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Summary

Context

The Employment and Health Discussion (EHD) involves a conversation between a Universal Credit (UC) Health Journey customer and an Employment and Health Practitioner (EHP), a Healthcare Professional by background.

The purpose of the conversation is to identify the range of barriers impacting the customer's ability to work and appropriate solutions to these. These barriers – or 'obstacles' – and matched solutions should then be documented in a Workability Action Plan that the customer can use to move towards work.

EHPs are encouraged to adopt a biopsychosocial approach, both through the training provided and the structure of the Workability Action Plan itself, to ensure the full range of customers barriers are explored and solutions identified.

The EHD is separate to and does not form part of the Work Capability Assessment (WCA). It is a voluntary offer.

The EHD has been tested in 13 Jobcentre Plus (JCP) offices and this evaluation relates to the period of delivery between 8th July and 5th November 2024.

Given the small scale of the test, the evaluation is predominantly centred around process, as opposed to impact. The research therefore aims to build understanding around how the EHD is delivered across a number of JCPs and what is perceived to work well or less well.

The research questions include:

- Is the EHD being delivered as intended?
- Do stakeholders report experiencing the assumed benefits of the EHD?
- What elements of the policy design are most important for the success of the EHD?
- Are there any unanticipated issues or unintended consequences?
- Does the EHD fill a gap in provision?
- How could the delivery of the EHD be improved?

To address these questions, research was conducted with EHD customers, EHPs and JCP staff, including surveys, follow-up interviews and observations. A sample of Workability Action Plans, case studies and Management Information collected during the evaluation period were also analysed.

Given the small scale of the test and therefore possible sample sizes, the evidence gathered should be treated as indicative.

Key findings

Customers, Work Coaches and Disability Employment Advisors (DEA) signalled high levels of satisfaction with the EHD, with some indicative evidence of positive outcomes amongst customers.

When surveyed immediately after completing the EHD, customers reported a range of benefits to participation in the EHD, although to varying degrees. Around half (48%) reported feeling more positively about work and slightly more (57%) reported that they were more likely to take up support offers such as training or volunteering. Smaller proportions reported feeling more confident about getting into work (40%) and that work was more important to them (35%).

Work Coaches, DEAs and Employment and Health Practitioners (EHP) similarly emphasised these benefits based on their interactions with customers and noted additional positive changes, including improved customer engagement with the JCP.

Where customers had more than one appointment, 6 in 10 saw improvements to their self-reported workability scores over the course of their EHD appointments. EHPs often set small goals for customers to achieve ahead of their next appointment, including encouraging some customers to attend their next appointment face-to-face once they had established a trusting relationship with the EHP, which may play a role in these observed improvements.

However, this was not sustained. When a small sample were surveyed 6 weeks after completing the EHD, few reported continued improvements to their workability scores after the EHD, even when they had taken the suggested steps in their Workability Action Plan. Approximately two thirds of customers reported having taken some or all of the steps suggested, and customers had broadly positive views about their Workability Action Plans.

It was therefore considered important to recognise that, while largely out of scope of this research, the support provided to the customer after the EHD is imperative to ensuring customer progression beyond the EHD which, in itself, is a relatively short intervention and considered part of the ‘pathway to work’. Notably, only some Work Coaches report using the Workability Action Plan effectively in their interactions with the customer after the EHD.

Nonetheless, customers particularly valued having dedicated time and space to speak about their health and feeling ‘heard’ through the EHD.

While Work Coaches and DEAs place significant emphasis on the status of EHPs as Healthcare Professionals when promoting the EHD to customers, customers did not explicitly cite the opportunity to speak to a Healthcare Professional as a reason for engaging with the EHD and often they approached the EHD feeling somewhat indifferent about the offer. Instead, research suggests that specific behaviours

demonstrated by EHPs underpin trust and engagement from those who completed the EHD, although the skills and experience required to demonstrate these behaviours may be implicitly acquired through EHPs' clinical backgrounds.

However, not all customers engage as intended. 1 in 5 (22%) are returned to the JCP due to non-engagement, such as not wanting to discuss work or steps they can take towards employment, and 1 in 6 (16%) are established as unsuitable during EHD appointments, such as being considered too far from the labour market. The WCA can pose a barrier to engagement, with examples of customers focused on 'achieving a certain outcome' or refraining from fully engaging in any support until after they have received an outcome. Some steps could be taken to attempt to counteract this, including repositioning the EHD after the WCA, although EHPs acknowledged a customer group who would likely remain resistant to any support towards work.

During the EHD, customers often require involved coaching and support, particularly to overcome limiting beliefs; an area in which it was identified EHPs could benefit from additional training.

Despite this, customers that completed the EHD felt that their EHP helped them to identify their obstacles and solutions, and few Work Coaches or DEAs felt they could identify these via routine appointments or existing provisions, suggestive of a gap that the EHD plugs.

However, in practice it appears solutions are not always best matched to obstacles in Workability Action Plans. Similarly, the full range of barriers within the biopsychosocial model may be underexplored in some cases. Workability Action Plans could therefore benefit from further monitoring.

Local knowledge of available resources and provisions is considered key to identifying appropriate solutions.

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Abbreviations

DEA	Disability Employment Advisor
EHD	Employment and Health Discussion
EHP	Employment and Health Practitioner
HCP	Healthcare Professional
HMO	Health Model Office
JCP	Jobcentre Plus
LCW	Limited Capability for Work
LCWRA	Limited Capability for Work and Work-Related Activity
MI	Management Information
UC	Universal Credit
WCA	Work Capability Assessment

1. Background

1.1 The Employment and Health Discussion as a concept

The Employment and Health Discussion (EHD) is a voluntary offer involving a conversation between a Universal Credit (UC) Health Journey customer and an Employment and Health Practitioner (EHP), a Healthcare Professional by background seconded to the DWP from Assessment Providers.

The purpose of the conversation is to identify the range of barriers impacting the customer's ability to work and appropriate solutions to these.

These barriers – or 'obstacles' – and matched solutions should then be documented in a Workability Action Plan that the customer can use to move towards work.

EHPs are encouraged to adopt a biopsychosocial approach, both through the training provided and the structure of the Workability Action Plan itself, to ensure the full range of customers barriers are explored and solutions identified.

The EHD may entail up to 3 appointments, lasting an hour each. The number of appointments offered to customers should be determined on a case-by-case basis, depending on the time required with the customer to produce a Workability Action Plan.

The EHD is therefore intended to be a short intervention, part of the pathway to work. It is separate to and does not form part of the Work Capability Assessment (WCA) or decisions that are made as a result of this.

To be referred to the EHD, customers must be on the Universal Credit (UC) Health Journey, have a valid fit note, have not yet had their WCA and be unemployed. However, as part of the testing strategy, customers who have had their WCA and were found to have Limited Capability for Work (LCW) or Limited Capability for Work and Related Activity (LCWRA) could also be referred in one select Jobcentre Plus (JCP), providing they fit all other eligibility criteria. The testing approach is outlined in the following section.

1.2 The testing approach

The EHD has been proactively tested on a small, incremental scale to enable cumulative evidence-building that can inform future delivery decisions.

The EHD was initially delivered in one JCP, Leeds Health Model Office (HMO), to understand if the policy could be feasibly delivered in this specific JCP and gather early insights about the best way to do so. Learning from this initial test supported the

expansion of the EHD into 13 JCPs and informed iterations to delivery, such as improvements to the referral process, clinical governance and EHP training materials.

The expansion to 13 JCPs took place in September 2023 with the intention of enabling further evidence to be gathered to determine the policy's feasibility across a wider span of the JCP network, including sites which are not Health Model Offices.

Expansion to additional JCPs brought with it challenges which, in turn, necessitated alterations to the delivery model. The delivery model was therefore iterated and refined until July 2024 when a finalised model was reached which could be formally evaluated.

All JCPs followed this delivery model, except Leeds JCP which additionally offered the EHD to customers post-WCA found to have LCW or LCWRA. The inclusion of LCW and LCWRA customers in Leeds was intended to enable insight to be gathered around how this group engage with the EHD, on the basis that there was some existing understanding of how the EHD operated in Leeds JCP having acted as the initial test site.

The period of stable delivery that has been formally evaluated ran from 8th July to 5th November 2024.

2. Research aims and methodology

2.1 Research aims

Given the small scale of the test, the evaluation is predominantly centred around process, as opposed to impact. The research therefore aims to build understanding around how the EHD is delivered across a number of JCPs and what is perceived to work well or less well. To do so, it draws upon the logic model developed as part of a Theory of Change exercise – see appendices.

The research questions are:

- Is the EHD being delivered as intended?
- Do stakeholders report experiencing the assumed benefits of the EHD?
- How is the EHD being delivered – are the causal assumptions in the logic model correct?
- What elements of the policy design are most important for the success of the EHD?
- Are there any unanticipated issues or unintended consequences?
- Does the EHD fill a gap in provision?
- How could the delivery of the EHD be improved?

The Critical Success Factors are:

- Work Coaches buy into EHD and make appropriate referrals
- Customers engage with EHD (such as attend appointments, EHPs consider them open to support)
- Customers understand the positive relationship between work and health
- Customers are supported to identify obstacles to work and formulate appropriate solutions
- Customers believe EHPs understand their circumstances and barriers to work
- EHPs feel able to address limiting beliefs during the EHD
- EHPs provide appropriate signposting to customers
- A Workability Action Plan is produced at the end of EHD that the customer buys into
- Work Coaches read and understand the Workability Action Plan and utilise it to support the customer to progress towards work

- Customers feel more positively about work following EHD
- Customers report taking the steps as set out in their workability plan
- Customers are more open to support following EHD

2.2 Research methodology

To address the research questions and gather evidence against the Critical Success Factors, research was conducted with EHD customers, EHPs and JCP staff. The following research methods were utilised:

- Research with customers:
    - 2 wave customer survey with those who successfully completed the EHD (attended the appointments necessary to produce a Workability Action Plan)
        - Wave 1 issued via customers' UC journal immediately after successfully completing the EHD (82 responses)
        - Wave 2 issued via UC journal 6 weeks after successfully completing the EHD, therefore issued to fewer customers during the evaluation period (34 responses)
    - Follow-up qualitative interviews with customers (10)
- Research with EHPs:
    - EHP survey (17 responses, 19 EHPs during evaluation period)
    - EHP follow-up interviews (6)
    - EHP managers focus group (3)
- Research with Work Coaches and Disability Employment Advisors (DEA) who could refer to the EHD and/or engage with customers after the EHD:
    - Work Coach/DEA survey (62 responses from 50 Work Coaches and 12 DEAs of ranging experience)
    - Work Coach/DEA follow-up interviews (13)
- Analysis of MI collected during the evaluation period (8th July – 5th November, 333 successfully completed cases)
- Analysis of Workability Action Plans (sample of 39 – 17 of those who responded to the customer survey, 8 of those who had a follow-up interview, and a random selection of 14)
- Analysis of case studies provided by EHPs (23)
- Observations of EHD appointments (11)

Surveys used both open and closed questions and were hosted online using a platform that enabled translation if required. Customers who did not have a UC

journal account were contacted by phone and given the opportunity to complete the survey by phone.

Throughout the research, participants were reminded that they would not be penalised or judged for their responses and customers were specifically reminded that their involvement in the research would have no impact on their claim. This was made explicit prior to participation and at specific points in participation, for example prior to asking questions about their outlook on work.

Bases to survey questions vary as participants are routed depending on their previous responses. For example, if Work Coaches or DEAs do not see customers after the EHD, they will not answer questions relating to engagement with customers after the EHD.

2.3 Caveats

There are specific caveats to this research that should be considered:

- As the EHD is a relatively small-scale test, the quantitative data collected are based on small samples (see methodology section) and are therefore indicative only. Likewise, this evaluation alone cannot robustly attribute any of the reported outcomes directly to the EHD, although the EHD may have been a contributory factor. To confidently attribute any outcomes to the EHD would require a dedicated impact evaluation and delivery on a larger and/or extended scale to generate sufficient volumes. Again, the data should be treated with caution and as indicative only.
- The research does not include the perspectives of those who declined engagement in the EHD or were referred to the EHD but did not successfully complete it.
- Those engaged in the research may have particularly positive or negative experiences of the EHD, which may have encouraged participation. For example, Work Coaches and DEAs who engaged in the research were typically very positive about referring to support offers in general, believing that extra help is beneficial for customers.
- Wider factors outside of the test's control, such as EHP availability, may have impacted findings such as the volume of successfully closed cases.

3. Findings

3.1 The referral

3.1.1 Promoting the EHD to the JCP

EHPs have individual, personalised ways of describing the EHD to JCP staff, although it appears EHPs in general have a good grasp on the policy intent.

For example, EHPs regularly described the EHD as a voluntary offer to:

- Set goals
- Identify barriers
- Identify actions or solutions to overcome these

Some EHPs reported explaining the perceived benefits of the EHD to Work Coaches to further encourage buy-in. For example, they explained that by the Work Coach referring a customer to the EHD, the EHP can provide them with a better understanding of the customer leading to better Work Coach support. Some also differentiate between what the EHD is versus what it is not. For example, some EHPs reported explicitly explaining that the EHD is “not just a nice chat with a nurse”.

3.1.2 JCP buy-in

EHPs’ perceptions of their relationship with the JCP and buy-in from Work Coaches was mixed, but nonetheless considered important by all in terms of the success of the EHD, specifically in terms of generating appropriate referrals and ensuring customers attend the EHD ready to engage with the process as intended.

In the EHP survey, none of the EHPs believed that all Work Coaches buy into the concept of the EHD, although the majority (10) felt most do. 5 EHPs felt some Work Coaches buy into the concept of EHD, and 2 felt few do. While most (12) described their relationship with the JCP as good or very good, one specifically described it as bad.

Where EHPs thought most Work Coaches bought into the EHD, they commonly felt this was because they were integrated into their JCP.

For example:

- By being physically present in the JCP and attending buzz meetings as ‘part of the team’, EHPs felt that this served as a constant reminder of the service to time limited Work Coaches
- By being physically present and having dedicated space in the JCP, Work Coaches could physically signpost customers to the EHP who could have an impromptu chat and reassure the customer of the intentions of the EHD

- By being easily contactable in person or by Teams, EHPs highlighted that this enabled informal discussion of ‘how things are going’ and provided opportunities to clarify and continually develop and improve in real time

A proactive EHP was considered important here, and having Work Coaches who engaged specifically with Health Journey customers was considered useful.

Senior buy-in was also considered a key driver in facilitating this sense of integration.

In contrast, EHPs noted that a lack of dedicated space in the JCP was a significant barrier to a conducive relationship with the JCP and subsequent engagement. Some Work Coaches felt that better integration and a greater presence would improve awareness of EHD and therefore engagement. Some felt that regular ‘nudges’ would help them. One Work Coach said, “we’re usually under pressure and will forget to offer this up”.

However, as previously outlined, none of the EHPs felt that all Work Coaches bought into the concept of the EHD.

The Work Coaches who engaged with the research are likely to be engaged in the EHD and therefore the views of those who are not engaged in the EHD are likely underexplored. Nonetheless, EHPs suggested some reasons why they thought not all Work Coaches bought into EHD, even with good integration, which centre around two areas:

- Overwhelm
    - Lack of time
    - Focus on targets, such as weekly appointments
    - Volume of other tests and trials as well as other referral provisions
- Lack of understanding of policy intent
    - Initial teething issues, for example around what EHD is versus is not
    - Confusion between the EHD and DEAs

However, EHPs reflected that, once Work Coaches did refer to the EHD, they understood the role of the EHD/EHP and its benefits. EHPs reflected that this can be facilitated by feeding back good news stories to the JCP to encourage wider buy-in.

EHPs made some further suggestions as to how referrals could be increased, including:

- Mandatory training for Work Coaches from management to signal top-down buy-in
- Building the EHD into the WCA referral process so all customers are considered
- EHPs identifying eligible customers from Work Coaches’ caseloads

3.1.3 Identifying customers to refer

Of those who could refer to the EHD, the majority (89%) thought it was easy or very easy to identify appropriate customers for the EHD. A very small minority (3%) thought it was difficult. These Work Coaches had less experience than others.

Some Work Coaches specifically highlighted how Additional Work Coach Time (AWCT) can be used to identify and pitch the EHD to customers.

Through the qualitative research, it was apparent that some Work Coaches and DEAs do not offer the EHD to all customers who, on paper, fit the eligibility criteria though. Some described how they made judgements about how willing to participate a customer would be, although when probed they struggled to explain how they made these judgements.

3.1.4 Pitching the EHD to customers

Although Work Coaches and DEAs take individual approaches to describing the EHD to customers, the EHD was commonly described as a unique opportunity whereby customers can speak with an experienced and knowledgeable medical professional.

Work Coach and DEAs strongly believed that the focus on health and the ability to speak to a Healthcare Professional is the enticing factor for customers when the EHD is posed to them.

In fact, some Work Coaches and DEAs believed that customers see the EHD as a health-related appointment first and foremost and noted that customers can be surprised that the EHD is offered by the DWP. Often this was explained in the wider context of customers struggling to get GP or other health-related appointments.

While some Work Coaches and DEAs recounted that they also explain the specific purpose of the EHD, such as identifying barriers and how these could be overcome, it is unclear if all do. Few explicitly said that they explain to the customer that they will produce a Workability Action Plan with the EHP.

However, while customers similarly recalled being introduced to the EHD as an opportunity to speak to a Healthcare Professional, this was often not explicitly outlined as the reason they engaged, even when probed, despite Work Coach and DEA perceptions. Those who successfully completed the EHD described feeling somewhat indifferent about engaging at first, for example:

> *“I didn’t really have any initial thoughts … If it worked, it worked, if it didn’t, it didn’t”*
> (EHD customer)
>
> *“I thought it was just procedure … If someone suggests it and it’s plausible then I’m happy, but that’s me, I didn’t argue back, just said yeah ok”*
> (EHD customer)
>
> *There’s no harm in trying*
> (EHD customer)

When asked about any concerns or questions customers had when they were pitching the EHD, Work Coaches and DEAs raised the following:

- Concerns that the EHD is an assessment for work (such as forming part of the WCA)
- Concerns that involvement will affect their benefit, for example being sanctioned if they do not agree to referral or if they do not feel well enough to attend the appointment
- Questions around the number of appointments, length and channel in the context of their health condition
- Some reluctance to engage where customers do not think getting into work is a possibility
- Overwhelm – with the EHD being something else to engage with where customers are having multiple JCP appointments, ongoing health-related appointments etc.

Of those who could refer to the EHD, just over half (54%) felt 'completely able' to address any concerns or questions customers have about the EHD. Around a third (36%) felt 'somewhat able', and a minority (10%) felt 'not very able' or 'not at all able'.

3.1.5 Making the referral

Work Coaches and DEAs make referrals to the EHD and book customers' initial appointments with the EHP via the UC build – the system used for Universal Credit. This process was developed during the iterative phase of testing in an attempt to overcome previous issues with EHD referrals made via email and ensure alignment with other referral processes in business-as-usual operational delivery. This referral process was effective in the evaluation period.

The research found that the majority of Work Coaches and DEAs found the process of making referrals to the EHD via the UC build and booking the initial EHD appointment via the UC build easy or very easy.

A minority said the referral and/or appointment booking process ever prevents them from making referrals to the EHD. However, it is important to recognise that those who do not engage with the EHD are likely underrepresented in the research.

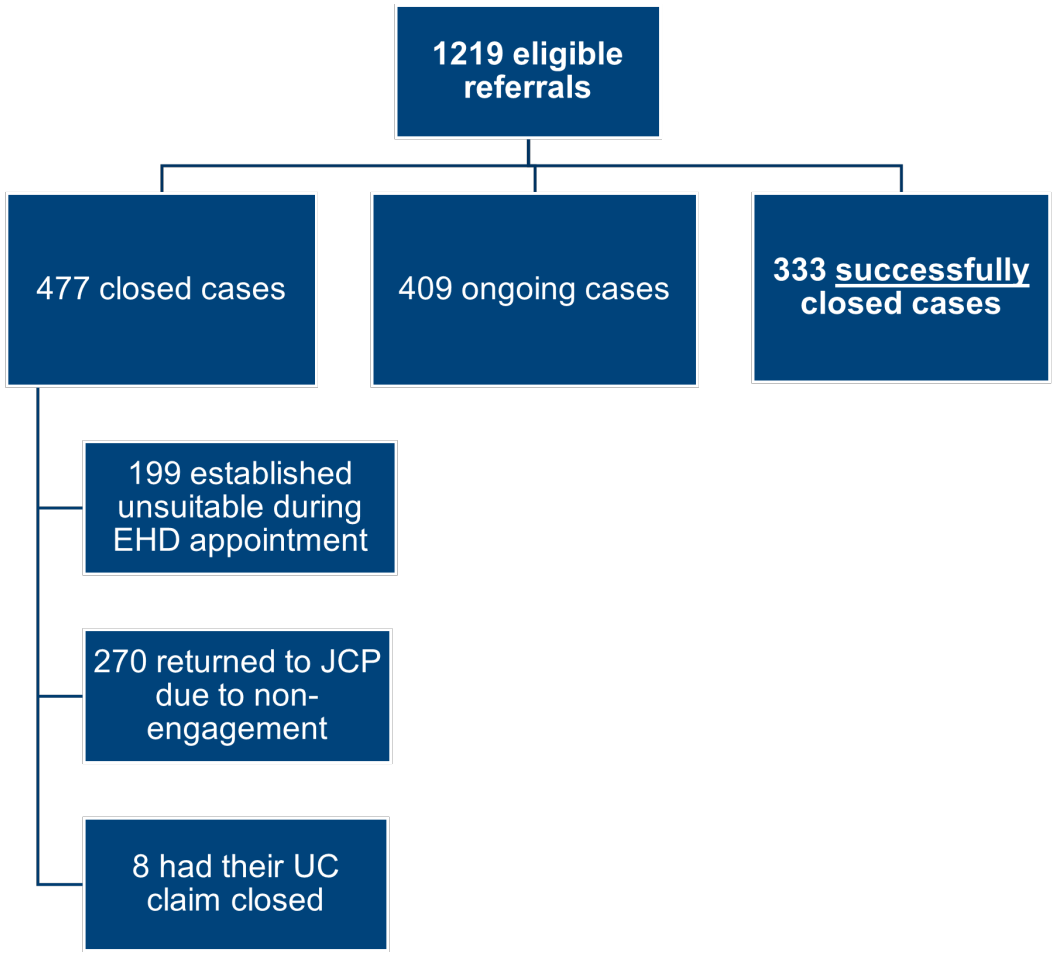
While some Work Coaches and DEAs appreciated the integration of the process into the UC build, a few expressed via the survey that they preferred the previous referral process whereby referrals were sent via email but did not explain why.

3.1.6 Referral volumes

During the evaluation period of 8th July 2024 – 5th November 2024, 1,219 eligible referrals were made to the EHD from 13 JCPs. As shown in Figure 3.1, 333 (27%) of these referrals also successfully completed the EHD during the approximate 3-month evaluation period. This means they attended the appointments necessary to produce a Workability Action Plan. 409 (34%) were still receiving support from the EHD, with

outstanding appointments scheduled and a Workability Action Plan not yet complete. 477 (39%) did not successfully complete the EHD. There are several reasons for this: 199 (42%) were identified as unsuitable during the EHD appointment, 270 (57%) either never engaged or stopped engaging with the EHD as intended, and 8 (2%) had their UC claim closed and therefore were no longer eligible for support.

Figure 3.1



For information purposes, the breakdown of eligible referrals and successfully closed cases within the evaluation period can be view in Table 3.1.

It is important to note that each JCP had varying caseloads, varying numbers of Work Coaches and DEAs who could refer and varying EHP resource (some JCPs have multiple EHPs and some EHPs work on a part-time basis). Therefore, it was not expected that all JCPs would have the same level of referrals and volume of successfully closed cases.

Table 3.1 Referral volumes and closed cases per JCP

JCP	Full-time equivalent (FTE)	Number of eligible referrals	Number of successfully closed cases
Aberdare HMO	1.6	86	26

Bradford	1	112	38
Chelmsford	0.7	39	9
Doncaster	1	96	27
Durham	2	96	24
Hull	2.2	182	51
Lancaster	1.4	79	22
Leeds HMO	0 (virtual cover)	73	18
Newcastle	1	115	36
Norwich	1	71	26
Sunderland HMO	1.6	68	11
Wigan HMO	1.8	126	34
York	0.6	76	11
Total	15.9	1,219	333

3.1.7 Making the right referrals

Amongst EHPs there is a general consensus that eligibility for the EHD does not necessarily translate into suitability. While some referrals may fit the formal eligibility criteria, upon further investigation EHPs feel some customers are not necessarily suitable for the EHD.

This is reflected in the MI. Approximately 1 in 6 (16%) of the ‘appropriate’ referrals made to the EHD during the evaluation period were later found to be unsuitable by the EHP during EHD appointments, and a slightly larger group (22%) were returned to the JCP due to non-engagement.

EHPs categorised these customers into two groups: those they considered too far from the labour market and those who they described as simply unwilling to work towards employment.

Those considered simply too far from the labour market

Examples include:

- Those who EHPs consider simply too unwell and therefore inappropriate to offer the EHD to
- Those with a multitude of barriers to work which EHPs believe also exhibit as barriers to successfully engaging with the EHD

Those who simply do not want to work towards employment

EHPs described customers who are referred to the EHD but have no intention of working. The distinction with this group is that EHPs believed these customers could engage in a pathway towards work, even if they are not "work ready". Some reflected that these customers might proceed with the appointment as it is an opportunity to talk to a Healthcare Professional, but they are unwilling to discuss any movement towards work.

> *"I don't wanna say they're not suitable because they are suitable but… you explain to people and you say we will talk about work and they say they want to take part but… there are those that just do not want to discuss work goals and don't take up any of the signposting suggested between the meetings … There are some who just have less of an intention to move forwards"*
> (EHP)

However, EHPs gave few examples where they could identify customers who fit the eligibility criteria but would not be suitable for the EHD prior to actually engaging with them. One of the limited examples given was customers undergoing active chemotherapy. Instead, EHPs reported that the majority of the time they identify that a customer is not suitable during EHD appointments.

Some EHPs said they identified that a customer was not suitable during the first appointment, while others said they tend to identify this in the second appointment. This may depend on when the EHP chooses to raise the topic of work, with some opting to do so at the second appointment as is explored later in the following section of this report.

EHPs therefore felt it would be challenging to define people out of the EHD eligibility criteria.

However, EHPs emphasised the role the JCP plays in 'selling' the EHD appropriately. Some observed that, in their JCP, the EHD had been sold as a conversation or chat with a nurse as a 'hook' to encourage the customer to attend.

While EHPs recognised the reasons why the JCP may sell the EHD in this way, they reiterated the importance of setting appropriate expectations at an early stage with the customer, particularly around the purpose and scope of the EHD to ensure

meaningful engagement with the EHD as intended. This included setting them up for some discussion of work, which some EHPs felt was missing based on their engagements with customers.

Some EHPs explained that they mitigated this by also explicitly explaining at the beginning of EHD appointments what they can and cannot do. For example, while they are a Healthcare Professional by background, they are not a “practicing” clinician and cannot offer any treatment or speed up health-related referrals, for example.

Some EHPs also reflected that, in a previous iteration of delivery where EHPs contacted customers to book the first EHD appointment themselves (rather than the Work Coach or DEA), EHPs could sometimes identify inappropriate customers during this short call prior to formal appointments.

3.2 The discussion

3.2.1 Customer attendance

As outlined in Table 3.2.1, the MI suggests that the majority (87%) of appointments scheduled for those who successfully completed the EHD are attended.

Table 3.2.1 Customer attendance at EHD appointments

	Proportion across all channels
Attended	87%
Unable to attend	8%
Failed to attend	5%
	Base 748

However, the research highlighted that appointments are regularly rescheduled which may not be captured in the MI but likely has an impact on EHP productivity.

Some Work Coaches advocated for EHD appointments to be made mandatory, for example:

> *“At the moment, it appears that claimants can disengage from the process very easily if they do not wish to continue with the support. However, many claimants may need to be encouraged more to continue otherwise we may not be supporting them as fully as we can and it leaves the problem with the Work Coach”*
> (Work Coach)

However, what was important to EHPs was that customers meaningfully engage and if the voluntary nature of this intervention assists that, then it is considered important.

Customers were asked in the follow-up interviews how they would have felt if the EHD was mandatory. Some said they would have viewed it as ‘part of what they had

to do' and this wouldn't have impacted their approach, although this perspective may have been shaped by their now realised experiences on the EHD. On the other hand, others felt it would have undermined the EHD's purpose:

> *"I'd be a bit off if it was mandatory because it defeats the purpose of them wanting to help… it's us, not them and it defeats the whole purpose"*
> (EHD customer)

It is difficult to understand the extent to which participants engaged because the offer was voluntary from this research alone.

3.2.2 Channel of delivery

Of all EHD appointments scheduled, the majority (83%) were scheduled to take place via telephone. 13% were scheduled to take place face-to-face (10% in the JCP and 3% in a neutral location – a space outside of the JCP) and 5% by video.
Note: percentages have been rounded and therefore do not sum 100.

Referring Work Coaches and DEAs book customers' initial EHD appointments via the UC build and, during this, select the channel by which the first appointment will be delivered. Work Coaches and DEAs said that this decision is driven by the customer's preference and their individual circumstances, however it is important to note that neutral locations are not an available option in all sites and, in Chelmsford specifically, there are no face-to-face options for EHD appointments.

Some Work Coaches and DEAs in the survey expressed that they would prefer the EHP to decide the most appropriate channel, perhaps highlighting a lack of confidence in decision-making with regards to health customers and preference for Healthcare Professional expertise.

EHPs book any subsequent appointments the customer may have. EHPs again explained that the scheduled channel is driven by customer preference, although some explained that they encourage those who are anxious going out, for example, to work towards having a face-to-face EHD appointment once they have established a trusting relationship with the EHP. EHPs highlighted how, when agreed by the customer, this can act as a small goal being achieved in itself.

While some EHPs did not observe any differences in how customers interacted by channel, some felt that interaction was easier when face-to-face, such as being able to gauge reactions and understand pauses more easily. Some EHPs also gave examples of customers who were not necessarily ready to engage at the time of scheduled phone appointments, such as being in a location where it is challenging to engage completely. Moreover, some EHPs reflected that the EHD being delivered face-to-face in the JCP can offer a positive experience in the JCP, perhaps contrary to previous experiences. One EHP said that it can "give them [customers] an experience of feeling supported by the jobcentre and it is not all negative". Likewise, some Work Coaches recognised how this can have positive knock-on effects on customer engagement.

Nonetheless, EHPs emphasised that they could still successfully deliver appointments by remote channels.

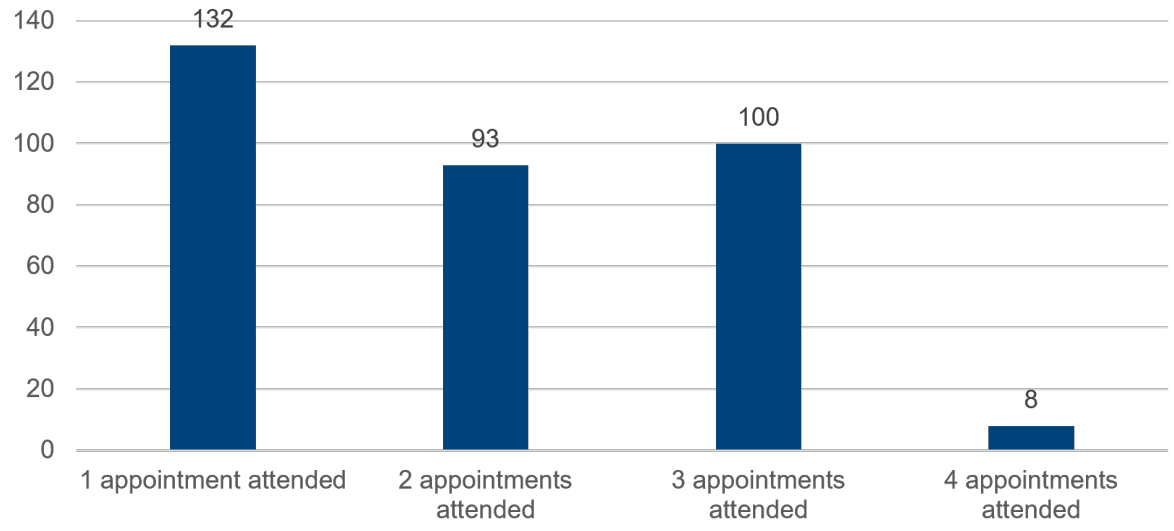
However, EHPs also recognised that customer engagement is paramount, and ultimately believed that the most important thing is to deliver appointments in a way that enables the customer to meaningfully engage. There was some concern that solely delivering face-to-face appointments would disengage some customers.

Notably, the majority (91%) of customer's agreed that the channel by which appointments were delivered was appropriate for them and gave specific reasons why. For example, those who had appointments by phone felt comfortable speaking within the comfort and familiarity of their own home and those who had appointments face-to-face believed this presented a good opportunity to go out and felt they could open up more easily face-to-face. Some appreciated the familiarity of the JCP location.

3.2.3 Number and length of appointments

As shown in Figure 3.2.1, of the 333 customers who were referred and successfully completed the EHD within the evaluation period, 40% (132) attended 1 appointment, 28% (93) attended 2 appointments, 30% attended 3 appointments and 2% (8) attended 4 appointments. As previously outlined, the intention was for the EHD to offer up to 3 appointments.

Figure 3.2.1 Number of appointments attended by those who successfully completed the EHD



Base 333

When asked how they decide on the number of appointments, EHPs felt that the number of appointments should be based on the individual. EHPs explained that the following factors impacted the number of appointments:

- how long a customer wants to talk about their health
- how 'gentle' an approach they need to take with the customer
- how much time they need to spend engaging the customer
- how far customers are from the labour market

The intended output of the EHD is a Workability Action Plan (see appendices for template Workability Action Plan) therefore the number of appointments should be those necessary to produce a meaningful plan. This was not explicitly cited by EHPs, although some of the factors mentioned above may facilitate the completion of a Workability Action Plan.

However, some appointments appear to more like a ‘check in’ and considerably shorter than the scheduled hour. For some, it is unclear how the appointments contributed towards the desired output of a Workability Action Plan. For example, observations of appointments where EHPs checked in on previous suggested steps and no additional actions were suggested. There therefore appears to be potential of scope creep from the original policy intent.

However, some EHPs believed if they did what they could to ensure customers took the suggested interim steps and had time to reflect, they are more likely to meaningfully engage with the rest of the EHD process, including buy into the Workability Action Plan, leading to longer term benefits.

4 in 5 (79%) customers agreed that the number of appointments was appropriate to them. Some customers said they would have liked more appointments. When asked in the follow-up interviews, these customers still felt they were able to discuss all their obstacles and formulate appropriate solutions. Likewise, some Work Coaches said that they think more time with the EHPs should be offered. In both cases, it is unclear why.

The majority (88%) of customers agreed that the length of appointments was appropriate to them.

3.2.4 Customer engagement

However, customers do not always engage with the EHD as intended.

EHPs perceptions of how often customers approach the EHD ‘ready to engage’ vary. Amongst 17 respondents to the EHP survey, just 1 believed customers always approach the EHD ready to engage. 11 respondents felt this is the case most of the time and 5 respondents just sometimes.

Where EHPs felt that customers do not always come to the EHD ready to engage, they felt they were either able to engage customers in the discussion most of the time (12) or some of the time (4). This suggests there is a customer group which some EHPs believe do not approach the EHD ready to engage nor can they successfully engage them.

1 in 5 (22%) were returned to the JCP due to non-engagement. Around a third (31%) of this group did not attend any appointments. While data was not routinely collected to quantitatively understand the reason for not engaging with the EHD, the qualitative research explored this and identified the following reasons:

- Not wanting to engage with the EHD as intended – as previously outlined, EHPs reported that some customers were not willing to discuss movement

towards work, produce a Workability Action Plan and/or were unreceptive to support

- No longer wanting to engage because they had received the outcome of their WCA – likewise, while EHPs acknowledged that some customers who receive an LCW or LCWRA outcome while referred to the EHD still want to engage and make a plan to move forwards, they also noted that some no longer want to participate in any further appointments or, as above, do not want to participate in the EHD as intended because of this outcome, which was explained by customers themselves
- Wider circumstances – EHPs often acknowledged the wider factors at play in a customer's life and, for this reason, support was not cut off until after several attempts at contact and/or rescheduling had been made. However, in some isolated cases, EHPs reflected that wider circumstances outside of their control can result in disengagement with the EHD

Critically, EHPs felt that, in some cases, the WCA can inhibit meaningful engagement in the EHD. For example, EHPs explained how customers can be hyper-focussed on the WCA and/or want to wait for it to take place before fully engaging in any support offers. Some EHPs reflected on instances where customers have explicitly said they are primarily focused on 'achieving' a specific outcome from the WCA. Likewise, as previously mentioned, some receive their WCA outcome while referred to the EHD and this can influence the dynamic. This may mean customers either do not engage with the EHD at all, or do not engage with certain aspects. In some cases, this exhibits as customers wanting to engage with the EHP – who they perhaps value and appreciate speaking to – but not the EHD process of producing a Workability Action Plan and discussing work as well as health.

Some EHPs explained how they try to mitigate this by reminding customers that there are numerous possible outcomes from the WCA or gently explaining to those with an LCW/LCWRA outcome that this decision is time-bound, and their situation may change in the future. From this, EHPs explained that they would then emphasise the opportunity customers have to formulate a plan via the EHD:

> *"They have the gift of time now to focus on their health and moving forward, getting treatment, looking at training … the decision won't last forever, and they can use this time to be in the best place possible"*
> (EHP)

Some EHPs also noted how customers with an LCW or LCWRA outcome are fearful about participating in any form of work or work preparation in case it has a detrimental impact on their benefits. In these cases, EHPs said they then need to reiterate the rules around what customers can do if they want to, as well as attempting to dispel the perceived 'unfit for work' label.

In this sense, an EHD after the WCA could be favourable. For example, some EHPs felt that the EHD could provide a useful stepping stone for customers who are found fit for work following a WCA. They noted that some of these customers feel that their health condition has not been heard or understood because they have been found fit

for work, but the EHD could offer an opportunity to be reassure these customers and support them onto a path to work:

> *"It isn't saying you aren't believed, just that there are some solutions for some work and we can try to find them together"*
> (EHP)

Some Work Coaches also reiterated the same sentiment, while others felt that the EHD taking place pre-WCA was beneficial as it can provide support to customers early in their journey – a time Work Coaches reported finding challenging.

Other Work Coaches also suggested the EHD could be beneficial for those found to have LCW or LCWRA who now have the security of this outcome and therefore are more open to try work, with one specifically highlighting how the EHD could fit well alongside the work allowance.

When asked about what might help them to further engage with customers, EHPs made the following suggestions:

- Expectation setting in the JCP – as previously outlined, clear communication with the customer on the purpose of the EHD and what it entails
- Further training – such as motivational interviewing or coaching training and upskilling on reasonable adjustments
- Widened scope of the EHD – such as the ability to advise on inhaler technique or low-level anxiety management to support customers on condition management
- Timing of the EHD – as previously outlined, it was identified by some that the EHD may be better received after the WCA

However, nonetheless there was again recognition amongst EHPs of a customer group who do not want to move towards work, regardless of the above.

3.2.4 Trust and rapport

All EHPs bar one agreed that they are able to build rapport with customers and support them to open up.

Customers had similar sentiments, with high levels of trust reported amongst those who successfully completed the EHD. As outlined in Table 3.2.2, almost all customers (96%) felt they were able to be honest and open with the EHP about their personal circumstances, and around 9 in 10 (89%) said they trusted the EHP. A similar amount (93%) also believed that the EHP understood their personal circumstances.

Table 3.2.2 Customer perceptions of the EHP

	Agree or strongly agree

I was able to be honest and open with the EHP about my personal circumstances	96% (79)
I trusted the EHP	89% (73)
The EHP understood my personal circumstances	93% (76)

Base 82

Around 6 in 10 (59%) customers said they felt more able to open up with the EHP than they would to their Work Coach. The remaining said they felt no more or less able, none said they feel less able.

Customers who successfully completed the EHD described EHPs positively, using adjectives such as friendly, supportive, helpful and welcoming.

Data from various strands of research (customer perceptions, EHP perceptions and observations specifically) suggests specific behaviours appear to drive trust and engagement with those who successfully complete the EHD. These include:

- Open questioning
- Active listening
- Empathy and compassion
- Respect
- Absence of judgement
- Demonstration of an interest in the customer's life as a whole (holistic approach)
- Tailored communication, such as speaking with the customer in a way that will resonate with them, using their own language and avoiding jargon
- Tailored advice
- Being honest and frank about the need for change and the effort required to move forwards
- Positive reinforcement
- (Where multiple appointments) Recognition of progress

Only one of the 19 EHPs who delivered the EHD during the evaluation period is male. This EHP specifically reflected on how they encouraged referring Work Coaches to consider whether customers would be willing and able to engage with a male EHP or if it would be most appropriate to refer to a female EHP for specific reasons. This is afforded by multiple EHPs being available in this JCP, although throughout the test cover has been provided in cases of absence across geographical boundaries by delivering phone appointments.

3.2.5 The role of clinical expertise

To Work Coaches and DEAs, the status of EHPs as Healthcare Professionals is particularly valued. Work Coaches and DEAs emphasise this when they pitch the EHD to customers and value the suggestions made by EHPs because of their clinical knowledge.

However, in contrast, few customers emphasised the status of the EHP as a Healthcare Professional as important. As previously outlined, customers also did not cite the fact the EHD is delivered by a Healthcare Professional as the reason they agreed to take part. Instead, customers placed emphasis on the broader opportunity to discuss their health and the way in which the EHP behaved. These specific behaviours are outlined in the previous section.

Nonetheless, many of these skills and behaviours may be implicitly acquired through EHPs' clinical backgrounds. EHPs felt strongly that their clinical backgrounds underpin the safe and successful delivery of the EHD and pinpointed ways in which they believed their experience generally as a Healthcare Professional and as a WCA assessor aided their ability to deliver the EHD.

EHPs believe their experience as a Healthcare Professional in general aids the delivery of the EHD

The breadth of knowledge of a variety of health conditions and associated treatments, including the pathways to accessing this treatment, is considered to:

- Aid EHPs' understanding of the 'art of the possible' in terms of current and future functional capacity
- Demonstrate understanding rooted in clinical expertise (validation of feelings)
- Support expectation management and myth busting
- Aid signposting
- Enable EHPs to positively challenge limiting beliefs
- Ensure appropriate escalation, where necessary

The experience of supporting patients with health-related matters is also considered to have developed the following skills:

- The ability to hold candid conversations with customers, applying independent judgement
- The ability to build rapport and trust
- The ability to demonstrate empathy and compassion
- Listening and communication skills
- An understanding of why people feel and act in certain ways

EHPs also believe their experience as a WCA assessor aids the delivery of the EHD

EHPs felt that their experience as a WCA assessor helped them to deliver the EHD in the following ways:

- Assessment Provider training further builds on existing ranging experience to ensure a 'broad brush of medical knowledge'
- A developed understanding of 'function' and functional impacts, which is believed to support EHPs to make appropriate and realistic suggestions
- An understanding of the customer base and their broader claim journey. For example, an appreciation of the significance of the WCA for some customers
- A unique understanding of when and how to ask questions to elicit the desired information from customers
- Ability to anticipate possible WCA outcomes and, without sharing this with the customer, prepare them for possible outcomes they may not hope for

EHPs ultimately felt that the EHD would fall down without clinical expertise, much of the time for opposite reasons to those previously highlighted, such as:

- Lack of knowledge of when and how to escalate health-related matters
- Ill-informed discussion
- Lack of ability to validate someone's experiences or feelings related to health

Comparisons were made to roles like DEAs and social prescribers which are not delivered by qualified Healthcare Professionals. EHPs felt that, while DEAs or social prescribers can provide a similar triage service in response to the personal, social and work-related barriers customers present, they would not be able to provide the same support in terms of identifying health-related barriers and appropriate solutions, therefore only fulfilling part of the biopsychosocial model upon which the EHD is based. For example, EHPs felt that non-Healthcare Professionals would not have the same understanding of the impact of different health conditions and therefore the barriers they present individual to that person, nor the 'art of the possible' in terms of appropriate steps to take.

All EHPs agreed that they have the right clinical knowledge to deliver the EHD, bar one EHP who neither agreed nor disagreed with the statement.

Interestingly, there was a strong sense that that the EHD does not need to be delivered by any one specific profession. The EHD has been delivered primarily by nurses alongside two Physiotherapists and one Occupational Therapist. A mix of professions was considered to offer a delivery model which could be scaled up, if appropriate.

EHPs and their managers alike felt that the experience and skillset required is not profession specific, but rather related to one's experience more broadly as a clinician. Again, a breadth of knowledge and learnt behaviors from engaging with people with health conditions is considered paramount.

Managers of EHPs added that a multi-disciplinary team can also be advantageous in terms of improving and developing the service by offering different perspectives.

> *"I don't think having one stream of Healthcare Professional is the option. The skills they are truly utilizing are the coaching and motivational interviewing. Those are the skills that really come out and help them in this role"*
> (EHP manager)

EHPs and managers alike felt that the service could be developed for existing and new staff by identifying the specific training, experience and skills required for optimal delivery of the role and upskilling staff against these. This was considered more important than recruiting from certain professions, within which they highlighted individual training backgrounds and experiences can vary vastly.

Customers in the research rarely reflected on the specific professional expertise of the EHP.

However, it is important to recognise that clinical expertise can bring challenges. Throughout the delivery of the EHD, some EHPs struggled to operate within the remit

of the EHP role, emphasising the importance of a robust clinical governance framework.

In the survey, while EHPs generally agreed that they feel confident to perform their role within the clinical governance boundaries set, there is evidence to suggest that navigating the scope of the role is still a challenge. 12 of the 17 EHPs who responded to the survey said they find themselves refraining from providing certain support for fear of overstepping their remit. This was likewise emphasised during the follow-up interviews. Managers of EHPs also felt that the risk of EHPs operating outside of their remit was still somewhat alive, indicated by continued discussions with EHPs around what they can and cannot do in the role.

Specifically, some EHPs report finding navigating what can be considered 'treatment' challenging. One EHP said "I feel the role is not providing treatment, but the advice or tips could be viewed as treatment".

Likewise, managers of EHPs reflected on this distinction. They highlighted that what one individual may consider to constitute treatment, another would not. An example was given of an individual who suggests to their neighbour that they try to get out once a day. This individual may be a nurse by profession, but the suggestion has not derived from their clinical background – it is a natural common sensical thing to suggest and they do not consider it clinical advice as they have not been trained to make these kinds of suggestions. However, an Occupational Therapist may disagree as they may have received training which included making suggestions like this. EHP managers perceived that such differences in training backgrounds can cause confusion.

EHPs and their managers alike agreed that there should be a greater understanding of what the scope of practice is. However, there was some concern that what EHPs can offer would be reduced to 'generic advice' if too risk-averse an approach is taken.

> *"EHPs are not sure what they should and should not be saying … this means we could err on the side of caution, and become robots offering generic NHS websites"*
> (EHP)

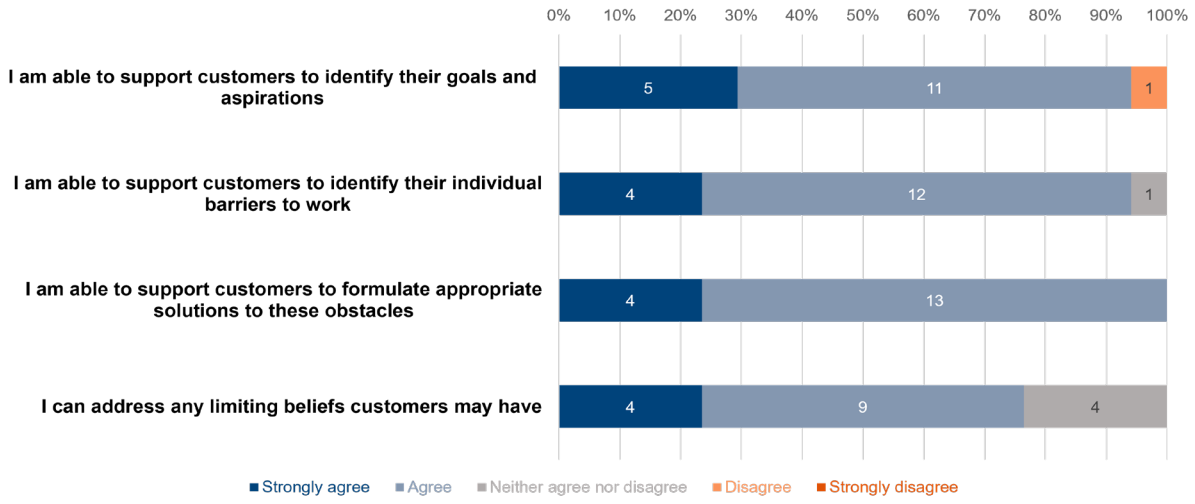
Some EHPs felt that the scope of practice could be extended. Some frustration was expressed with the current boundaries, arising from the knowledge EHPs have from previous roles that they have to withhold. Plentiful examples were given of EHPs reflecting on situations where they reflected 'if only the customer did X' but cannot advise this as an EHP in the EHD. One EHP said "there needs to be a bigger embrace of our clinical knowledge and expertise rather than trying to move away from that".

Some questioned whether specific occupational health training and subsequent qualifications could pave the way for EHPs to deliver a wider remit.

3.2.6 Identifying goals, obstacles and solutions

As shown in Figure 3.2.2, almost all EHPs felt able to support customers to identify their goals, obstacles and solutions. Slightly fewer (13 of 17 respondents) agreed that they could address customer's limiting beliefs.

Figure 3.2.2 EHPs' ability to support customers to identify goals, barriers and solutions and address limiting beliefs



Base 17

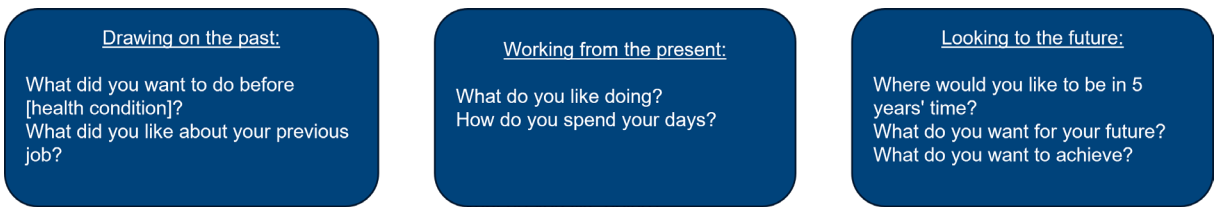
Around 9 in 10 customers agreed that the EHP helped them to identify all of the different obstacles they face (88%) as well as appropriate solutions to these (89%).

Goals

When asked how they support customers to identify their goals, EHPs reflected that customers are all different. For example, some have existing goals, or they can be easily supported to identify these through discussion.

EHPs use different approaches to do so but, as outlined in Figure 3.2.3, these can be broadly categorised into three approaches – drawing on the past, working from the present and looking to the future.

Figure 3.2.3 Approaches to identifying customer goals



However, EHPs reflected that, for some, identifying goals is much more challenging. EHPs reflected on how some customers have much more engrained negative mindsets and are resistant to numerous different approaches.

When asked about the types of goals customers have, EHPs again reiterated how they depend on the customer. While some have more directly work-focussed goals, many are basic lifestyle-related goals, such as establishing a structure to days or getting outside. EHPs often set these small non-work-related goals to review at

follow-up appointments (where these take place). During these follow-up appointments, positive reinforcement and recognition of progress is often given.

However, the Workability Action Plan analysis suggests that obstacles and solutions are not always clearly linked to goals. Likewise, sometimes goals are absent in the plans, although it is unclear whether this is due to a simple lack of customer goals, lack of EHP support to identify, lack of clarity in recording or any other factors.

Obstacles

The intention of the EHD is to identify the range of barriers affecting a customer's ability to work and the design of the EHD is based upon a biopsychosocial model to support this. When explored in the research, EHPs said they felt able and confident to apply the biopsychosocial approach and highlighted how it aligns with what they do in healthcare. For example, EHPs drew attention to how past roles stretch beyond solely operating in the 'bio' space and also lean into the psychological and social elements, such as through helping patients with their recovery.

When identifying obstacles, it appears that customers are forthcoming with discussing their health and therefore health-related barriers. Likewise, it was clear through the observations that EHPs were confident and at ease discussing health.

However, EHPs often ask more directed questions to identify personal (aligning with the psychological element of the model, such as beliefs), social (such as family matters) and specific work-related obstacles. EHPs explained how the timing and delivery of these questions should be tailored to the customer and conversation. They emphasised that they do not follow a script or 'go through the plan like a checklist' but instead ask relevant questions in a conversational manner.

In this sense, EHPs often allow customers the time and space to talk about what is important to them before trying to funnel the conversation. Often this involves the customer being able to talk about their health condition(s) and establish a relationship with the EHP.

However, EHPs reflected on experiences with customers whereby it can be challenging to move past solely discussing health explaining this is often customers' focus. The Workability Action Plans analysis similarly suggests that plans often centre around the health-related obstacles and solutions. The Workability Action Plan is intended to identify the full range of barriers a customer faces, categorised into health, personal, social and work-related obstacles (see appendices for blank template). However, in some plans, the personal and social elements are left blank or with limited detail. While there may legitimately have been fewer or no barriers in these areas, some examples where there were potential opportunities for development include those with low confidence scores indicating potential mindset or self-belief issues, but no exploration of this is documented.

Similarly, it was clear from the research that work is not mentioned in every appointment. Some EHPs choose to broach the topic of work at second or third appointments, allowing the first appointment to be a space for the customer to discuss their health only. EHPs felt this was more 'appropriate'. This approach may

contribute to the heavily weighted focus on health-related obstacles and solutions, as opposed to other factors, observed in Workability Action Plans.

Likewise, it is unclear whether the benefits of work are consistently explained to customers and, where this takes place, some differences were noted in when this is discussed, for example at the outset of the discussion or when customers challenge work-related discussion. Nonetheless, most EHPs reported feeling able to confidently explain the benefits of work to customers.

Addressing limiting beliefs

EHPs recognised that customers have varying mindsets – some more positive, some more negative.

For example, some customers may:

- focus on what they cannot do, such as believing that a fit note means they cannot work at all
- be resistant to suggestions, such as being unwilling to consider any steps they can take until they have received treatment for their health condition
- circle back to negative past experiences in the workplace

EHPs said they approach this in various ways, including:

- Providing reassurance, such as explaining how the customer is feeling is 'normal' and they are not alone
- Offering positive challenge and reframing negative into positive
- Compartmentalising – breaking each limiting belief down one by one and identifying root cause
- Explaining the impact of good work on health
- Educating on developments in medical space, for example if the customer had treatment a long time ago
- Separating thought from truth, such as raising awareness on what support is available in workplace settings, including reasonable adjustments
- Signposting to self-esteem and self-belief related resources
- Offering honesty and reality – '[I] ask them if they want their lives to change'

However, only just over half of the EHPs felt able to confidently respond to any challenges from customers around the benefits of work.

EHPs fed back that additional motivational interviewing or coaching training could be beneficial in developing their skillset to respond positively to these challenges. Managers of the EHPs likewise felt that further training to support them to challenge negative beliefs would be beneficial, noting the potential for some nervousness around losing rapport with customers.

Nonetheless, EHPs acknowledged a customer group for whom their mindset is heavily engrained and they do not believe they would be able to help them any further, explaining 'they have to want to change'.

Identifying solutions

Analysis of a sample of Workability Action Plans indicated that solutions are individual to the customer. Examples include:

- signposting to external support services, such as Andy's Man Club, drug and alcohol support, IT courses and GP services
- signposting to online resources, such as on managing a health condition, Access to Work and reasonable adjustments
- practical steps, such as getting outside or seeing friends

EHPs reflected that, for those who are perceived to be a long distance from the labour market, it is not possible to formulate a complete 'return to work' plan through a short intervention like the EHD, for reasons such as the customer must often take the initial steps to realise the benefits and then buy-into further steps, and that individual journeys are not linear or predictable. For this group, they felt that the focus may be more so on small steps the customer can take to improve their day-to-day life which can aid customers on the pathway to work, even if they do not explicitly recognize this themselves.

> *"If I can signpost someone towards specific free sexual abuse counselling to help their mental health, that's going to eventually lead them towards the labour market, although maybe not while I'm seeing them as it takes time"* (EHP)

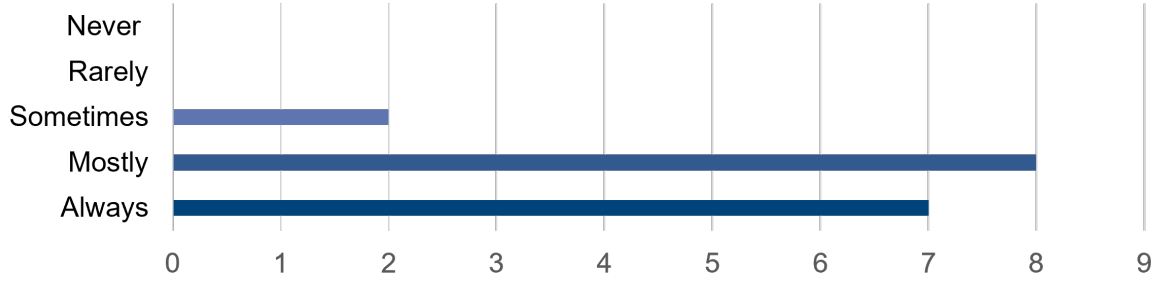
> *"Most of the work I do is getting people back on track with their healthcare and giving people the confidence and different ways to approach their GPs*" (EHP)

EHPs noted that it is often important to package suggested steps with coaching during the EHD appointments to encourage buy-in, although recognised that the responsibility ultimately lies with the customer after the EHD to actually take these steps. One EHP questioned whether the suggested steps could translate into claimant commitments to ensure accountability, as well as further embed the EHD process into business-as-usual operational delivery.

When considering the support available in their local area, EHPs varied in how often they felt that they could find appropriate resources and provisions to signpost customers to in relation to the obstacles identified – as outlined in Figure 3.2.4.

Figure 3.2.4 Availability of appropriate resources or provisions to signpost to

Thinking about the support available in your local area, how often can you find an appropriate resource or provision to signpost to?



Base 17

It is important to note that this may be influenced by factors beyond geography too, such as individual capability or the EHP's integration into the JCP and therefore their map of support services. For example, one EHP reflected that they are specifically linked into their DEA and share resources to build their networks.

In the qualitative research, geographic differences were explicitly explored as the EHD is delivered in England and Wales. The EHP in Aberdare noted that, while they believed fewer resources were available in Wales, especially for rarer health conditions, there was always something they could signpost to as an appropriate solution.

Ultimately, up-to-date local knowledge of available resources and provisions is considered integral. One EHP said:

> *"It's about knowing your area, [we] attend ICB meetings, engage with voluntary sectors etc. so have local knowledge … That's absolutely vital, so when you are covering other areas, that's a real challenge to delivering a good service"*

However, analysis of the Workability Action Plans highlighted that some solutions are not clearly matched to the obstacles identified and some simply state that the 'customer could not think of any', suggesting a lack of collaboration between the customer and EHP and positive challenge.

Some EHPs felt that they could offer more comprehensive 'solutions' to customers if the scope of the EHD was widened, for example:

> *"Most people have mental health issues and we cannot provide good structure tools to help them. The websites are not very good. If we can teach people about unhelpful thoughts, CBT techniques… this would be more beneficial than directing to other places"*
> (EHP)

3.2.7 The Workability Action Plan

The Workability Action Plan should document the customer's full range of barriers and solutions. The plan is designed to enable the adoption of a biopsychosocial approach and categorises barriers under the following headings: health, personal, social and work-related. The plan also enables recording of what customers can do

now, their goals, and their potential ‘work ability’, as perceived by the customer, if they pursued all of the actions documented. A blank Workability Action Plan is included in the appendices.

Analysis of a sample of Workability Action Plans identified notable variation in how plans are completed.

It appears the quality of completed Workability Action Plans vary. For example:

- Some do not include anything the customer can do, regardless of how small this may be
- Some refer to what the customer cannot do, as opposed to what they can do – even in parts dedicated to what the customer can do
- Some have unclear goals, or limitations built into a goal
- Some lack specific and clearly matched obstacles and solutions, including examples of solution sections noting ‘customer could not think of any’ – suggesting a lack of collaboration between the customer and EHP and positive challenge
- Some mix up the different sections aligning to the biopsychosocial model. Often less is included in the ‘personal’ and ‘social’ sections, and sometimes it appears there is a lack of clarity on what should be included in these sections.
- Some have poor formatting

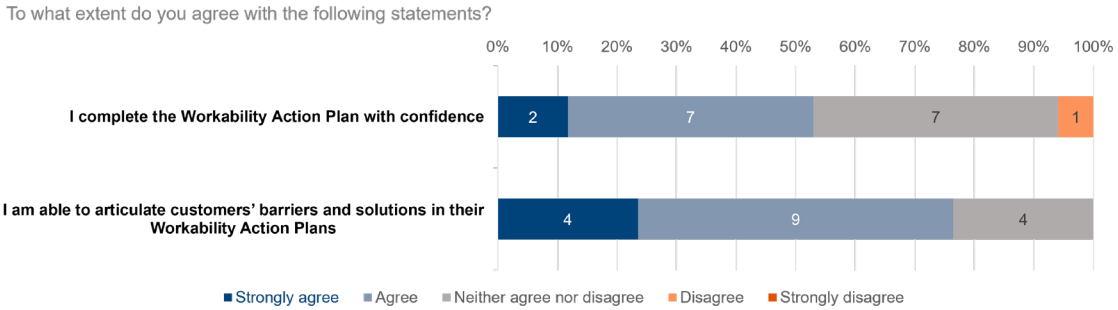
While other plans exhibit the opposite.

Similarly, EHPs appear to also have individual stylistic differences in how they complete the plans. For example:

- Some are written in a very personal and reassuring manner, including wording such as “you are not alone”, “remind yourself that…” and “don’t be afraid to…”, while others take a much more informative stance
- Some are written in first person, some second, some third person, and some a mixture of the three in one plan
- Some are written in note style, which could cause difficulty in understanding some of the content for those outside the conversation (for example, Work Coach) or perhaps if revisiting a period of time after the EHD

Interestingly, as outlined in Figure 3.2.5, around half (8) of the EHPs in the survey did not express clear confidence in completing the Workability Action Plan, although few specific suggestions for improvement were made. Slightly more (13) agreed they could articulate customers’ barriers and solutions in the Workability Action Plans.

Figure 3.2.5 EHP ability to complete the Workability Action Plan



Base 17

Workability Action Plans may therefore benefit from monitoring or QA, as well as agreements around where consistency is desired and where individual nuance is useful.

The majority (89%) of customers said they had read their Workability Action Plan, although a minority (11%) had not. Those who had not read their Workability Action Plan commonly said they had not received it, or they do not know where to find it.

As outlined in Table 3.2.3, the majority of customers believed their Workability Action Plan was tailored to them (86%) and accurately recorded the obstacles and solutions identified during their appointments (84%). Three quarters (75%) believed the solutions in their Workability Action Plan were clear, realistic and actionable and 4 in 5 (81%) said they planned on taking forward the suggested steps. However, in the follow-up interviews, customers struggled to pinpoint specific parts of the Workability Action Plan they liked.

Table 3.2.3 Customer views on the Workability Action Plan

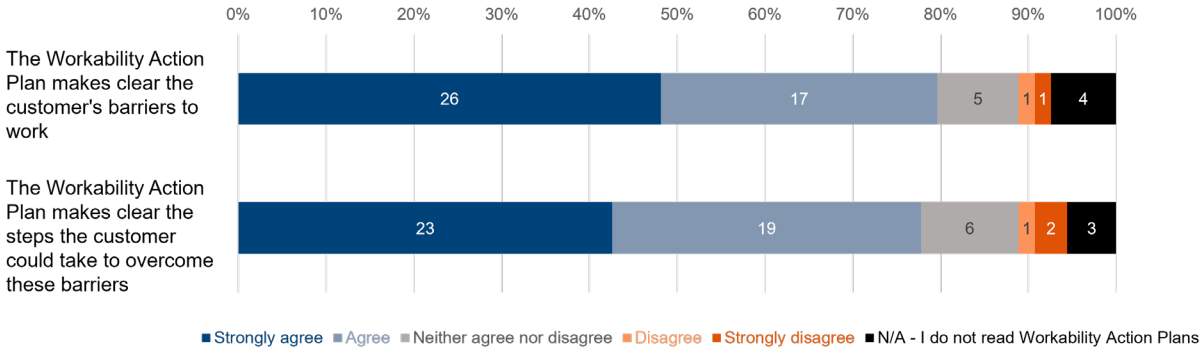
	Agree or strongly agree
My Workability Action Plan is tailored to me	86% (63)
My Workability Action Plan accurately records the obstacles and solutions identified during appointments with my EHP	84% (61)
The solutions in my Workability Action Plan are clear, realistic and actionable	75% (55)
I plan to take forward the actions set out in my Workability Action Plan	81% (59)

Base 73

Interestingly, while all EHPs felt that the Workability Action Plan is co-created between themselves and the customer, mention of the Workability Action Plan during appointments appears to be inconsistent and could play a role in agreement with the aforementioned statements.

As shown in Figure 3.2.6, around 4 in 5 Work Coaches and DEAs felt that the Workability Action Plan clearly documents the customer's barriers to work (80%) and the steps they can take to overcome these (78%).

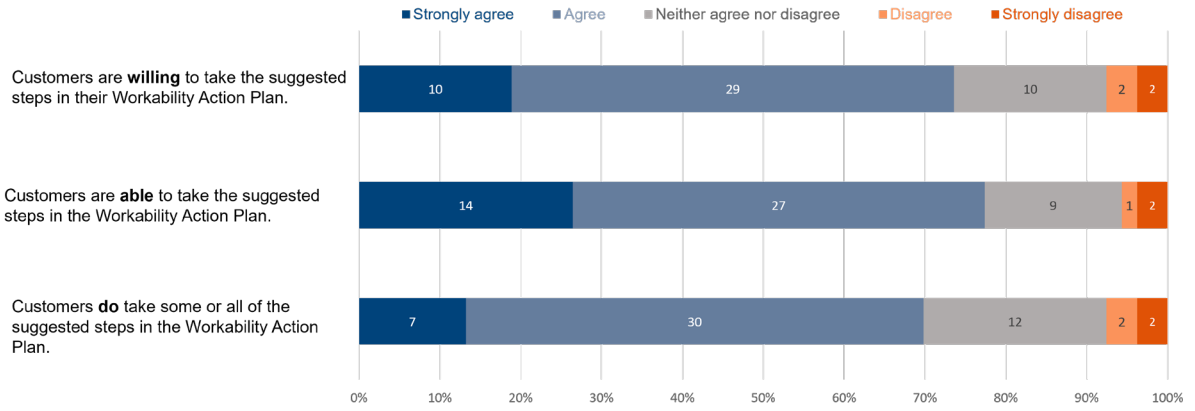
Figure 3.2.6 Work Coach and DEA views on the Workability Action Plan



Base 54

As shown in Figure 3.2.7, around three quarters of Work Coaches and DEAs also believe that customers are willing (74%) and able (77%) to take forward the suggested steps in the Workability Action Plan. Slightly fewer (70%) believe customers do take some or all of the suggested steps in actuality.

Figure 3.2.7 Work Coach and DEA perceptions of customer ability, willingness and actuality of taking suggested steps outlined in the Workability Action Plans

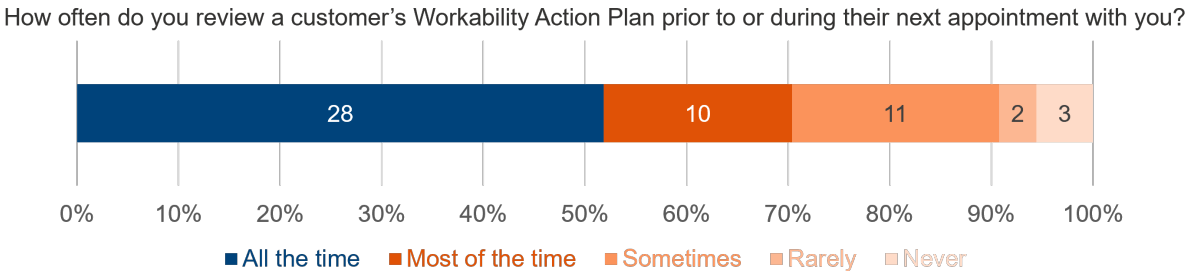


Base 53*

*Note: 1 Work Coach responded that they were unsure to all of the statements and have therefore been omitted from the chart.

However, of those Work Coaches and DEAs who engage with customers after they have completed the EHD, there is notable inconsistency in whether they regularly review the customer's Workability Action Plan. As shown in Figure 3.2.8, only around half (52%) say they always read the Workability Action Plan prior to or during their next appointment with the customer.

Figure 3.2.8 Commonality of Work Coaches and DEAs reviewing Workability Action Plans



Base 54

Of those who do not always review the Workability Action Plan, lack of time is continually cited as a barrier. Some also reported not finding the plan useful enough to prioritise within their available time. A small number of Work Coaches said they had difficulty accessing the Workability Action Plans and this also influenced their likelihood of accessing them. Some suggested having all documents on the UC build, explaining how one place for everything would offer convenience and could further support the integration of the service into business-as-usual.

In contrast, a larger majority (76%) said that they always read the meeting notes the EHP completes. Some of this group reported that they read each individual set of meeting notes after each EHD appointment the customer attends, while the rest said they read these once the customer has attended all of their EHD appointments.

For those who do not always read the meeting notes, the primary reason was again lack of time and, likewise, there were some isolated instances of Work Coaches saying they had difficulty accessing the meeting notes. However, in contrast to the Workability Action Plans, the relative importance of the meeting notes was not identified as a reason for not reviewing them, suggesting some Work Coaches and DEAs prioritise reviewing these over the Workability Action Plan. During the qualitative research, some expressed that they found the meeting notes more useful as they were more specific and personal.

3.3 The return to the JCP

3.3.1 Customer satisfaction

Customers reported high levels of satisfaction with the EHD, with almost all (95%) customers reporting being extremely satisfied or satisfied by the service provided.

3.3.2 Customers' perceived work ability

During the EHD, customers are asked the following question:

> “Assume that your ability to work has, at its best, a value of 10 points. How many points would you give your work ability?”

This question is asked at every EHD appointment and is intended to be used by the EHPs to tailor their discussion and suggestions. The score the customer gives at the end of their engagement with the EHD is recorded on their Workability Action Plan to share with the Work Coach as their ‘current’ workability score.

While not an intended outcome of the EHD, it is worth noting that 6 in 10 customers who successfully completed the EHD and had more than one appointment saw an improvement in their ‘workability score’ over the course of the EHD – see Table 3.3.

Table 3.3 Change in workability score during the EHD

Change in workability score during the course of the EHD (where customers had more than one appointment)	Proportion of customers
Improved	60%
Stayed the same	33%
Deteriorated	7%
	Base 201

Note: 132 customers only had one EHD appointment, therefore it is not possible to detect any improvement during the EHD.

However, as previously noted, we cannot robustly attribute any of the reported outcomes to the EHD alone. For example, observed changes may be a result of:

- Engagement with the EHP, such as mindset changes
- Taking forwards the steps suggested by EHPs in between appointments

and/or

- External factors outside of the EHD, such as improvements to health outside of EHD’s control or circumstantial changes
- Steps customers would have naturally taken in this time anyway, regardless of the EHP’s suggestions

Customers who successfully completed the EHD were also asked the same question again in a follow up survey (wave 2 customer survey) issued 6 weeks after their last EHD appointment (this may have been only one appointment).

Of those who responded to the wave 2 follow-up survey (34), 28 responses could be matched to their previous scores. Just 5 of these customers gave a workability score 6 weeks after the EHD which was higher than the score they reported at the end of the EHD. It is important to recognise that no reminder was given of customer’s

previous scores and, again, the caveats outlined earlier must still be recognised alongside the very small sample size of 28.

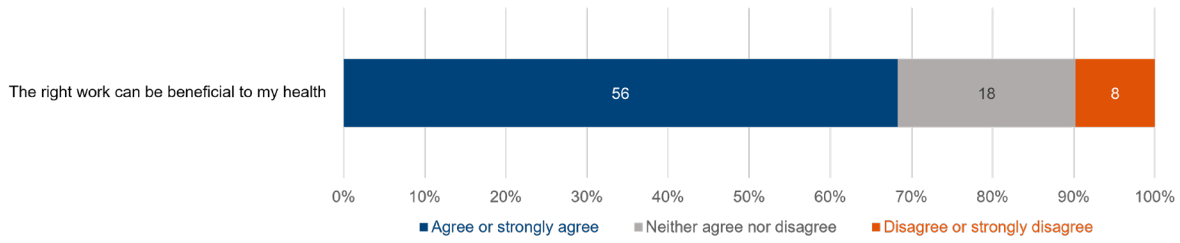
While this finding aims to provide insight into the longer-term effects of the EHD, it is important to note qualitative findings which emphasise the follow-up support necessary to ensure benefits of the EHD are sustained. It has been reiterated by EHPs and Work Coaches and DEAs throughout the research that the EHD is a short intervention and part of the pathway to work, therefore effective follow-up support is necessary, alongside customer willingness to move forwards.

The support provided as part of business-as-usual or externally to DWP is outside of the scope of this research.

3.3.3 Customer outlook on work

In the customer survey issued immediately after successful completion of the EHD, around 7 in 10 (68%) customers agreed that the right work can be beneficial to their health. This is shown in Figure 3.3.1.

Figure 3.3.1 Customer agreement that the right work can be beneficial to their health



Base 82

However, it is not possible to identify the extent to which agreement with this statement is influenced by the EHD. For example, as previously outlined, it is unclear whether the benefits of work are consistently explained to customers during the EHD. Customers may likewise have believed the right work could be beneficial to their health prior to engaging in the EHD.

Likewise in the survey issued immediately after successfully completing the EHD, customers were asked whether they felt:

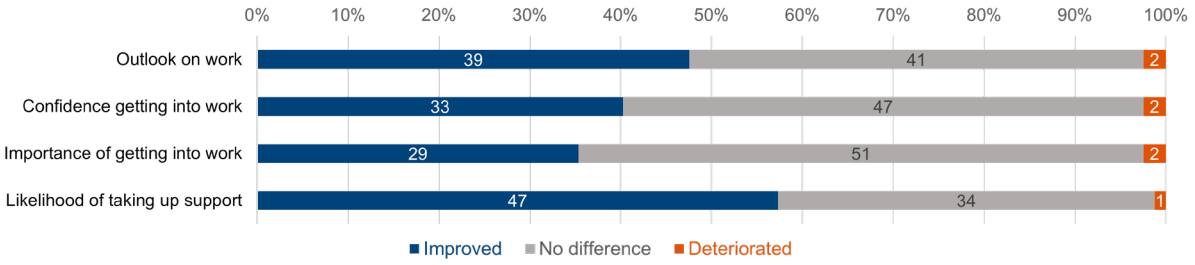
- More or less positively about work
- More or less confident about getting into work
- Getting into work is more or less important
- More or less positively about taking up support offers (examples such as training courses or volunteering opportunities were given)

now than before the EHD.

As shown in Figure 3.3.2, around half (48%) reported feeling more positively about work and slightly more (57%) reported feeling more likely to take up support offers.

Smaller proportions reported feeling more confident about getting into work (40%) and that work was more important to them (35%).

Figure 3.3.2 Customer views on work and work-related activity



Base 82

Small minorities (2% or less) felt less positively across all of the aforementioned areas following the EHD. The remaining reported feeling indifferently. For this group, health was commonly still cited as a barrier – emphasising how focal this is to customers.

At the end of the EHD (during the customer's final appointment if multiple), customers are also asked to give a score for their confidence getting into work and the importance of getting into work.

> "On a scale of 0 to 10 where 0 is not at all confident and 10 is very confident, how confident do you feel about getting into work now?"
>
> "On a scale of 0 to 10 where 0 is not at all important and 10 is very important, how important is it for you to get into work now?"

Again, this is recorded in the customer's Workability Action Plan which is shared with their Work Coach.

Customers who successfully completed the EHD were then asked the same question again in a follow up survey (wave 2 survey) issued 6 weeks after their last EHD appointment.

As previously outlined, of those who responded to the wave 2 survey (34), 28 could be matched to their previous scores. Just 3 of these customers gave a confidence score 6 weeks after the EHD which was higher than the score they reported at the end of the EHD. Likewise, just 3 of these customers gave an importance score 6 weeks after the EHD which was higher than the score they reported at the end of the EHD. As above, no reminder was given of customer's previous scores and, again, the caveats previously outlined must still be recognised alongside the very small sample size of 28. Nonetheless, this indicative finding again points to the qualitative findings which emphasise the importance of follow-up support to ensure sustained improvements.

Some Work Coaches and DEAs also reported observing the following differences in customers after engaging with the EHD:

- Increased confidence

- Increased awareness of what they are capable of
- Increased positivity towards work and/or openness to work
- Improved engagement with the Work Coach
- More empowered with regards to managing health condition

However, a few did not recall observing any differences in customers following the EHD.

Some highlighted that it depends on the customer. For example, Work Coaches can observe positive changes in customers they perceive to approach the EHD with at least some level of willingness to move forward.

> *"I have had some customers who have not taken up the advice and are just set in a mindset they cannot work, and other customers have said it has been extremely helpful, and they have started to feel better and take steps to actively overcome their health issues and search for work*"
> (Work Coach)

Work Coaches believed that some of these perceived benefits can fade over time for customers who require constant nudges, support and guidance though. For example, one Work Coach said, "for the types of customers [where] we have to nudge them, when they're no longer nudged, they might go back to bad habits".

As previously outlined, the EHD alone is therefore not considered the sole solution to support this whole customer group into work and follow up support and encouragement, such as from the JCP, is considered imperative for some.

Through the case studies, EHPs also perceived there to have been positive progression amongst customers during the EHD, citing:

- Increased motivation
- Increased confidence
- Improved mindset/outlook (including on work)
- Improved self esteem
- Improved management of health conditions

EHPs felt this was often achieved through taking forward steps they had suggested during the EHD, such as establishing a routine, picking up old hobbies and engaging with signposting.

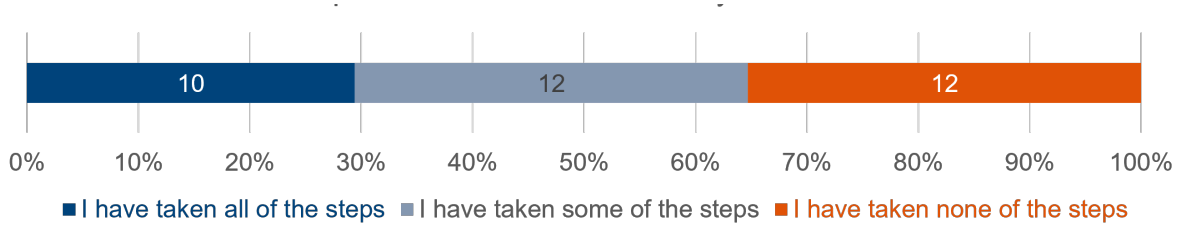
However, amongst EHPs there was a general acknowledgement that many customers are a long distance from the labour market and, similarly, the EHD is therefore part of the pathway to work.

Amongst customers, Work Coaches, DEAs and EHPs alike, the importance of the customer feeling heard or listened to (and by this very nature including health in the conversation) was imperative and considered to underpin any behavioural or mindset changes.

3.3.4 Taking the suggested steps

Of the limited volume of customers who responded to the wave 2 survey (34), around two thirds (22) said that they had taken all or some of the steps outlined in their Workability Action Plan. The other third (12) said they had not taken any of these steps. This is shown in Figure 3.3.3.

Figure 3.3.3 Proportion of customers who report taking all, some or none of the steps outlined in their Workability Action Plan



Base 34

Of the limited number that reported taking all of the suggested steps (10), some (5) thought these had helped them to move closer towards work and some (5) were unsure. None explicitly thought that they did not help.

Of the limited number that reported taking some of the suggested steps (12), likewise some (3) thought these helped them move closer towards work, some (5) were unsure but some (4) did not think they helped.

Those who did not take any or only some of the steps (24) reported that their health was a continued barrier to taking the suggested steps, with some saying their health had deteriorated. Many of the respondents also reported that they had received an LCW or LCWRA outcome following their WCA, although did not raise this when asking why they had not taken forward any of the steps. Some said that they were facing issues beyond their health which has impacted their ability to take some of the steps forwards, such as family issues. It is unclear if these issues have arisen since the EHD. One said that the course they were suggested to attend had no places in their area.

When asked if this customer group planned on taking any more of the suggested steps in their Workability Action Plan in the future, most (14) of them said they would take forwards some of them, although some (7) said they would not take any forwards. Few (3) said they would take forwards all of them.

It is important to recognise that the steps suggested in customers' Workability Action Plans are individual to the customer, and some will have longer trajectories. There is therefore not an expectation that all customers will have completed all actions by the 6-week follow-up, although this was considered an appropriate point to follow-up on a universal basis and within the timescales of testing delivery.

EHPs also reiterated the variety of customers who were referred to the EHD, including a group who were more resistant to moving towards work. One EHP said, 'some you think, are they really going to do this and others where you think, I really feel I've made a difference'.

3.3.5 Discussion of the EHD with the Work Coach

The majority (82%) of those who responded to the Work Coach/DEA survey continue to have routine appointments with the customer while they are referred to the EHD. Almost all of this group (96%) said they discuss the EHD during these appointments. Many of them said they proactively raise the topic of the EHD, rather than the customer, 'asking outright'. For example:

- How did it go with [EHP name]?
- How was your last appointment?
- How are you finding it?
- Has it been helpful?
- What do you think the next steps are?

The join up between the EHD staff and JCP staff was highlighted as important here. The ability to refer to the EHP by their name and know a bit about them was considered important to some Work Coaches in terms of having an informal, conversational discussion with the customer about how they were getting on. Some also raised how they could personally check in with the EHP given their presence in the JCP to understand their perspective on the customer's progress.

3.3.6 Discussion of the Workability Action Plan with the Work Coach

The majority (78%) of Work Coaches and DEAs that engage with customers after the EHD believe the Workability Action Plan is a useful tool for the customer to move forwards.

However, of those customers who said they have had at least one appointment with their Work Coach within 6 weeks of completing the EHD (20 of 34 responses to the wave 2 survey), around half (12) said they actually discussed their Workability Action Plan during this. This group largely report that they believe the Workability Action Plan has helped their Work Coach to understand the barriers they face to work.

It therefore appears there is inconsistency in whether Workability Action Plans are discussed with customers.

On the one hand, some Work Coaches reported discussing and using the Workability Action Plan effectively, broadly using it to help 'move the customer forward'. This may be through further encouragement to take the steps suggested by the EHP and, in some cases, further building on the suggested steps with anything additional they may be able to offer. Those that gave further encouragement and reinforcement felt this was imperative to ensuring sustained progression after the EHD, particularly where customers journeys are not linear, and they experience setbacks. Without this, some felt that the benefits of the EHD may not be realised. Work Coaches and DEAs saw the EHD as a stepping stone towards work, although recognised it is not a 'one stop shop' for all. Work Coaches delivering their role as intended is therefore important.

Around two thirds (67%) of the Work Coaches and DEAs surveyed who set conditionality requirements reported using the Workability Action Plan to shape the conditionality requirements of the customer.

It appears these Work Coaches and DEAs genuinely buy into the Workability Action Plans, for several reasons:

- They believe the plan documents more than what they knew about the customer as their Work Coach. Work Coaches and DEAs specifically noted liking having the customer's aspirations, barriers and actions they can take clearly outlined. For example, one Work Coach said "often issues, experiences or conditions are uncovered that we don't have time to help the claimant share during a 10-minute work search review".
- The suggested steps are from a trained Healthcare Professional, and this provided the Work Coach with the confidence to reinforce suggestions

On the other hand, a small group of Work Coaches explicitly reported not using the Workability Action Plan after the EHD.

Some felt that the plan only includes suggestions that a Work Coach would provide. There is also concern that, where customers do not see the same Work Coach for routine appointments or business-as-usual operations are not followed (such as Work Coaches not performing role or delivering the Health Journey as intended), Workability Action Plans are not always used or used effectively. Compliance with business-as-usual operational delivery therefore impacts on the extent to which the EHD can also be delivered as intended.

Nonetheless, the vast majority (90%) of Work Coaches and DEAs believed that the EHD in general helps them to support the customer to move towards work. This is a slightly greater proportion than those who believe the Workability Action Plan is a useful tool for the customer to move towards (78%).

Of the customers who responded to the wave 2 survey and had had an appointment with their Work Coach following this (20), over half (13) thought that their relationship with their Work Coach had improved following the EHD. The remaining (7) felt indifferently about their relationship with their Work Coach following the EHD. For some of this group, they had not discussed their Workability Action Plan with their Work Coach.

3.3.7 The value to the JCP

Work Coaches and DEAs were asked if, without the EHD and Workability Action Plan, they would be able to identify the obstacles and solutions documented in customers' Workability Action Plans via their routine appointments or as a result of other existing provisions. Notably, just 13% said they would be able to identify the barriers outlined, and only 19% said they would be able to identify the solutions. Interestingly, none of the DEAs thought they could do so. Many therefore viewed the EHD as support that they could not currently provide as a Work Coach or DEA. Specifically, they felt that they did not have the clinical understanding nor the time with customers to do so. Some also felt customers would not open up to them. In this

sense, the EHD could be considered to bridge the gap in communication between customers and the JCP.

Some Work Coaches and DEAs also noted wider benefits to the time EHPs spend in the JCP. EHPs have ringfenced time to engage with JCP staff and they have autonomy in how they spend this. Examples include delivering pre-prepared presentations on different health conditions or answering questions staff have on specific health-related matters in relation to customers. Some JCP staff reflected that this activity further supports them in delivering their day-to-day roles effectively as they have a greater awareness and understanding of health conditions and therefore some of their customers' circumstances. However, some JCP staff did not observe these wider benefits, although this was sometimes due to lesser integration and/or diary pressures limiting the ability for staff to engage with EHPs.

3.4 Testing inclusion of LCW and LCWRA customers

3.4.1 Background

The EHD is being tested with customers found to have Limited Capability for Work (LCW) and Limited Capability for Work and Related Activity (LCWRA) in Leeds JCP only.

The decision to test widened eligibility in Leeds was made because of the existing understanding of how the EHD is delivered there from the initial very small-scale one site test.

However, delivery in Leeds has been impacted by the absence of a dedicated EHP in this site for a significant period of time. EHPs based in other JCPs have provided remote cover for Leeds and one EHP in particular has covered the LCW and LCWRA referrals. All appointments with this group have therefore been conducted remotely and the EHP may be less likely to have specific knowledge of local provisions.

Volumes of LCW and LCWRA referrals during the evaluation period are also low. Only 7 eligible referrals were made during the evaluation period, although experience has been noted from outside this period too.

Learning from testing a widened eligibility criteria is therefore limited.

3.4.2 The referral

Of the Work Coaches and DEAs who responded to the survey, 7 were based in Leeds JCP and not all report being able to refer LCW/LCWRA customers to the EHD, for example only engaging with pre-WCA customers. Of those that can, they mostly said they explain the EHD in the same way to LCW and LCWRA customers as pre-WCA customers (although note inconsistencies in how the EHD is explained regardless). One said they may focus less on the 'employment' part of the EHD.

While some felt that there was not a difference in how LCW and LCWRA customers received the offer of the EHD, others felt there was. Interestingly, while some thought this group were more likely to decline, others thought they are more likely to be interested in the 'work' elements than the pre-WCA group.

> *"Although pre WCA customers are interested, their focus tends to be on their immediate health, not work, whereas LCW/LCWRA customers are more likely to want to discuss moving forward towards work"*
> (Work Coach)

3.4.3 The discussion

Explaining the EHD
During the appointments, the EHP reported that they do not introduce the EHD any differently to LCW or LCWRA customers and specifically noted that they still mention work, although commented that some of this customer group are keen to focus on health only. This is somewhat in contrast to some Work Coach perspectives previously noted.

Engagement
The EHP felt that LCW and LCWRA customers often see the EHD as an opportunity to speak with a Healthcare Professional. Speaking from the perspective of this customer group, they said: "this is a registered nurse – I've been on a waiting list for over a year, let's take this opportunity as something".

Interestingly, they noted that, despite having received their outcome decision from the WCA, for some the WCA still presented a barrier to engagement with the EHD as designed. They noted experiences of customers who have received an LCW decision but continue to be focused on the assessment, telling the EHP they wanted to appeal for an LCWRA outcome, and this was their focus.

Suggested steps
For much of this group, it was believed by the EHP that any actions were based in the future as opposed to the "here and now". For example, "I might do that in the future, but not now". The EHP also noted that this customer group was, in their experience, less willing to complete a Workability Action Plan, commenting that some customers simply do not want to think about work.

The EHP reflected that much of their role with LCW or LCWRA customers feels motivational in relation to day-to-day life activities, such as encouraging customers to get outside and go to a local shop to get fresh food and prepare and eat this at home, rather than eating processed food. This is based on what they feel is appropriate to discuss with the customer. The EHP felt that this customer group are often very symptomatic, and treatment is therefore their focus. Wait lists for treatments were reiterated as structural barriers to progression here.

3.4.4 The return to the JCP

Exiting customers

Notably, the EHP observed that some sense of dependency can form amongst LCW and LCWRA customers. However, they recognized that engagement needed to come to an end at an appropriate point, critically where no further progress is going to be made. They feel able to do so, although this highlights the alive risk of straying from policy intent should other EHPs feel less confident to do so.

Customer outcomes

The EHP felt that positive work-related outcomes were less likely for this customer group, not necessarily simply because they may be further from the labour market but because the steps the EHP can appropriately suggest during the EHD are small and aimed at improving day-to-day living as part of the pathway towards work. They reiterated that they could not formulate a comprehensive return-to-work plan through the EHD alone as it would not be appropriate to do so (customers are not in the appropriate frame of mind, often awaiting significant treatment) nor would the design of the EHD – a short intervention – enable it. The EHP felt that this would require a longer-term project, such as a check-in 6 months down the line, or flex in when the EHD could be delivered. For example, after treatment and closer to reassessment, although they recognized this nuanced timing may be difficult to deliver.

Appendices

Theory of Change logic model

Figure 4.1 Theory of Change (ToC) Part 1: the referral

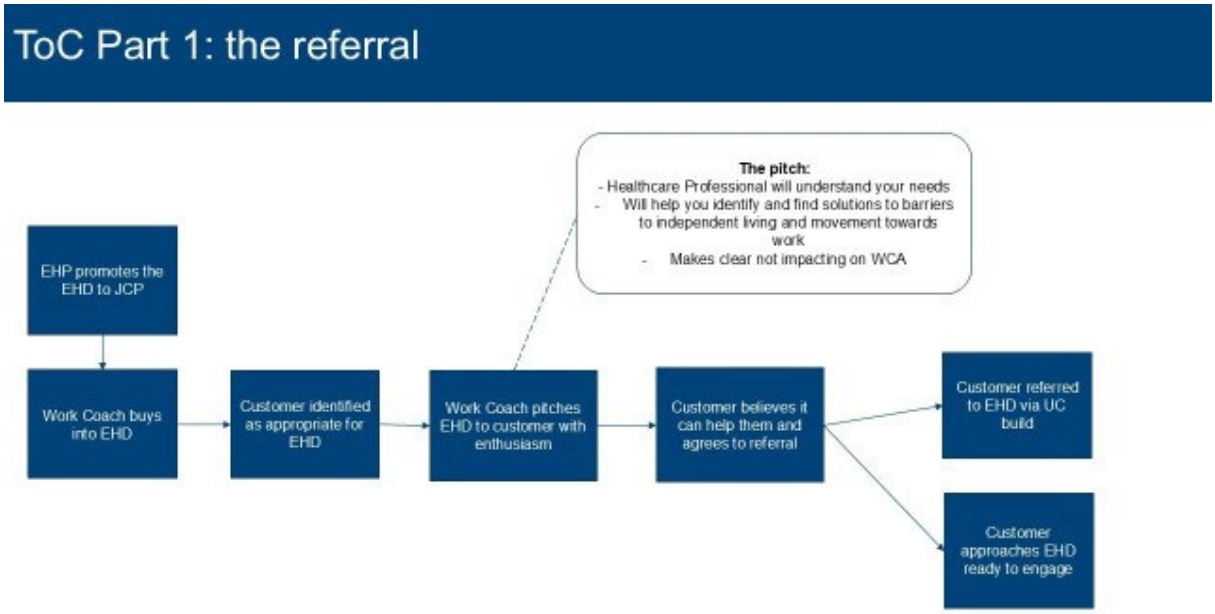


Figure 4.2 ToC Part 2: the discussion

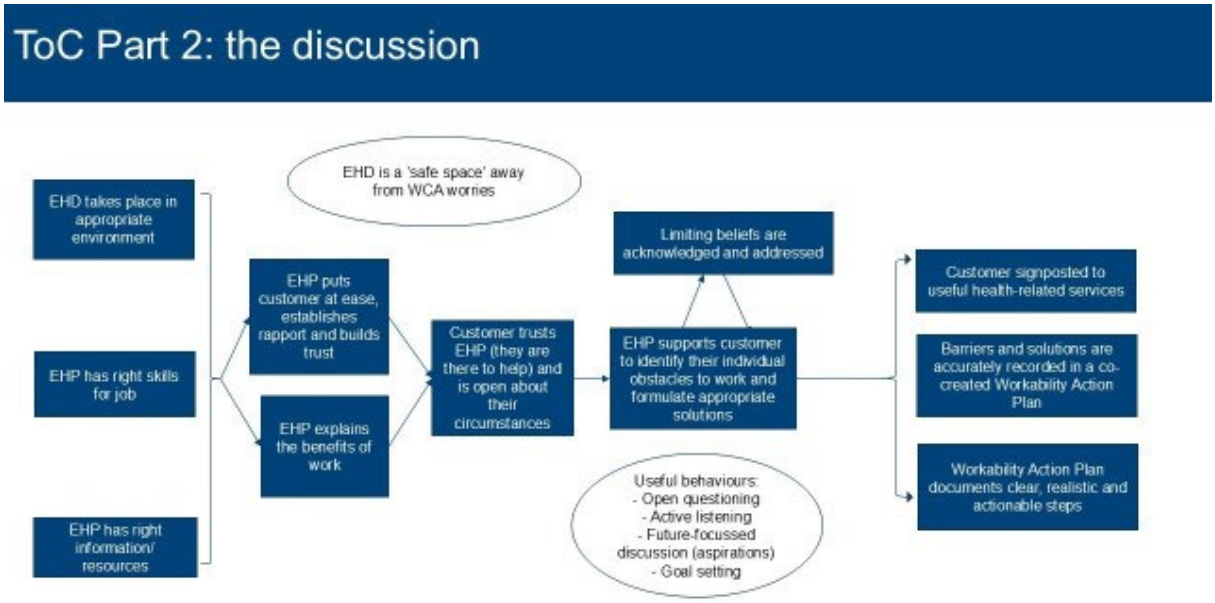
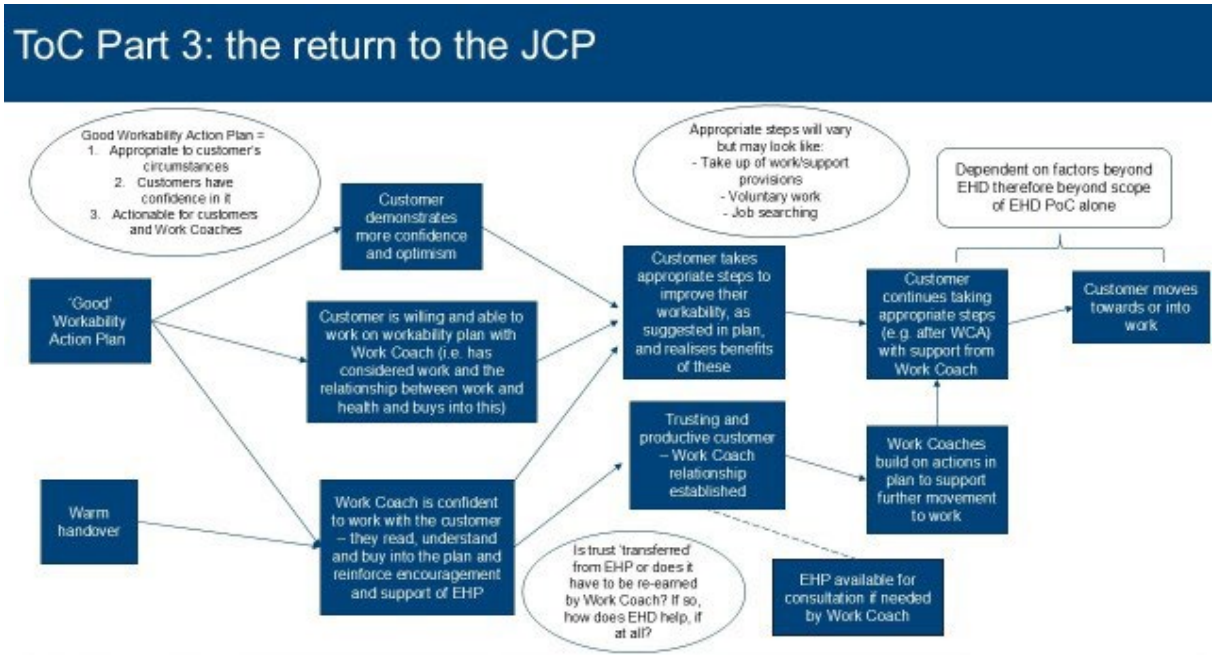


Figure 4.3 ToC Part 3: the return to the JCP



Workability Action Plan template

Figure 4.4 Workability Action Plan template

EHD	WORKABILITY ACTION PLAN		
Name:	Date:	Consent given to share with Work Coach: Yes/No	
Initial work ability: *'Assume that your ability to work has, at its best, a value of 10 points. How many points would you give your work ability?'* (0-10)			>> Enter score from first EHD appointment
Current work ability: *'How many points would you give your work ability now?'* (0-10)			>> Enter score from final EHD appointment
GENERAL LIFE – GETTING READY FOR WORK			
'Can do now' – activities:	>> Enter positive abilities		
'Goals' – want to do:	>> Enter life-related goals (with timeline)		
	Obstacles – what's making things difficult	**Actions** – solutions to obstacles	
Health (treatment concerns etc)	>> 1 Enter obstacle – what's making things difficult and what's needed… >> 2 Enter obstacle – what's making things difficult and what's needed…	>> 1 Enter corresponding solutions – actions to overcome obstacle… >> 2 Enter corresponding solutions – actions to overcome obstacle…	
Personal (beliefs etc)	>> 1 Enter obstacle – what's making things difficult and what's needed… >> 2 Enter obstacle – what's making things difficult and what's needed…	>> 1 Enter corresponding solutions – actions to overcome obstacle… >> 2 Enter corresponding solutions – actions to overcome obstacle…	
Social (family, finances etc)	>> 1 Enter obstacle – what's making things difficult and what's needed… >> 2 Enter obstacle – what's making things difficult and what's needed…	>> 1 Enter corresponding solutions – actions to overcome obstacle… >> 2 Enter corresponding solutions – actions to overcome obstacle…	
WORK – GETTING A JOB			
How confident do you feel about getting into work? (0-10)			
How important is it for you to get into work? (0-10)			
'Can do now' – type of job or skills:	>> Enter job type/skills		
'Work goals' – want to do:	>> Enter agreed pathway for move to work (with timeline). May include desired job or anything leading up to, e.g. training, courses, volunteering.		
	Obstacles – what's making things difficult	**Actions** – solutions to obstacles	
Work (potential problems with a job, expectations etc)	>> 1 Enter obstacle – what's making things difficult and what's needed… >> 2 Enter obstacle – what's making things difficult and what's needed…	>> 1 Enter corresponding solutions – actions to overcome obstacle… >> 2 Enter corresponding solutions – actions to overcome obstacle…	
Potential work ability: *'How many points would you give your work ability **if this plan was put into action**?'* (0-10)			