2011).*

The Work Programme policy documents also anticipated that a non-prescriptive approach would encourage Primes to draw in appropriate skills and support from other agencies and organizations in their local areas. *'This approach [the Black Box] encourages Work Programme providers to form partnerships with other organisations such as local authorities, health service providers and colleges that have an interest in helping people to move into work and to stay in work'* (DWP 2011a: 9). It is important to note that, in contrast to PtW, the Work Programme policy was generated by DWP without any formal involvement of the Department of Health and without a clearly defined role for the NHS. Therefore, any partnerships between the NHS and Primes and their sub-contractors would need to be established on a case-by-case basis.

The discussion above highlights some core assumptions of the Work Programme revealed by our analysis of the policy documents, including that:

- Primes, their sub-contractors, and particularly Personal Advisers, will have the skills and expertise to assess claimants' health-related needs and provide an appropriately tailored offer of support to each claimant.
- Primes will have the expertise to determine which health-focused interventions are effective and cost-effective at helping claimants move into and sustain work and will innovate in this area.

- Primes will be able to establish partnerships with the NHS and other agencies to secure the health-related interventions that their claimants need.

Underpinning these assumptions was an ideological position that sees large numbers of people being in receipt of sickness-related benefits as a highly undesirable situation and an avoidable drain on the public purse. Furthermore, free market competition is viewed as the best way to establish effective solutions to this problem. The Work Programme policy documentation was found to be further suffused in a rhetoric that constructs ill health-related unemployment as relatively easy to address.

### **Work Programme provision: Supporting claimants' health-related needs**

The analysis above suggests some key areas that deserve scrutiny within the Primes' responsive bids, including:

- the extent to which the need to address claimants' health-related barriers is recognized and prioritized;
- how claimants' health-related needs will be assessed and appropriate responses identified;
- the role of Personal Advisers and their preparedness in relation to addressing health issues;
- the health condition management interventions to be made available to claimants with health conditions; and
- how functioning partnerships with NHS organizations will be established.



More generally, questions are raised in relation to the degree of variability and potential inequity in provision across Contract Package Areas, particularly since claimants are unable to choose their Prime.

### *Prominence of health*

All of the 18 Primes included some reference to claimants' health-related needs, with most making reference to local health profiles at some point. However, we found varied prominence and a lack of common detail. Scrutiny of the Primes' minimum service levels provides a useful indication of the prominence given to claimants' health. Only five of these made explicit reference to addressing claimants' health-related needs, as shown in table 1. The lack of reference to addressing health within the majority of these summaries raises queries regarding which claimants might receive an offer of health-related support in practice, or be in a position to request such support. Since minimum service levels form part of the basis upon which DWP monitors performance against contracts (House of Commons Work and Pensions Committee 2011a), it seems likely that most Primes will not routinely be assessed on the adequacy of their provision of health-related support.

### *Assessment and claimants' Work Programme journey*

Assessment of claimants' health conditions is important because it can help to identify their health-related barriers to employment. Variability in the way in which

Primes proposed to use claimant assessments was evident. Assessments described included: initial, on-going, pre-work and in-work and some of these were specifically health-related, as shown in table 2. All of the described Work Programme journeys differed, but there were similar claimant stages and processes regardless of benefit type. A generalized Work Programme journey is presented in figure 1 to illustrate typical programme stages which ranged from three (e.g. Serco 2011) to six (e.g. Maximus 2011). The minimum frequency of claimants' appointments was defined in the Primes' minimum service levels, and was found to range from every two weeks (e.g. Seetec 2011) to once a month (e.g. A4e 2011). Health-related intervention might be offered at any stage in these journeys, as shown by the asterisks in figure 1, and there was no consistency across Primes in this regard. In keeping with the principle of personalisation, several bids emphasized that the frequency of contact and speed of movement through the claimant journey would depend upon individual need and progress.

### *Personal Advisers*

All of the Primes outlined a Personal Adviser role which was typically described as central to supporting claimants' progress into, and sustainment in, work. The extent to which a Personal Adviser was indicated to stay with a claimant across the whole journey varied. Fourteen Primes showed a preference for continuity, aiming to ensure that claimants would have a "dedicated" Personal Adviser, and in some cases terming this "case management" (e.g. CDG 2011). In contrast, a split model, which was adopted by Serco, intentionally aims to ensure that claimants change

Personal Advisers during their Work Programme journey, arguing that this ‘*challenges comfort zones*’ and provides ‘*extra impetus*’ (Serco 2011: 17).

A range of Personal Adviser role titles were identified and although there were similarities across the bid documents, this role was not found to be standardized. Five out of 18 Primes included some mention of specialist Personal Advisers with health-related roles. However, there was a good deal of variation in the type of specialist skills mentioned, for instance ‘mental health awareness versus ‘cognitive behavioural therapy’. A variety of other specialist roles were also identified in the documents, but it was difficult to clarify the exact nature of their expertise and whether or not they would have a health focus. Some Primes such as EOS and Working Links, indicated that they would provide health-related training to all Personal Advisers, others to only some. However, the extent to which such training will prepare and equip Personal Advisers to support claimants’ health-related barriers is difficult to assess.

### *Health-focused Interventions*

#### Healthcare professional roles

Only four out of the 18 Primes documented in-house healthcare professional roles as part of their delivery model (A4e 2011; EOS 2011; Ingeus 2011; Maximus 2011). Despite different titles - Health Advisor, Health Consultant, Occupational Health Coach and Work Health Expert - further examination of these roles suggested that

they all are intended to have a similar combined health and work focus. Three of these roles also have a requirement to support Personal Advisers: A4e, Ingeus and Maximus. Clarifying whether Primes' health-related interventions would be delivered by healthcare professionals, or someone else, was not always possible. For example, Prospects (2011) stated that they will provide '*well being groups*' but it was not clear who would deliver these (: 11). Investigations of sub-contractor/partner websites helped in some cases to identify the healthcare professional roles that might be involved as shown in table 2.

### Condition Management

All of the Primes referred to some kind of health-management interventional support, but these suggested variability across Primes in terms of which claimants would be eligible for receipt of these interventions. It was unclear how such eligibility criteria would be defined or operationalized in practice, but bids suggest some kind of prioritisation or rationing of the interventions. Fifteen out of the 18 bids used the term 'condition management' to refer to health-related interventional support, but there appeared to be significant variation in terms of the content of the interventions on offer. Interventional approaches included: cognitive behavioural therapy, solution focused therapy, counselling and motivational interviewing techniques. What might be perceived as more clinical interventions, ("hands on") such as physiotherapy were also mentioned in a minority of the bids. Health management interventions included: advice and guidance (such as pain management techniques), promotion of healthy lifestyles and encouragement of activities such as walking and healthy diets (e.g.

Ingeus 2011). More complementary health-related interventions such as yoga and Tai Chi were also proposed by one Prime (EOS 2011). Importantly, some bids included mention of interventions involving employers to explore workplace adjustments and proposed provision of ongoing condition management support post-employment (e.g. A4e 2011). These varied interventions were planned to be carried out through group work and /or 1:1, via face-to-face in a range of venues and locations, or via telephone support services.

Arrangements for provision of these health-management interventions varied amongst Primes, with some proposing to make use of existing statutory health-related provision for example A4e (2011), while others intended to provide them in-house. All of the 18 Primes proposed the use of a range of specialist providers, and many of these are indicated to be used in an ad hoc fashion as-and-when claimants' needs arise.

### NHS partnerships

The DWP encouraged Primes to demonstrate in their bids an awareness of local provision to avoid duplicating services and develop effective partnerships (DWP 2010a), including with local health services. Table 3 provides an overview of the Primes' statements about their proposed NHS partnerships and engagement. As shown, half of the Primes indicated they had an established connection with the NHS, which had been developed through an existing programme or their supply chain. For example, Serco highlighted that one of their sub-contractors (Yes2Ventures) has links with GPs: '*South Yorkshire Condition Management*

*(Yes2Ventures) works with 104 GP practices across Sheffield'* (Serco 2011: 20). However, table 3 also shows that it was more common for Primes to have stated an intention to consult with NHS stakeholders when designing their programme, rather than to have already developed specific plans for co-location or commissioning of services at the bidding stage.

## **Discussion**

The review sought to generate insight into the Work Programme national policy and how it is being operationalized by Primes via an interpretive documentary review. It is important to recognize that any documentary review can only provide a partial picture of public policy and its translation into practice. It was evident that many details were lacking within the Primes' bid documents and therefore that elements of health-related provision may have been overlooked or misunderstood in this review. On the other hand, recent research has revealed that some elements mentioned in the bids have not been forthcoming in practice (Lane *et al.* 2013). Notwithstanding these limitations, the review does provide valuable information about what DWP considered to be acceptable in terms of proposed health-related support. It also serves to identify a number of potential risks and opportunities that deserve attention as the programme is rolled out and evaluative research is undertaken.

It is important to highlight first a number of general issues that relate to the overall design of the Work Programme and the implications for the health-related support that is offered to claimants across the country. Overall the bid documents

acknowledged that claimants' health-related issues can become barriers to employment, suggesting that this dimension was considered within their broad delivery model. However, the allocation of DWP contracts to a large number of Primes with minimal prescription has resulted in very varied delivery models and content across Contract Package Areas. Further, since some Primes also operate as sub-contractors for other Primes in different Contract Package Areas, different service offers to claimants are provided even by the same provider organization. The result is a highly variable offer and the potential for significant inequity within the system. Individuals facing similar health-related obstacles to employment can expect to receive very different levels and types of support depending on which Primes' programme they are assigned to join. Further, the lack of prescription around minimum service levels means that very few of the Primes will be explicitly performance managed against health-related support. The extent to which this commissioning model will encourage innovation of more effective support models for claimants with health-related needs remains to be seen.

Primes appear to have responded to DWP's call to establish partnership arrangements and thereby draw on local resources and expertise to meet claimant needs. However, the resultant sub-contracting arrangements appear to be highly complex and it was not possible to clarify the exact details regarding health-management intervention delivery from the bid documents. This lack of clarity in successful bids suggests that there was limited scrutiny of the adequacy and feasibility of proposed arrangements on the part of DWP commissioners. Emerging evidence supports concerns that sub-contracting arrangements are highly variable and inconsistent with expected patterns in practice (see Lane *et al.* 2013; Newton et

*al.* 2012; Kerr 2013). This suggests the need for further investigation into the health-related support provision that is materialising on the ground.

In relation to more specific elements of the delivery models, a number of issues are worth highlighting. In common with earlier work (Coleman and Parry 2011), our analysis suggests significant variation in the form and use of claimant assessment procedures across Primes. This raises questions about the consistency with which individual health-related barriers will be recognized and responded to. In particular, many of the Primes intended to 'spot purchase' specialist health management input from sub-contractors for claimants deemed in need of such support. Typically, access to such provision was often at the discretion of Personal Advisers and highly dependent on the organizations' assessment processes, raising the potential for claimants' health-related needs to be inadequately identified, or missed. Given that some health conditions can be hidden, Personal Advisers' expertise in assessing claimants' health-related barriers to employment is likely to be essential.

Personal Advisers were central to the Work Programme delivery across all Primes, and there was an expectation that they would be able to support claimants with health conditions. However, there were inconsistencies in whether, and how, Primes would ensure their Personal Advisers were adequately skilled and trained to respond to claimants' health-related needs. This is of concern because only a minority of Primes made explicit reference to having in-house healthcare professionals to support Personal Advisers. Co-location of Personal Advisers and healthcare professionals has been shown to provide a number of advantages, enabling some Personal Advisers to become more knowledgeable about healthcare professionals'



practice (Lindsay and Dutton 2012) and claimants' health-related needs (Barnes and Hudson 2006). Therefore, questions are raised about how Personal Advisers are practicing if they have not received adequate health training, and no healthcare professional support is available.

In fact, only four of the 18 Primes actually proposed an in-house healthcare professional role and it is not yet known how many of these in-house roles are available in practice. There were unanswered questions about how some of the health-related provision, (in-house and external led) would be provided. The proposed limited involvement of healthcare professionals in the delivery models suggests that some Primes may opt to address claimants' health-related needs with nonclinical staff, a pattern that was also evident within some of the PtW CMPs (Nice and Davidson 2010). Although this approach was not necessarily considered to be ineffective, supervisory structures are important (Nice and Davidson 2010). It remains unclear whether these will be established within the Work Programme. This raises a set of questions relating to both risk to claimants and value for money, as cheaper models may not be as cost effective if outcomes are poor.

There were also variations in whether Primes stated they had worked, or intended to work in partnership with the NHS. Vague statements suggested underdeveloped relationships in some Contract Package Areas. For instance, while some bids were clear about their intentions to support claimants to access NHS provision, there was minimal awareness that demand for these services might exceed supply. Additionally, it was uncommon for Primes to state that they would consider paying for additional services that might be needed. As there are a large number of Work Programme providers operating within each geographical area, (i.e. Primes and sub-contractors) navigation is likely to be time consuming. Therefore, exploration of how

care for claimants can be integrated at a system level, including referral pathways and payment mechanisms is clearly needed.

The bid review identified that all Primes intended to offer health-management interventions to at least some of their claimants, often via sub-contracting arrangements. While it is not possible to comment on the effectiveness of the proposed interventions, the wide variety of descriptors raises questions regarding the quality, adequacy and equity of services provided to different claimants. Uncertainty also exists regarding eligibility criteria since several Primes employed additional eligibility descriptors such as 'severe' or 'serious' and these may be poorly defined and variably understood in practice. Whether support will be rationed for those deemed to be in most need or closer to starting work deserves future investigation. On the other hand, some Primes stated their intention to make health-related support available for all claimants and yet appear to have made minimal provision, raising concerns about demand-supply mismatch.

On a more positive note, there appears to be some promising innovation, for example the offer of bespoke CMP by one Prime (EOS 2011). This suggests that claimants will receive support for a range of health conditions rather than prioritising interventions for musculoskeletal, cardio respiratory and mild to moderate mental health, as was the earlier pattern in PtW. There also appeared to be further innovation with the inclusion of telephone support interventions which have been found to be both effective and cost effective (Burton et al. 2013). Telephone interventions may also reduce claimants' anxieties and concerns about sharing their problems in a group setting and the problems associated with having to travel to venues which were highlighted as potential barriers in the PtW CMP (Nice and Davidson 2010). Ongoing and longer-term support was another gap in the PtW

CMP and this was addressed in some bids through proposed in-work support interventions. Given the competitive nature of the Work Programme contracts, there may be a lack of willingness to share best practice amongst Primes which may limit service developments. However, there is scope for Primes to find out what interventions are working well in circumstances where they also operate as subcontractors in other areas. Therefore variations in Primes' offers may lessen over time.

## **Conclusion**

Through the adoption of the black box approach, Primes have been given considerable leeway in designing their delivery. The resultant high variability in health-related support mean that claimants with similar health conditions are likely to experience very differential levels of service. When reconsidering the three assumptions identified above, it appears likely that some Primes and Personal Advisers may not be equipped to assess and respond to claimants' health-related needs. This is important because the Personal Adviser role was central to much of the proposed Work Programme delivery, yet concerns have been raised regarding their preparedness and training in assessing and addressing claimants' health-related needs. Given there are known pressures in terms of some Personal Advisers having high caseload numbers and struggles in the financing of programmes, there is an increasing need to ensure that Work Programme assessment processes are effective (Newton *et al.* 2012; House of Commons and

Pensions Committee 2013). Integration with appropriate healthcare professionals and provision is therefore likely to be essential but is currently under-developed.

Some Primes have shown promise of designing innovative interventions, but it is not known if these will be effective and cost effective. Given there were variations in whether Primes stated they had worked, or intended to work in partnership with the NHS, claimants' access to health-related provision may be limited. Thus, the review's findings question whether the Work Programme policy is sufficiently health focused and whether the 'black box' commissioning approach can stimulate innovation of effective health-related approaches.

Importantly, while policy rhetoric has implied that claimants health problems are easy to address, the latest research evaluations and evidence reveal poor outcomes for many claimants who have health-related needs (House of Commons and Pensions Committee 2013; Newton *et al.* 2012; Kerr 2013). Thus, policy needs to ensure that claimants' health-related barriers are adequately addressed. Research to explore whether and how Primes are operating on the ground to address claimants' health-related needs in practice is now a priority.

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Table 1 Explicit reference to supporting claimants' health in Primes' summarized minimum service levels (5 out of 18 organizations)

Prime	Reference to health
A4e	Health support: we will assess health as a barrier to working. Those identified as needing additional assessment/support will be referred to a specialised health assessment and support to develop a health-focused back to work plan.
CDG (Since merged with Shaw Trust)	Stage Four: Pre-Employment Preparation 1. Customers with health problems or caring responsibilities are to be offered Work Programme support through a community hub or alternative convenient location, including home visits where required.
G4S	Every Customer will have access to the G4S Knowledge Bank. Many Customers will require expert additional intervention to overcome barriers to finding and sustaining employment. All Customers have access to specialist Knowledge Bank services. This includes a range of support including condition management, occupational health support, childcare services, career advice, mentoring, debt advice, housing advice and vocational training.
Maximus	Phase Three – Assessment All customers undertake an assessment with a dedicated EC [Employment Coach] or Health Officer.
Serco	Refer you to one of our specialist providers if you have particular needs, such as a health condition or physical disability, or want specific employment advice, such as how to start your own business.

NOTE: 13/18 Primes make no explicit reference to addressing claimants' health prior to starting work in their minimum service levels (Department for Work and Pensions 2011c: 1-14).

Table 2 Primes' bid statements (2011) in relation to claimant assessment process

Prime	Initial assessment process	Mentions health barriers	Initial assessment carried out by	Initial health assessments available through filtering process*	Health assessment carried out by
A4E	Initial call from Customer Support Centre to discuss needs. Dialogue-driven assessment.	✓	Personal Adviser.	Specialist health assessments which aim to identify capacity to work.	Healthcare professionals from Advanced Personnel Management.
AVANTA	Face-to-face dialogue driven. Use of on-line and paper based assessment tools and diagnostics.	X	Personal Adviser.	X	X
BEST (Now Interserve)	A range of diagnostic tests to inform the initial assessment. Use of Rickter Scale.	✓	Customer service consultant then Personal Adviser.	Occupational health assessments pre-work.	A physiotherapist and nurse.
CDG (Since merged with Shaw Trust)	Initial phone triage assessment. Self Assessment- a brief questionnaire. Work Focused Assessment via interview.	X	An adviser. Claimant. Personal Adviser.	X	X
ESG HOLDINGS	Diagnostic assessment tool. 2 part assessment: an online psychometric questionnaire and structured interview.	✓	Trained assessor. Personal Adviser.	X	X
EOS (Formerly Fourstar)	Market tested diagnostic. The Work Star and own diagnostics.	X	Personal Adviser.	In-depth assessment of work capability.	In-house Work Health Expert role.
G4S	Diagnostics.	✓	Personal Adviser.	Specific needs assessment tools such as Mental Health First Aid and Hidden Disabilities Diagnostics.	Subcontractor Advisors; Mind and Dyslexia Action.
INGEUS	Online self-diagnosis tool. Diagnostics.	X	Claimant with guidance from Personal Adviser.	Where relevant to assess workplace capabilities.	In-house healthcare professionals. (Health Advisors-physical and mental health)
JHP TRAINING	Bespoke screening tool and further in-depth assessment.	✓	Customer Service Administrator then Personal Adviser.	X	X
MAXIMUS	Initial screening with self assessment online where possible.	X	Claimant Personal Adviser.	Claimants with ' <i>serious health issues</i> ' limiting their ability to get a job (:14).	Mobile Health Consultant led via the

Table 2 Primes' bid statements (2011) in relation to claimant assessment process

Prime	Initial assessment process	Mentions health barriers	Initial assessment carried out by	Initial health assessments available through filtering process*	Health assessment carried out by
	1:1 with an Employment Consultant using web tool, or with a Health Consultant.				in-house health team.
NCG	Personalised, psychological and motivational intervention over 2 days. Followed by an employability assessment.	✓	Personal Adviser.	X	X
PERTEMPS	Employability Diagnostic and further diagnostic assessment.	X	Personal Adviser.	Enhanced assessments indicated such as mental health assessments.	Specialist partner organizations.
PROSPECTS	Initial assessment by phone then a face-to-face assessment.	✓	Personal Adviser.	X	X
REED	Diagnostics Tool and progression model.	X	Personal Adviser.	X	X
REHAB	Specialist assessments conducted in different situations including groups.	✓	Personal Adviser.	X	X
SEETEC	Face-to-face or telephone/online. Online self assessment questionnaires then solution focused interviewing.	✓	Personal Adviser.	X	X
SERCO	In-depth assessment process.	✓	Personal Adviser.	X	X
WORKING LINKS	Diagnostic assessment.	✓	Personal Adviser.	X	X

NOTE: ✓ indicates identified and X indicates not identified in bid document. \* Excludes statements relating to specialist assessments which could potentially include health.



Table 3 Summary of Primes' bid statements (2011) in relation to proposed NHS partnerships and engagement strategies

Prime	Existing relationship	Initial talks held	Continue engagement	Plans to:			Other statements
				Co- locate services	Align services	Co- commission	
A4E	✓	✓	✓	✓	✓		
AVANTA				✓			
BEST	✓		✓				
CDG	✓		✓				
EOS		✓					
ESG HOLDINGS		✓	✓				
G4S		✓	✓				
INGEUS				✓	✓	✓	
JHP TRAINING			✓				✓ 1
MAXIMUS	✓		✓				
NCG			✓				✓ 2
PERTEMPS	✓		✓				
PROSPECTS	✓				✓		
REED	✓	✓	✓				
REHAB							✓ 3
SEETEC	✓	✓	✓				
SERCO	✓				✓		
WORKING LINKS							✓ 4

NOTE: ✓ Relates to section 7.1 of the bid document.

Some Primes state more general plans to have on-going engagement with known stakeholders which may include the NHS.

✓ 1 To join with NHS services.

✓ 2 To provide in-house space for NHS trainers to deliver their services.

✓ 3 Nothing identified that was specific.

✓ 4 Will work with health/specialist provider organizations.

Figure 1 **Generalized Work Programme Journey** is provided as a separate attachment.