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The 2015 ESA Trials: A Synthesis

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Summary

This report summarises the evaluations of three trials that formed part of a package of support for Employment and Support Allowance (ESA) claimants launched in spring 2015, namely, Voluntary Early Intervention (VEI), Claimant Commitment (CC) and More Intensive Support (MIS).

VEI provided, on a voluntary basis, an average 6 hours Work Coach support in the period of time prior to the Work Capability Assessment. VEI comprised two variants as well as a 'core' model. One variant offered Occupational Health Advice (OHA) to the Work Coach to help improve the quality of their advice to claimants, and the other variant, the Back Pain Pilot (BPP), offered physiotherapy for claimants with suitable back pain problems.

CC tested, on a voluntary basis, the principles and practices of the CC approach to supporting people who have a work limiting health condition. A CC is an integral part of the Universal Credit (UC) claimant journey so this trial was a test of the CC prior to the roll out of UC to people with health conditions.

MIS provided, on a mandatory basis, additional Work Coach support to ESA claimants in the Work Related Activity Group who completed a spell on the Work Programme but did move into employment.

The evaluation of these trials comprised qualitative interviews with both Work Coaches and trial participants as well as observations of the meetings that they held with each other. Quantitative analysis of both the processes underpinning the trials and participants outcomes was also carried out.

We did not find evidence that VEI led to participants moving off benefits and into employment more rapidly. MIS however, has led to participants spending an average 3.2 fewer days on benefits in the 12 months following recruitment to the trial.
The physiotherapy service had a high level of interest amongst people who were eligible but the number of eligible people was low. The OHA service, when used, was often valued and appreciated, notably by less experienced Work Coaches. On the CC trial, many Work Coaches found that the CC form helped structure conversations and allowed them to track progress better than they would have done with an Action Plan (the predecessor to a CC).

For further details on the qualitative studies please see: https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

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List of Abbreviations

AP	Action Plan
BPP	Back Pain Pilot
CBT	Cognitive Behavioural Therapy
CC	Claimant Commitment
DoH	Department of Health
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
FTA	Failure To Attend
HMRC	Her Majesty's Revenue and Customs
IES	Institute for Employment Studies
JCP	Jobcentre Plus
JSA	Jobseeker's Allowance
LMS	Labour Market System
MIS	More Intensive Support
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NiNo	National Insurance Number
OHA	Occupational Health Advice
PP	Personalisation Pathfinder
PSM	Propensity Score Matching
RCT	Randomised Controlled Trial
UC	Universal Credit
VEI	Voluntary Early Intervention
WCA	Work Capability Assessment
WP	Work Programme
WPCI	Work Programme Completer Interview
WRA	Work Related Activity
WRAG	Work Related Activity Group

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Executive Summary

Background

The Employment and Support Allowance (ESA) trials discussed in this report formed part of a package of support for ESA claimants and were launched in spring 2015. This report summarises the evaluations of three of these trials, namely, Voluntary Early Intervention (VEI), Claimant Commitment (CC) and More Intensive Support (MIS).

VEI provided a nominal average of six hours voluntary Work Coach support prior to the Work Capability Assessment[1] (WCA). VEI had two variants over and above the core model; Occupational Health Advice (OHA) for the Work Coach to help them improve their advice to claimants, and a Back Pain Pilot (BPP) variant which offered physiotherapy for claimants with suitable back pain problems.

CC tested, at all stages of the ESA claim and on a voluntary basis, the principles and practices of the CC approach to supporting people who have a work limiting health condition. A CC is an integral part of the Universal Credit (UC) claimant journey so this trial was a test of the CC prior to the roll out of UC to people with health conditions.

MIS provided, on a mandatory basis, additional Work Coach support to ESA claimants in the Work Related Activity Group (WRAG) who completed a spell on the Work Programme (WP) but did not move into employment. The additional support amounted to just under four and half hours over a six month period, which compares with a normal level of mandatory support of nearly one and a half hours per year.

VEI and MIS were quantitative trials, whose primary purpose was to measure the additional benefit and employment outcomes associated with those interventions. VEI was a quasi-experimental trial which means that a control group was not designed into the delivery of the trial. MIS was a randomised controlled trial and therefore a control group was defined as part of that trial's design. The VEI variants were feasibility studies and the CC was a wholly qualitative study. No impact assessment was undertaken for these trials.

The evaluations of all these trials comprised both qualitative and quantitative elements. For all trials, and their variants, qualitative interviews were carried out with both trial participants and Work Coaches. Observations of claimant and Work Coach

[1] The WCA assesses whether an ESA claimant has limited capability for work and if so, whether they also have limited capability for work related activity.

meetings were also carried out in order to add to the qualitative data. Process analysis provides a description of the activities carried out during the trials and offers a context for the qualitative evidence. As mentioned above, quantitative impact assessments were then carried out for both VEI and MIS.

Findings

VEI

VEI was not associated with an improvement in benefit or employment outcomes. Our approach to estimating a counter-factual suggests that on average and for a limited period of time (approximately 10 months), participants may actually have spent more time on benefits. We consider some possible reasons for this in the main body of the report but ultimately the evidence we have at our disposal does not explain this finding. We do note though, that volunteers may be predisposed to having longer term claims and that our analysis may not have fully compensated for that bias. That said, it is unlikely that any selection bias would be so strong that it not only negates any impact due to VEI but also further reduces the likelihood of leaving DWP benefits to the extent that we measure.

Work Coaches used significantly less time to support participants than the trial policy intended, the actual amount of time was closer to 60 to 90 minutes. The reasons for this were varied, but the reduction in the waiting time for a WCA was certainly a factor as was claimant opt-out and modes of contact (e.g. phone calls were shorter than face to face conversations). Nonetheless, there was broad support for early intervention amongst Work Coaches and strong demand amongst claimants as evidenced by both the qualitative research and high take up rates (47%).

VEI: BPP Variant

In the BPP variant of VEI, the physiotherapy service was popular with both Work Coaches and eligible claimants. Work Coaches appreciated being able to offer ‘tangible’ support whilst claimants valued the opportunity to receive a therapy that could potentially improve their health and quality of life. Claimants were overwhelmingly positive about accessing the service though some claimants did drop out after a few sessions, sometimes because they had received physiotherapy before and the trial support did not offer anything new.

Even though most people who were offered physiotherapy initially accepted, the number of eligible people was not large. The absence of an impact from the core VEI support is problematic for expanding the BPP model more widely should the core VEI model underpin recruitment to the physiotherapy services. However, there may be

alternative ways of providing a physiotherapy service that do not depend upon a core VEI-like model to identify eligible claimants.

VEI: OHA Variant

The OHA service, when used, was often valued and appreciated, notably by less experienced Work Coaches. The service was reported to provide additional insight into a claimant's circumstances and a professional view on the claimants' abilities. However, some more experienced Work Coaches formed the view that the advice simply confirmed their own perspective. Coupled with quantitative data that showed low usage of the service except under managerial pressure, the evidence suggests that demand for an OHA service is not as strong as expected. That is not to say that such a service is unfeasible. The remote nature of the service means that barriers to a national roll-out would be lower than a service requiring a physical presence. However, demand for that service is likely to be low when expressed as a proportion of the ESA caseload.

CC

On the CC trial, many Work Coaches found that the CC form helped structure conversations and allowed them to track progress better than they would have done with an Action Plan (the predecessor to a CC). That said, some more experienced Work Coaches did not believe the CC added much value. Additionally, there were some criticisms of the content of the CC form but these were minor and easily rectified.

CC participants appeared to carry out more Work Related Activity (WRA) than MIS and VEI participants who were at a similar stage in their ESA claim. However, we have not been able to measure all WRA and also, regional differences, selection bias and small sample sizes mean that we cannot confidently say that the higher levels of WRA are due to the CC.

MIS

MIS achieved a marginal improvement in benefit outcomes (3.2 additional days off benefit over the first 12 months). As with VEI, the amount of time that participants spent with Work Coaches was significantly less than the policy intended. According to some of the Work Coaches delivering the trial this was because, contrary to the policy assumption, eligible participants were usually not closer to the labour market as a result of their time spent on the WP. Work Coaches sometimes had the view that many participants had deteriorated during this time and presented seemingly severe conditions. As a result Work Coaches suggested that they had to take a slower, often more pastoral than work focused approach in their support. There were

also suggestions from some Work Coaches that the Jobcentre Plus off-flow target incentivised them to support claimants who were earlier in their claim than MIS participants and might therefore be treated as a higher priority.

Further, administrative data suggests that some sites did not appear to distinguish between the intervention and the control participants, providing similar amounts of support to each group. This quantitative finding is corroborated by some Work Coach accounts that they did not feel comfortable treating individuals differently. Rather, they based their support on the individual claimant's needs.

General

Qualitative research of the VEI and CC trials suggests that, subject to the support fitting in with a claimant's treatment and recovery schedule, Work Coaches approve of early engagement. They believe that intervening at this point in the claim allows them to identify a claimant's support needs as soon as possible and helps to avoid deterioration in claimant attitudes and longer term benefit dependency. According to some views, 'challenging assumptions about inability to work' as soon as possible was important. Similarly, many claimants appreciate the support that they received and benefited from the clarity about the ESA claim process and the wider advice about employment related opportunities available to them.

In general, qualitative research with both claimants and Work Coaches suggests that claimants are very varied both in their medical conditions and their attitudes towards work. Some were 'job ready' in the immediate term and might even have had jobs to return to. Work Coaches were often observed to be encouraging and collaborative in these cases. Some claimants did not think they could work immediately but were willing to do so in the future, typically when their health condition allowed. Work Coaches were similarly encouraging with these claimants but might sometimes accept that work was not an option in the short term. Nonetheless, it was with this group that most progress was observed in the qualitative data. Other claimants had severe and often multiple conditions and did not see work as ever being an option. This was despite the fact they were in the WRAG and/or had volunteered for the trial. With these cases, Work Coaches sometimes acquiesced to the claimant's opinion of their condition and what they could achieve, either because they agreed with or were not sufficiently confident to challenge the claimant's opinion, or because they felt a more prescriptive style would be counterproductive. A limited understanding of the claimant's medical condition and uncertainty concerning what WRA was reasonable to ask of the claimant sometimes led to a lack of confidence in prescribing WRA.

The qualitative data did not often identify instances where participants significantly changed their attitude towards work. Some claimants did make some progress towards the labour market and most of the claimant views expressed in the research

were favourable of the Work Coach support and their experience of the trial that they took part in. Where claimants were less positive about Work Coach support, this was often linked to the Work Coach being perceived as having a more prescriptive style rather than the more favourably viewed acquiescent or collaborative style. However, the (at best) marginal improvement in quantitative outcomes suggests that where progress was made, in many cases progress would have been made in the absence of the trial and generally cannot be attributed to the trial interventions.

Common to all trials was a contrast between experienced and inexperienced Work Coaches. The latter sometimes expressed a lack of confidence, a need for training, and an apprehension towards working with ESA claimants. These Work Coaches perceived more value in the OHA and CC interventions. Experienced Work Coaches were more confident in their knowledge and abilities, and sometimes saw less value in those trial interventions.

Report Structure

This report brings together research and analysis from all of the strands of work that comprise the evaluation of the 2015 ESA trials.

Chapter 1 provides an introduction into the trials covered by this report.

Chapter 2 summarises the theories of change that underpin the trial interventions and outlines the policy assumptions that provide the motivation for the trials.

Chapter 3 describes the recruitment processes and outcomes (e.g. contact rates and take up rates) for the voluntary trials (VEI and CC). Research evidence and data on claimant characteristics is drawn upon in order to provide a possible explanation of the values and variations in that data.

Chapter 4 overviews the claimant typologies and Work Coach approaches that were articulated by the contractors who carried out the qualitative claimant interviews and the observations of the Work Coach and claimant meetings.

This provides some context for Chapter 5 which describes levels and variation in engagement with the trial support, and the possible reasons for that variation.

Chapter 6 then describes the quantitative analysis of the impacts that the core VEI and MIS models have had on benefit and employment outcomes.

Finally, chapter 7 summarises the overarching lessons that can be drawn from the trials.

1. Introduction

1.1. In response to the Work and Pensions Select Committee report[2] on the Work Capability Assessment (WCA) and the Disability and Health Employment Strategy[3], the Government announced a package of measures to increase health and employment support for claimants with health conditions[4]. This announcement was re-iterated in the December 2014 Autumn Statement[5]. The objectives for these measures were to:

- enhance the Employment and Support Allowance (ESA) process
- learn about the support and approaches that work best for this claimant group
- provide evidence to support the cultural transformation required as the DWP opens up Universal Credit (UC) to new claimants with health conditions.

1.2. Four trials were proposed in order to follow up on the above commitments, namely, Voluntary Early Intervention (VEI); Claimant Commitment (CC) for ESA; More Intensive Support (MIS) and the Personalisation Pathfinder (PP).

1.3. This report summarises the evaluations and findings from three of these trials; CC, VEI and MIS. The fourth trial, PP, has been evaluated separately and is therefore out of scope of this summary. The evaluation of the CC, VEI and MIS trials was composed of several strands:

- Qualitative research with Work Coaches, carried out in-house by DWP researchers.
- Qualitative research with claimants, carried out by research contractors.
- Observations of Work Coach and claimant interviews, carried out by research contractors.
- Quantitative analysis of trial processes and outputs, carried out in-house by DWP analysts.
- Impact assessments of VEI and MIS, carried out in-house by DWP analysts.

[2] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmworpen/302/30202.htm

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266373/disability-and-health-employment-strategy.pdf

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380265/esa-and-wca-work-and-pensions-committee-response.pdf

[5]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/382327/44695_Accessible.pdf

1.4. The claimant research has been published separately as part of DWP's Research Report series[6] and the qualitative research with WCs has also been published as an ad hoc publication[7]. We repeat some of that evidence here but also bring those findings together with the wider evaluation to present a more complete overview of the implementation and the efficacy of the trial interventions.

1.5. We begin this report with a brief summary of each trial and the policy assumptions or theoretical underpinning that provided the motivation for the trial. The report then provides a comparative overview of shared aspects of each trial beginning with the trial recruitment processes, proceeding to the claimant characteristics and attitudes, and staff approaches to moving participants closer to the labour market, and finishing with a summary of the qualitative and quantitative impacts discerned by the evaluation stands. We then close this report with various recommendations for future policy and practice.

Trial Overviews

VEI

1.6. The VEI trial encouraged claimants to engage with Jobcentre Plus at the start of their claim, instead of waiting until after their WCA to take up support. The trial policy proposal was in the context of increasing waiting times for the WCA, during which there was no mandatory engagement and claimants were at risk of becoming detached from the labour market.

1.7. Therefore, the core principle of VEI was to provide employment related support, on a voluntary basis, early in the ESA claim. Elements of that support included:

- a focus on the move into employment
- behavioural insight/nudge techniques
- better communications/messaging
- improving Work Coach skills and knowledge
- skills screening
- links with employers and local services

6 https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

7 https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

1.8. Jobcentre Plus contacted new and repeat ESA claimants to offer support to help them move into or return to employment by discussing employment strengths and skills and by addressing barriers to work. The employment related support took the form of more Jobcentre Plus Work Coach time; an average of six hours per participant was funded but the actual amount spent with each person was variable and at the discretion of both the Work Coach and the participant.

1.9. The extra time might lead to further voluntary activity. No specific type of activity was funded and no trial specific training was provided for Work Coaches. However, additional 'flexible support funds' were made available to pay for incidental costs (such as fares and childcare) and local provision. Further, some staff training was arranged and provided locally and this included activities such as meetings, workshops, formal training sessions and guidance.

1.10. The aim of the core VEI trial was therefore to test whether engagement with claimants at this early stage would prevent a drift away from the labour market, reduce time spent on DWP benefits by bringing forward off flows into employment and, consequently, reduce the volume of WCAs.

1.11. The trialled Work Coach support, and therefore trial participation, terminated when the WCA was undertaken. Because the timing of the WCA is variable so too was the nominal duration of a spell in the trial. A planning assumption of 6 months was used in the trial development but support beyond this period was not proscribed should the Work Coach and participant agree that that support would be beneficial.

1.12. As well as the 'core' VEI model, two variants were tested. One provided Occupational Health Advice (OHA) to Work Coaches whilst the other, the Back Pain Pilot (BPP)[8] provided physiotherapy on a voluntary basis for suitable participants with back pain problems.

1.13. The OHA variant provided Work Coaches with access to professional OHA in order to test whether access to this would lead to more informed employment related advice when talking to ESA claimants. Work Coaches, already working with claimants as part of the Core VEI model, could ring the OHA service to book a call with an Occupational Health professional. The Work

[8] This variant of VEI was referred to as the 'Back Pain Pilot' during the development and live running of the trial. Therefore we use the same term in this report even though the trial was not strictly speaking a 'pilot'. We also note that the same acronym was sometimes used to refer to 'Back Pain Problems' in trial guidance and communications.

Coach then received advice that they could use at their next appointment with the claimant.

1.14. The BPP variant of the VEI trial provided access to manual, physical and psychological therapies, such as physiotherapy, osteopathy and Cognitive Behavioural Therapy (CBT). Claimants who volunteered for extra employment support were asked if lower back pain was affecting their return to work. If it was, they were asked if they wanted a referral to a new service and possible treatment. If happy to continue, claimants received a booked telephone call from a healthcare professional to assess if those therapies were appropriate. Treatment could then include verbal advice, written information, referral for face-to-face sessions including up to six physical or manual therapy sessions and up to six CBT sessions in line with NHS best practise and National Institute for Health and Care Excellence (NICE) guidelines.

1.15. These variants, which were not co-located, were not quantitative trials in the sense that their purpose was not to measure the added value of those models in terms of reduced benefit caseloads and increased employment. Rather, the purpose of these variants was to establish the feasibility of providing these services to Work Coaches (OHA) and claimants (BPP).

CC

1.16. The CC trial had its origins in the 'Loughton' trial[9] and similar 'behavioural insight' approaches tested within the Essex Jobcentre Plus District. The trials ideas were then taken forward into the national roll-out of a mandatory CC that all Jobseekers Allowance (JSA) claimants were required to fulfil[10]. That roll-out began in October 2013 and is now a standard part of JSA conditionality. The CC has also been incorporated into UC and with the expansion of UC to client types beyond the JSA equivalent the roll out of the CC amongst that wider client base is an important consideration.

1.17. People claiming the ESA are not required to look for work. However, those placed in the Work Related Activity Group (WRAG), as the name implies, may be required to carry out some work related activity, the nature of which is tailored to the individual and agreed between the ESA claimant and their Work Coach. Currently that activity is recorded within an 'Action Plan' (AP). However, under UC, all claimants have a CC, which replaces the AP.

[9] http://www.behaviouralinsights.co.uk/labour-market-and-economic-growth/new-bit-trial-results-helping-people-back-into-work/

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305801/claimant-commitment-early-results.pdf

1.18. In order to understand the implications of this change, the CC has been tested within the ESA benefit prior to the expansion of UC to claimants with a work limiting health condition (who would have otherwise claimed ESA). The ESA CC trial was not intended to estimate any quantitative impacts (with respect to the AP) upon outcomes such as job entries or benefit off-flows. Rather, the purpose of the trial was to provide evidence of a more qualitative nature together with quantitative information on claimant behaviours and trial processes.

1.19. The CC trial was voluntary and recruitment took place at several stages in the ESA claim:

- before the WCA
- after the WCA where a person was put into the WRAG but not required to join the Work Programme (WP)
- after completing the WP, where a person was in the WRAG and did not move into employment whilst on the WP.

1.20. For the pre-WCA stage there is currently no engagement with ESA claimants. Therefore the recruitment process that was put in place for VEI was also put in place for CC. However, in this instance the CC would form an integral part of the support offer. Post-WCA and post-WP, claimants in the WRAG may be expected to undertake WRA and/or attend interviews with a work coach. However, whilst the AP is mandatory for these groups the CC was not, so the CC trial recruited voluntary participants at these stages as well. This happened during the 'New Joiner Interview' for those who were post-WCA and the 'Work Programme Completer Interview' for those who were post-WP. In both cases the CC replaced the AP where this would in any event have been a mandatory requirement for the claimant.

MIS

1.21. The MIS trial increased the level of mandatory support to ESA claimants in the WRAG who completed a spell on the WP and did not achieve an employment outcome. The amount of support was increased from the standard 88 minutes per year to just under four and half hours in the six months following the WP spell.

1.22. MIS was tested using a randomised controlled trial approach. People in scope of the trial were randomly allocated to either the MIS group or the 'business as usual' group where the latter received the standard 88 minutes per year. Within this report we name these two groups the 'intervention' and the 'control' group respectively. The policy assumption underpinning this trial was

that the support received during the two years on the WP would have resulted in ESA claimants progressing towards the labour market and therefore the additional investment in support provided by the trial would make the difference between gaining a job and not gaining a job

1.23. Further details on all the trials' implementation are provided in Annex A. Specifically, the timing and locations of the trials as well as descriptions of the recruitment and (where relevant) random allocation processes are described, as are additional qualifying criterion such as exemption categories.

1.24. A summary of the evaluation approaches is provided in Annex B. However, briefly, we conducted a number of qualitative interviews with Work Coaches who delivered the trial interventions and claimants who took part in the trials. A sample of meetings between Work Coaches and claimants were also observed. Separately, DWP administrative data was used to quantify some of the activities underpinning the trials' recruitment and the support subsequently delivered. Finally, analysis of the impact that the VEI and MIS trials had upon benefit and employment outcomes was carried out.

2. Theories of Change

2.1. This section of the report briefly summarises the 'theory of change' underpinning each of the trials. A theory of change is a description of the causal chain of events by which some change is brought about. In the context of these trials the theory of change is an articulation of the specific and detailed way in which the additional Work Coach time (in conjunction with the recruitment processes for the voluntary trials) and in the case of Claimant Commitment (CC), the psychological principles that that approach is predicated upon, bring about the behavioural change that ultimately leads to improved benefit and employment outcomes.

2.2. Social and psychological interventions rely upon a wealth of assumptions and apply to a complex environment. Therefore, for an intervention to bring about the desired effect those assumptions have to be valid. A theory of change aims to expose and test those assumptions with a view to establishing the plausibility that the intervention will 'work'. Where there are multiple actors a theory of change also seeks to establish if there is a shared understanding of the intervention and its purpose because this too is important to the plausibility of achieving the desired effect, particularly in large and/or complex organisations or systems. A key aim of an evaluation is to establish the extent to which the theory of change model reflects real world behaviours and outcomes.

2.3. As part of the evaluation of the Employment and Support Allowance (ESA) trials, research contractors carried out a number of interviews and workshops in order to identify what the critical elements of the trial interventions were, the beliefs concerning how those interventions would bring about positive outcomes and what those positive outcomes were.

2.4. In figures 2.1, 2.2 and 2.3 we present the models of the theories of change that underpin the trials. These models are more fully discussed in the published research reports[11]. For brevity we do not include similar models for the Voluntary Early Intervention (VEI) variants but we do comment on the additional aspects of those variants.

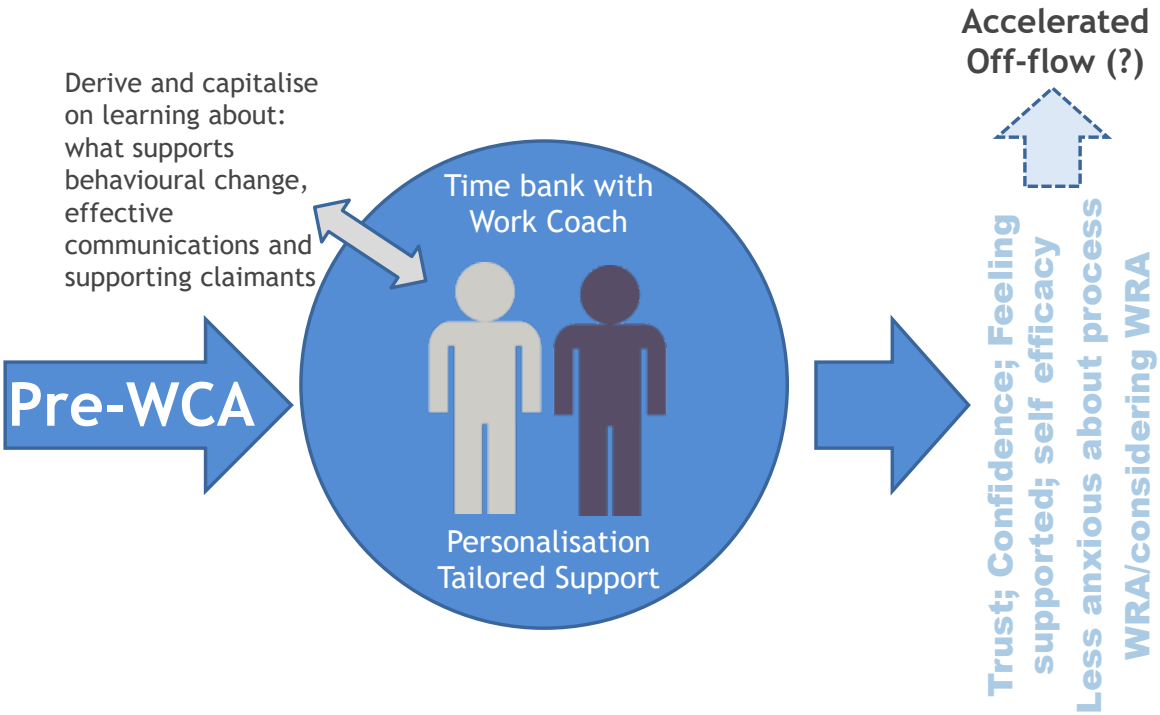
2.5. Common to all theories of change is the notion that additional Work Coach time is an essential component of the intervention. This might not be obvious in the context of the CC. After all, the CC aims to employ principles of

[11] https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

behavioural psychology and this in itself does not need more time. However, particularly in the pre-Work Capability Assessment (WCA) period where no time was hitherto allocated to that part of the claimant journey, additional Work Coach time was a prerequisite for the CC to function.

2.6. That time was manifest as 'time bank' rather than a specific allotment per person. This brings us to the other element common to all trials which is that in order for additional Work Coach time to have its desired effect it had to be tailored (i.e. personalised) to each individual. A prescriptive, rigid intervention, was presumed to be inappropriate to the ESA claimant type given the diverse range of circumstances and medical conditions that they were presented with.

Figure 2.1 The VEI (core) theory of change model



'Something where previously there was no formal national support provision'

'Entirely voluntary'

Understand how best to engage those early in their claim

DWP Research Report No: 933

Figure 2.2 The CC theory of change model

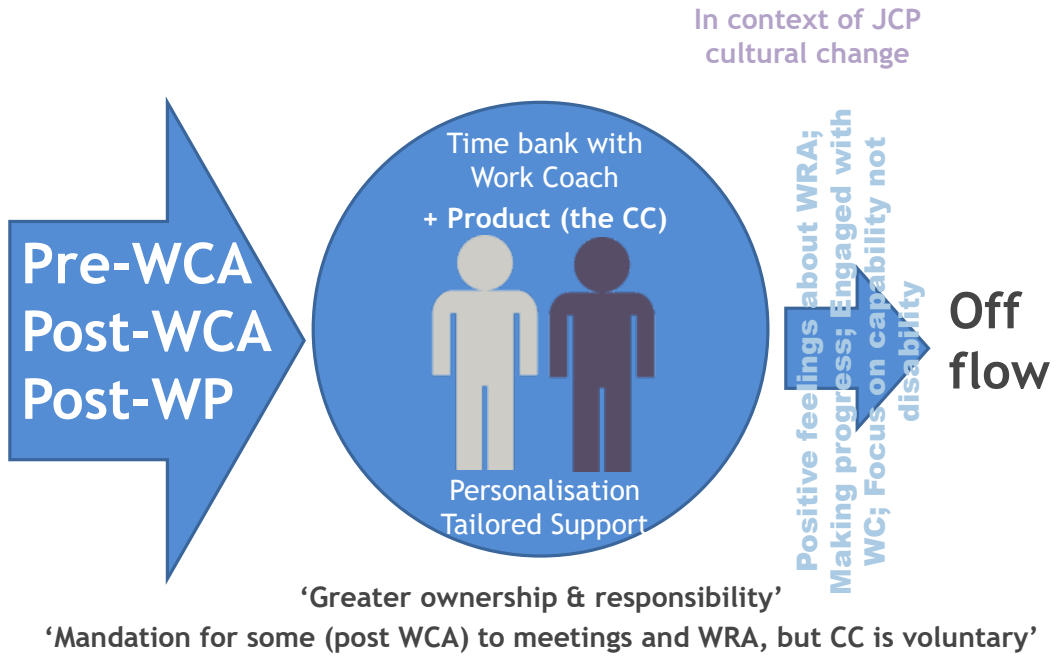


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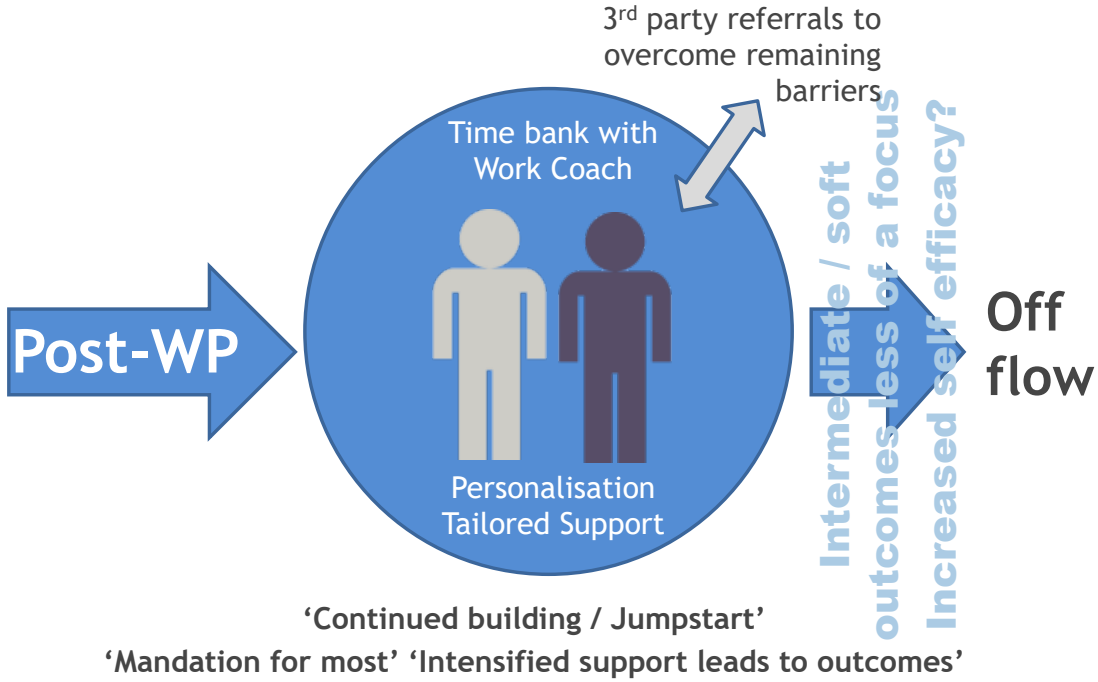
Figure 2.3 The MIS theory of change model



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2.7. Drawing a distinction between the pre-WCA stages (of VEI and CC) and later stages of the ESA claim, these trials introduced an entitlement to Work Coach support when beforehand there was none. This is an important difference to the post-WCA stage of CC and the post-Work Programme (WP) stage of CC and More Intensive Support (MIS), which provided more time when previously there was some (88 minutes per year). Here then, we are looking at marginal improvements in some underlying (presumed) effect rather than a 'do nothing' baseline.

2.8. Whilst in all trials a lot of autonomy was given to Work Coaches to respond to individual needs as they saw fit, to innovate and to take advantage of locally available opportunities and solutions, with the VEI trial being wholly in a new part of the claim journey there was an additional emphasis on learning about what works, to feed back that learning in an iterative way to facilitate continuous improvement and to develop communications in order to sell the support that Work Coaches could offer and achieve 'buy-in' from claimants.

2.9. This was also true of the pre-WCA element of the CC trial but that trial, in all claim stages, also sought to bring about greater ownership of the actions specified in the CC form on the assumption that this made those actions more likely to be undertaken. The CC also aimed to employ behavioural or 'nudge' methods in order to encourage improved steps back into the work place but no formal training was provided in order to bring about or systematise the use of specific techniques. No formal training was provided for any of the trials, rather, existing learning and development routes and 'on the job' training was presumed to be sufficient.

2.10. For MIS, additional Work Coach time and personalisation of support were highly important components. No additional specialist support was set up in the trial areas but Jobcentre Plus offices were able to use the pre-existing forms of specialist support (such as Access to Work) and local organisations who offered further specialist services (e.g. MENCAP and other charities for the sick and disabled). However, what distinguishes MIS was the assumption that because participants had received support from a WP provider in the two years prior to the trial, progress would have been made during that time and therefore, under the theory of change, there was an assumption that MIS participants would be relatively job ready. The additional time was seen as an additional (marginal) investment in order to bring about a positive outcome.

2.11. On the VEI variants, these were feasibility studies, so the purpose of those variants was not so much to quantitatively test the efficacy of these interventions. However, these trials did offer opportunities to test the validity of the underlying theory of change.

2.12. In the case of the Occupational Health Advice variant, this was that a more knowledgeable Work Coach, possessed of greater insight into the specifics of a particular condition and claimant's circumstance would provide more personalised support that would be even more effective than the support provided under the core model.

2.13. In the case of the Back Pain Pilot (BPP) variant, there was a belief that a lot of people with back pain claimed ESA and given the duration and variation in waiting times for physiotherapy services there would be merit in speeding up access to these services with the benefit that people would be less detached from the labour market and return to work more speedily as a result. Importantly, this was not a test of physiotherapy as such. That therapy is National Institute for Health and Care Excellence approved and is therefore assumed to be medically effective.

2.14. With respect to the desired outcomes, a reduced reliance upon DWP benefits (manifest as shorter claim durations and, over the longer term, fewer days spent on benefit in total) was the ultimate objective of the trial interventions. However, intermediate outcomes such as improved confidence, greater self-efficacy and a more favourable attitude to carrying out work related activity were also stated (by participants in the theory of change exercise) as desirable outcomes. For the VEI trial, an additional outcome was articulated, which was a reduced anxiety about the ESA process and the demands that it would place upon the claimant.

2.15. The aim of the evaluation of the ESA trials is to provide evidence on the extent to which the interventions were realised and whether the theories of change were ultimately valid. The trials were not set up to test all elements of the theories of change. For example the BPP variant of VEI will not tell us whether people moved off benefit more speedily. However, as this report will show, the theory of change was in some respects realised and valid and in other respects less so.

3. Trial Recruitment

3.1. This section presents a quantitative and qualitative account of the trial recruitment processes where participation in the trial was voluntary, namely, Voluntary Early Intervention (VEI) and Claimant Commitment (CC). More Intensive Support (MIS) was mandatory and employed a Randomised Controlled Trial (RCT) approach, so staff and claimant behaviours should not, in principle, have a great deal of influence in that process. Nonetheless some aspects of the quantitative and qualitative data on the MIS recruitment are of interest and we briefly touch upon that trial towards the end of this section.

3.2. The recruitment process has been described in Chapter 1 and Annex A so we do not repeat that material here. Rather, we present in table 3.1 below the contact rates for the VEI trial and the pre-Work Capability Assessment (WCA) stage of the CC trail. Also shown, but discussed later in this section, are the take up rates consequent to those contacts where we express take up as a proportion of all those contacted and offered support.

Table 3.1 VEI and CC contact and take up rates

District	Attempted Contacts	Successful Contacts	Contact Rate	Take Up	Take Up Rate
Black Country	5233	3628	69%	2195	61%
Central Scotland	8052	4993	62%	2191	44%
Birmingham & Solihull	6185	3716	60%	1809	49%
South East Wales	6794	4782	70%	1806	38%
VEI	**26264**	**17119**	**65%**	**8001**	**47%**
CC	**1717**	**1161**	**68%**	**328**	**28%**

Source: Labour Market System August 2016

3.3. By virtue of the fact that Jobcentre Plus staff could not contact some people, the claimant research offers little insight into the data in table 3.1. The operational approach to the initial contact stage was not tightly defined and we do know that different approaches were taken to this process. For example, in some areas the contact stage was centralised for the whole District, others covered clusters of sites and elsewhere each site attempted to contact only those claimants associated with their own office.

3.4. Across the VEI and CC trials, in some cases, introductory letters about the trial provision were sent to the claimants before Work Coaches rang the claimants, while in other cases a follow-up letter was sent after the phone conversation to confirm details of the appointment. Some Work Coaches

mentioned difficulties in making initial contact with claimants, for example that their calls to claimants went unanswered. Some Work Coaches felt that this may be because claimants did not answer phone calls from unknown numbers. Work Coaches mentioned a variety of approaches to overcome this issue; some Work Coaches continued to try to contact the claimant by phone, while other Work Coaches sent a text, email or letter to the claimant. Another view was that a face to face approach could work better, and one Work Coach described recruiting claimants on an opportunistic basis when they came into the jobcentre. Some Work Coaches reported that due to limited time they were not able to make three attempts at contact in all cases.

3.5. We have no systematic data on which attempted contacts were exposed to which practice so we are unable to say whether one particular method was more or less successful than another. However, we do reflect upon the fact that the variation in table 3.1 is not dramatic and neither are the contact rates notably high. After a nominal three attempted contacts Jobcentre Plus staff were unable to get through to approximately one third of people.

3.6. An examination of the different contact rates for different types of people showed[12]:

- contact rates for females are higher than for males (67% cf. 64%),
- contact rates are higher for older people (70% for the over 50s cf. 61% for the under 25s),
- people who are claiming the adult dependents allowance are easier to contact than other claimants (71% cf. 65%),
- similarly parents are easier to contact than non-parents (69% cf. 65%),
- people who we know to have a mental health difficulty have lower contact rates than other claimants (63% cf. 68%)
- and those who had a live benefit claim in the prior two years were harder to contact compared with those who had no prior claim in that period (62% cf. 67%),
- and finally, contact rates in more deprived and disadvantaged areas tended to be lower than average.

3.7. Once contact has been made, Jobcentre Plus staff then invited claimants to take advantage of the support on offer. Take up rates are shown in table 3.1. For clarity, the CC take up rate only relates to the pre-WCA stage of the Employment and Support Allowance (ESA) claim and not the later recruitment points. This is to enable a more valid comparison with the VEI Districts.

[12] All the differences presented in the paragraph are statistically significant with at least 95% degree of confidence and after accounting for the fact that we have carried out multiple tests.

3.8. Inevitably because the contact process was centralised in some Districts but not in others, there was scope for variation in the approaches taken to recruiting trial participants. A specific script was not prescribed as part of the trial (though some Work Coaches said that they would have liked one) and a variety of approaches for selling the support to claimants were indeed used. Work Coaches tailored their approach to different claimants focussing on a variety of selling points whereas others might only focus on a single selling point. Some Work Coaches were uncertain how to explain VEI to the people that they contacted.

3.9. Within the VEI trial, some Work Coaches framed the 'core' offer as an 'additional service' or 'new initiative' that the claimant had been specially 'selected' for. WCs often emphasised the flexible nature of the support, not necessarily specifying individual interventions, but explaining that the support would be tailored to the individual, and they suggested that this led to a favourable response from the claimant. For both the VEI Core and the CC trial some Work Coaches did however, explain the wider support options that Jobcentre Plus offers.

3.10. Across the trials some Work Coaches mentioned that the voluntary aspect of the trial helped claimants to engage. For example, in the CC trial, some Work Coaches were keen to express that the claimant would not be 'forced to work'. The voluntary nature of the trial also helped to deal with claimants who, due to their health condition, were unhappy about being contacted. The lack of any obligation to take part was reported to reassure the claimant.

3.11. That said, some Work Coaches reported that they were vague about the voluntary nature of the trial during the initial phone call in order to maximise attendance at face-to-face appointments, where these Work Coaches would make clear the trial was voluntary. Reasons for this approach included the fact that the voluntary nature of the trial made it more difficult to get claimants to opt into the trial and in the absence of any pressure, to turn up to Work Coach meetings, Failure To Attend (FTA) rates were at risk of being high (and indeed, FTA rates were reported to be high by some Work Coaches). On a related theme, in VEI Core, some Work Coaches felt that even though the trial was voluntary, claimants engaged through fear of benefit sanctions or they engaged until they were sure that the trial was voluntary at which point they stopped engaging, and this was for both claimants who had received benefits before and those who were new claimants (i.e. one might expect familiarity with the benefits system to be associated with greater knowledge of the sanctions regime). In line with the absence of conditionality prior to the WCA we examined DWP administrative data and found no instances of any sanctions being incurred by pre-WCA trial participants.

3.12. Some Work Coaches had the view that recruitment took place too early in the ESA claim, a point when claimants would be more concerned about their medical condition and establishing their entitlement to benefits. Also, some Work Coaches expressed a need for more detailed information on the claimant's condition so that they might better assess the suitability of work related support at that time. Similarly, screening out people who had a job to go back to would enable Work Coaches to target their time more appropriately.

3.13. From the claimant's perspective, people new to the ESA were not troubled by being invited to take part in the trial. Having little idea of what 'standard practice' was they did not perceive the trial to be anything different or new. This possibly contributed to some of the lack of clarity on the voluntary nature of the trials. Without a clear counter-point of reference, obligations when claiming benefits may not be fully understood even when explained. That said, only trial participants were interviewed in the research, so it is possible that non-participants had a different viewpoint.

3.14. Whilst it is a little early in this report to elaborate on any benefits of early support it is worthwhile noting that the claimant research suggested that an extended period of time without contact could lead to increased social isolation and greater inactivity and many claimants wanted support at this stage in their claim. In that respect, early intervention could be 'crucial' and a 'defining point in their experience' according to some Work Coaches. Some Work Coaches felt that early intervention helped claimants 'hit the ground running' by preparing them for the ESA journey; that early engagement was beneficial because claimants had a more positive mind-set early in their claim; and that early intervention changed some claimants' mind-sets, making them more receptive to work.

3.15. Some Work Coaches were of the opinion that whether or not claimants signed up to the trial (the VEI trial in this instance) depended on the claimant circumstances or, in the case of CC, their state of mind. In CC, some Work Coaches felt that claimants who had previously claimed Jobseeker's Allowance (JSA) were more open to completing a CC because they were familiar with that process under JSA and understood the help that Work Coaches could offer. Work Coaches also mentioned that new claimants were more willing to join the trial as they were keen to understand the support on offer.

3.16. The claimant research corroborated some of the Work Coach accounts. Most claimants reported receiving a letter or telephone call but some mentioned an invitation to attend an open day at their local Jobcentre Plus office. Some

claimants said that they were called to a meeting with a Work Coach and told about the trial support then.

3.17. Few of the claimants interviewed had clear expectations about what the trial that they took part in would deliver at the outset of their experience though the majority of VEI and CC participants understood their involvement to be voluntary and were motivated to take part because of the support they would receive. Many of these claimants were keen to find and re-enter work and were motivated by this to engage with Jobcentre Plus.

3.18. A few claimants initially perceived that they had to attend the meetings with the Work Coach and described that it was only later that they realised entering into the trial was voluntary. However, this did not necessarily affect their engagement as they expected to have to do something in order to receive their benefits anyway. As such, claimants described how they were always open to receiving support and help, and many thought it was a good idea that people in their situation received some support to think about work. For some with mental health conditions there was recognition that getting out of the house would be a positive step in their recovery.

3.19. The overall impression was that most claimants volunteered to join the trial for positive reasons, in order to gain support. Where they did not perceive their participation as voluntary, their motivations were neutral and they were nonetheless open to engaging with Jobcentre Plus. However, in a small number of cases, claimants described a perception that they had to attend meetings with a Work Coach, which they experienced as a pressure and stress in light of their particular circumstances.

3.20. Statistical analysis of the recruitment data suggests that, once contacted[13]:

- This listed in the data as black and mixed race claimants are more likely to volunteer (59% and 62% cf. 47% take up amongst white people). This might be a reflection of the higher take up rates in Black Country and Birmingham and Solihull, or conversely, it might be one of the reasons why those Districts have higher take up rates. We note that these figures may be being distorted by the number of cases of unknown ethnicity. ‘Unknown’ cases had a low take up rate of 33% and if a disproportionately high number of the unknowns are from the ethnic minority groups then the actual difference in take up rates may be smaller than the difference we have measured.

[13] All the differences presented in the paragraph are statistically significant with at least 95% degree of confidence and after accounting for the fact that we have carried out multiple tests.

- People known to speak English as a second language are less likely to volunteer (36% cf. 46%), possibly because of communication difficulties during the recruitment process.

- People age 50 or over are less likely to volunteer (41% cf. 49% for the under 25s), possibly because they are less motivated to move back into employment due to perceived age related barriers compounded by health barriers.

- People who claim the adult dependents allowance are less likely to volunteer (42% cf. 46%) whereas parents are moderately more likely to volunteer compared to their counterparts (48% cf. 45%).

- People who we know to have a mental health difficulty are more likely to volunteer (47% cf. 43%).

- Both people with an employment spell in the two years prior to their ESA claim and those with a benefit spell over the same period are more likely to volunteer (49% cf. 43% and 49% cf. 44% respectively).

3.21. Volunteers live, on average, in more deprived areas. It is difficult to disentangle the associations with measures of deprivation from the personal characteristics described in the previous paragraph. However, living in a deprived area does appear to be associated with marginally higher take up rates.

CC post-WCA and post-Work Programme

3.22. For the post-WCA and post-Work Programme (WP) stages of the CC trial, the CC component was voluntary but the underlying meetings were not. However, the claimant research suggests that not all participants were aware of the voluntary nature of the CC or in some cases that they were part of a trial.

3.23. As part of the recruitment process, some Work Coaches mentioned specific features of the CC tool (for example that the claimant's progress is put down in writing and that the CC is mutually owned). Additionally, some Work Coaches were concerned that the language used within the CC was off-putting to claimants and this may have prevented some claimants volunteering for the trial.

Back Pain Pilot variant

3.24. When offering physiotherapy support in the Back Pain Pilot variant of VEI, Work Coaches did recount explaining the voluntary nature of the treatment so that claimants were not under the impression that they had to participate. Work Coaches compared the support to other avenues such as longer waiting times to see a physiotherapist, so that claimants would effectively be 'jumping the queue'. Work Coaches also mentioned to claimants that the provision was free, unlike private healthcare.

3.25. Some Work Coaches promoting the physiotherapy specifically focussed on the benefits of the clinical treatment and not the wider support that they could take advantage of, possibly because they thought the physiotherapy offer was sufficient to sell the trial. Indeed, Work Coaches felt that the majority of claimants who were offered physiotherapy were 'keen' to take up the support and described physiotherapy as an 'easy sell'.

3.26. Work Coaches might draw upon the experiences of previous participants to persuade new recruits of the value of the service. This reportedly had the consequence that some participants were more interested in the physiotherapy than they were wider work related activity. Indeed, it was also suggested that the voluntary nature of the trial meant some claimants ignored the contact from Work Coach after the first couple of meetings (an issue we return to later in this report). It was interesting to note that there were reports of people accepting physiotherapy from the trial when they had previously refused a similar offer through occupation health at work, suggesting that the timing of the support is crucial. It may be therefore, that the timing of the offer during the VEI trial may not have been right for some people.

3.27. Where people refused physiotherapy this was sometimes because people were already receiving treatment through the NHS or expected to do so shortly. In other cases it was because of the acute nature of the pain, which might restrict mobility so much that getting to the clinic would be difficult. There was no evidence that DWP being the intermediary was a deterrent to accepting health related support though neither was that question explicitly asked.

Post-WCA and post-WP recruitment

3.28. Given the very different nature of the post-WCA and post-WP recruitment processes we discuss those stages separately to the pre-WCA discussion above. Recall that, for CC, the Work Coach meetings are mandatory but the CC was voluntary. And for MIS, participation in additional Work Coach meetings was mandatory.

3.29. Post-WCA CC claimants had mixed recollections about how they joined the trial, with some recalling a letter requesting their attendance at a meeting or the trial being introduced as part of meetings they were already having at a Jobcentre Plus office. A lack of familiarity with the standard offer meant that the trial was not necessarily distinctive to some claimants.

3.30. Some claimants who took part in the post-WP CC qualitative interviews found it difficult to unpick the trial from the standard post-WP offer (again, often through unfamiliarity with the business as usual process). Overall, many claimants in the research interviews, across the claimant journey, lacked clear knowledge or understanding of the CC trial, giving the impression that claimants had either not been given or not comprehended information about the trial. There was some lack of recognition of the CC document and terminology itself, affecting around half of the interview sample and all sampled stages (of the ESA claim). This broadly reflected data obtained during the observations of claimant and Work Coach meetings, which showed that Work Coaches often did not directly use the term 'claimant commitment' or refer to the CC during meetings with individuals on the trial.

3.31. For a complete account we show in table 3.2 below the take up figures for the post-WCA and post-WP stages (recall, these were omitted from table 3.1). The take up rates are notably higher than the pre-WCA figures, possibly because the requirements for taking part in the CC trial were not as different to the alternative as was the case with the pre-WCA period (if claimants had refused the CC they would have had to fill in an AP).

Table 3.2 CC take-up rates in the post-WCA and post-WP stages of claim.

	Post-WCA			**Post-WP**		
	CC Offered	CC Taken Up	Take Up Rate	CC Offered	CC Taken Up	Take Up Rate
Total	412	172	42%	143	65	45%

Source: Labour Market System August 2016

MIS

3.32. As mentioned earlier, MIS was a mandatory trial and used an RCT approach. Therefore recruitment was, in principle, a formality. However, we do note a few issues in this section.

3.33. Firstly, the qualitative research suggested many Work Coaches felt that most post-WP claimants had complex health conditions, often both mental and

physical health conditions. Some Work Coaches considered this group to often be demotivated and the furthest from the labour market amongst their caseloads and believed that some claimants' health had deteriorated significantly since their WCA. Indeed, Work Coaches sometimes did not feel that the claimant was suitable for the Work Related Activity Group and might recommend that the claimant apply for a re-assessment. We do note though that not every Work Coach held this view, with some considering the post-WP group's health conditions to be no different to ESA claimants at other stages in the claim.

3.34. With regards to the claimant research, typically, those interviewed were not aware that they were part of a trial, though sometimes there was recognition that the intended support was part of something new. Few recognised the term 'more intensive support'. That said, it was widely understood that involvement with Jobcentre Plus following completion of a spell on the WP was mandatory.

3.35. Statistical analysis suggested few issues with the recruitment process. There were regular but low numbers of people put into a group that was not the one the random allocation scheme suggested. Sometimes these cases were reported to be due to human error. However, in light of the Work Coach research, it may be possible that staff allocated some people into the control group because they did not believe that the MIS intervention was appropriate for a particular individual. We elaborate on this issue later on in this report, but for now we note that the actual proportion of participants that were not allocated to the correct group was very low at 0.3%.

4. Claimant Typologies and Work Coach Approaches

4.1. In the previous chapter we described the process by which claimants came to participate in the Employment and Support Allowance (ESA) trials. This report will similarly quantify the activities carried out consequent to recruitment and draw upon qualitative evidence to account for the patterns in that data. However, to understand the context of those activities it is helpful to consider some characteristics of the claimants taking part in the trials and the general approaches taken by Work Coaches delivering the support.

4.2. By the nature of the trials, all the claimants who participated had some work limiting health condition. However, Work Coaches reported dealing with the 'entire spectrum' of conditions, from a 'simple' condition such as a broken limb to a long term, multiple, fluctuating and/or potentially terminal condition. Claimants might have had severe mental health conditions, often brought on or exacerbated by a long term physical illness. Mental health conditions could themselves vary in nature and severity. Depression and anxiety were particularly common according to the staff research, and other conditions such as agoraphobia were mentioned. At the extreme, some claimants presented themselves as being suicidal and Work Coaches had to handle such cases with particular care. Some Work Coaches raised concerns that it could be difficult for them to judge how claimants are affected by their health conditions, particularly in relation to mental health.

4.3. Relatedly, the stage in the recovery or treatment process varied with some claimants reporting recent illnesses or injuries (sometimes associated with the workplace), others being in the midst of longer term therapy or experiencing a change in medication that required a period of adjustment. For those with fluctuating conditions the sequential progression from illness to treatment to recovery clearly did not apply. Likewise, initial conditions might worsen and/or precipitate secondary conditions (for example, deterioration in mental health as a result of social isolation).

4.4. In a similar vein, attachment to the labour market varied, with some people who had only recently made their ESA claim incurring a seemingly short term condition and having a job to go back to, to those who had recently claimed Jobseeker's Allowance but had transitioned from that benefit to ESA, and those who had been on ESA for several years, some of whom had been claiming Incapacity Benefit beforehand and had relied upon DWP benefits for significantly more than a decade.

4.5. Annex C summarises some of the characteristics that we are able to measure using DWP's administrative data. The data is split by trial, with two sets of data for the More Intensive Support (MIS) trial in order to demonstrate the equivalence of the intervention and the control groups. In reality the characteristics can be more nuanced. For example, in the Annex we present data on the primary condition that is the reason for the ESA claim. However, as mentioned above, a person may have two or more conditions. Persistent conditions can often lead to additional conditions. Also, conditions might fluctuate so at different points in time different conditions might present the main barrier to employment (indeed, different conditions will present different barriers to different jobs).

4.6. The statistical data corroborates the qualitative accounts in that mental health features most heavily amongst the claimant conditions. Also notable are the varied ages of the participants. In the qualitative evidence, younger people could consider themselves to have enough time to recover from their condition and re-enter employment whereas older people could regard age discrimination as an additional barrier or employment less relevant because they were close to retirement age. The high proportion of people from ethnic minorities in the Voluntary Early Intervention (VEI) trial can be put down to the areas in which those trials ran. Further, the proportion of people with basic skills needs will, at least in part, be a function of DWP screening processes and may not capture every instance of a need amongst the participant population.

4.7. Beyond what we know from DWP administrative data, the qualitative research with claimants provided additional insight on claimant's distance from the labour market as perceived by the claimants themselves. Based upon these self-perceptions, the researchers reported three types of claimant as follows:

- Job Ready Now
- Work is Possible in the Future, and
- Work is Not Possible

Job Ready Now

4.8. Claimants in this analysis category felt work ready, or close to being work ready. However, they nonetheless believed that adjustments and flexibility in the workplace might be needed given their health conditions. Claimants in this category did have an active desire to work, and some may have already been in the process of looking for work or engaging in Work Related Activity (WRA) such as voluntary work.

4.9. There was some evidence of insecurity in employment status amongst this group. For example some claimants were unsure whether work could be sustained or were unsure about the number of hours they could manage. Some claimants believed that they could not work in a stressful environment and for this or other reasons (such as musculoskeletal problems) took the view that they would need to change the type of work they did. They therefore expressed a need for advice on the types of work they could consider.

4.10. Unsurprisingly there were differences in the prevalence of 'job ready now' claimants amongst the different trials. They were more commonly found in the pre-Work Capability Assessment (WCA) and post-WCA groups than they were the post-Work Programme (WP) groups. In short, the earlier in the claim, the more prevalent they were.

4.11. The claimants that formed part of the VEI Back Pain Pilot (BPP) variant sample, by virtue of the intervention, showed particular similarity to each other and shared a similar enthusiasm about working. Though that condition did lead some to think they had a limited ability to work.

4.12. Post-WP participants (in CC and MIS), though having similar positive attitudes to other 'job ready' claimants and in some cases being engaged in job search activities, still faced perceived barriers, such as the need to change industries, age discrimination from employers, and the negative consequences of having being inactive and out of the labour market for such a long period of time.

Work is Possible in the Future

4.13. This group contained people who did not think that they could work immediately but wanted to in the future. They believed that they would first need to see improvements in their health condition. They had sometimes been advised by their doctors to undergo a period of recuperation, they might be on a new medication which required a period of adjustment or they might be awaiting an operation. Indeed, particularly, where the claimant was relatively young, they believed that recovery might take a very long time, but they were nevertheless optimistic about their long term prospects. They viewed then, their recovery period to be distinct from any prospective period of employment.

4.14. 'Work possible in the future' claimants were found to be similar across the VEI Core, VEI Occupational Health Advice (OHA), and CC pre-WCA samples. Given the similar stage in claim and the drivers of the usage of the OHA service (i.e. the managerial pressure increased the likelihood of the

service being used less discriminately) this might not be too surprising. The VEI BPP participants in this group differed owing to their specific and distinct ailment and, as is common with those suffering long term back pain, were sometimes also affected by poor mental health.

4.15. Post-WCA participants (in CC) envisaged more obstacles to work, less directly associated with their health. These obstacles were sometimes specific to that individual's circumstances (e.g. caring responsibility, criminal record, skills or qualifications), but the time spent out of the labour market added to the relative lack of confidence of this group.

4.16. Similarly, post-WP participants (in CC) also felt disadvantaged owing to the time spent out of the labour market and (arguably relatedly) their age. However, they tended to have more complex and multiple health conditions and/or more severe impairments, sometimes experiencing both mental and physical ill-health. They nonetheless believed that they would work in the future.

Work Not Possible in the Future

4.17. Some participants had the view that they would never work again (mainly due to the severity of their health conditions). In the pre-WCA trials (Core VEI, VEI OHA and CC) some participants did express a wish to work but believed that their health conditions would prevent them from doing so. The same was true for VEI BPP respondents, but their specific reasons were more distinct to the condition that they shared. Their health conditions did tend to be chronic and long term, often suffering multiple conditions, and their lack of confidence in their employment prospects was sometimes based upon a belief that they could not be as productive as an employer would expect them to be. Therefore, these claimants' involvement in those trials may have reflected a willingness to have their perception challenged and to explore previously unknown options.

4.18. Post-WCA claimants in the CC trial and post-WP claimants in the CC and MIS trials who did not think they would work again, had long term and often multiple conditions. In many cases, and as suggested earlier, they did not think they should be in the WRAG. Their long term conditions meant that many had little recent employment experience, which was perceived as an additional barrier.

4.19. We briefly note that there was little evidence of claimants moving between typologies. Whilst many participants showed improvements in their attitude and work related activities across all three groups, the research suggests that this built upon a pre-existing view of their self-efficacy or willingness to take

steps to move into employment. There was little evidence of significant movement between the groups discussed here, though aside from a small number of follow-up interviews, the study was not a longitudinal one and neither were the interventions long term, so arguably observations of considerable change cannot be expected.

Work Coach Approaches

4.20. Having overviewed the claimant typologies, we now describe the Work Coach approaches. These classifications were also based upon the interpretation of the research contractors and their view is derived from both the claimant interviews and the observations of the Work Coach and claimant meetings. The qualitative research with Work Coaches did not generally articulate particular styles, but we do call upon corroborative evidence from that study where it exists.

4.21. The approaches that were articulated within the research were described as:

- Collaborative
- Encouraging
- Empathetic
- Acquiescent
- Prescriptive

Collaborative

4.22. Where the claimant considered themselves job ready, collaborative styles were often characterised by a shared approach to the identification of next steps in the progression towards work. In some instances the conversation was led by the claimant and the Work Coach left the agreed actions to the autonomy of the claimant. Work Coaches might take this approach to understand, and not pre-suppose, the support that claimants would like. In other instances the Work Coach might offer suggestions of additional activity that might supplement those planned by the claimant.

4.23. One possible consequence of a collaborative approach with this type of claimant is that the claimant may not identify the added value of the Work Coach support. Many claimants involved in the research, particularly those in the pre-WCA stage of their claim, were taking their own steps to move back into work and were not of the opinion that the support and advice from the Work Coach helped them to move closer to employment. They did nonetheless tend to have a positive view of their experience of the trial in which they took part.

4.24. In other ‘collaborative’ interactions, the Work Coach could be challenging (for example, in the post-WP stage of the claim) but they would listen and respond to the claimant where the claimant did not agree that the Work Coach’s suggestion was appropriate for them. A collaborative approach of this nature did not necessarily lead to conflict in the discussions. Rather, the claimant viewed themselves as having a say in the support that they received and felt engaged rather than pressured.

4.25. Similarly, collaborative approaches were often central to building up a good rapport and ensuring a more holistic (as opposed to exclusively work focussed) type of support. Some Work Coaches avoided raising WRA in the initial meetings and allowed claimants to ’set the agenda’, which typically meant focussing on health conditions rather than employment. Such ‘slow but steady’ approaches meant that claimants felt that they were being listened to and their circumstances and health conditions being considered. Accordingly, claimants who encountered collaborative approaches were often positive about their trial experience and this in turn led to improved confidence, motivation and engagement in WRA. Other Work Coaches reported that they would always try to include some discussion about WRA but felt it was important to allow claimants time to speak about their health in order to help build a trusting relationship. Work Coaches reported that decisions about what WRA was suitable could still be difficult if the claimant’s prognosis was unclear.

Encouraging

4.26. An encouraging approach was quite common, particularly in the CC trial. This approach was often taken in response to more negative claimant perspectives. For example, where a claimant expressed despondency or downplayed their abilities, an encouraging Work Coach might bring up previous achievements; persuade the claimant to continue further WRA and present activities in a positive light. Similarly, by focussing on opportunities, such as the fact that a particular job or workplace might offer a variety of different roles, some more suited to the claimant’s abilities, ‘encouraging’ approaches focussed on possibilities and solutions with a view to changing claimants’ perspective on their personal situation and employment prospects.

4.27. Work Coaches reported spending a ‘substantial amount of time’ in changing attitudes, ‘gently’ suggesting that claimants might be ‘misplaced’ about their lack of abilities. There was some evidence that Work Coaches were successful and claimants considered WRA (such as voluntary work) when they otherwise might have not.

4.28. An encouraging approach was most often accompanied with a collaborative approach given the complementary nature of these types of interaction. Encouraging approaches were to be found at all stages of the claim (and therefore in all trials) given the suitability of this approach with both people who were positive about and/or willing to take steps to move back into work and people who were more pessimistic and would therefore need a positive challenge in order to change their perspective.

Empathetic

4.29. Empathetic approaches were commonly reported by claimants when they believed that their Work Coach understood their health condition. This was sometimes because the Work Coach had experience of that condition, either directly themselves or through a member of their family, a colleague or a friend. There was some evidence that the OHA variant of VEI was also associated with a greater understanding and appreciation of the claimant's medical condition.

4.30. Experience and understanding of the medical condition reportedly (according to the Work Coach research) had the benefit that WRA suggested by the Work Coach could be demonstrated to be feasible for someone with the medical condition in question, but equally, by empathising with the difficulties, neither was the suggestion prescriptive. Rather, options were presented as possibilities though not necessarily easily attainable ones.

4.31. Empathetic and supportive approaches were associated with improvements in self-efficacy and a perceived personalisation of the support, though this was more commonly evident in those who considered themselves to be work ready.

Acquiescent

4.32. Acquiescent approaches were also evident in the research. These were not as common as the previous approaches, but they were characterised by an acceptance and lack of challenge of a claimant's inability or unwillingness to consider WRA. Neither, in some cases, were alternative options considered.

4.33. Acquiescent approaches were found in a range of circumstances and as might be expected were mainly associated with progress towards the work place where the claimant already considered themselves to be work ready and were taking their own steps to gain employment.

4.34. With other claimant types an acquiescent approach was typified by the Work Coach accepting that the claimant's condition was work limiting, or assessing

the suitability of WRA based upon the claimant's own view of their abilities, and this led to less challenge as a result.

4.35. There was also a suggestion that an acquiescent approach led to fewer or less frequent meetings (which claimants approved of) because neither claimant nor Work Coach viewed employment as feasible or, in the MIS trial, to alleviate negative effects of the mandated meetings. Similarly, some Work Coaches found conversations with ESA claimants 'tricky' or concerns that the claimant might have had about the WCA meant that it was difficult for Work Coaches to introduce the subject of WRA.

4.36. Whilst acquiescent approaches may not, at face value, bring about the desired attitudinal change, they nonetheless tended to be received by claimants positively, typically because of the lack of pressure or challenge.

Prescriptive

4.37. Some interactions were more prescriptive. Where this was the case claimants felt less supported and less positive about their experiences. In most cases the claimant's view was based upon a belief that the Work Coach did not understand the limitations that their medical condition imposed or did not take those limitations into consideration.

4.38. Where an approach was prescriptive, claimants sometimes felt that the Work Coach was going 'by the book' and following a process rather than tailoring support. In other words, prescribing activities because they believed they had to and not because they thought that the claimant would benefit from them.

4.39. Initially prescriptive approaches did sometimes evolve into more acquiescent and/or more encouraging approaches. Where this happened the relationship between the Work Coach and the claimant might improve and a rapport be established. This was not true in every case. In a small minority of instances, a prescriptive approach was reported by claimants to have led to the discontinuation of their involvement in the (VEI) trail and more commonly led to a belief that the trial did not add value.

4.40. Prescriptive approaches were not found as often as collaborative or encouraging ones. Work Coaches did not describe their support in these terms but it is possible that from their point of view they were being 'encouraging' or 'challenging', so the qualitative accounts may partly reflect a difference in perception.

4.41. To summarise the discussion on Work Coach approaches, collaborative and encouraging approaches were commonly associated with a positive view of

the trials. They were also most commonly associated with apparent progress towards employment. Empathetic approaches were considered important to building up a good rapport and were very generally appreciated by the claimant. Empathetic approaches could be complimentary to collaboration and encouragement but they were also associated with acquiescent approaches which did not noticeably lead to reported progress towards the labour market that would not have been achieved in the absence of the trials. Acquiescent approaches were also observed to accompany or follow prescriptive approaches which, whilst rare (within the research), did not lead to positive views of the trials or clear progress towards the labour market.

Concluding comments

4.42. The observations presented in this section support the idea that the trials were in keeping with the theory of change insofar that there is a strong sense of personalisation across all trials and all claimant types. Similarly, a sense of trust and feeling supported can be inferred from many claimant accounts. In some cases this does seem to have led to an improvement in the claimant's confidence and a more positive attitude towards WRA, which were amongst the objectives of the trials.

4.43. However, personalisation appears to have been manifest in a variety of different ways. For example, with 'job ready now' claimants, Work Coaches sometimes agreed with and did not suggest additional contributions to the claimant's plan of action. Other job ready claimants experienced a more encouraging and collaborative approach and this was associated with a positive claimant experience.

4.44. Most progress appeared to have been made by the 'work possible in the future' claimants. Support for this claimant type encompassed a sense of empathy and understanding of the claimant's health condition whereupon the Work Coach might endeavour to motivate the claimant and increase their confidence. A collaborative and encouraging approach would then build upon the established rapport. It is perhaps with this client type that the theory of change was most clearly realised (on the basis of the qualitative data).

4.45. That said, the 'work possible in the future' claimant type was often more focussed on their medical recovery and this could lead to some Work Coaches taking a 'no pressure' approach, possibly reducing frequency of contact as a result. This approach, whilst clearly personalised, is arguably less in keeping with the theory of change given that progress towards the labour market is unlikely to have been speeded up, in the short term at least.

4.46. The theory of change implicitly, and with MIS explicitly, assumed either a willingness or capability to take steps to move closer to the labour market. The observation of a ‘work not possible in the future’ claimant type does not sit comfortably with this assumption and appears to be another reason why acquiescent Work Coaches approaches were taken. Expectations could be low on both sides.

4.47. That said, changes in self-efficacy were observed with ‘work not possible in the future’ claimants and where progress was made this was typically due to an encouraging approach where actions were mutually agreed. Prescriptive approaches were noted by claimants in this group (and specifically in the MIS trial) however, and it was these claimants that tended to be most critical of their experience of the trial.

4.48. We conclude by noting that that an empathetic approach was observed across all claimant types and was seen by Work Coaches as being essential to building trust and rapport. However, as we have seen, whether that initially empathic approach developed into an encouraging and collaborative approach or an acquiescent one appears to have been significantly driven by the claimant’s view of their distance to the labour market.

5. Levels and Variation in Engagement

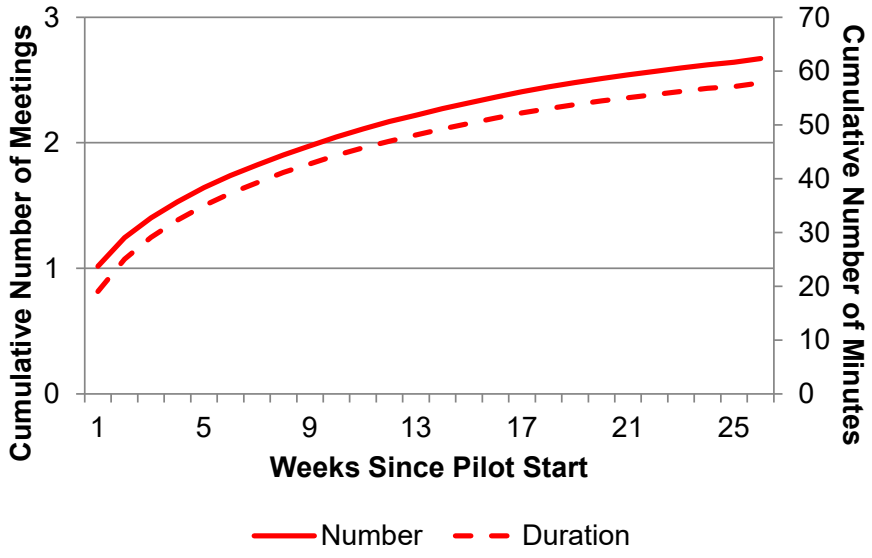
5.1. Having overviewed claimant types and Work Coach approaches we now move on to provide evidence of the nature and extent of Work Coach engagement with trial participants and the activities that participants undertook. We present quantitative data where possible and draw upon the qualitative research to provide some context for that data.

5.2. Charts 5.1, 5.2 and 5.3 show, for Voluntary Early Intervention (VEI), Claimant Commitment (CC) and More Intensive Support (MIS) respectively, the average of the cumulative number of meetings and cumulative periods of time spent in Work Coach meetings the longer the involvement in the trial.

5.3. All people who volunteered for the VEI and CC trials or were allocated to the MIS intervention or control group are included in the charts regardless of how many meetings they attended (which could be none in some instances). However, only spells that lasted long enough to count towards a particular duration are included in that part of the chart.

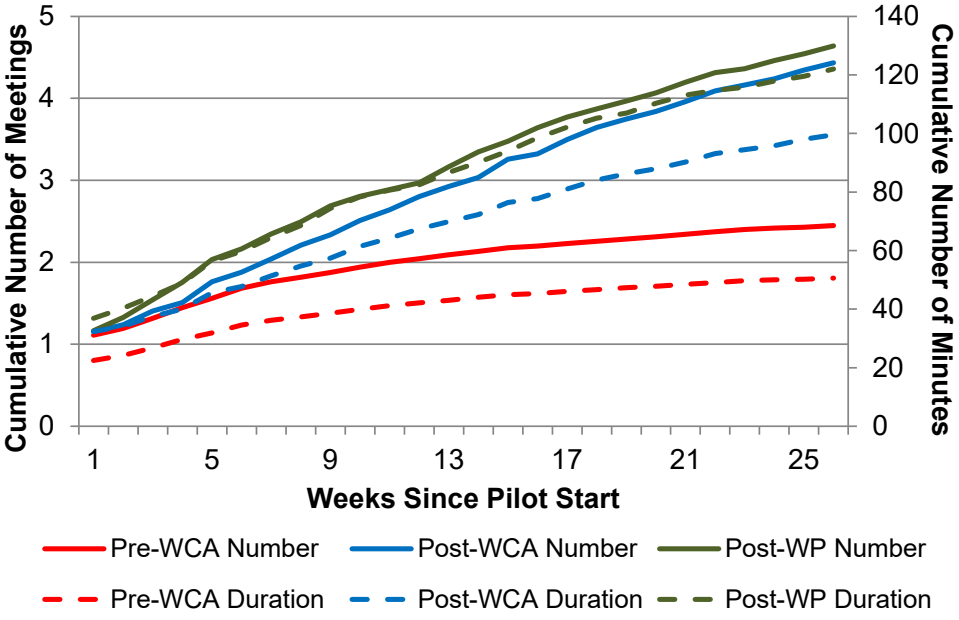
5.4. Meeting durations are assumed to be the nominal duration of the meeting (according to guidance or the specific appointment type). Where there is no nominal duration we assume it to be the average of the known durations. Of course, meeting durations may be quite different to the nominal duration so we do not expect these figures to be extremely accurate. They are likely, however, to be broadly reflective of the extent of the Work Coach support.

Chart 5.1 Cumulative number and duration of VEI Work Coach meetings



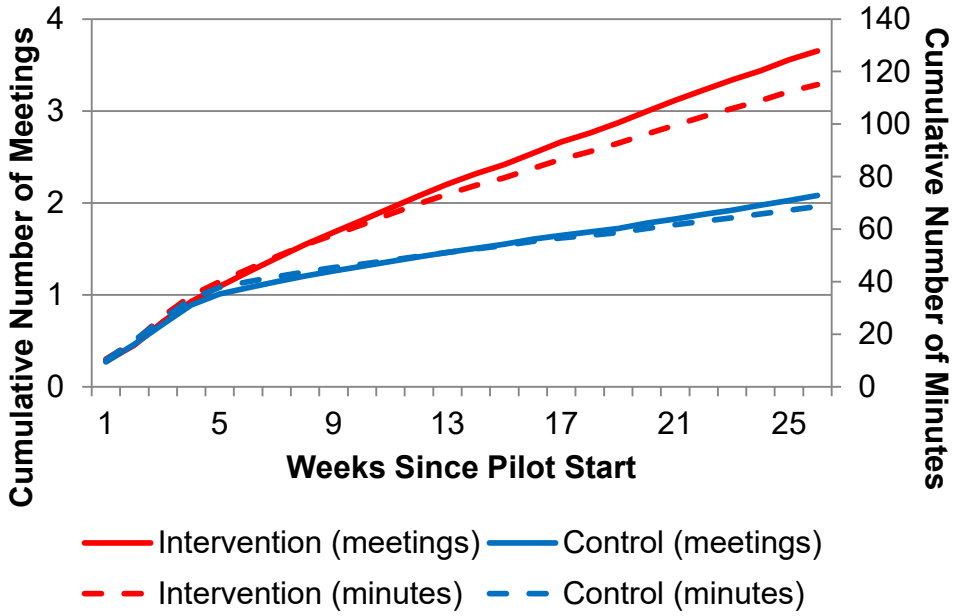
Source: Labour Market System August 2016

Chart 5.2 Cumulative number and duration of CC Work Coach meetings



Source: Labour Market System August 2016

Chart 5.3 Cumulative number and duration of MIS Work Coach meetings



Source: Labour Market System August 2016

5.5. The period of time considered in the charts is from the point at which a 'marker' is set to signify recruitment[14]. The point beyond which meetings are

[14] When looking for attended meetings however, we allowed a two week time window prior to the date when the marker was first set. We did this because some voluntary meetings took place shortly before the marker was set which suggests that the marker was set after

not considered is the earliest of a recorded 'exit', the Employment and Support Allowance (ESA) claim closing, the Work Capability Assessment (WCA) for pre-WCA trials and the nominal trial duration of 6 months for CC and MIS. Annex B provides more detail on the meetings data and the degree to which we can be confident in it.

5.6. As mentioned earlier in this report, for VEI and the pre-WCA stage of CC, Work Coaches had an average of six hours per participant that was intended to operate as a 'time bank' that could be used in according with each participant's needs. There was no expectation that each participant would require six hours support. However, as seen from charts 5.1 and the pre-WCA curves in chart 5.2, the actual amount of time (as far as we can tell, given the limited accuracy of the data) was closer to one hour for VEI and a little under that for pre-WCA CC. The time taken to implement the recruitment process was part of the six hour allocation but that part of the process will not take long enough to make up the shortfall

5.7. Some reasons for the shortfall mentioned by Work Coaches included short WCA waiting times, claimant opt outs and benefit off-flows. Charts 5.1 to 5.3 account for these reasons because the figures in the chart are based only on the spells that last the number of weeks shown in the horizontal axis. For example, a spell that last 13 weeks will not contribute to the part of the chart that shows the number of meetings and minutes after 26 weeks.

5.8. For interest, table 5.1 shows the proportion of spells that have closed for each of the reasons outlined in the previous paragraph and the nominal end point of 6 months duration. All CC spells have closed given that at least 6 months has elapsed since the last person was recruited, whereas for a small number of MIS recruits the 6 month period had not elapsed in the period of time covered by the data available to this study. No VEI spells ended because of the 6 month period elapsing because that was not a criterion for that trial and accordingly, some VEI spells appear to be on-going.

Table 5.1 Reason for the end of a trial spell

Reason	VEI	CC	MIS
Spell On-going	9%	0%	1%
Claimant Opt-out	19%	4%	5%
Claim Closed	41%	26%	8%
WCA	32%	27%	5%
6 Months Reached	N/A	43%	81%

the claimant joined the trial. Discounting meetings that took place before the marker was set would therefore lead us to undercount the level of activity during the trial.

Source: Labour Market System August 2016 and DWP Administrative Data July 2016

5.9. In respect of the opt-outs for the VEI trial, our earlier discussion on the extent to which participants were fully aware of the voluntary nature of the trials may be relevant here. It is possible that opt outs might have been lower if all participants were fully informed volunteers.

5.10. Regardless, charts 5.1 to 5.3 show that even when participants remain in the trial for at least six months, the average amount of support received still falls short of the allocation. Reported reasons for the shortfall include:

- many interventions take place via phone and phone calls tend to be shorter and to the point
- hand-offs to providers and other forms of support
- competing work pressures

5.11. We are unable to quantify the extent to which the above reasons do account for the shortfall. Rather, we offer them as possible explanations for that shortfall.

5.12. Face to face meetings were Work Coaches' preferred method of contact but they acknowledged that due to distance, physical injuries or psychological conditions travel could be difficult, so phone conversations were common (indeed we note one incident of correspondence by email alone). Some staff would have liked access to more modern means of communication, such as 'Skype' or 'WhatsApp' but these will have technological and commercial implications that are beyond the remit of this report to consider.

5.13. As shown in chart 5.2 is the number and duration of meetings for the post-WCA and post-WP stages of the CC trial, and these also fall short of expectations but nonetheless are significantly higher than the 'business as usual' baseline of 88 minutes per year. On average, these claimants remain on benefits for a longer period of time than pre-WCA claimants, so one reason for the higher levels of meetings will simply be a greater opportunity to attend a meeting. The mandated nature of the post-WCA and post-Work Programme (WP) regimes will no doubt also be contributing.

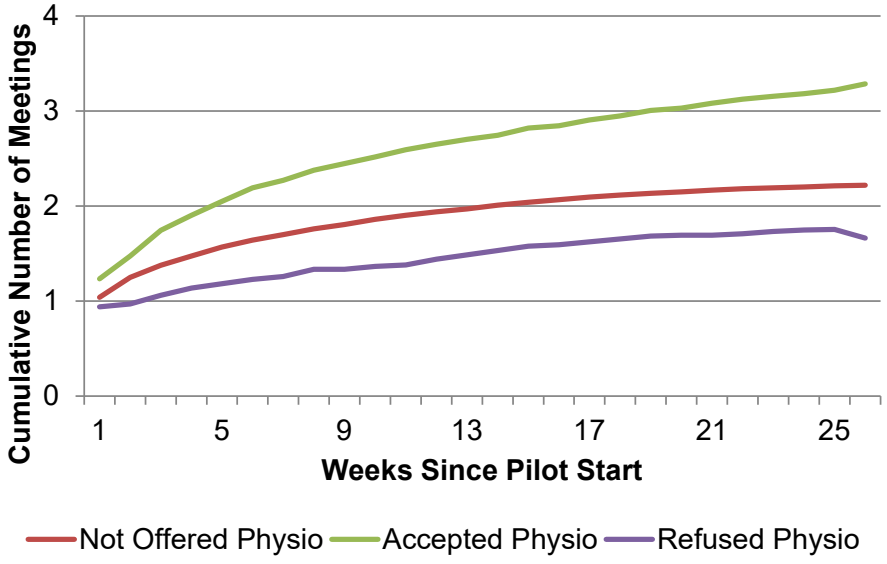
5.14. The qualitative evidence did suggest that the CC appeared to encourage greater levels of Work Related Activity (WRA). Whilst attendance of Work Coach meetings is not markedly higher in the CC trial (for equivalent ESA client types), the WRA over and above those meetings is notably higher (see table 5.2 shortly). Though as we note later in this chapter it is possible that the observed differences are, at least in part, due to better partnerships in the CC trial area, a different staff culture or claimant selection bias (though the

latter would not explain differences in WRA between the VEI and CC pre-WCA trial groups).

5.15. On the BPP variant of VEI, the claimant and Work Coach research suggested that those who did not accept the offer of physiotherapy sometimes had to be pro-active in requesting further Work Coach support and could become less engaged. Conversely, those who did accept physiotherapy might be contacted regularly to see how their treatment was going. This is borne out by the quantitative data (see chart 5.4) that shows that those who accepted physiotherapy (though we note not everyone who accepted went on to receive treatment) attended significantly more Work Coach meetings than those who refused (an average of 3.2 cf. 1.8). Those who were not offered physiotherapy fell somewhere in between (an average of 2.3 meetings).

5.16. The short term focus of the regular catch-ups in the Back Pain Pilot (BPP) variant tended to be on the participant's health condition and how the treatment was progressing though some Work Coaches did suggest that the focus shifted to employment later on. Where work was discussed, this was sometimes in relation to the options and constraints arising from the claimant's physical condition and sometimes work was an activity that was framed in the future once treatment was complete, and this could be the case even for job ready claimants. This might suggest a degree of acquiescence and possibly suggests any theoretical improvement in employment outcomes may be more strongly linked to the physiotherapy support than the Work Coach advice.

Chart 5.4 Cumulative number of Work Coach meetings in the BPP variant of VEI



Source: Labour Market System August 2016

5.17. The greater focus on those receiving treatment may be a trial effect, with Work Coaches focussing more heavily on the variant (which would not be a variant under a national policy) than the core offer. Indeed, some Work Coaches suggested that they would have 'little to offer' in the absence of the physiotherapy support. Accordingly, if Work Coaches believe that the main focus of a trial is a subgroup of claimants then that subgroup may receive a disproportionate amount of attention.

5.18. We observe a broadly similar pattern in the Occupational Health Advice (OHA) variant of VEI with those for whom the service was used being seen more often than those for whom it was not used (an average of 6 meetings cf. 2.7). This difference may not be due to any intrinsic biases of the Work Coach. Prior to using the OHA service the Work Coach must build up a relationship with the claimant to some degree and the use of the service typically involves a follow up meeting, so the OHA process biases those cases towards a greater number of meetings.

5.19. Turning to MIS, two things are notable. Firstly, the average cumulative duration of attended meetings after 26 weeks is similarly short of expectations (for the intervention group that is, the control group is broadly in line with an expectation of 88 minutes per year). Secondly, the measured difference between the intervention and control groups is much lower than that stipulated by the trial design (264 minutes cf. 88 minutes). The difference is less than a factor of two.

5.20. The claimant and Work Coach research suggests that some of the reasons for the pattern in chart 5.3 might be:

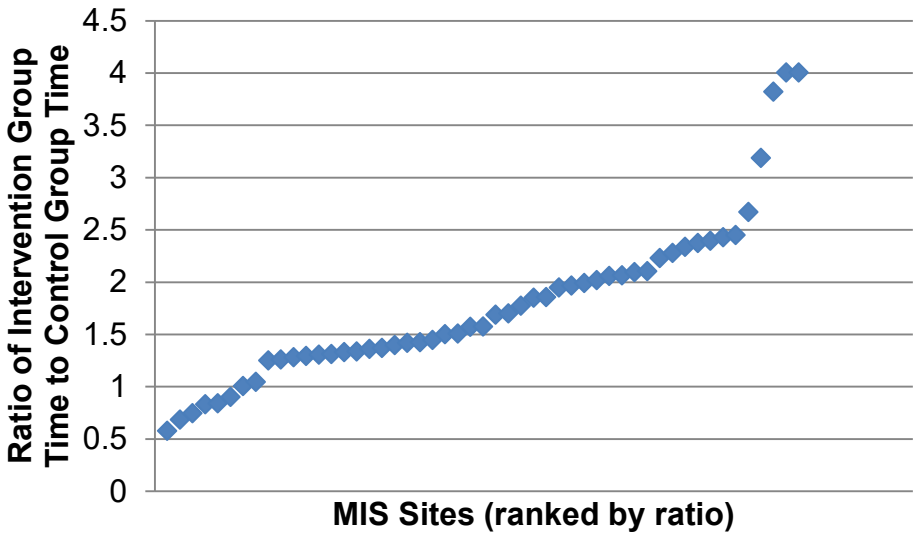
- Some post-WP claimants were very far from the labour market and difficult to help.
- Some claimants were regarded as unsuitable for the trial, often because their medical condition was deemed too severe to impose intensive requirements upon them (indeed, some were effectively exempted even though there was no provision for exemption in the trial design).
- Some staff felt uncomfortable treating the intervention group differently to the control, regarding differential treatment as 'unfair'.
- Similarly, if a member of the control group requested additional support then the Work Coach would provide that support under the 'business as usual arrangements'.
- Staff had limited time and/or high caseloads.
- And as with the pre-WCA stage, many interviews were held over the phone, which tended to be shorter than face to face.

- Some Work Coaches in MIS were unclear about the concept of 'minute allocation' which may have meant that they did not pursue the nominal 264 minutes.

5.21. Whilst Work Coaches did recall instances where the claimant received support on the WP, it was not uncommon for them to claim that claimants may not have been aware that they were receiving provision, that they received very little support (e.g. one phone call every two to three months), did not have basic needs such as literacy addressed and the Work Coaches therefore needed to 'start again'. On top of this, some claimants had been told by their doctors that they were unfit for work or might never work again so Work Coaches were having to address attitudes arising from that advice.

5.22. Expanding upon the third bullet of paragraph 5.19, site level data of MIS Work Coach meetings shows a large degree of variation. Chart 5.5 shows the ratio of support (measured in minutes, but measuring support by the number of meetings leads to similar conclusions) provided to the intervention group compared with the control group. The nominal ratio is at least three and could be expected to be as high as six (264 minutes over six months cf. 88 minutes over one year). However, some sites only delivered marginally more support to the intervention group whilst a small number actually delivered less. Notwithstanding the limited accuracy of the meetings data (durations are mainly in 10 minute intervals whereas meetings will vary around this increment), chart 5.5 tends to corroborate elements of the qualitative research that suggest Work Coaches struggled to deliver the trial model. Some Work Coaches stated that they 'wanted to choose' who to support, which whilst understandable is of course at odds with the trial design.

Chart 5.5 Ratio of support delivered to the MIS intervention group compared to the control group.



Source: Labour Market System August 2016

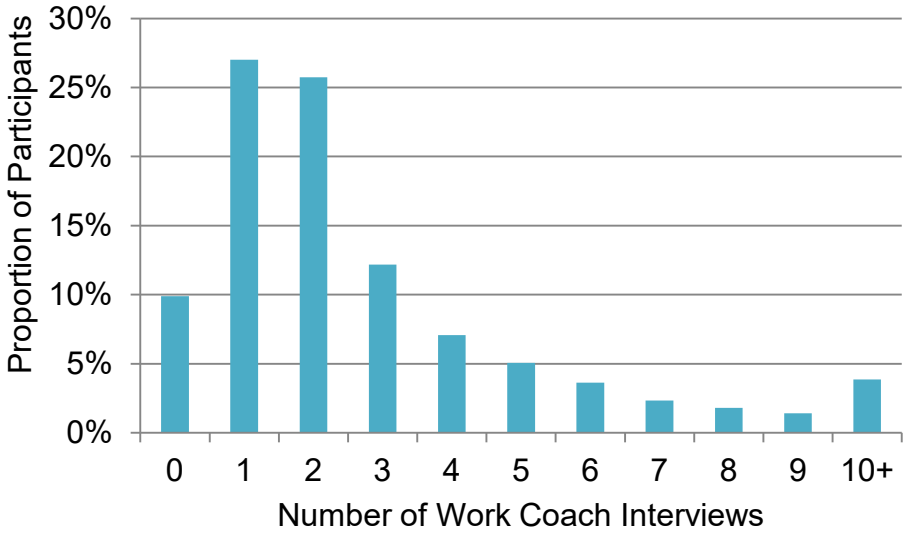
5.23. Charts 5.1 to 5.4 present average figures for particular spell durations. They give little information about personalisation. Charts 5.6, 5.7 and 5.8 below present the variation in the number of meetings. Equivalent charts of the durations show a similar pattern and therefore, for brevity, are not provided.

5.24. Notable is the fact that a significant number of people do not appear to attend any meetings:

- 10% for VEI,
- 6%, 5% and 3% for the CC pre-WCA, post-WCA and post-WP groups respectively, and
- 5% for both the MIS intervention and control group.

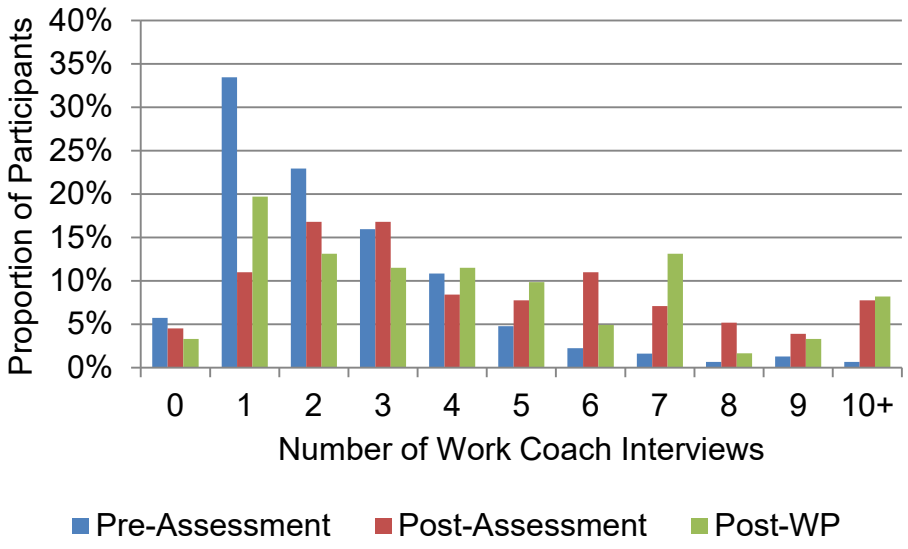
5.25. Some of the claimants who did not attend a meeting did actually make a booking during the trial period. The proportion of non-attendees that did book was roughly one third to one half (slightly more than half for VEI). The higher figure for VEI perhaps reflects the voluntary nature of the trial and the absence of any sanction for non-attendance. The qualitative research did suggest that some claimants did not fully appreciate that the VEI and CC trials were voluntary, particularly at the pre-WCA stage, so the non-attendance may be reflective of a lack of real interest in the trials. It is also possible that some of these cases are simply administrative errors whereby people were recorded as having joined the trial when in fact they had not.

Chart 5.6 Variation in number of VEI Work Coach meetings



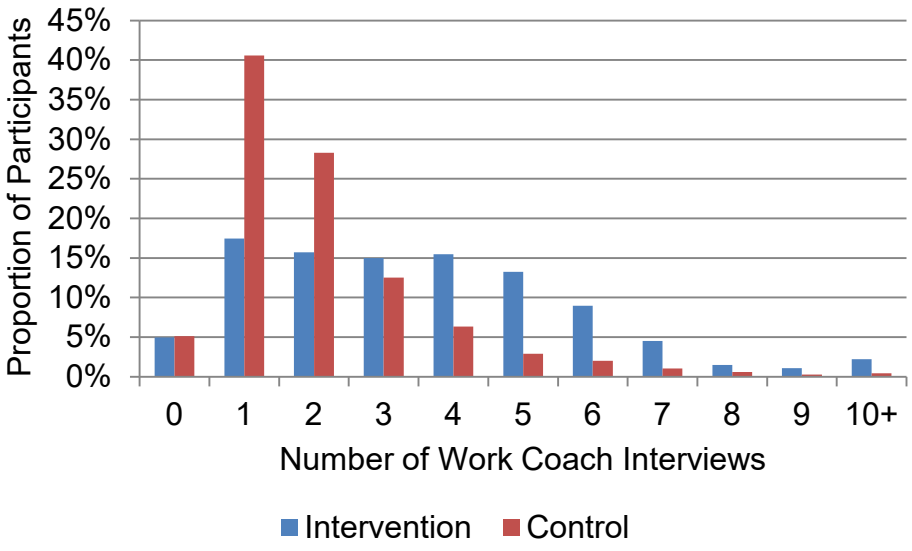
Source: Labour Market System August 2016

Chart 5.7 Variation in number of CC Work Coach meetings



Source: Labour Market System August 2016

Chart 5.8 Variation in number of MIS Work Coach meetings



Source: Labour Market System August 2016

5.26. The other pattern of note is that, where a trial involves voluntary meetings, the majority of participants attend only one or two, whereas the distribution of meetings in trials where meetings are mandatory tend to show a greater proportion of people attending larger numbers of meetings. The exception here is the MIS control group, the majority of whom only attend one or two meetings. But this group are only mandated to attend for 88 minutes per year, so one would not necessarily expect to observe more than one or two meetings in the 26 week period.

5.27. Regardless, the reason for drawing this distinction is because many voluntary participants could, in principle, attend a lot more meetings; as many as the mandatory clients given the time bank available to Work Coaches. The fact that they do not attend as many meeting is not due to the eligibility requirements; charts 5.1, 5.2 and 5.3 take into account spell durations and therefore there is the same opportunity to attend meetings at each of the points in time covered by the charts. But then, the fact that voluntary participants attend fewer meetings is perhaps not surprising given that the nature of mandation suggests that people may be required to undertake more activity than they would otherwise have done on a voluntary basis.

5.28. Despite some particularly common numbers of meetings being evident in some trial groups, what is also notable is the variation. A minority of participants in all trial groups attend ten or more meetings suggesting that Work Coaches are focussing more heavily on some claimants than others. As will be discussed shortly, it does not follow that a larger number of meetings are associated with those people who are closer to the labour market. Qualitative evidence suggests that frequent interactions could be pastoral or social as much as work focussed, depending upon the nature and severity of the claimant's condition.

5.29. Recalling the classification of Work Coach approaches, Work Coaches were observed to sometimes acquiesce to the claimant's view of their condition and were not often prescriptive. Further, encouraging and collaborative approaches were taken in response to a positive claimant attitude. This is consistent with the quantitative data in that it suggests a very varied amount of time is spent according to the varied natured of the claimants. Work Coaches appear therefore to be targeting their time and support (presumably where they think their time is best used) and not applying a uniform service. This is consistent with the idea of personalisation and flexibility and according to the claimant research appears to be in line with claimants' expectations and approval.

5.30. Whilst the nominal focus of the meetings is employment, both in the short and longer term, Work Coaches did report providing more pastoral support at times. The emphasis here could be to increase levels of social contact or to encourage claimants to overcome their anxiety about being in public spaces or in some instances to tackle their agoraphobia. In these cases, the conversation would be more about how the claimant felt and less about the work that they could do. Meetings of this nature might not be frequent, but they could be sufficiently regular to maintain that progress (as perceived by the Work Coach).

5.31. Within MIS, some Work Coaches made use of a ‘template’ that was designed by Work Psychologists to support the claimant conversation, and this was reported to be helpful. In other cases, and notably with MIS, the claimant’s condition might be so severe that the Work Coach effectively exempted them (partially or wholly) from the trial, hence the significant number of people with only one or two meetings. Claimants seemed to be content about this as some were happy to be ‘left alone’. Elsewhere, Work Coaches might put the onus on the claimant to guide the conversation on what they felt able to achieve in terms of WRA. Similar to the previous decision in this section, this approach is another example of personalisation, and arguably, acquiescence to the claimant’s view of their abilities.

5.32. The sometimes severe or sensitive conditions amongst MIS claimants is perhaps exemplified by the fact that where the meeting was in a Jobcentre Plus office this was occasionally held in a private room so that the claimant’s condition could be more freely discussed and sometimes a community practice nurse or mental health professional assisted in the discussion. Such cases evidence the claim raised earlier that Work Coaches had to deal with the ‘entire spectrum’ of claimant conditions.

5.33. As noted above, it should not be assumed that the hardest to help have fewest meetings. Pastoral support can be in the form of regular meetings focussing on the claimant’s wellbeing and not WRA. Alternatively, where someone is very far from the labour market Work Coaches might take a softer approach and encourage ‘baby steps’, which would be in keeping with the notion of multiple meetings over an extended period of time.

5.34. Neither can we say that prescriptive approaches are more likely to be associated with more meetings. The qualitative research suggested that prescriptive approaches sometimes developed into collaborative relationships, so it seems unlikely that these situations would have led to excessive number of meetings. That said, one might at least assume that multiple meetings took place in order for that relationship to have developed in the first place.

5.35. The reasons for low numbers of meetings are not strongly linked to any one reason for ending involvement in a trial. People who remain with a trial for the full nominal duration do tend to have more meetings than other participants, presumably because of greater opportunity and continued interest in support. However, the distribution of meetings for those who opt out (in the VEI trial, for example) is not dramatically different to those whose spell closes because of a WCA or a claim closure. Some Work Coaches did say that the claimant’s health condition was a strong driver of the frequency of meetings, and some Work Coaches were of the view that six hours was not needed for most

claimants so the reasons for the patterns in charts 5.6, 5.7 and 5.8 might be ones that hard to identify with the data available to this study.

5.36. Where lots of meetings are attended, according to the qualitative research they could sometimes be short catch ups to check up on progress, so frequent support does not necessarily mean extensive support (in terms of total amount of time).

5.37. The quantitative data is quite varied in that respect. Where a person only appeared to attend a single meeting, for VEI that meeting was often (i.e. in half of cases) very short, that is, around ten minutes. A few meetings of five minutes duration were recorded and these were reportedly (by the Work Coach) held with the less motivated claimants. For the CC trial, the meeting duration tended to be a bit longer (in 60% of cases it lasted 20 minutes) whilst for MIS it was nearly always the 40 minutes suggested by the standard guidance for the 'Work Programme Completer Interview'.

5.38. Where a person attended a relatively large number of meetings (e.g. 6 or more) for VEI and CC those meetings were most commonly 20 minutes in duration whereas for MIS, durations of 30 or 40 minutes were more likely. Meetings of 50 of 60 minutes duration were rare, typically around 1% of all meetings. However, we cannot rule out the possibility that some meetings extended significantly beyond the nominal duration.

5.39. In summary, the quantitative data and qualitative accounts between them describe a highly varied, often claimant driven service, with some people receiving no or very little support and others being given more support as part of a personalised, encouraging and collaborative interaction. It is also interesting to note that whether participation was viewed by the claimant as voluntary or compulsory, this appeared to make no difference to their level of engagement, which was reportedly more determined by perceived job readiness.

Work Related Activity

5.40. We next provide an overview of activities over and above attendance of meetings with Work Coaches. Whilst we do not know of activities that were not orchestrated by Jobcentre Plus, we do know where a participant attended a so-called 'Opportunity'. An Opportunity is usually a period of provision, sometimes contracted, or a referral to receive some kind of screening or advice (e.g. an assessment of a person's skills).

5.41. Table 5.2 shows the proportion of each trial group that attended at least one Opportunity during their trial spell, excluding referrals to physiotherapy, which

are discussed later in this section. The great majority of attended Opportunities were work related, commonly Work Experience. Therefore we do not elaborate on other types of Opportunity because they were the focus of very little activity during the trials. Neither do we offer an explanation for the variation in table 5.2 because the figures may reflect the areas in which the trials were run rather than another other aspects of the trial interventions.

5.42. We do note though that the qualitative research suggested that the CC was associated with higher levels of WRA and this corroborates the figures in chart 5.2.

5.43. We also note (though we do not show in table 5.2) that the subset of VEI participants for whom the OHA service was used attended more Opportunities than other VEI participants in that District (23% cf. 14%). Again, the majority of these are work related Opportunities. This may indicate that the greater confidence that Work Coaches gained from the professional advice (as evidenced by the Work Coach research) leads them to be more willing to suggest WRA. Alternatively, the increased number of Opportunities may be due to the greater number of meetings (see earlier) and therefore additional chances to suggest activities. There are some differences in the characteristics of those for whom the OHA service was used but none that can intuitively account for the different numbers of Opportunities.

Table 5.2 Attendance of opportunities other than physiotherapy

Trial Group	Number of participants considered[1]	Proportion that attended an Opportunity (%)
VEI	7877	11
CC Pre-WCA	313	14
CC Post-WCA	155	30
CC Post-WP	62	36
MIS Intervention	2084	5.2
MIS Control	2107	3.7

Source: Labour Market System August 2016

1 *Participants who joined the trial more than one month after the nominal recruitment end date are not considered in order to allow a reasonable period of time during which activities can be tracked.*

5.44. The differences in attendance of Opportunities (aside from the physiotherapy opportunity) between those who accepted, did not accept or were not offered physiotherapy within the BPP variant are marginal and not statistically significant. The data suggests that people who refused physiotherapy received less support and whilst this is true in terms of Work Coach meetings, almost the same proportion attend an Opportunity (3.3% cf. 3%, nearly all work related).

5.45. Overall, these figures show that over and above the Work Coach meetings there is a variable amount of activity and some of that activity evidences distinct steps towards moving into employment. We also reiterate that table 5.2 will not capture all activity, work related or otherwise. Not all signposting done by Work Coaches will be recorded as an Opportunity and many claimants may self-refer to some external organisation (indeed, in the CC research one Work Coach claimed that 'there was always some WRA'). In general, according to the Work Coach research, some of the services encouraged and/or signposted by Work Coaches include:

- Local mental health support
- Pain management or encouragement to see their General Practitioner
- Counselling services (including bereavement) and self-help groups
- Independent Living courses (arranged by the British Blind Institute)
- Motivational and confidence building courses.
- Activities intended to promote well-being (e.g. yoga, pottery, flower arranging),

as well as some of the more traditional services offered or encouraged by Jobcentre Plus such as,

- Registering with an on-line recruitment agency (mainly job ready claimants)
- Help with Curriculum Vitae writing and jobsearch
- Setting up a Universal Jobmatch account
- Voluntary work
- Referral to the National Careers Service for a skills assessment or some skills training such as in numeracy or literacy (some of these referrals will have been captured in the Opportunities data discussed above)

5.46. This list is certainly not exhaustive, but provides some insight into the types of solutions that Work Coaches consider as suitable steps towards employment and what is perhaps notable is that some (e.g. bereavement counselling) are possibly associated with the earlier stages in a process of recovery, which is consistent with the suggestion that many people taking part in the trials are quite far from the labour market and have medical conditions that need to be addressed before employment is an option (be this a perceived or actual barrier).

5.47. Beyond these activities, Work Coach advice might veer towards the psychological. For example, encouraging agoraphobics to leave the house or encouraging people with anxiety to visit a public place such as the Jobcentre

Plus office. Less contentious are softer approaches reported in the qualitative research whereby Work Coaches would encourage greater social activity, prompt claimants to employ 'positive thinking', try to shift focus on what the claimant can do rather than what they can't, and persuade claimants to visualise their future (from an optimistic perspective) as something to aspire and work towards.

5.48. So, some aspects of the Work Coach advice blur the distinction between employment advice and therapeutic support and raises questions as to the boundaries in the Work Coach function. Indeed, this was reflected in frustration and difficulties expressed in the Work Coach research, in deciding what constituted WRA and therefore what could be put on an Action Plan (AP) or CC. Related to this, some (less experienced) Work Coaches felt uneasy about how 'forceful' they could be with claimants. Setting deadlines for WRA was also an area where some Work Coaches lacked confidence, particularly in the voluntary trials where there was no obligation to undertake WRA. In such cases a concern was expressed that the claimant might incorrectly feel obliged to carry out some WRA that they had voluntarily agreed to, particularly where that claimant was of a vulnerable predisposition. Similarly, some Work Coaches expressed frustration where WRA was not carried out, presumably because this led them to feel their efforts were to no effect.

5.49. In some cases (notably in the post-WP groups), according to the Work Coach research, claimants could feel defensive about or threatened by the prospect of WRA. We cannot say how Work Coaches reacted in these situations, but as noted earlier, initially directive approaches were observed to develop into collaborative approaches, signifying a degree of acquiescence to the claimants' perspective of their abilities. Therefore, one should not presume that the claimant's attitude persisted throughout their involvement in the trial.

5.50. It would seem that approaches to negotiating WRA did vary, as evidenced by the variation in Work Coach approaches discussed earlier, and it is also evident that these approaches were perceived differently depending upon the typology of the claimant. A lack of confidence in how best to interact with and support some ESA claimants led some Work Coaches to believe that they needed training in dealing with health related issues (e.g. conversations with people who suffer poor mental health, understanding physical conditions and guidance on how best to help people with particular conditions). That said, some Work Coaches were of the view that they did not need to have that understanding because they were not medical professionals and therefore they could not be expected to provide solutions on health related matters. These contrasting views expose the difficulties associated with a work focussed service having to deal with claimants whose primary concerns and

needs are medical in nature. Those difficulties can be compounded by conditions that fluctuate whereby, owing to deterioration in health, previously achievable WRA may no longer be possible.

5.51. More generally, Work Coaches did express a need for more support in other areas, commonly a greater need for provision (and medical provision in particular), better links with local organisations (again, charitable and public sector health related organisations were raised), and more provision specifically tailored to ESA claimants from professional backgrounds.

On the CC

5.52. We have already commented that the CC was not particularly associated with more Work Coach meetings, but may have led to more WRA being undertaken. Wider benefits, from the Work Coach perspectives, include better structuring of conversations, more in-depth conversations and being able to track activities and progress better. Work Coaches did believe some claimants were more positive as a result of their conversations, though we do note that having those conversations at the same time as filling in the form was reported to be difficult, interrupting the flow of the discussion. That said, having all the relevant information together in a single place was considered helpful.

5.53. The regular review of activities was also deemed beneficial though the review period was reported (by Work Coaches) to vary from every meeting to only every face to face meeting, noting that many meetings took place by phone. When reviewing WCA some Work Coaches took on trust that that activity had been completed whilst others asked for evidence (such as print-outs or certificates).

5.54. Some Work Coaches believed that the CC worked better with pre-WCA claimants than post-WCA and post-WP claimants because the former were more focussed on work. However, and as mentioned earlier, the voluntary nature of activities on the CC form did raise difficulties insofar as there was no actual commitment in the pre-WCA period to carry out those activities.

5.55. The language on the CC form was considered off-putting by some Work Coaches. For example, the mention of ‘sanctions’ was not considered helpful. The CC form was also considered to be ‘more formal’ than the AP.

5.56. Other concerns include the structure of the form, the space available, duplication in the information and rigidity in those information requirements. The strong work focus was not always liked given that there might be a

'bigger picture', that is, the claimant might have wider difficulties that need to be overcome by smaller (and not necessarily directly work related) steps. Similarly, the CC was sometimes viewed to be 'pushing work' when the claimant was not ready for work at that time.

5.57. Some Work Coaches did not think the CC form added any value over the AP and did not improve the way that they interacted with and supported their caseloads. These views tended to be expressed by the more experienced Work Coaches. In summary then, Work Coach views were mixed as to whether the CC moved people towards more employment more speedily.

5.58. Claimants who took part in the research interviews sometimes did not recognise the term 'Claimant Commitment'. This may be because the term was not always used in the recruitment process. Indeed, some claimants were not aware that they were part of a trial, believing that the CC was just part of the normal process.

The VEI Variants

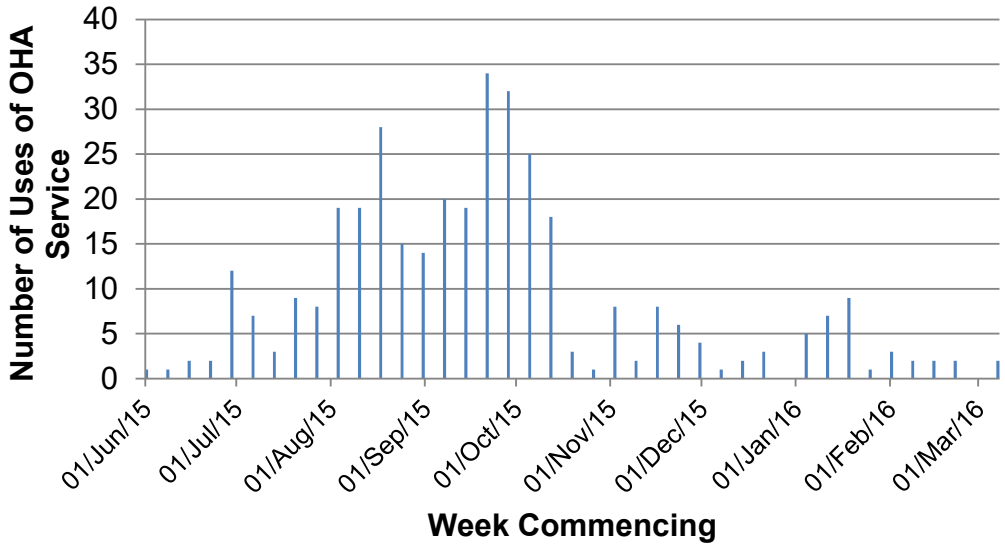
OHA

5.59. This OHA variant of VEI is conceptually rather simple involving as it does a Work Coach requesting advice from an Occupational Health Professional and receiving a written report and holding a follow up conversation.

5.60. Chart 5.9 shows the week by week pattern of usage of the OHA service. The usage is characterised by an initially low level that peaked in September 2015 and proceeded to reduce back to a low level. 470 referrals were purchased but according to the Labour Market System (LMS) data 361 were used. The OHA contract expired at the end of the 2015/16 financial year so there was ample opportunity to use the service beyond the peak in September 2015.

5.61. The pattern in chart 5.9 can be explained by the qualitative data and operational feedback during live running of the trial. Initially, levels were low due to limited awareness of the service, awareness of its value and knowledge of the administrative processes by which the OHA could be accessed. In response to the initially low number of cases managers of Work Coaches strongly encouraged the use of the service to the point where its use was very nearly deemed mandatory. However, when that managerial pressure abated so too did the use of the service.

Chart 5.9 Usage of the OHA service



Source: Labour Market System August 2016

5.62. That being said Work Coaches involved in the qualitative research reported using the service anything from 10 to 20 times and in one instance some 80 times. 14 Jobcentre Plus offices recorded uses of the OHA service, none more than 50 times. This suggests that there may be some under-reporting of the usage of the OHA service in chart 5.9, unless Work Coaches worked across sites and their uses of the service were attributed to multiple sites.

5.63. Qualitative research did provide examples where the Work Coach valued the OHA service, providing as it did a knowledgeable view of what a given claimant could achieve and what would be reasonable WRA under their particular circumstances. This gave some Work Coaches confidence that they were dealing with a claimant in an appropriate and 'professional' way. Work Coaches sometimes reported that they came away with a deeper understanding of the claimant's condition, such as potential side-effects and typical recovery times.

5.64. Some Work Coaches commented that the service was particularly useful when dealing with mental health cases. Statistical data suggests that people for whom the OHA service was used were less likely than other trial participants (in the OHA trial area) to primarily claim ESA because of a mental health condition. However, it is possible that mental health problems are more prevalent than that source of data suggests.

5.65. Other perceived benefits of the OHA service include better guidance on follow-up questions and suitable 'next steps' on the progression of WRA, improved awareness of 3rd party support that was available, checks on whether a return to a previous job role was appropriate and better liaison with

employers, for example, on the issue of negotiating reasonable adjustments in the workplace. Worked Coaches sometimes felt that the OHA service improved their understanding of the claimant's medical conditions and in some cases the Work Coach valued the service because it allowed them to check that the claimant's own perception or account of their condition was correct. Improved confidence was also noted by Work Coaches involved in the OHA trial.

5.66. Some Work Coaches reported that the OHA service had helped them to change claimants' perspective on their condition, particularly younger claimants who more readily envisaged recovery than older claimants. That said, the claimant research found it to be difficult to pick up on a clear difference in perspectives amongst OHA trial participants compared with the other pre-WCA trial groups.

5.67. Nonetheless, Work Coaches in the OHA trial did believe that claimants tended to view the advice that they imparted positively (and positive experiences were indeed reported in the claimant research). That being said, some claimants were reported (by the Work Coach) to have disagreed with the OHA, or did not like having their details shared with a third party organisation. And at least one Work Coach had the view that they benefited from the OHA more than the claimant, owing to the fact that some claimants were already knowledgeable about their condition and would have sometimes received advice from elsewhere.

5.68. Some more experienced Work Coaches did not think the service led them to provide different advice than they would have done anyway. Also, some Work Coaches used the internet to research claimants' health conditions and that approach may have led them to be less likely to call upon the OHA service.

5.69. Some Work Coaches felt that they were receiving the same advice as they had received before for a claimant with a similar condition. Where this was the case the Work Coaches might be using the service because of managerial pressure to do so and not because they believed that they needed the advice. Some Work Coaches refrained from using the OHA service because they had not received training in the referral process. For more difficult cases such as substance abusers and people with certain mental health conditions an OHA service was considered inadequate and more specific support was required. And on a different theme, there was a concern that if an employer refused to make 'reasonable adjustments' then the OHA service may not lead to real improvements to a claimant's job prospects (this was framed as a hypothetical risk – we did not have reports of any actual instances).

5.70. Despite the numerous positive reports, the data points to a very low ambient level of demand for an OHA service. However, the demand was not zero and given that the service was a remote one it is possible that maintaining a service on a national level may be commercially feasible, albeit with a level of demand that is lower than might have been presumed otherwise.

5.71. Some other concerns, raised within the Work Coach research included questions on the form, such as those related to 'work goals' which may not always be appropriate at that time. Calls from the OHA service were also missed on occasion so some Work Coaches expressed a need for a better appointment system. During those calls, the claimant would typically not be present, so some of the further details asked for by the occupational health professional would not be available. Finally, discussing confidential details during those calls, in an open-plan environment, was raised as a particular concern.

5.72. Suggested improvements include having an OHA service on-site, allowing the claimant to access the service directly, involve the OHA service in a three-way conversation with both the claimant and the Work Coach, a more detailed referral form and a streamlining of the administrative process which was noted as burdensome by some Work Coaches. Some Work Coaches thought that the service should be limited to the more complex cases as they believed simpler conditions were easier to deal with themselves.

BPP Variant

5.73. The BPP variant of VEI operated in South East Wales. The core VEI offer was available to all eligible ESA claimants but those participants with BPP were specifically offered a referral to a physiotherapy provider who would make an assessment as to whether that medical treatment was appropriate. People potentially eligible for the physiotherapy were either identified by referring to the details of their benefit claim or by chance should the subject come up in the Work Coach and claimant conversation.

5.74. Where the service was offered we do not have detailed information on the reason for the back pain but causes such as fibromyalgia, a slipped disc, arthritis, car accidents and repetitive activities in the work place were mentioned by Work Coaches involved in the qualitative research.

5.75. Guidance was set up to facilitate the delivery of the trial and this was supplemented by meetings with the provider, support from colleagues, workshops and meetings with other participating offices. Though we do note that the Work Coach research did identify cases where the Work Coach was

not clear on the boundary between the Jobcentre Plus role and the triage stage in respect of deciding who was suitable to go on for treatment. Better working with NHS was also mentioned as an operational need should the service offer be continued.

5.76. Approaches to offering the service did vary. Some Work Coaches offered the service to everybody who was seemingly eligible, trusting the triage stage to identify suitable participants. Other Work Coaches expressed enough confidence to bring their own judgement or 'common sense' to bear and only offered the service where they felt it appropriate. Some Work Coaches believed that only medics should be making this decision. Others still, believed that the decision should be the claimant's alone, though it is not clear how the approach of Work Coaches with this view differed to those who made a blanket offer to all seemingly eligible claimants. We note that a triage questionnaire provided by the physiotherapist was considered useful by some of the Work Coaches who took part in the staff research.

5.77. Where a person was offered physiotherapy that event should have been recorded on the LMS. If the person accepted the referral then the LMS should also record that in the form of a trial 'marker' and an Opportunity record created to track that person's progression through the referral process. The LMS data identifies 279 people as having been offered physiotherapy and 212 as having accepted, an acceptance rate of 76%.

5.78. However, Opportunities data identifies 233 people as having been referred to the physiotherapist (higher than the 212 recorded as accepting the offer), 183 of these 'started' the programme (we note that local data put this figure at 193 so there would appear to be some inconsistency in the recording of data). 11 of the 233 people have no LMS trial data and are only recorded by the Opportunities. A further 14 (eight of whom 'started' the support) did not have a consistent LMS marker set. In these cases, the marker indicated that they had refused physiotherapy (five cases), not been offered physiotherapy (seven cases) or not even volunteered for VEI at all (two cases). In a further six cases the LMS marker suggests that they had accepted physiotherapy but did not have any Opportunity so we assume that these people proceeded no further in the referral process beyond the meeting where physiotherapy was discussed.

5.79. By 'started', we do not mean underwent physiotherapy. Rather, we mean presented themselves to the provider and underwent the triage stage. It is at this point that the provider is able to request payment for their services to an individual claimant. Claims were made for 55 third treatments, 51 sixth treatment sessions and 36 tenth treatment sessions. In other words, of all those that reached the triage stage just 19% underwent the most amount of

sessions that DWP had agreed to pay for. Given that not everyone reached the triage stage, we can re-express that percentage as 15% or 17% of all people who initially agreed to the physiotherapy depending upon which source (the Opportunities or the LMS markers), is the more accurate reflection of levels of interest.

5.80. On the question as to the feasibility of the physiotherapy service, what we can say is that, where offered, the service is extremely popular. Few DWP programmes have an initial take up rate in the order of 70% to 80%. That said, given the attrition at later stages of the referral and triage process, the actual proportion that underwent some form of therapy is closer to 50%. This is nonetheless a very high figure.

5.81. Despite the high levels of interest amongst those eligible, total usage of the service was low. Work Coaches believed that as few as 5% to 10% of participants suffered back pain (others put the figure close to 20% or 25%). As a result a little over 140 people received treatment across an entire Jobcentre Plus District during an eligibility period of approximately 8 months[15] and these figures suggest that annual usage under the VEI model would amount to fewer than 10K participants per year. Given that recruitment to the BPP variant was reliant upon there being a VEI Core-like service in place as well, and that support for volunteers not referred to the physiotherapy service would need to be funded, the feasibility of a physiotherapy service in the form that was tested here is questionable.

5.82. The number of referrals stipulated in the provider contract was not sufficient to ensure a physiotherapy service in all main population centres within the South East Wales District which will have increased travelling distances for some claimants. Nonetheless, there was strong support for this offer amongst Work Coaches involved in the BPP variant of VEI (though at least one Work Coach thought that the service should be offered through the NHS). Many suggested that it improved engagement with claimants, allowed them to offer tangible and beneficial support, and that it should part of the 'mainstream offer'. In particular, some Work Coaches thought the Cognitive Behavioural Therapy aspect of the service to be particularly useful. This was because, in their view, mental health problems could be more common than back pain. So common that they held the view that having a physiotherapy service was a lower priority. Indeed, even for some claimants with back pain, some Work Coached believed that poor mental health was the greater barrier to employment.

[15] Referrals did not take place towards the end of the contract period because all payments needed to have been made by the end of the 2015/16 financial year.

5.83. Indeed Work Coaches did note improvements in both the physical and mental health of physiotherapy participants and some did believe that the physiotherapy led claimants to return to work more speedily, resulted in improved 'positivity' in their conversations and led to claimants considering a wider range of jobs. That said, there were cases where other barriers such a skills shortages hindered movement back into work despite the physical improvement in the claimant's condition.

Concluding comments

5.84. To summarise the evidence presented in this chapter, both the qualitative research with claimants and Work Coaches reported a wide range of medical conditions, distances from the labour market and levels of claimant self-efficacy and the need to personalise may necessitate the variation in levels of support that we quantitatively observe. Nonetheless, the majority Work Coach view was that early engagement was crucial to engendering a more positive mind-set to future employment. That said, claimant conditions sometimes preclude WRA pre-WCA and many Work Coaches felt that imposing WRA would therefore be inappropriate. Accordingly, one might infer that the perceived benefit of pre-WCA support in some cases is more about changing or maintaining attitudes as opposed to tangible forms of support. Nonetheless, the significant use of work related Opportunities amongst the pre-WCA client groups does suggest tangible support for some claimants is a practical solution.

5.85. Conversely, at the post-WP stage in the claim, Work Coaches could hold the view that support was too late, that claimant's conditions had deteriorated and distance from the labour market increased. This sometimes led to a negative claimant attitude and therefore engagement with those claimants was more difficult. This agrees with the claimant research, which found the 'work not possible' group to be more prevalent in the post-WCA and post-WP stages and claimants to be less interested in employment related support. All of which is corroborated by the quantitative data which does indeed show post-WP claimants (mainly in MIS) to be more likely to suffer a mental health condition, to be less likely to undertake WRA (the small CC post-WP group excepting) and to have received significantly less Work Coach support than the trial design suggested.

5.86. ESA claimants can sometimes be regarded by Work Coaches as a particularly challenging group to work with, with some staff finding delivering the support 'daunting' and 'uncomfortable'. There was recognition that Work Coaches could benefit from a better understanding of medical conditions. In particular, where people suffered poor mental health Work Coaches

expressed a need for assistance or training. The nature of the Work Coach concerns was not just in how best to support someone with a mental health difficulty but also how to hold a conversation with some types of people. For example, if a claimant said that they had suicidal feelings then Work Coaches would have to be particularly careful about what they said to that claimant[16].

5.87. Another area where there was a perceived need for further training and guidance concerned what did and did not qualify as WRA and what was reasonable to request of claimants, which will of course vary according to their condition and their individual circumstances. Related to this, Work Coaches raised concerns about the possibility of adverse consequence should the WRA turn out to be not appropriate for the claimant.

5.88. In this respect, where the OHA service was used, in the VEI variant, Work Coaches said that they appreciated the advice, with it giving them a better idea of the claimant's abilities and what WRA would be suitable, based upon 'scientific fact' and not opinion. We note though, that more experienced Work Coaches often considered the OHA service to simply confirm their pre-existing view or knowledge. Quantitative data suggests that the perceived benefits were not enough to ensure widespread and consistent usage of that service. Nonetheless, advice from an Occupational Health professional was a form of support that was repeatedly raised as a potential need in the Work Coach research, ideally on-site though this was acknowledged as being potentially prohibitively expensive.

5.89. Similarly, some Work Coaches held the view that, not being medical professionals, there should be no expectations for them to have specialist medical knowledge, or they held the view that continuous learning on the job was sufficient to equip Work Coaches with the skills to deal with ESA claimants. Relatedly, some Work Coaches expressed a need for improved working with the NHS and training in how to work with people who have terminal conditions (though it is not clear whether this was said in the context of the trials or in relation to the Work Coach's general role).

5.90. Some less experienced Work Coaches suggested that they 'learned from their mistakes' and others expressed concerns that a general Work Coach function, supporting all DWP client types, would make dealing with ESA claimants more difficult (the OHA service was mentioned as a possible solution to this). These comments exemplify the demand for training more

[16] DWP provides guidance for handling customers' declarations of intention to attempt suicide or self-harm, though the qualitative evidence does not reveal the degree to which Work Coaches are aware of that guidance or how useful they find it to be.

specifically tailored to the ESA client type, particularly for more recently recruited Work Coaches.

5.91. A recurrent theme was the benefit that Work Coaches gained from the support received by colleagues, by attending regular trial meetings, by visiting nearby or 'model' offices or a trial's 'Single Point of Contact' illustrating the benefits of professional networks in the Jobcentre Plus environment.

5.92. On the CC, whilst the training and guidance was generally viewed to be sufficient (though some Work Coaches said that they were often too busy to read the guidance), some of the areas where Work Coaches said further training or guidance might be beneficial included what action to put on a CC and how to update the CC (which may mean how best to build upon earlier activities). Potential solutions such as discussions and reviews with other Work Coaches were mentioned in relation to these difficulties. We do note though that where Work Coaches had had prior experience of using the CC, with JSA claimants, they were more confident with using the CC with ESA claimants

5.93. Training in 'selling' the CC was another issue that was raised, which on the one hand might be considered superfluous once the CC becomes mandatory but nonetheless, gaining 'buy-in' would still be beneficial, suggesting a need for a continued focus on how to 'sell' the intervention.

5.94. In general, the difficulty with working with particular types of ESA claimant has led to a degree of insecurity amongst some Work Coaches and a resultant reluctance to challenge claimants. This accords with some claimant experiences where acquiescent approaches were noted, and encouragement was sometimes in response to the claimant's own positive views of their abilities. Encouragement was less evident, though not absent, as a form of challenge to negative perceptions. This might explain why the claimant research provided little evidence of significant change from one typology to another and more evidence of improvement within that typology.

6. Impact Assessments

Voluntary Early Intervention

6.1. The Voluntary Early Intervention (VEI) trial was a quasi-experimental design, which means that a control group was not built into the trial's implementation but was constructed from outside the trial. The aim of any quasi-experimental approach to constructing a control group is to predict what would have happened to some intervention group in the absence of that intervention. Clearly we cannot know this, even had we designed a control group into the trial. However, if we can identify a group of people who are sufficiently similar to the intervention group, in ways that are relevant to the outcome under consideration, then we can assume that the control group's outcomes are a reasonable analogy to the so called 'counterfactual' for the intervention group.

6.2. A simple way to construct such a control group would be to identify one or more individuals with exactly the same characteristics as each person in the intervention group and compare their respective outcomes. However, we typically need to consider so many characteristics that there are in fact very few individuals in the group of potential controls that share all the characteristics of people within the intervention group. This is commonly known as 'the curse of dimensionality'.

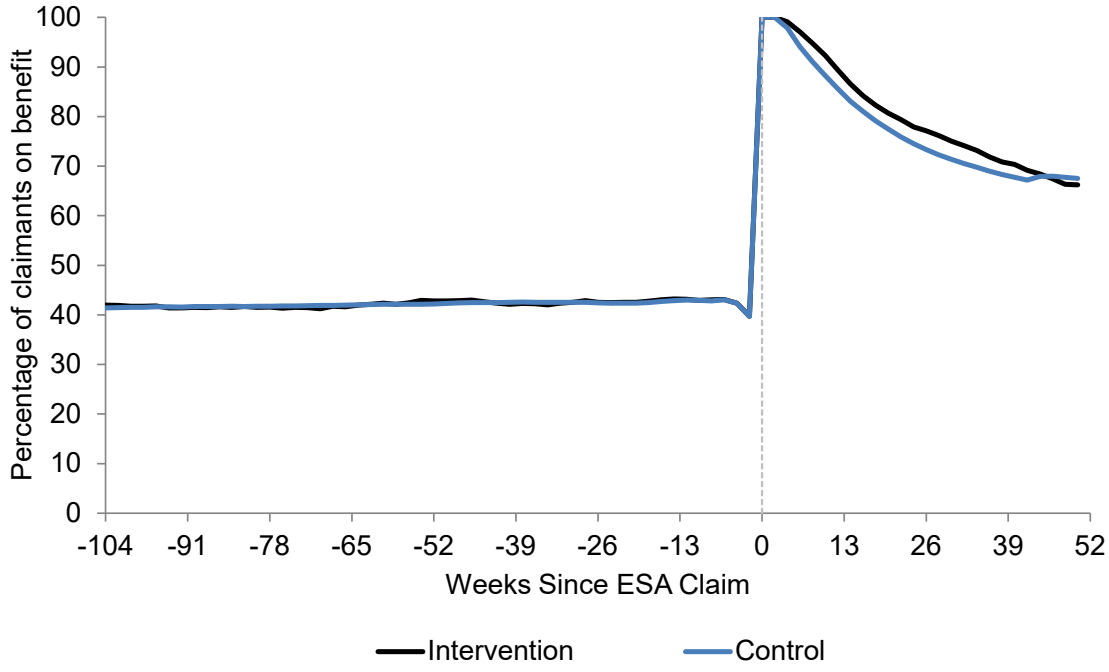
6.3. An alternative approach is to identify a group of people who, at a population level, have the same overall characteristics of the intervention group even if any individual in the control group is not exactly alike an individual in the intervention group. This is, in fact, what one can expect in a Randomised Controlled Trial (RCT) and therefore all quasi-experimental approaches seek to do is to replicate the distribution of characteristics that an experimental trial aims to achieve.

6.4. The approach for constructing a quasi-experimental control group that we have used is a method called Propensity Score Matching (PSM). A brief summary of that method and the way that we have structured our analysis is provided in Annex E. Using PSM we were able to identify a control group that is similar to the intervention group in all characteristics that we were able to measure (those characteristics are described in Annex D).

6.5. Chart 6.1 shows the intervention and the control groups' presence on benefit in the time period before and after the claim that led to participation in VEI. We have aligned the groups according to the first day of their Employment

and Support Allowance (ESA) claim and not according to the point of recruitment because members of the control group have no point of recruitment (though it would be possible to estimate a proxy) and because aligning to the point of claim means that we can rule out differences in claim duration contributing to the measured difference in pre- and post-trial presence on benefits.

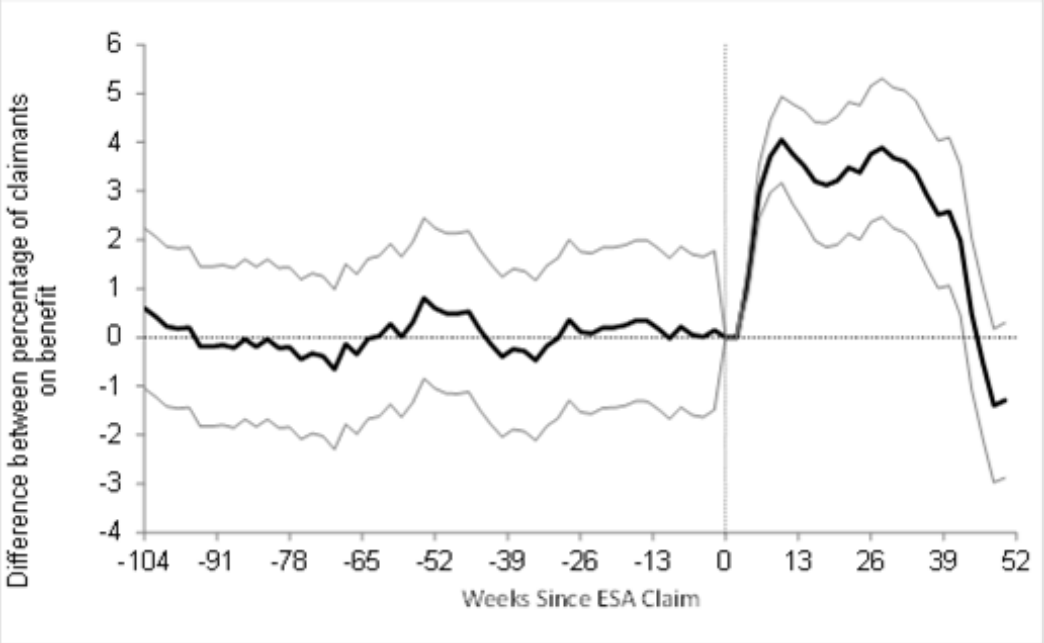
Chart 6.1 Proportion of the core VEI intervention and control group that are claiming DWP benefits



Source: DWP Benefits Administrative Data July 2016

6.6. Chart 6.2 shows the difference between the curves shown in chart 6.1. Also shown are the 95% confidence intervals around that difference. Given that we have tested VEI with a sample of claimants the confidence intervals describe the range of values the true difference is likely (to a 95% degree of confidence) to lie within.

Chart 6.2 Difference in the proportion of the core VEI intervention and control group that are claiming DWP benefits



Source: DWP Benefits Administrative Data July 2016
Positive values signify that VEI participants are more likely to be on benefits than the control group.

6.7. Charts 6.1 and 6.2 do not provide evidence that VEI has had a positive impact upon benefit outcomes. Indeed, for a limited period of time (to around 10 months after the start of the ESA claim), the charts actually exhibit a negative impact. In other words, for a period of time, VEI results in claimants spending more time on benefits and not less. Essentially, there are two general reasons why we might be observing this difference.

6.8. VEI participants have different characteristics to other ESA claimants and our matching process might not be fully correcting for the 'selection bias' intrinsic to the intervention group. We have data on a wide range of personal characteristics and labour market behaviours (see Annex E) and our methodology has allowed us to put together a control group that has similar characteristics to the VEI group in respect of these 'observable' drivers of benefit and employment outcomes. However, in common with all PSM studies we cannot rule out the existence of differences in unobserved factors.

6.9. However, if some unobserved bias remained, not only would it have to cancel out a non-trivial effect of VEI (assuming VEI did lead to people leaving benefits more quickly) it would also have to have led to an apparent negative impact of some several percentage points.

6.10. Alternatively, it may be that VEI does indeed lead to claimants remaining on benefits longer than they would have otherwise done. The qualitative data does not unequivocally account for this difference but we might refer to conclusions made earlier in the report that claimants are often primarily focussed on their medical recovery in the early stages of their ESA claim and that Work Coaches could sometimes acquiescence to the claimants' view of what they could achieve in terms of Work Related Activity (WRA) and employment. Empathy and sociability may have a reassuring effect such that claimants feel less pressure to move off benefits than they might have done at the outset of their claim. Conversely, people who do not attend Work Coach meetings may not have this reassurance and uncertainty about the expectations placed upon them may lead them to seek employment earlier than VEI participants.

6.11. There are other possibilities that may account for the apparent difference in labour market behaviours. However, neither the qualitative nor the quantitative data supports or refutes any particular explanation. Therefore, we do not elaborate on those possibilities given that the evidence does not lead us to believe that they played a significant role in the VEI trial.

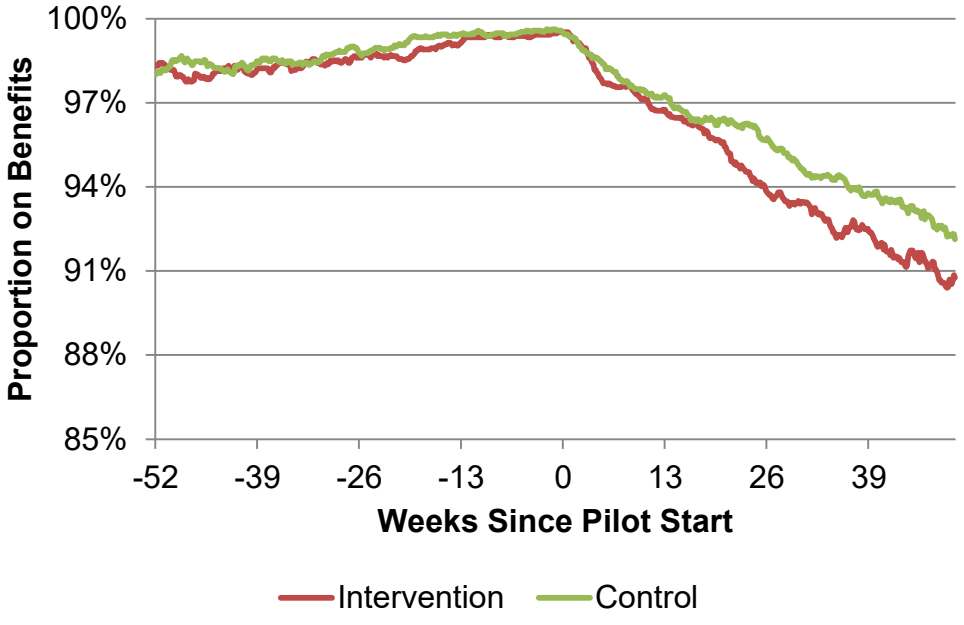
6.12. We do not preclude continued study of the VEI data in order to explore further the characteristics of the VEI population and ways of constructing a balanced counterfactual in respect of more of those characteristics. We note that we only track VEI and control participants for 52 weeks in charts 6.1 and 6.2. It is possible that at later claim durations VEI participants might leave benefits more rapidly than the control. However, we do have more recent data for a limited number of trial participants (those who were recruited the earliest) but at the time of conducting our analysis this data does not support that suggestion. We do not show that data here because it is insufficiently complete and stable.

More Intensive Support

6.13. More Intensive Support (MIS) was an RCT so much of the discussion with VEI does not apply. A control group was designed into the delivery of the trial. Further, the random allocation process was implemented very well, with a misallocation rate of just 0.3%. Regardless of that rate, in our analysis we allocate people to the nominal group and not the actual group. This improves the chances that our estimate of the impact is unbiased, but because some people in the control group actually underwent the intervention and some in the intervention group experienced the 'business as usual' service, this, in principle reduces any observed differences in outcomes between the two groups. In the case of MIS, because of the very low misallocation rate that reduction will be negligible.

6.14. Annex D lists a range of characteristics for both the intervention and the control group and this data confirms the equivalence (in observable characteristics) between the two groups. We also checked trial participants' presence on benefits and in employment prior to joining the trial (see chart 6.3). Most people had spent most of their time on the Work Programme (WP), so there is little scope for differences to exist in that time period. Nonetheless, to confirm their prior status, the charts that profile the benefit and employment outcomes and the trial's impact upon those outcomes also show pre-trial behaviours in order to illustrate the absence of biases in those behaviours.

Chart 6.3 Presence on benefits of the MIS intervention and control groups

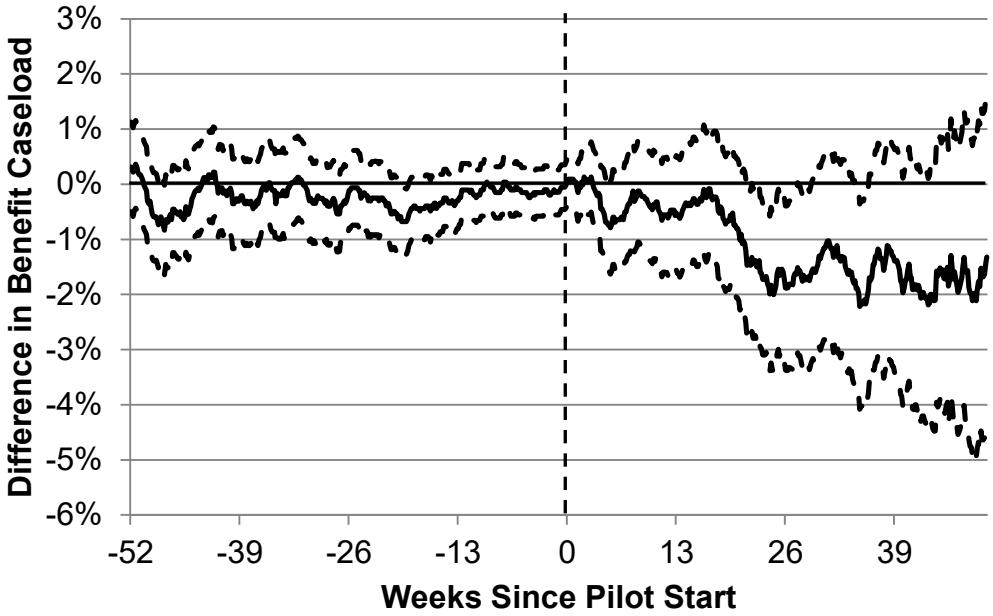


Source: DWP Benefits Administrative Data July 2016

6.15. Chart 6.3 shows the presence on DWP primary benefits of the intervention and the control groups, before and after trial recruitment. Chart 6.4 shows the difference between the curves in chart 6.3 and the 95% confidence intervals around that difference. Given that we are measuring outcomes from a sample of people the confidence intervals define the range of values that we can be 95% sure that the true difference lies between. If the x-axis (i.e. zero impact or difference) lies outside of this range then the chance of that difference being due to random variation alone is smaller than 1 in 20. Conversely, if the x-axis lies within this range then it is not unlikely that the difference occurred through chance alone.

6.16. Chart 6.3 corroborates Work Coach claims that this group is very hard to help insofar that very few people move off benefits in the period of time after completing the WP. By 39 weeks, significantly more than 90% of intervention and control participants remain on DWP benefits. However, chart 6.3, and more clearly chart 6.4 also shows that members of the intervention group move off benefits more quickly than members of the control group. This is despite the fact that the additional support that the intervention group received is less than that described by the trial design.

Chart 6.4 Difference in presence on benefits between the MIS intervention and control groups



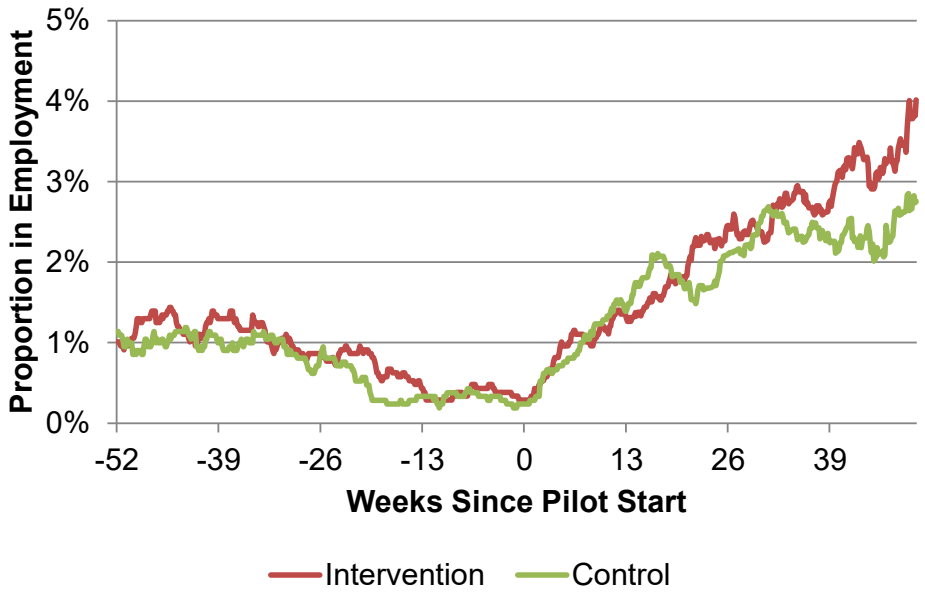
Source: DWP Benefits Administrative Data July 2016
Negative values signify that MIS participants are less likely to be on benefits than the control group.

6.17. The peak benefit impact shown in chart 6.4 is 2.2% +/-1.8% and occurs around 34 weeks after starting the trial. However, the impact is sustained over the longer term and may increase further as participants are tracked for

longer periods of time. When expressed in terms of cumulative days off benefit we measure an additional 3.2 days off benefit +/-5. The figure of 3.2 days is measured from the central estimate of the difference in benefit receipt from the point when participants joined the trial. The upper and lower margins of error are measured over the same period of time. However, because the margins of error at any one point in time allow for a wide range of possibilities, so too does the margin of error on the overall days off benefit. We could have measured the impact, and the margins of error around that impact just from the points at which the difference is statistically significant (with a 95% degree of confidence). However, this would have led to an unduly conservative value of the central estimate of the net impact.

6.18. Charts 6.5 and 6.6 respectively show the employment rates and the differences in employment rates of MIS participants before and after recruitment onto the trial. Charts 6.5 and 6.6 broadly corroborate charts 6.3 and 6.4 in that very few people appear to be in employment prior to trial recruitment and very few are in employment after. However, a (non-statistically significant) difference appears to be emerging some seven to eight months after recruitment. To date, cumulatively, that difference amounts to 0.5 days +/- 3 days. However, chart 6.6 suggests that the difference is increasing and therefore we could expect to measure a larger impact if we tracked for longer periods of time.

Chart 6.5 Employment rates of MIS intervention and control groups

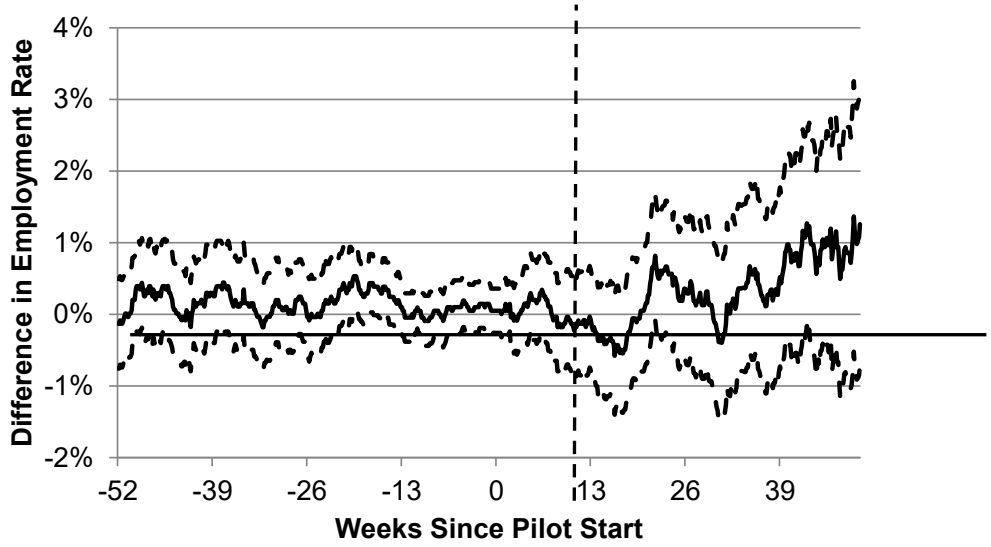


Source: HMRC's P45 data

6.19. Whilst we do measure a positive difference in employment rates during and after participating in MIS, over the time period considered that difference is

not statistically significant with a 95% degree of confidence. The upward trend in that difference may mean that in the longer term the difference does become statistically significant. Also, as we stress in Annex B, our employment data is known to under-represent some types of job such as self-employment. Large time lags in that data also limit how quickly we are able to pick up on any impacts. Therefore, the smaller differences shown in chart 6.6 compared with chart 6.4 do not necessarily mean that fewer additional people are moving into employment than move off benefits.

Chart 6.6 Difference in employment rates of MIS intervention and control groups



Source: HMRC's P45 data
Positive values signify that MIS participants are more likely to be in employment than the control group.

6.20. It would appear then, that MIS has been successful in moving participants closer to the labour market, albeit marginally. The qualitative evidence with both Work Coaches and claimants suggests that participants are not as close to the labour market as the theory of change model assumed, which probably explains why the benefit and employment impacts are not large. There is evidence of a high degree of personalisation, though the evidence on both progress with softer outcomes and the involvement of third parties is relatively limited. Therefore we would conclude that the theory of change model was partially realised in the implementation of MIS and the improvement in outcomes is only a marginal one as a result.

Subgroup Analysis

6.21. We complete this chapter with an overview of the impacts measured for particular subgroups of MIS participants. Tables 6.1 and 6.2 show our central

estimates of the cumulative (over 12 months) additional days off benefit and in employment for each subgroup. Also shown are the margins of error, represented by the lower and upper bounds of the range in which we can be 95% sure the true value lies within.

6.22. We are unable to confirm that MIS did have an impact for most subgroups. This is largely because of the small numbers of people in those subgroups and therefore the wider margins of error. Because the margins of error cover a wide range of values, we are unable to rule out the possibility that the difference in outcomes is due to chance alone. The exception is for people of a white ethnic origin, for whom a statistically significant benefit impact can be identified, but this is mainly because they comprise the great majority of participants and therefore the margin of error is not much larger than for the MIS group as a whole.

6.23. The wide margins of error for all subgroups also mean that we cannot unambiguously say whether one subgroup impact is larger or smaller than another. Whilst we do measure a difference, that difference may be down to chance and not because of differential impacts of MIS. Nonetheless, we present those differences in tables 6.1 and 6.2 but stress the caveat that the data only describes the trial participants and little can be inferred about how MIS would perform more generally for these subgroups.

Table 6.1 MIS subgroup benefit impacts (additional days off benefit)

Subgroup	Central Estimate	Lower Bound[1]	Upper Bound[1]
All	-4.1	-9.9	1.7
E&SE Scotland	-6.5	-16	2.5
Kent	0	-12	12
West Yorkshire	-4.7	-14	4.8
Male	-2.8	-11	5.5
Female	-5.5	-14	2.7
Under 40	-2.4	-13	8.7
40 to 49	-5.6	-15	3.4
50 or over	-4.1	-14	5.9
Mental Health Problem	-3.9	-11	2.7
No Mental Health Problem	-4.5	-16	7.3
White	-6.3	-12	-0.2
BAME[2]	13	-9.9	36

Partner	0.3	-15	15
No Partner	-4.9	-11	1.4
Child[3]	-2.4	-14	8.9
No Child[3]	-4.6	-11	2.1

Source: DWP Administrative Data

1 Represents the range of values that we can be 95% certain that the true impact would lie within.

2 Black and Minority Ethnic: does not include cases where the ethnicity is not known

3 Includes dependent children aged under 16.There may be some under-reporting of parental status in our administrative data.

Table 6.2 MIS subgroup employment impacts (additional days in employment)

Subgroup	Central Estimate	Lower Bound[1]	Upper Bound[1]
All	1.2	-2.6	5
E&SE Scotland	2.6	-3.7	8.9
Kent	0.4	-6.8	7.6
West Yorkshire	0.3	-5.8	6.3
Male	-1.2	-6.6	4.1
Female	3.6	-1.7	9
Under 40	1.7	-6.4	9.8
40 to 49	-0.3	-5.6	5
50 or over	1.7	-4.1	7.5
Mental Health Problem	-1.1	-5.5	3.3
No Mental Health Problem	6.7	-0.7	14
White	1.8	-2.3	5.9
BAME[2]	-6.5	-17	4.3
Partner	-2.9	-10	4.4
No Partner	2	-2.2	6.3
Child[3]	-3.2	-10	3.7
No Child[3]	2.5	-1.9	7

Source: DWP Administrative Data

1 Represents the range of values that we can be 95% certain that the true impact would lie within.

2 Black and Minority Ethnic: does not include cases where the ethnicity is not known

3 Includes dependent children aged under 16.There may be some under-reporting of parental status in our administrative data.

7. Overall Lessons

Pre-Work Capability Assessment

7.1. The qualitative Work Coach and claimant data on the pre-Work Capability Assessment (WCA) stage of the Employment and Support Allowance (ESA) claim generally supports the policy of providing support during this part of the claimant journey. Intervening early on in the ESA claim, at a time that fits in with the claimant's treatment and recovery schedule, has broad approval from Work Coaches and claimants alike. However, where that support is voluntary, clear communication is important given that some claimants did not appear to be fully aware that the pre-WCA support was voluntary.

7.2. There is a clear motivation to work amongst many claimants, if not immediately then at some point in the future, and where this is the case an engaging and collaborative Work Coach approach is conducive to a more positive attitude towards Work Related Activity (WRA) and employment. That said, a quantitative impact assessment does not provide evidence that pre-WCA support leads people to move off benefits more speedily, so the justification for providing early intervention would have to be based upon non-monetary benefits, in the short term at least. We cannot rule out positive monetary benefits in the longer term.

7.3. Where a claimant did not think that their Work Coach understood their medical condition and the restrictions that this imposed, they expressed dissatisfaction with the support that they received. Conversely, 'empathetic' approaches were more associated with a positive claimant experience. Relatedly, many Work Coaches expressed a need for training on dealing with health issues, particularly mental health. In principle, the Occupational Health Advice (OHA) variant of Voluntary Early Intervention (VEI) provided a solution to this. However, in the absence of managerial pressure, levels of demand for this service were very low, despite that fact that when used, the service was often (though not universally) valued, providing as it did a professional view of what WRA the claimant could carry out and would be beneficial for them.

7.4. Several Work Coaches expressed a lack of confidence in negotiating WRA with ESA claimants, both in respect of what qualified as WRA and what was reasonable to ask of claimants. For example, where a claimant was far from the labour market and/or their medical condition severe, activities and support could sometimes be pastoral in nature, with the Work Coach providing social contact and encouraging other activities outside of the claimant's house. Some Work Coaches were not confident that those activities truly qualified as WRA. Further, because Work Coaches were not

health professionals they sometimes acquiesced to the claimant's view of what WRA was and was not reasonable. This may have contributed to the absence of a positive quantitative impact in the VEI trial. If claimants determined the nature and timing of WRA more than the Work Coach then this may not speed up the progress back into the workplace.

7.5. On the Claimant Commitment (CC), some (mainly less experienced) Work Coaches did suggest that the form helped structure their conversations and allowed them to track claimant progress more easily. Indeed, the CC trial was associated with higher levels of WRA. However, more experienced Work Coaches did not think that the CC added value and there were some criticisms of the language within the CC form and frustrations with the use of the CC in a voluntary context. Work Coaches applying the CC, in common with Work Coaches involved in the other trials, also attested to a lack of confidence on what constituted WRA and what was reasonable to ask of claimants.

7.6. Also evident was a frustration that Work Coaches were not able to provide support on medical related matters, partly because of provision gaps but also due to the limited nature of local partnerships. Where a 'tangible and beneficial service' was offered in the 'Back Pain Pilot' (BPP), the service proved popular with both Work Coaches and eligible claimants. However, the BPP model involved additional overheads through the core VEI recruitment process (and associated support) which evidence suggests does not lead to monetary savings in and of itself so the cost effectiveness of providing a physiotherapy service via a VEI core-like recruitment process would seem doubtful. There might however, be other ways of providing access to a physiotherapy service that are more feasible.

7.7. Some views expressed by both Work Coaches and claimants suggested that post-Work Programme (WP) claimants, to be found in the CC and More Intensive Support (MIS) trials, could be very far from the labour market and might present Work Coaches with severe medical conditions. In some cases Work Coaches wholly or partly exempted claimants from the trial. In other cases support was more pastoral in nature. Work Coaches in some sites did not distinguish between the intervention and the control group, treating each individual according to their perceived needs. Nonetheless, Work Coaches were able to make marginal impacts upon benefit outcomes for this group (within the MIS trial, the CC trial was not a quantitative one), amounting to 3.2 additional days off benefits in the 12 months following recruitment. Despite the reported difficulties in working with this group, and the view that support has come 'too late', Work Coaches do often believe that support should be continued at this stage of the ESA claim albeit over a longer period of time than the trial duration of six months.

7.8. In general, the qualitative research identified three types of claimant: those who felt job ready now; those who felt work was possible in the future but not now; and those who thought they will never work again. Qualitative research suggested that support for the first group (job ready) was seen as being of limited value as many of these claimants were already highly motivated and were taking steps to move back into the work place of their own volition. Conversely, those who believed that they would work in the future were more willing recipients of support and appeared to benefit from that advice and support, particularly where a collaborative and engaging Work Coach approach was employed. There was little sign of progress amongst those who did not think they would ever work again and some Work Coaches acquiesced with that view, sometimes, but not always, deprioritising those claimants in the process. There is no doubt that changing attitudes amongst this group is a particular challenge and this evaluation did not find a great deal in the way of solutions. However, the fact that the MIS trial, where the 'never work again' group is most prevalent, did achieve a marginal quantitative impact suggests that changing attitudes may well be possible.

Annex A Further Details on the Trials

Voluntary Early Intervention

The Voluntary Early Intervention (VEI) trial operated in four Jobcentre Plus Districts. Two ran the core VEI model only, one ran the Occupational Health Advice (OHA) variant and the other ran the Back Pain Pilot (BPP) variant. Those Districts are as follows:

- Black Country (core)
- Central Scotland (core)
- Birmingham & Solihull (OHA)
- South East Wales (BPP)

Recruitment started on the 23rd March 2015 and nominally continued until the end of December 2015. However, because of the Christmas break the final recruitment date is likely to have varied.

The recruitment process targeted claims of at least 4 weeks duration on the assumption that providing support to extremely short term claimants would add little value. Beyond that period, all new and repeat Employment and Support Allowance (ESA) claimants were included in the trial with the following exceptions: claimants on the Work Programme (WP) or Work Choice provision and ex-Incapacity Benefit reassessment claimants. Claimants with a terminal illness or suffering from cancer, claimants with an appointee and Pension Credit claimants, were not contacted in the formal recruitment process but could opt in if they wished. The following claimants were included in the entire trial: credits only claimants; appeals cases; full time carers; Multi Agency Public Protection Arrangement claimants; lone parents.

Claimants in scope were identified from DWP's administrative systems and on the basis of the trial design. Up to three attempts were made to contact each person by phone. Where contact could not be made, a follow-up letter was sent. Some sites, which had the capability, sent texts either before or after the phone calls. However, this was not a formal part of the trial design.

Occupational Health Advice model

The OHA model ran in the Birmingham and Solihull Jobcentre Plus district. Owing to the additional time taken to establish contractual agreements the OHA service was not in place until June 2015. However, the contract ran beyond the end of the recruitment period, into the end of March 2016.

The OHA service could be called upon by any Work Coach involved in the trial. When presented with a VEI participant that a Work Coach required OHA advice on, the Work Coach would complete a referral form and provide a brief description of the

claimant's condition and circumstances. The details would be anonymised to prevent the possible identification of the claimant. That form would then be emailed to the OHA service. An Occupational Health Professional (OHP) would call back (reportedly within one to three days) asking for further details. The OHP then provided verbal advice on the case and issued a written summary of that advice. The Work Coach would then incorporate the advice into the subsequent discussion that they had with the trial participant. According to the Work Coach research, consent was sometimes sought from the claimant before the OHA service was used, but because the OHA referral form was anonymised, consent was not deemed necessary and was therefore not a formal part of the trial process.

The BPP Variant

The BPP ran in the South East Wales Jobcentre Plus District. As with the OHA variant, a contract with a physiotherapist provider was not in place when recruitment to VEI began. The initial referrals took place from June onwards and all treatment needed to be completed in time for all payments to be made before the end of the 2015/16 financial year. In principle, the physiotherapy offer played no part in the VEI recruitment phone calls and letter. Rather, where a person volunteered for the trial their ESA claim details were later checked for evidence of back pain problems and the trial variant offer would be raised within the initial voluntary interview. Regardless of the basis of the person's ESA claim, if back pain problems came up in conversation then the Work Coach had the options of offering a referral to the physiotherapist in response. Neither was there anything to preclude raising physiotherapy in second and subsequent interviews should the service not have been discussed beforehand.

Having identified suitable claimants with back pain problems, the Work Coach then offered the option of physiotherapy. If the claimant agreed to the service then a marker was set on a case management system called the Labour Market System and they were referred onwards to the provider.

The claimant still had the option of dropping out of the service but if they subsequently made contact with the provider then a medical professional would make an assessment of that individual and triage them in or out of the service. The course of physiotherapy was tailored to the individual's needs and if appropriate could be combined with Cognitive Behavioural Therapy (CBT) in line with National Institute for Health and Care Excellence (NICE) guidelines. However, it was not part of the trial design to receive just the CBT and not the physiotherapy. DWP was willing to fund up to 12 sessions of physiotherapy and CBT (a maximum of 6 each).

The funding model did not pay per session as such. Rather, there was an attachment fee for the initial triage stage and the provider could later claim for each person that reached three, six and ten sessions. So, by way of example, the provider would not be paid additional amounts if a person underwent 11 or twelve treatments.

The core VEI offer of Work Coach support could be maintained during the period of time when participants were undergoing physiotherapy. Whether or not they did so was at the discretion of both the Work Coach and the claimant.

Claimant Commitment

The Claimant Commitment (CC) trial operated within 16 sites in the East Anglia Jobcentre Plus District. The trial was rolled out over three phases, with two sites beginning recruitment on the 23rd March 2016 and the remaining sites beginning recruitment at two different dates in June 2016. All sites finished recruitment at the end of October 2016.

CC operated at all stages of the ESA claim but because there is no formal contact between Work Coaches and ESA claimants prior to the latter's Work Capability Assessment (WCA) a recruitment process had to be set up. That process is essentially the same as the process for VEI, which is described above. Therefore we do not repeat that description here.

At later stages of the ESA claim, mandatory Work Coach meetings are a part of the conditionality for the ESA benefit and the offer of taking part in the CC trial was made in those meetings, the 'New Joiner Interview' for post-WCA participants and the 'Work Programme Completer Interview' for post-WP participants.

More Intensive Support

The More Intensive Support (MIS) trial was a randomised controlled trial. The trial ran in three Jobcentre Plus Districts:

- East and South East Scotland
- Kent
- West Yorkshire

Recruits were identified from a scan of WP completers and prior to or during their WPCI, they were randomly allocated to either the MIS intervention group or a control group. The allocation process began on the 23rd March 2016 and finished at the end of February 2016.

Allocation was done on the basis of the last three digits of the claimant's National Insurance Number (NiNo). Different NiNos endings mapped to a different group in a random way. That is, there was no relationship between the groups that consecutive NiNo endings were allocated to. However, the same NiNo ending was always allocated to the same group. This approach was to allow allocation to be audited and non-compliance with the trial design to be checked.

Annex B Evaluation Methodologies

As mentioned earlier, there were several strands to the Employment and Support Allowance (ESA) trial evaluation. This section provides a brief summary of the different strands.

Qualitative Research with Claimants

The claimant research was carried out by contracted Researchers: the Institute for Employment Studies (IES) and the Department of Social Policy and Social Work (SPRU) at the University of York. Their work comprised qualitative in-depth interviews with seven distinct trial groups; three in the Claimant Commitment (CC) trial corresponding to each of the three points in the ESA claim at which a person might be recruited; three in the Voluntary Early Intervention (VEI) trial (the core trial plus its two variants) and the More Intensive Support (MIS) intervention group (though not the control group). Table B.1 summarises the sizes of the sample frame and the interviews that were achieved by this research.

Table B.1 Sample frame and achieved number of interviews for the claimant research

Trial/variant/ phase	Sample frame Sept 2015	Sample frame Nov 2015	Achieved sample	Opt-out	Unable to contact	Failed to interview
VEI Core Model	197	-	36 (9)	37	13	5
CC Pre WCA	137	169	51 (10) †	50	39	7
CC Post WCA	75	56	36 (9)	27	9	6
CC Post WP	27	28	18 (8‡)	11	10	1
MIS	189	-	36 (9)	46	48	4
VEI BPP	-	150	36 (9)	25	12	6
VEI OHA	-	190	37 (9)	29	8	3

Notes: achieved follow-up interviews shown in brackets; the purpose of the follow up interviews was to provide learning where (i) progress had been made or actions planned or (ii) progress had not been made, with the idea being to check for possible changes.
† when it was not possible to achieve the planned number of interviews from the post-WP CC sample frame, most additional interviews were drawn from the pre-WCA sample although one was drawn from VEI OHA
‡ maximum number it was possible to achieve on this sample

Source: IES and SPRU 2016

IES and SPRU have published a full account of their research[17] so we do not reproduce those details here. However, we do reproduce the high level themes of that work in table B.2 below.

Table B.2: Common core issues for the claimant research

High level theme	Sub level themes	Questions
Programme experience	Claimant experience	What were claimants' experiences of the trial? What did their support experience comprised? What operational/process issues did claimants face? Did claimants believe their barriers to employment were addressed?
Entry to the trial	Routes in	How did claimants hear about the trial? What were claimants told about the trial? Were they receiving other forms of support pre-trial? How did they feel about their ability to work pre-trial?
	Nature of engagement	What were claimants' views on the trial on entry – did they think it would help them? What did claimants understand about entry – e.g. voluntary/mandatory?
	Operational implementation	Did claimants believe the solutions offered were sufficient to address their barriers? Did claimants believe they had a personalised, tailored service?
Trial experience	Delivery and engagement	Did claimants attend? Did they actively engage and participate in their meetings? What were claimants' perceptions of this form of support? Did they believe the support was (sufficiently) work-focused? Was it (sufficiently) focused on condition management?
	Effectiveness of support	How close were claimants to the labour market pre- and post- trial intervention?
Perceived outcomes		How close were claimants to the labour market pre- and post- trial intervention? What did they think made the most difference to the distance they travelled towards the labour market?
	Impact on soft outcomes and behaviours	What impact did working with a Work Coach have on claimants': work-related activities? perceptions of their health and wellbeing?

[17] https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

	attitudes to work? expectations about returning to work? Had support driven behavioural changes?

Source: IES and SPRU 2016

Follow up interviews (63) were carried out with some of the people who were interviewed in the first wave of research. There were largely equal numbers (9) of interviews in each the seven groups[18]. The people included in this second wave were chosen purposively on the basis of their particular experiences, be that their exposure to the VEI variants or their actual or expected progress (or lack of progress) towards the labour market.

The claimant research also included observations of Work Coach and claimant interviews. These interviews were usually recorded but where permission was not given to record the interviews note takers produced written accounts of the meetings. In all circumstances, informed consent was gained from both the Work Coach and the claimant prior to any observations being recorded. Table B.3 summarises the number of observations recorded for each of the trial groups of interest. Owing to low numbers of interviews in any particular office, the sample frame did not distinguish between the individual CC groups. Rather, CC participants were treated as a whole.

Table B.3: The number of achieved observations for each trial

Trial	Meetings observed (FTAs)	Video	Audio	Notes	Number of Jobcentre Plus offices visited
VEI Core	10 (11)	5	5	-	2
VEI BPP	8 (5)	1	-	7	2
VEI OHA	13 (5)	7	6	-	2
CC	18 (14)	11	4	3	3†
MIS	21 (17)	9	11	1	2†

Note: Number of claimants failing to attend (FTA) planned meetings shown in brackets
† Offices visited twice to achieve this sample

Source: IES and SPRU 2016

Qualitative Research with Work Coaches

The Work Coach research was carried out by DWP Researchers. The research comprised semi-structured interviews by telephone. The sites where interviewed staff were based were chosen on the basis of various factors including the size of the office (in terms of its trial caseload), the amount of trial activity being undertaken

[18] The exceptions being 10 in the CC pre-WCA group and 8 in the CC post-WP group

(measured by the number of staff and claimant interviews carried out) and trial take up rates (where participation was voluntary).

We summarise, in table B.4, the number of interviews that were carried out for each trial group and the number of jobcentres that those interviews covered. For reasons of privacy we do not identify the sites where the interviewed staff were located. As with the claimant research a more complete account of the research with Work Coaches has been published elsewhere so we do not include further detail in this report[19].

Table B.4: The number of Work Coach interviews carried out across the trials.

Trial	Number of Work Coach Interviews	Number of Jobcentres
VEI Core	13	8
VEI BPP	12	7
VEI OHA	11	7
CC	16	10
MIS	17	7
Total	69	39

Process Analysis

Within this report we summarise some aspects of the trials' processes. The claimant and Work Coach research referred to above contribute to this content. However, we also quantify various claimant behaviours and staff activities using DWP administrative data. Most of the data that we use to describe the trial processes originates from a case management system called the 'Labour Market System' (LMS). The technical details of that data and the types of information that is captures are covered in Annex C.

The LMS data comprises separate records for individual people experiencing particular events. For example, a single record might describe whether or not a person eligible for VEI support accepted that support. Individuals are identifiable via encrypted National Insurance Numbers so it is possible to use the LMS data to longitudinally describe each individual's progression through the trial process, from initial recruitment to the ensuing support that they receive and in some cases the cessation of their involvement in the trial.

[19] https://www.gov.uk/government/publications/employment-and-support-allowance-trials-2015

Impact Analysis

For the VEI and MIS trials we have produced estimates of the additional benefit and employment outcomes specifically attributable to the trial interventions. MIS was a randomised controlled trial so a control group had been designed into that trial's recruitment processes. This was not the case for VEI. In order to construct a so-called 'counterfactual' for the VEI trial we have used a method called 'Propensity Score Matching'. The details underpinning this method are discussed in Annex E. For now, we simply note that impact assessments for both MIS and VEI draw heavily upon a variety of DWP administrative data sources. Those data sources are described in more detail in Annex C.

Within our impact assessments we track trial participants' presence on benefit and in employment (as far as we are able to tell - see Annex C for the caveats associated with the employment data). Our tracking of benefit and employment behaviours covers the period of time prior to trial participation in order to confirm that, in respect of these behaviours, our central estimates of the trial impacts are bias free. Our tracking continues into the post participation period for as long as is possible with the available data. For example, our benefits data is reasonably complete and stable up to the end of July 2016. This means that we can track people who were recruited into the ESA trials at the very outset (23rd March 2015) for nearly seven months. However, those who joined towards the end of the recruitment period can only be tracked for five months in the case of MIS and six months for VEI.

To accommodate these different time periods we 'censor' our data, which simply means that our longer term impact estimates are based upon fewer people (i.e. the earliest recruits) than are the short term estimates (which all participants contribute to). This means that the statistical uncertainty associated with our impact estimates increases the longer term that measure is.

We do note however, that to ensure that both the experimental (in the case of MIS) and non-experimental (in the case for VEI) control groups are similar to their respective intervention groups we employ a range of data on personal of local area characteristics. That data is described in Annex C and appropriate caveats associated with the data highlighted in the relevant sections of this report.

Annex C Data Used in the Statistical Analysis

This Annex briefly summarises the quantitative data that is available to the analysis described in this report. We exploit different sources of information for different purposes and each has its own characteristics as follows:

Pilot Marker data

When administering a trial recruitment process, be that the contact process for Voluntary Early Intervention (VEI) or the random allocation process of More Intensive Support (MIS), a 'pilot marker' is set on the Labour Market System (LMS). This system is used to administer some aspects of DWP benefits' conditionality and Jobcentre Plus's employment related support and houses a range of markers that we have used to identify a complete list of claimants who have played a role in the Employment and Support Allowance trials.

This data is at individual level which means that each person can be tracked from the trial recruitment process through to their subsequent benefit and employment outcomes via an encrypted version of their National Insurance Number (NiNo). We note that a single individual might have more than one trial marker record and sometimes these can be contradictory (e.g. a person being allocated to both the MIS intervention and control group). We do not elaborate on the technical details of how we reconcile multiple records. Rather, we note that this data can be subject to an element of interpretation but we do not believe that this could significantly affect our headline conclusions.

We also note that some LMS markers have been set later than the trial guidance suggests. Specifically, some people appear to have been recruited beyond the nominal recruitment periods. Within most of our process analysis and all of our impact analysis we allow for one month's run on and discard LMS data (describing the recruitment process) beyond that date, if only to allow for a minimal post-recruitment tracking period. We mention this because the trial marker data is notionally complete and stable but we have not employed all the data at our disposal within our analysis. The exception is the data in chapter two which uses all the pilot marker data in order to avoid possibly misrepresenting that process. For example, people who refused support in the voluntary trials might have their marker set late owing to local recording practices.

Other LMS data:

In order to monitor the number and duration of meetings that trial participants have with their Work Coaches we draw upon generic LMS data, not specific to the trial processes, that describes those activities. We note that there can be difficulties in interpreting LMS meetings data. The purpose, and sometimes the duration, of each meeting is reflected in its title. However, sometimes the title of that meeting might be

at odds with the underlying claim or conditionality (e.g. a 'JSA' meeting might take place within an ESA claim or a mandatory meeting might be recorded where there is no requirement to attend a meeting) and we cannot be sure that the nominal duration of the meeting reflects the actual duration. Nonetheless, the majority of meetings are recorded accurately and therefore we believe that this data source provides an acceptably indicative, if not especially accurate, description of meetings activity within the trials.

'Opportunities' (described in the main body of this report) are also recorded on the LMS and are generally a more accurate reflection of the work related activity undertaken by trial participants.

Over and above the meetings and Opportunities data, in order to assess the personal characteristics of trial participants and thereby confirm that the (experimental and non-experimental) intervention and control groups are very similar, we draw upon a wider range of LMS data that provides information on, for example, ethnicities, disabilities and sought occupations. This data covers the time period up to and including August 2016.

DWP Benefits Administrative data

In order to monitor participants' presence on DWP benefits both before and after trial participation we draw upon the 'National Benefits Database'. This data is sourced from several benefit systems and provides information on all past and present DWP benefit claims since 1999. We only use information for Primary DWP benefits (i.e. income replacement benefits). This information is not as up to date as the LMS data owing to various factors such as the time it takes to collate and process the data, backdated claims and retrospective changes (due, for example, to appeals and changes of circumstance). This data is reasonably complete up to and including July 2016 with the caveat that the leading edge of this data will to a small extent be subject to incompleteness and retrospective revisions. In principle, owing to the unbiased nature of the trials' intervention and control groups, the data for all trial groups is equally likely to be affected by these shortcomings, so we can still make comparisons on the basis of the data that we have.

We note that our analysis does not currently consider Universal Credit (UC). This is because that data is processed, housed and must be treated in a very different way to the more traditional DWP benefits. However, given the roll-out schedule of UC we do not anticipate a significant number of UC claims amongst the trial participants and therefore do not believe that including UC claims would significantly alter our conclusions.

Employment data

In order to track movements into employment we use HMRC's P45 data. This data is subject to considerable time lags and generally only approaches completeness some

6 months after the event. As well as being a relatively out of date source there are known shortcomings in the HMRC data. For example, many employment start and end dates are set to the beginning and end of the tax year respectively and do not reflect the true employment period. Many employment records do not have end dates which may be because the jobs are on-going but it is also possible that some jobs have ended without our knowledge. There is also a known and significant under-representation of self-employment as well as jobs where the earnings are lower than the tax threshold (and therefore do not need to be declared to HMRC). As well as these shortcomings, we do not expect the P45 data to be complete and stable much beyond February 2016. Nonetheless, for consistency, we track employment outcomes for the same time periods as we do benefit outcomes on the assumption that the intervention and control groups are similarly exposed to these shortcomings. We know that the measured levels of employment (and by implication any differences that we identify) are likely to underestimate the true values, so the increasing incompleteness of more recent employment data can be deemed an extension of this shortcoming.

In summary, whilst we have complete trial participant data, we can only evaluate post-trial presence on benefits up to July 2016 and complete and stable employment behaviours to February 2016 though we do have and we do use employment data beyond this date.

Socioeconomic data: the Propensity Score analysis constructs a logistic regression model of participation on the basis of personal descriptors (derived from the LMS and benefits data described above). However, that model also employs local area data. We have used Index of Multiple Deprivation (IMD) data, specifically, the employment and income indices, to describe those areas. That data has been sourced from the respective Government websites (Welsh and Scottish IMD data is available separately to the English data, which is accessible via the main UK Government Statistics website).

We used IMD data at Super Output Area (SOA) level and matched the deprivation indicators to the individual level data on the basis of the SOA within which each participant lived. The data was then standardised in order to minimise leverage within the regression model.

Similarly, we incorporated population density data into the logistic regression model, which for England and Wales was sourced from the website of the Office of National Statistics and, for Scotland, from the website of the Scottish Government. This too was standardised but whilst we were able to match (to the participant records) English and Welsh data at SOA level, we were only able to source and match Scottish data at Local Authority level, which we acknowledge is a shortcoming of our analysis. Nonetheless, in all measurable respects, our matching does produce a balanced set of characteristics.

Annex D Table of ESA Trials Participant Characteristics

Characteristic	VEI	CC	MIS Intervention	MIS Control
Participants	7865	561	2084	2108
Gender				
Male	54%	56%	51%	50%
Female	46%	44%	49%	50%
Ethnicity				
White	75%	91%	89%	89%
Black	4%	0.7%	1.1%	0.6%
Asian	7%	1.1%	4.7%	4.6%
Mixed	2%	0.7%	1.6%	0.8%
Chinese/Other	1.4%	0.2%	0.7%	1%
Prefer Not To Say	5.6%	4.1%	3.1%	4.2%
Unknown	5%	2.7%	0.1%	0%
Age At Start of Trial				
16 to 24	17%	17%	5.6%	5.7%
25 to 29	12%	11%	7.8%	6.5%
30 to 39	23%	17%	22%	20%
40 to 49	22%	25%	31%	34%
50 to 59	22%	23%	27%	29%
60 or Over	3.9%	5.7%	6.1%	5.9%
Primary Condition[1]				
Mental and Behavioural Disorders	46%	48%	57%	59%
Diseases of the Musculoskeletal system and Connective Tissue	17%	15%	15%	14%
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified	9.8%	8.7%	8.3%	7.6%
Injury, Poisoning and certain other consequences of external causes	10%	8.9%	4.2%	4.7%
Diseases of the Nervous System	2.5%	3.6%	5.5%	4.7%
Diseases of the Circulatory System	2.9%	1.6%	2.3%	2%

Other	12%	13.2%	7.6%	8%
Unknown	0.8%	0.5%	0.5%	0.5%
Basic Skills Need[2]	8.5%	8.9%	8.6%	7.9%
Number of Dependent Children				
1 Child	9.1%	11%	11%	12%
2 Children	6.8%	6.8%	7.1%	6.9%
3 Children	3%	3%	3.7%	3.6%
4 or More Children	1.8%	1.4%	2%	1.9%
Age of Youngest Child				
0 to 2	2.5%	2%	1.5%	1.2%
3 or 4	2.2%	1.8%	2.1%	1.4%
5 to 10	8.5%	7.1%	8.5%	8%
11 to 15	3.9%	5.9%	5.8%	6.1%
16 or Over	1.9%	2.7%	3.5%	5.6%
Unknown	1.7%	2.5%	2.4%	1.9%
In Receipt of Adult Dependents Allowance[3]	11%	14%	16%	15%

Source: DWP Administrative Data

1We only present the most common conditions in this table. We have grouped into an 'other' category a wide range of conditions, each of which is reported by only a few participants.

2 Only skills needs identified via the DWP skills screening process are counted.

3 Not all partners are reported. For example, Contributions-based claimants are more likely than Income Based claimants to not declare their partner because their partner's income does not determine benefit eligibility.

Annex E Summary of Propensity Score Match Method

In the approach we have taken to our analysis, propensity scores are calculated by first creating a model of the probability of being in the group that undergoes the trial intervention. That model is based upon 'observable' characteristics of the trial participants and the potential controls. In other words, given a set of known characteristics, a person has a modelled probability of being in the intervention group. For example, if half of all males were in the intervention group then, all else being equal, males would have a 50% chance of being in that group.

The qualification criterion for our potential controls is as follows:

- They must have made an Employment and Support Allowance (ESA) claim during the trial period (23rd March 2015 to 31st January 2016, where we allow for one month's run-on)
- That claim must be of at least 4 weeks duration
- They must not live in the trial area
- They must not live in an area that was running a trial at the same time as VEI.

Levels of pre-Work Capability Assessment (WCA) employment related support do vary from area to area and this is a potential limitation in our analysis. We are comparing VEI's outcomes with a particular group of people who have experienced a particular level of pre-WCA support. Ideally, our counterfactual will have experienced no support prior to their Work Capability Assessment because then we would be measuring the full added value of early intervention. However, by stipulating this in our conditions we risk screening out people with a predisposition to opting into Work Coach meetings at the pre-WCA stage in the claim, who may well be more (or less) likely to move off benefits than those who do not opt in. Conversely, by not stipulating that condition, we potentially dilute the impact that we measure because our comparison group is also having meetings.

Within our analysis we chose to include claimants whether or not they had opted in to meetings. This means that our baseline is 'business as usual', rather than a 'do nothing' baseline. To explore the implications of decision, we tested variants of our analysis in which we did impose that constraint and our findings did not significantly change. Regardless, to mitigate the risks associated with our approach we examined levels of pre-WCA activity across all Jobcentre Plus Districts during the trial period and excluded Districts with the highest levels of activity.

Another, well established, limitation to our method is that there might be other 'unobserved' characteristics that are important determinants of labour market

outcomes, most notably attitudinal factors, and our control group may differ in these characteristics without our knowledge.

Table E1 summarises the data that we have based our propensity scores on, and the way that we have categorised that data.

Table E1 Variables used in the Propensity Score model

Variable	Description
Age	Age at the start of the ESA claim: Grouped according to: 16-17, 18-24, 25-29, 30-39, 40-49, over 50
Sex	Male or female
Ethnicity	Ethnic group, in the categories White, Black, Asian, Mixed, Chinese/Other, prefer not to say
Partner	Primary claimant in receipt of the adult dependents allowance
Medical condition	Based upon International Classification of Disease Codes
Mental health	Based upon the claimant's primary condition
Number of children	Classified as: 0, 1, 2, 3 and 4 or more
Age of youngest child	The age of the youngest child (0 if not applicable)
Sought occupation	These are self-reported categories of employment (e.g. professional, sales etc...) that are the preferred or normal types of job that the claimant would seek if they were looking for employment.
Benefit and employment history	Claimant status has been analysed and classified in the two years prior to the ESA claim that led to trial participation. Claimants are classified as being on benefit or in employment during various periods of time if more than half that time was spent in that status.
Index of Multiple Deprivation (IMD)	Overall IMD score, housing score, employment score, income score and population density for the lower level Super Output Area where the claimant lives. Data has been standardised for use in the model.

The process by which a control group is constructed is a variation on the so-called kernel matching approach. Specifically, we take each member of the intervention group in turn and identify controls that have a propensity score that lies with a certain range of values (the 'bandwidth') centred on the intervention group member's value. A weighting is applied to each member of the matched control group and that weighting adheres to a Gaussian distribution.

The weights are normalised such that they add up to 1. In other words, the control used for a given member of the intervention group is a composite of many different individuals. These individuals cannot by definition combine to provide a valid counterfactual for a specific member of the intervention group. The control may comprise males and females for example whereas the member of the intervention group is of a single sex. However, a large number of people from the intervention group can be considered as a single group and the combined weighted average of all that group's controls should, in theory, resemble the intervention group. We have checked whether or not this is the case and all characteristics agree insofar that any differences between the intervention and the matched control group are no larger than would be expected by random variation alone, which is what one would expect within a randomised controlled trial.