May 2024

Working Well: Individual Placement and Support in Primary Care

Evaluation Report - 2024

WORKING WELL

DOING THINGS DIFFERENTLY FOR GREATER MANCHESTER

SQW

Funded by UK Government

Contents

Contact:
Luke Williams
Tel: 0161 475 2115
email: lwilliams@sqw.co.uk

Approved by:
Graham Thom
Director
Date: 12/07/2024

Disclaimer
Cover image by David Tett via Centre for Ageing Better's age-positive image library.

Executive Summary

1. This report is the first of two planned annual evaluation reports on Greater Manchester's Working Well: Individual Placement and Support in Primary Care (WWIPSPC) programme. WWIPSPC commenced delivery in October 2023 and is due to run until March 2025. Greater Manchester (GM) is one of twelve areas piloting IPSPC. In GM it sits within the Working Well portfolio of devolved employment programmes and is expected to support 1,500 people.

2. The IPSPC programme uses an adapted Individual Placement and Support (IPS) model. IPS is a well-established model for supporting people with severe mental illness based on a series of principles and 25 fidelity measures. Three notable ways IPSPC differs from IPS are:

   - It is generating programme starts through a different part of the health system (primary care) and more widely, including through non-health routes, outreach and marketing
   - It is targeted at a different cohort other than those with severe mental illness, including those with physical health conditions
   - It is targeted at both people out of work (OOW) and people in work but at risk of falling out of work (IW).

3. The emphasis of this first evaluation report is on referrals, starts and the profile of participants. Given the programme is still relatively new there is less to report at this stage on support and particularly outcomes, albeit they are considered based on early progress.

Referrals and starts

4. Generating programme starts (and the referrals needed for these) has been the key focus and extensively resourced throughout planning, mobilisation and the initial delivery period. Referrals to the programme can be generated from a wide range of sources, including primary care, community care, Jobcentre Plus, local authority services, the voluntary, community and social enterprise (VCSE) sector and employers, plus self-referrals via the programme's website. Activity to generate referrals has included: liaison at senior levels between prospective referral partners, provider managers and GMCA; extensive outreach by Employment Specialists (ES) and the NHS Integration Coordinator targeting prospective referral partners and locations/events frequented by prospective participants; and developing marketing materials.

5. The targeted number of starts was challenging to achieve during the early stages of the programme. Despite this, a total of 445 participants had started on WWIPSPC by the end of March 2024, equivalent to 91% of target over that period, and starts targets have since been exceeded. Primary care has accounted for the largest proportion of starts, however fewer than half of starts are recorded as coming directly through that route. The proportion of starts coming directly from the health system more widely has also shrunk over time. Parts of the health system that referrals

have come from include GPs, Social Prescribers, Mental Health Practitioners and Living Well. Notably, there is considerable variation in referral sources between individual local authorities.

6. The challenges faced in generating programme starts have included:

   - The nature of the health system. The primary care landscape is complex, diverse and diffuse, with the teams, and their associated services, often having high levels of autonomy and little central coordination. Challenges also arise from a lack of prioritisation and/or time from prospective partners. The IPS model includes a focus on outreach, co-location, attendance at meetings and access to systems, all of which have faced practical barriers.

   - The broad scope of WWIPSPC, with referrals permitted from a wide range of sources, which increases the likelihood of ES time being directed towards other referral sources.

   - The length of time and resources needed to develop buy-in from partners, working against a short recruitment timeframe of just 14 months. This tension and the prioritisation of start profiles appears to be having negative implications for integration with the health system, IPS fidelity and the 'test and learn' focus of the programme.

7. Approaches that appear to have helped generate referrals have included focusing on the parts of the health system which see appropriate participants at scale, have opportunities for and are accustomed to co-location, joint meetings, joint systems and working in multi-disciplinary teams (MDTs), and are more likely to prioritise addressing employment as a social determinant of health. Living Well teams and Primary Care Network MDTs fit this description. Other things that have been beneficial include: persistence, tailoring messages, adopting both top-down and bottom-up approaches to integration, and GMCA being an active and interventionist commissioner.

Participant characteristics and barriers

8. Extensive monitoring data is captured on participants' characteristics and barriers to work. Participants have mixed employment situations. The OOW cohort accounts for around three-quarters of participants and the IW cohorts account for the remainder. For the OOW, many but not all are short-term unemployed and the vast majority think they can go into work soon, albeit confidence around entering work is mixed (but very few expressed very low confidence). Amongst the IW cohort there is a higher prevalence of participants wanting to change job than anticipated. The common attribute of WWIPSPC participants is the motivation to work.

9. Mental health issues are very prevalent amongst participants. To some extent this will reflect the targeted referral routes, which have a mental health focus. The programme used the EQ-5D-5L tool and found one in three participants reporting severe/extreme health issues, and one in five reporting severe to extreme anxiety/depression. There has been a lower prevalence of participants with physical health conditions, which could limit insights into whether the IPS model is also effective for these groups.

10. Comparing the two cohorts, the IW cohort has greater health issues and issues around family life, while the OOW cohort still have high levels of health issues but are relatively more likely to report issues relating to work experience, skills, transport and wider barriers. This shows common support needs around health, but otherwise the needs of the cohorts differ in a way that reflects their different employment statuses.

11. Analysis of WWIPSPC against some of GM's other Working Well programmes suggest participants are relatively employable, particularly due to less time out of work and higher qualification levels.

Support

12. The ES is responsible for all aspects of a participant's support journey once they have started the programme. Positively, ESs reported mostly being able to maintain a focus on employment, in line with the expectations of the IPS model. This was considered a reflection of participants being motivated and feeling able to find employment. Participants with more severe mental health issues or other significant issues have been more likely to draw ES time onto issues other than employment, but this was only the case for a minority of participants.

13. Support to participants includes helping them to identify their job goals, developing their job searching skills and the proactive engagement of prospective employers. This latter aspect of the role has been challenging for some ESs, due to the time it takes against the time available, along with lack of confidence and skills gaps. While challenging, where it had been achieved it was considered to have generated positive results for participants.

14. Support to sustain employment for IW participants and OOW participants who moved into work includes advice and regular in-work contact with the participant. Delivery staff and participants emphasised the value of an independent and impartial perspective on the issues participants were facing. ESs have also engaged directly with the participants' employers to assist in resolving issues, although not all participants have wanted the ES to be directly involved in this capacity.

15. There has also been support with health and wider issues, through collaboration with partners and signposting to wider support. The IPS model is premised on participants having the health support they need from the health services they are engaging with, however for WWIPSPC this has not always been the case (especially for referrals generated outside the health system) or the support in place has not been adequate or effective. These issues arise partly from implementing the IPS model in a space and manner that reduces scope for integration with health services. The implications of this for WWIPSPC's effectiveness will be important to consider going forwards.

16. A key challenge and risk to the quality of support during the early stages of the programme has been ES workloads. Staff with experience of delivering other IPS programmes felt this programme was more demanding and suggested WWIPSPC was not a 'true IPS' programme. Contributing factors include the challenges around generating starts, time-consuming engagement of employers, and administration and contractual requirements. Over time some of these pressures have reduced, but others appear are due to the focus and design of WWIPSPC, and are unlikely to abate.

17. Overall though, the IPS model and support offer was regarded as appropriate for those joining the programme. The features most commonly highlighted as important during the fieldwork were:

- Its flexible, individualised and participant-led nature, which has meant it is appropriate across the varying levels of need amongst those joining the programme.
- The role of the ES in being there for participants to talk issues through, with a particular focus on employment and building confidence; but also, supporting wellbeing throughout the process of securing and sustaining employment, and drawing on wider services as needed.

Outcomes

18. It is relatively early to evidence outcomes due to the time it takes for them to be realised. By the end of March 2024, a total of 124 participants had achieved a 'job start' which can be claimed once a participant has undertaken 7 hours of paid work in a single week, which could be either: starting a new job, a return to their current job, or an in-work participant self-certifying they are no longer at risk of falling out of work.

19. The IW cohort have achieved considerably higher levels of job starts, which is to be expected given the IW cohort are already in-work and the low threshold for claiming a job start. More than half of IW participants have achieved a 'job start' within a month of starting the programme. Given this, it is recommended that further consideration be given to how much support these participants have received and to assess levels of additionality.

Conclusions

20. The relatively short timeframe for the implementation and delivery of WWIPSPC – and resulting pressures – has been a key contributor to the challenges encountered in the early stages of delivery. Much of this report focuses on the implications that timelines have had for generating referrals, integration with the system health and the broader implementation of the IPS model. The short delivery timeframe means by the time the programme reaches a more 'mature' state there will be limited delivery time remaining.

21. Some of the challenges covered reflect the usual issues of rolling out and embedding a new programme which are being resolved over time. Others point to tensions arising from implementation of the IPS model in the primary care space and the programme's competing priorities, most significantly between generating start numbers and fidelity.

22. There is good buy-in to the value of the fidelity model amongst delivery staff, but also widespread concern about its viability within the primary care space. The tensions between fidelity, start profiles and timelines have exacerbated this and resulted in fidelity being de-prioritised. It also appears that different parts of the health system are more able or willing to engage/accommodate a high fidelity model. Some of the difficulties IPSPC has faced in implementing the IPS model reflect the programme piloting it with parts of the health system for which the fit appears less good. This is an issue to be returned to as more evidence becomes available.

1. Introduction

1.0 This report is the first of two annual evaluation reports on the delivery of Greater Manchester's Working Well: Individual Placement and Support in Primary Care (WWIPSPC) programme. WWIPSPC commenced delivery in October 2023 and is due to run until March 2025.

1.1 Greater Manchester (GM) is one of twelve areas selected to pilot the Individual Placement and Support in Primary Care (IPSPC) programme, which is a 'first step' in the delivery of the Department for Work and Pension's Universal Support programme.[1] It is funded by both the Department for Work and Pensions (DWP) and Department for Health and Social Care (DHSC), and is administered through DWP.

1.2 In GM, IPSPC sits within Greater Manchester Combined Authority's (GMCA) Working Well portfolio of devolved employment programmes that began with the Working Well: Pilot programme in 2014. An overview of the full portfolio of Working Well programmes can be found here.

The Individual Placement and Support (IPS) model

1.3 Individual Placement and Support is a model of supported employment found to be effective in assisting people with severe mental illness (SMI) to find and sustain employment.[2] Participants are supported by an Employment Specialist (ES), with the model based around:

- **Eight principles**[3]
  - Focus on competitive employment
  - Open to all those who want to work (no exclusion on the basis of readiness, disability/health conditions or benefits claim)
  - Integration with clinical health teams
  - Rapid job search
  - Focus on jobs consistent with the participant's preferences (enabled by a focus on vocational profiling)
  - Relationships are built with employers who are targeted based on participant preferences
  - Ongoing, time-unlimited and individualised support for the person and their employer
  - Benefits counselling is included

[1] DWP (2023) Over 25,000 long term ill and disabled people supported into work with £58m boost
[2] For example, see: Bond, G et al (2020) An update on Individual Placement and Support, World Psychiatry, 19(3), p.390-391.
[3] See IPS Grow: IPS is based on 8 evidence based principles and The IPS Employment Center: IPS Practice and Principles

- **A scale of 25 fidelity measures** associated with delivery of a high-quality service.[4] Aspects of delivery covered include the role of the Employment Specialist, caseload sizes, team structures, a zero exclusion criteria, the types, pace and length of support to be offered, employer engagement, operational and strategic integration with the health system, and the culture and prioritisation of employment within the health system. These fidelity measures are referenced throughout the report.

1.4 In England, the IPS model has been implemented within the NHS for people with SMI and more recently to support people receiving treatment for drug and/or alcohol misuse.[5]

Individual Placement and Support in Primary Care (IPSPC)

1.5 The IPSPC programme is an adapted IPS model. The adaptations include a different focus, a modified fidelity scale[6] and modified principles.[7] The adaptations are intended to retain the spirit of the IPS model but do represent a degree of divergence. Most notably, it varies from a pure IPS model in the following ways:

- Firstly, for a traditional IPS programme referrals are expected to come via clinical teams whereas for IPSPC referrals can be generated from a wide range of sources. This includes primary care, community care, social prescribing, Jobcentre Plus, the voluntary, community and social enterprise (VCSE) sector and employers, plus self-referrals from marketing, including from social media.

- Second, the IPSPC programme is targeted at different cohorts from the SMI cohort for which the evidence base is strongest. It is instead targeted at those in primary care including people with mild to moderate mental and physical health conditions.

- Third, it is targeted at both people out of work (OOW cohort) and people in work (IW cohort) who are at risk of falling out of employment. The programme targets are for 75% to come from the OOW cohort and 25% from IW. The IPS model is designed for those OOW rather so much of the focus of model is on securing employment. In-work support is also a feature but the IPS model is not designed as a purely IW support mechanism.

- Fourth, rather than being time-unlimited, IPSPC is time-limited. The OOW cohort can receive a maximum of 12 months support and the IW cohort can receive a maximum of 4 months support.

- Lastly, rather than being zero-exclusion there are various eligibility criteria (including: having a physical or mental health disability as defined by the Equality Act 2010, not receiving support from other DWP employment programmes, being in work for at least 6 months if in

[4] IPSPC is using a modified version of the fidelity scale. See IPS Grow: Fidelity Reviews for more information on the Primary Care including links to the full modified 25-item scale and guidance document.
[5] NHS England (2023) Individual placement and support for severe mental illness
[6] See IPS Grow: Fidelity Reviews for more information on the Primary Care including links to the full modified 25-item scale and guidance document.
[7] DWP and DHSC (2024) New £64 million plan to help people stay in work

the IW cohort).[8] Unlike many other employment support programmes there is no minimum length of unemployment to qualify, however.

1.6 The programme builds on piloting of the model undertaken by DWP through the Health-Led Trials (HLTs) in Sheffield City Region and the West Midlands Combined Authority. Two reflections on the HLT evaluation warrant highlighting upfront:[9]

- The HLT evaluation tested their impact with a randomised control trial and found mixed results: in one area there was a positive impact on employment but not health indicators; in the other area there was a positive impact on health indicators but not employment. The programmes were scored as having achieved 'fair' and 'good' fidelity. The efficacy of the model for the primary care groups is therefore not clearly established by these trials.

- The evaluation identified various challenges around implementation of the IPS programme within the primary care space, especially around integration (most referrals did not come through primary care, and there were challenges providing integrated support), employer engagement and disclosure. These are considered throughout this report where relevant to the challenges Greater Manchester have faced during its early delivery.

1.7 IPSPC delivery is being supported by IPS Grow. The support includes ongoing training and advice, plus a Fidelity Review (scheduled for December 2024 in GM) which will assess the delivery of individual IPSPC programmes against the 25 fidelity measures.

Working Well: Individual Placement and Support in Primary Care (WWIPSPC)

1.8 In Greater Manchester the programme is targeted to support 1,500 participants. The first participants were recruited in October 2023. Recruitment is due to stop in November 2024 and support will stop in March 2025. Any OOW participants recruited in November 2024 will only receive four months of support rather than the full twelve months.

1.9 The programme is being delivered by The Growth Company (TGC) and Groundwork (GW).[10] The delivery teams consist of Employment Specialists (ES), Team Leaders and Programme Managers for each provider. TGC have recruited to additional roles to support capacity for integration with the health system with an NHS Integration Coordinator (a second is due to start in June 2024) and for employer engagement with an Employer Engagement Consultant (who started in May 2024). The Working Well team within Greater Manchester Combined Authority provides oversight and support for WWIPSPC and the broader Working Well portfolio.

1.10 The aims of WWIPSPC align with commitments in the Greater Manchester Strategy (March 2022), particularly the commitments around reducing health inequalities and poverty, and improving access to good employment.

[8] DWP (2023) Guidance: Individual Placement and Support in Primary Care
[9] DWP (2022) Health-led Employment Trial Evaluation: 12-month outcomes.
[10] TGC cover Bolton, Bury, Manchester, Salford, Stockport, Trafford and Wigan. GW cover Oldham, Rochdale and Tameside.

The local delivery landscape

1.11 Primary care includes general practice (GPs), community pharmacy, dental, and optometry services. Most GP practices are part of a Primary Care Network (PCN), which typically cover 30,000-50,000 people, and draw together wider community, mental health, social care, pharmacy, hospital and voluntary services.[11] PCN workforces include mental health practitioners, social prescribers, care coordinators, physiotherapists and more funded through the Additional Roles Reimbursement Scheme (ARRS) who form Multi-Disciplinary Teams (MDTs).[12] In Greater Manchester there are over 60 PCNs.[13] Working with and alongside PCNs are mental health community services, which are undergoing a transformation programme, with each of GM's ten boroughs having developed or developing a Living Well service. Living Well similarly consists of MDTs, bringing together different partners, and bridging the gap between primary care and secondary care.[14]

1.12 The health system in Greater Manchester is overseen by NHS Greater Manchester (GM's Integrated Care Partnership) and mental health services are provided by two Foundation Trusts: Greater Manchester Mental Health NHS Foundation Trust (covering Bolton, Manchester, Salford, Trafford and Wigan) and Pennine Care NHS Foundation Trust (Bury, Oldham, Rochdale, Stockport, Tameside). Senior representatives from the health system sit on GM's IPS Steering Group which covers both WWIPSPC and IPS in Secondary Care which is delivered as part of the Working Well: Specialist Employment Service (WWSES). The involvement of senior health stakeholders is in line with Fidelity Measure 11.

1.13 An important piece of context is that WWIPSPC is operating in a relatively crowded delivery landscape. Other current or forthcoming provision targeted at similar cohorts and/or undertaking outreach to source participants includes Working Well: Pioneer (the other strand of Universal Support), Working Well: Work and Health Programme, Working Well: Support to Succeed, WorkWell Partnerships, and Employment Advisors within NHS Talking Therapies and Musculoskeletal Services, plus various localised support offers from the voluntary, community and social enterprise (VCSE) landscape. The implications of this are considered at times in this report.

Evaluation focus and methodology

1.14 The evaluation is considering both process and impact. WWIPSPC is considered a 'test and learn' programme for the future rollout of Universal Support by both GMCA and DWP. Of particular interest to this are:

- The role and effectiveness of outreach and integration with the primary care system
- The appropriateness of and outcomes achieved through the IPS model for the target cohorts and within the primary care space.

[11] NHS England: Primary care networks
[12] GM Primary Care Provider Board: Additional Roles Reimbursement Scheme
[13] GM Primary Care Provider Board: PCN health inequalities data
[14] Greater Manchester Mental Health NHS FT: Transforming Community Mental Health Together

1.15 These points are considered throughout the report. Both entail consideration of the relevance and achievability of IPS principles and fidelity for the WWIPSPC programme.

1.16 The emphasis of this first evaluation report is on referrals, starts and the profile of participants. Given the programme is still relatively new there is less to report on support and particularly outcomes, albeit they are considered based on early progress. The second evaluation report will have a greater emphasis on these aspects.

1.17 The report draws on the following data/information sources:

- Monitoring data collected by providers at onboarding, throughout the participant journey and at exit. The data capture was designed to meet DWP's monitoring requirements and augmented with further fields to address gaps in those requirements. All analysis presented in the report is based on this data and runs up until the end of March 2024, unless otherwise stated. Please note there may be slight differences in figures between different pieces of analysis, reflecting the different data sources and not all clients consenting to their data being shared for evaluation purposes.

- A series of 34 individual and group interviews with a total of 37 people involved in programme delivery and stakeholders, conducted in between March and May 2024. This covered the GMCA Working Well team, provider staff including Managers, Employment Specialists and an NHS Coordinator, plus referral partners, senior stakeholders in the health system, DWP and IPS Grow. Managers and the NHS Coordinator were interviewed twice. Six participants were also interviewed.

- Insights generated through the evaluation team's attendance at mobilisation meetings, monthly Operations Boards, and other ad-hoc meetings.

Structure of report

1.18 The remainder of the report is structured into the following chapters:

- Chapter 2: Referrals and starts
- Chapter 3: Participant characteristics and barriers
- Chapter 4: Support
- Chapter 5: Outcomes
- Annex A: Data annex.

2. Referrals and starts

2.1 The generation of programme starts (and the referrals needed for these) has been the key focus throughout planning, mobilisation and the initial delivery period.

2.2 Referrals to the programme can be generated from a wide range of sources. This includes primary care, community care, Jobcentre Plus, local authority services, the voluntary, community and social enterprise (VCSE) sector and employers, plus self-referrals via the programme's website.

2.3 These various routes have been the focus of extensive efforts to date, including:

- Liaison at senior levels between prospective referral partners, provider managers and GMCA. This included the development of local Integration Plans and implementation of monthly WWIPSPC meetings for each of Greater Manchester's ten boroughs, with representation from key local partners.
- Outreach by Employment Specialists and the NHS Integration Coordinator targeting prospective referral partners and locations/events frequented by prospective participants. Engagement of partners has included presentations and attendance at team meetings, co-location and shadowing. The focus on locations/events includes co-location with key partners, including within community and service hubs, plus attendance at job fairs.
- Development and distribution of marketing materials, such as posters and leaflets shared in GP surgeries and community and service hubs, and advertising via social media and radio. This is expected to lead to self-referrals as well as helping to raise awareness with partners.

2.4 This chapter starts by drawing on monitoring data to consider the number of programme starts achieved, the source of those starts and the variation by area. It then reflects on the challenges and successes experienced around the generation of referrals faced in the initial phases of delivery. This includes reflection on the expectations of the IPS model and the extent to which WWIPSPC has been able to (and might be able to) align with these.

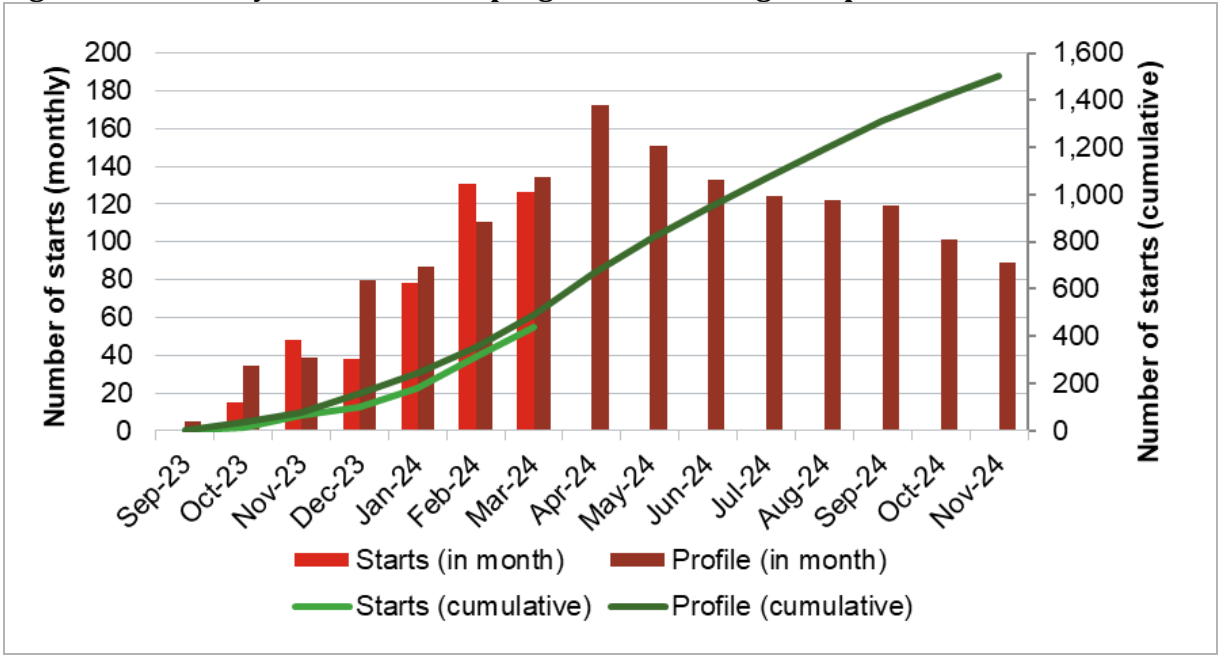
Programme starts

2.5 A total of 445 participants had started on WWIPSPC by the end of March 2024 from 676 referrals.[15] This is equivalent to 91% of the programme's profile of 489 starts over that period.[16] TGC have achieved 98% of its profiled starts and GW have achieved 81% (noting that GW's profiled starts were more frontloaded than TGC's).

[15] The start figure comes directly from WWIPSPC reports. The figures used for most of the analysis in the report uses monitoring data shared with SQW which gives 436 programme starts. This is 9 fewer and reflects a small portion of participants not consenting to their data being shared for evaluation purposes.
[16] WWIPSPC's profile establishes its target for monthly programme starts. The shape of the profile came from TGC and GW in their bid.

2.6 As shown in Figure 2-1, there has been a steady increase in starts during the first six months of recruitment. It has tracked slightly behind profile due to under-recruitment during the early months in particular. There was consensus amongst staff about the start profile being challenging to achieve during early stages of the programme. Following the data cut-off the programme has since exceeded its start target, and was at 103% by the end of April.

Figure 2-1: Monthly and cumulative programme starts against profile over time



Source: WWIPSPC monitoring data

2.7 Table 2-1 shows programme starts by participants' local authority of residence.[17] There is a wide variation in performance against profile between areas. Partly this reflects some areas commencing later than others – while Manchester, Salford and Tameside onboarded their first participants in October 2023, the majority did so in November, while Bury's first starts were in December. Challenges around recruiting and onboarding staff contributed to some of these delays. Various other successes and challenges in generating referrals within individual areas have contributed to the variation in start performances. These challenges are considered later in this chapter.

2.8 Table 2-1 also shows the breakdown of starts against profile for the OOW and IW cohorts. Overall, WWIPSPC is at 84% of its OOW profile and 113% of its IW profile. The achieved split between the cohorts is 71% OOW and 29% IW, which is close to the expected 75/25 split. Again there is variation between the local authorities on the OOW/IW split, with OOW accounting for 56% in Bury and 83% in Tameside.

[17] As above, this figure comes directly from WWIPSPC reports so uses a different data source to the rest of the report. The shape of profiles differs between the providers and areas, with some expected to recruit more quickly and others more slowly. These differences are based on perceived readiness prior to recruitment starting.

Table 2-1: Starts by local authority

LA	All	Profile	% of profile	OOW	% of profile	IW	% of profile
Bolton	34	40	72%	24	80%	10	100%
Bury	25	27	78%	14	70%	11	183%
Manchester	84	90	80%	58	85%	26	118%
Oldham	58	39	147%	46	153%	12	133%
Rochdale	43	40	116%	30	97%	13	130%
Salford	70	33	150%	47	188%	23	288%
Stockport	31	47	65%	18	50%	13	118%
Tameside	36	57	94%	30	65%	6	46%
Trafford	39	58	100%	29	66%	10	83%
Wigan	25	56	45%	20	45%	5	38%
Total	**445**	**489**	**91%**	**316**	**84%**	**129**	**113%**

Source: WWIPSPC monitoring data

Sources of programme starts

2.9 The sources of programme starts are set out in Table 2-2. This uses the categories mandated by DWP and provides a high-level indication of where participants have joined from.[18] It shows that primary care has accounted for the largest proportion of starts. Data showing more precise referral sources has not been captured to date, but referrals from the health system are known to have come from GPs, Social Prescribers, Mental Health Practitioners and Living Well. There are plans to collect this detailed information going forwards.

Table 2-2: Starts per referral source, by cohort

Source	OOW	IW	All	%
Primary care referral	40%	48%	185	42%
Self-referral	15%	17%	69	16%
Signposted by Jobcentre Plus	14%	9%	54	12%
Community care referral	11%	9%	46	11%
Signposted by voluntary/charity sector	7%	7%	32	7%
Other signpost	5%	7%	25	6%
Other referral route	7%	3%	25	6%

[18] Programme staff reported this data is not entirely accurate as some referrals via signposts are recorded as self-referrals and signposting via intermediaries is not well reflected. That said, it provides a reasonable indication of where participants are coming from.

Source	OOW	IW	All	%
Out of:	**128**	**308**	**-**	**436**

Source: WWIPSPC monitoring data

2.10 It is notable that fewer than half of starts are recorded as coming directly through the primary care route despite WWIPSPC nominally being a 'primary care' programme. The proportion from primary care has shrunk over time from 67% of starts in the first three months to 35% in the next three months. If including community care, it has shrunk from 74% to 47%. The remainder of starts have come from a range of other referral partners and self-referrals – recognising that some self-referrals could have been influenced by primary care or come through marketing in primary care settings. These other sources of starts have included local authorities, mental health charities, housing associations, food banks, colleges and children's centres. Outreach has been undertaken in community settings and hubs, at events ranging from jobs fairs to charity football matches, and through engaging local job seeking groups online. The programme does not have any formal expectations on where referrals should be sourced from.

2.11 Approximately 82% of participants who started on the programme said that they heard about the service through a professional, which generally applies where participants were referred via primary care, community care, Jobcentre Plus and voluntary/charity sector. The remaining participants cited general marketing (6%), friends and/or family (2%) or 'other' sources (8%).

2.12 A significant feature of WWIPSPC to date has been the variation in referral sources between individual local authorities. Table 2-3 shows primary care has accounted for 84% of referrals in Salford compared to just 5% in Rochdale[19] and 7% in Oldham. Other referral sources similarly vary. Notably, Jobcentre Plus has accounted for 42% of starts in Wigan and 39% in Oldham. The variation is explained by the various challenges considered later having applied to differing extents within each locality. Referral sources have been evolving throughout the first six months as relationships are built, and are expected to continue evolving over the coming months as the programme continues to raise awareness and embed itself locally.

Table 2-3: Proportion of starts by referral source, by local authority (%)

Source of starts	Bolton	Bury	Manchest	Oldham	Rochdale	Salford	Stockport	Tameside	Trafford	Wigan	GM
Primary care	55	40	61	7	5	84	39	15	55	13	42
Self-referral	26	44	16	27	10	9	6	6	16	8	16
Signposted by Jobcentre Plus	6	0	4	39	12	0	13	15	8	42	13

[19] In Rochdale a distinct approach has been adopted to embed the programme in the local support landscape. The council's Get Rochdale Working (GRW) service serves as a single access point for referrals to employment support. GRW triages participants and sends them to the most appropriate support. Therefore the original source of their referrals may be primary care, but they are coming via an intermediary. GRW is considered more later.

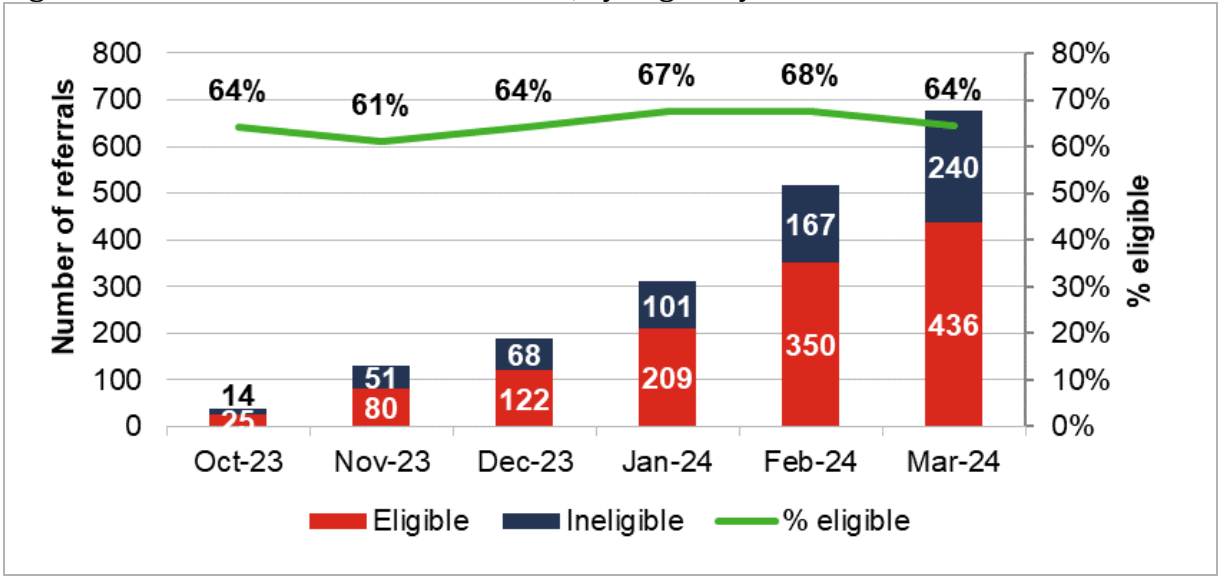
Community care	6	4	10	11	21	1	10	21	11	17	10
Signposted by voluntary/charity sector	0	4	5	5	33	1	13	12	0	4	7
Other referral route	0	4	2	5	12	1	16	15	3	8	6
Signposted by other route	6	4	2	5	7	3	3	15	8	8	6
Out of:	31	25	82	56	42	70	31	33	38	24	432

Source: WWIPSPC monitoring data

Ineligible and non-starting referrals

2.13 Overall, 240 out of 676 referrals to the WWIPSPC have not been eligible to join which is equivalent to 36%. Figure 2-2 below shows the proportion of referrals found eligible has been broadly steady over time as referrals have increased.

Figure 2-2: Cumulative referrals over time, by eligibility



Source: WWIPSPC monitoring data

2.14 Table 2-4shows data on ineligibility by referral sources. This shows the sources with the highest levels of ineligibility are self-referrals. An increase in self-referrals might be expected as more marketing materials are put out in the community. Dealing with the ineligible referrals this generates will have resource implications.

Table 2-4: Source of referrals by eligibility status (data was not pre-coded so has been coded for the analysis)

Source	No. of eligible referrals	No. of ineligible referrals	% ineligible
Primary care	270	85	31%
Self-referral	141	72	51%

Signposted by Jobcentre Plus	76	22	29%
Community care	81	35	43%
Signposted by voluntary/charity sector	34	2	6%
Signposted by other route	46	21	46%
Other referral route	28	3	11%
All routes	676	240	36%

Source: WWIPSPC monitoring data

2.15 Some data is captured on the reasons that referrals have not started the programme. It is not pre-coded so the quality is variable, with many simply recorded as 'ineligible', but it gives an indication of the different reasons which are:

- Not being able to contact participants, not wanting to work or to engage (particularly those referred by JCP and by family, and those who felt their health needs were too severe)
- Not meeting eligibility criteria around employment status (e.g. employed for less than six months, working fewer than 7 hrs a week on a zero hours contract)
- Not meeting eligibility criteria around accessing support (e.g. already receiving support from another employment support programme, not being able to receive public funds, not having right to work in the UK)
- It being the wrong point in time (e.g. because the participant is about to undergo surgery)
- The participant is better suited to another programme (including other Working Well programmes and IPS services, for example because they wanted support with training before seeking work).

2.16 Multiple attempts are made to contact participants across multiple days and modes of contact. If unsuccessful making contact it is expected that ES will contact the referrer to ask for their further support and so in increase the likelihood of making contact.

2.17 During the fieldwork it was reported that for some participants who initially said they did not want to work, upon discussion it has been found they want to work but felt unable to due to their condition(s). In such cases ES have been able to challenge this initial mindset barrier, and have started the participants on the programme. This helps highlight some of the nuances around eligibility and attitudes towards employment, and the need for an exploratory discussion at the time of the referral and start process.

2.18 No information is captured on characteristics at the point of referral. As a result, it is not possible to explore whether certain types of people are more or less likely to convert from a referral to a programme start.

Challenges in implementing the IPS model

2.19 IPS fidelity includes various measures relevant to the generation of referrals. To achieve a high fidelity score, WWIPSPC would need to achieve the following:[20]

- ESs have 90-100% of their caseload from one or two primary or community health services (Fidelity Measure 4)
- ESs have frequent contact with health services including through attending regular meetings, integrating IPSPC documentation into health records and working in close proximity (Fidelity Measure 5)
- ES spend 65% or more of their time in community settings (Fidelity Measure 24)
- Prioritisation of employment within the culture and activities of health teams (Fidelity Measure 10).

2.20 Implementation of this IPS model for WWIPSPC has faced various challenges referrals as a result of three interacting factors: the nature of the primary care health system; the broad scope of WWIPSPC; and time and resourcing. These are considered below before giving consideration to what has worked in implementing the model.

Challenges arising from the nature of the health system

2.21 The challenges to implementation of the IPS model arising from the nature of the primary care space have included:

- The primary care landscape is complex, diverse and diffuse, and differs between areas – in contrast to secondary care for SMI which is relatively structured in its set-up. There are 411 GP practices[21] and over 60 PCNs[22] across GM, and a range of other potential referral partners in scope. The complexity of primary care is compounded by changes to services and staffing. For example, Living Well is in the process of being rolled out and is at different stages across GM. WWIPSPC staff without a background in primary care or the health system reported a steep learning curve.

"In the health and care system – with new Hubs, new teams, new staff coming in – at the minute there is a lot of change." – WWIPSPC staff

- Teams/services are often diffuse, with high levels of autonomy and little central coordination. This has created difficulties for dissemination of information, accountability and escalation. Social prescribers were identified as a key example of this, with no GM-wide co-ordination or mailing list for WWIPSPC to utilise to develop awareness and engagement during the

[20] IPS Grow: IPS fidelity scale for primary care
[21] GM Integrated Care Partnership: About primary care in Greater Manchester
[22] GM Primary Care Provider Board: PCN health inequalities data

mobilisation phase. This is in contrast to the experiences of staff accustomed to working with JCP as a source of referrals.

- Often WWIPSPC has been reliant on a 'gatekeeper' for engaging certain teams. This has been beneficial where they have become a champion for the service, but it has been detrimental in instances where they have not disseminated information as effectively as anticipated or have restricted direct access to teams.

- Lack of buy-in and prioritisation. There is no formal requirement of delivery staff to make referrals to WWIPSPC and considerable autonomy in the system, so the programme is reliant on referral partners buying in to the programme. Yet primary care partners are often time-poor, have competing priorities and employment is often of relatively low significance, despite employment considered to be widely recognised as a determinant of health. WWIPSPC staff and health stakeholders talked of the need to change the mindsets of some partners to see employment and WWIPSPC support as part of participants' recovery.

- The IPS model includes attendance in team meetings and access to systems (Fidelity Measure 5). Information governance concerns have been a barrier to this in some areas, particularly for access to systems which has not yet been achieved in any area. Service Level Agreements are being progressed in Pennine Care areas to address this, however it is taking time to work through. In Salford, integration with Living Well was initially strong but information governance concerns meant access to meetings and systems was suddenly lost. There were related concerns highlighted about possible mistrust of commercial providers.

- The IPS model includes co-location and outreach but a practical barrier has been the availability of appropriate spaces in each locality. While health services in some areas have shared hubs, not all have enough space or are providing access, and some areas do not have hubs at all. In localities awaiting the establishment of Living Well Hubs this may be resolved once those become available, but the issue is proving difficult to resolve in certain areas, including some where Living Well has been established.

- Complexity and competition for referral partners. Alike the primary care landscape, the employment support landscape is complex and in flux. WWIPSPC itself is a relatively short programme, and is one of multiple programmes in a similar space undertaking outreach and/or seeking to support people with disabilities and health conditions. This complexity can mean health providers being sceptical of new programmes and not sure where to refer particular cases.

Broad scope of WWIPSPC

2.22 Other challenges to implementation of the IPS model have arisen because referrals are permitted from a wide range of sources. Although nominally a 'primary care' programme, IPSPC can source referrals through routes such as Jobcentre Plus, local authorities, VCSE organisations and self-referrals generated through marketing and active outreach. The inclusion of this wider set of referral routes increases the likelihood of ES time being directed towards other referral sources

rather than integrating with health services (Fidelity Measure 5), and reduces the likelihood their caseload will come from just one or two health teams (Fidelity Measure 4).

2.23 In Rochdale, WWIPSPC is primarily taking referrals via Get Rochdale Working. The service provides a single access point and triages residents onto the provision considered most relevant. The intention of this model is to simplify access to support for referral partners and residents, including as provision changes, and to help participants access the right provision. The downside of this set-up has been restrictions on the ability of WWIPSPC to approach prospective referrers directly. Tameside Council has a similar set-up and has been making referrals to WWIPSPC, although staff have had more freedom to approach other referral partners directly.

2.24 Where referrals have come through other sources the ES tends to lack a direct link with that participant's health support. This has been the case in Rochdale where referrals came through Get Rochdale Working. This has implications for the delivery of support in an integrated manner, which are considered in Chapter 4.

Time and resourcing

2.25 The size and nature of the primary care system has made the generation of referrals and integration much more resource intensive (because there are more teams to target meaning more meetings to attend, more managers to engage, more systems to engage with, etc). Developing integration has required a significant time investment by GMCA, programme managers/leads and ES, and augmentation of the IPS model with the inclusion of a dedicated NHS Integration Coordinator role. This broad effort started with a long lead-in period to identify and engage stakeholders and prospective partners before launch, yet it has still been challenging and is ongoing.

2.26 Many of the barriers to referrals and integration with the health system may be resolvable over time. Progress has been made in developing awareness, buy-in and integration with referral partners – but progress has been variable between different areas and partners, and often it has not been quick or easy. The diversity and diffuseness of the primary care landscape means there are not simple fixes. Individual localities and partners have each had their own series of challenges to work through to address awareness, buy-in, co-location, outreach, meeting attendance and access to systems. Sometimes it has required months of engagement at different levels to address barriers before referrals started coming through, but in many cases numbers are still small or not yet coming through. This has meant returns on the investment of time and resource are uncertain.

2.27 This highlights the need for resource, time and patience for achieving integration with primary care. However:

- The profile for WWIPSPC has required the recruitment of participants at pace. Primary care has not generated sufficient numbers to meet start profiles, despite extensive investment of time and resource.

- WWIPSPC is only able to take referrals for 14 months so time to work through any issues is limited. It also means less incentive for partners to work through issues given it will not provide an obvious longer-term benefit (the planned introduction of Universal Support for the longer term may help in this regard, but not in the short term unless well explained as part of the programme marketing effort).

"It takes time for services to get bedded in … it takes time to integrate [and] because it is a pilot there is some uncertainty over what is next, so I wouldn't say we are rushing to invest in it."
– Referral partner

2.28 This creates a tension between achieving profiles and integrating with the health system. An emphasis on achieving starts has meant pressure to prioritise numbers over the sources and quality of referrals, with delivery staff having to engage with other referral routes to try and generate required start numbers. In doing so, it has made generating referrals even more resource intensive because delivery staff are spending their time liaising with more partners and undertaking exploratory outreach (again with no guaranteed return on this investment). The consequence of this is less time, resource and focus for integrating with health services. Over the longer-term this focus on a breadth of referral sources, possibly at the expense of deepening relationships with primary care, could prove more resource intensive. It could also have implications for:

- The extent to which WWIPSPC is a 'test and learn' programme on how to work with primary care as a referral source
- Levels of fidelity because referrals are less likely to come from a small number of teams (Fidelity Measure 4) and there is less time, resource and focus on integrating with health partners (Fidelity Measure 5)
- Participant support due to the effects of less integration with health services and a greater workload for ESs (these are considered more in Chapter 4).

2.29 The prioritisation of start numbers above these other priorities – primary care integration, test and learn, and fidelity – has been needed in response to DWP, and therefore GMCA, placing the highest priority on start numbers.

Learning from elsewhere

2.30 Evaluations of similar programmes further support the view that integrating with primary care is challenging and takes time:

- The Health-led Trials were slow in ramping up its referral numbers and had its referral window extended from 12 to 18 months due to difficulties generating referrals.[23] Engaging with GPs and health partners was a key delivery challenge, and despite early engagement it

[23] DWP and DHSC (2022) Health-led Employment Trials Evaluation 12-month outcomes evidence synthesis, p.27

was difficult to secure sustained involvement. In the two areas just 42% and 20% of referrals came from health settings (GPs and specialist care) whereas 56% and 80% came from 'other' sources which included routes such as JCP (although it also included self-referrals which may have been via primary care settings).[24]

- For Working Well: Early Help nearly half of all referrals came from JCP (49%) although 40% did come via GPs, with delivery during the pandemic which likely had a negative effect, and a further 12% from employers.[25]

What has worked in implementing the IPS model

2.31 Considering what has worked, the factors and approaches considered to have been beneficial in generating referrals from primary care and other partners include:

- Focusing on the parts of the health system which see the right types of participants at scale, have opportunities for and are accustomed to co-location, joint meetings, joint systems and working in MDTs, and are more likely to prioritise addressing employment as a social determinant of health – as these are all features that will help with alignment to fidelity. Living Well teams and PCN MDTs seem to fit this description. While there have been barriers to integrating with these teams in some areas, where it has been achieved there appears to be scope to achieve a high fidelity model. This is in contrast to targeting individual GP practices, which are far greater in number, and have generally been found to be less able or open to working in an integrated manner.

"I think there is a strong need for a programme like IPS when we think about our patients. A lot of them may be facing complex issues, but a lot may also be facing mental health issues directly because they don't have a job, they might not want to take medication or attend therapy, they might just want to get a job – so having IPS on offer is perfect because our clinicians don't have time or capabilities to do all the employment side of things." – Health referral partner

"If [WWIPSPC] wasn't around I think we would be struggling to address the work issue through Living Well alone – our clinicians don't have the time or knowledge to provide things like CV support, job applications, interview prep. It just wouldn't be covered." – Health referral partner

- Persistence and time are key to building awareness, understanding and buy-in. In some areas ES have only just been able to start co-locating and joining Living Well or PCN MDT meetings more than six months into delivery (plus months of lead-in time during which partners were also engaged in advance). It can take even more time to become embedded and feel part of the team.

"People know who I am now … the other day in a meeting they were seeking my input … [and] picking my brain. It's the first time it's felt like we're part of their team … It's about building trust and familiarity, being accessible." – WWIPSPC staff

[24] Ibid, p.42-44
[25] GMCA (2022) Working Well: Early Help, p.8

- Understanding how to sell IPSPC to different partners through tailored messaging, with a focus on how it will benefit them. For primary care it was suggested the key sells were improving health, how it benefits individual patients and how it will reduce their workload through reduced demand for their services. This can be demonstrated by sharing individual case studies with partners.

- Adopting both a top-down and bottom-up approach to integration enabled by engagement at strategic and operational levels. This approach is in line with expectations of IPS fidelity, and has entailed engagement with senior GM health stakeholders who sit on the IPS Steering Group through to the NHS Integration Coordinator and ES engaging with on-the-ground delivery staff. This has regularly helped to address issues from different angles and circumvent bottlenecks where they exist.

- Direct contact with referrers has been seen as key to building strong relationships (i.e. avoiding intermediaries and emails) which again is in line with the expectations of the IPS model from fidelity measures around outreach and co-location. In some instances ESs have shadowed Social Prescribers and Mental Health Practitioners which has developed relationships and mutual understanding.

- Identifying efficient solutions for marketing the programme for self-referrals via primary care. For example, some GPs in Bolton and Manchester are now advertising WWIPSPC in Fit Notes for their patients to self-refer. Once in place this overcomes the issue of GPs being particularly time poor.

- GMCA have been an active and interventionist commissioner, which has been very well received. They have convened key partners at a GM and local level, and have been able to 'open doors' and address blockages. GMCA undertook a substantial amount of preparatory work prior to programme commission and launch to support referral generation, local dialogue and relationship development. This included drawing on the relationships Working Well staff had with the health system through delivery of IPS in Secondary Care for WWSES, which were stronger within the mental health space given it is the focus for the programme.

Looking forwards

Achieving and testing fidelity

2.32 The early stages of delivery have generated plenty of learning around challenges and what works. The nature of the health system, rapid ramp-up in start numbers and challenges with staff recruitment during the early stages of delivery made some of the barriers to achieving fidelity – namely the resource and time pressures – particularly acute. As these pressures ease there may be greater scope to focus on fidelity around referrals. Encouragingly there was widespread recognition that, despite the requirements around fidelity being difficult to achieve, where they had been achieved they were useful for referral generation and strengthening integration. There is therefore a rationale for seeking to optimise fidelity on these measures where possible.

2.33 The table included earlier on the different sources of starts by locality (Table 2-3) illustrates the varying levels of success WWIPSPC has had in generating referrals from the health system across GM. Going forwards this variation could provide a series of natural experiments on the extent to which different approaches align with fidelity, and therefore how important different aspects of fidelity are to successful delivery of WWIPSPC. For example:

- In some areas there has been greater success in focusing on services that such appear more likely to deliver an IPS fidelity model i.e. Living Well Hubs and PCN MDTs. These areas might find it is possible to generate the scale of referrals needed from these services alone, and referral generation and integration may be less resource intensive with relationships now established and as they become 'business as usual.' If so, these areas would help in testing the impact of a strong alignment to Fidelity Measure 4 and Fidelity Measure 5.

"The fidelity model is possible in time. It takes time, and we'll need the relevant parts of system to settle down into place – by that I mean Living Well." – WWIPSPC staff

- In other areas there has been success in engaging a higher volume and greater diversity of health sources, including individual GP surgeries. These areas would help in testing the achievability of integration with more diverse health services, and the impact of likely weaker alignment to Fidelity Measure 4 and Fidelity Measure 5.

- In other areas non-health routes and outreach have been more prominent. In Rochdale the approach has been particularly distinctive, with health referrals signposted via Get Rochdale Working as an intermediary. There are also untapped non-health routes that could be become more important in these areas over time, such as employer referrals. These areas could enable WWIPSPC to test the impact of even weaker alignment to Fidelity Measure 4 and Fidelity Measure 5.

- Looking forwards, work is also ongoing to integrate WWIPSPC into other parts of the health landscape. Examples include post-COVID services, musculoskeletal services and people on NHS Talking Therapies Service (TTS). For TTS the programme is targeting those needing more intensive support than the light-touch Employment Advisor offer and those on the waiting list for support so they are getting some support sooner. Exploring these additional referral routes would further generate learning on the achievability and impacts of a fidelity model with other parts of the health system.

2.34 Pursuing these different approaches across GM would help in better understanding to what extent the IPS model is achievable and how, and what impact higher and lower fidelity has on the quality of support and outcomes.

Managing excess demand

2.35 The early stages of the programme were concerned with generating demand. The situation has now improved and overall referrals appear sufficient, and in places demand is outstripping capacity. This excess demand is being managed by asking referral partners to slow referrals while

continuing to take referrals that do get sent through. This could benefit from strategic direction around priorities. This could include prioritising certain referral routes (i.e. primary care) or certain participant types of interest (i.e. those with physical health conditions), acknowledging the scope for natural experiments set out above and the spirit with the 'test and learn' ethos of the programme. It is worth noting that improved promotional material is now out in the community. It will not be possible to control the volume or flow of self-referrals generated by these, so it is possible that self-referrals could grow as a proportion of starts.

Alternative approaches to generating referrals

2.36 Going forwards, both for WWIPSPC and Universal Support, consideration could be given the desirability of testing alternative approaches to generating referrals.

2.37 One alternative approach would be the use of incentives and/or targets for referral partners. The West Midlands HLT used these for GPs via a clinical research network, which were seen to have helped. The use of incentives for GPs to make referrals to WWIPSPC as one of a broader suite of interventions/provision is also understood as being explored in another IPSPC pilot area. Consideration would need to be given to how to implement this practically, whether it could be streamlined as part of a wider suite of programmes (i.e. the Working Well portfolio), and how desirable or necessary it actually is versus a focus on generating buy-in by demonstrating the value of the service. It is important to note that senior health stakeholders warned about the complexity and risks involved with such an approach.

2.38 Another approach could be the use of single access points and triage services across GM similar to Get Rochdale Working (recognising these do already exist in some guise across most of GM). The benefits of this approach include: simplicity and efficiency for referral partners; establishing a brand that can have greater longevity than the provision sitting behind it; potentially reducing staff time needed for generating referrals; and scope for a shared and co-ordinated approach to marketing between different provision. However:

- There are potential challenges in its operation. It has resource implications, and it introduces an additional layer of processing/assessment for participants prior to accessing support.
- It also presents a challenge to the IPS model in particular: referrals come from a wide range of sources including non-PC routes with lack of control over where these referrals come from; the programme would be a step removed from referral sources that is expected to work collaboratively with; and there is a risk to this approach if the single access point is resistant to provision having direct contact with referral partners. The impact of this divergence for WWIPSPC will be considered by the evaluation, using Rochdale as an experiment.

2.39 Implementing a single access and triage service is more likely to be successful if there is trust amongst the services being referred out to – which is helped by the perception of impartiality and by clear eligibility criteria. This may or may not be challenging to achieve.

Transition and continuity with a successor programme

2.40 Finally, the future of WWIPSPC is uncertain. Currently it is scheduled to stop taking referrals in November with uncertainty about what will follow or when. If there is a transition to new provision and/or temporary gap in provision this could benefit from planning as to how to manage it with partners. WWIPSPC has invested significant time and resource into generating awareness, relationships and buy-in, which future provision stands to benefit from, and priority should be given to avoiding a successor programme having to start entirely anew. Most beneficial, however, would be funding for the successor programme being in place as prompt as possible. The general election may present a risk to this.

3. Participant characteristics and barriers

3.1 This section considers the profile of those who have joined WWIPSPC to date. It considers their employment situation, key characteristics, disability and health, and wider barriers to finding and sustaining employment. It draws on extensive monitoring data collected at onboarding, plus insights from fieldwork with delivery staff and participants.

3.2 The analysis includes breakdowns by cohort and referral source to explore whether there are differences in the types of participants in each cohort and joining via different routes, and to understand any differences between these. Numbers are still quite small for some of these sub-groups, and the programme is still at an early stage, so we caution that the identified data trends may change in the coming months.

Employment situation

3.3 Table 3-1 sets out the employment situation of participants upon joining the programme.[26] It shows the majority of participants are unemployed including a small number in voluntary work. Of those who are employed, the majority (76%) are 'in-work' either as an employee or self-employed, and the remainder (24%) were absent from work at the point on joining.

Table 3-1: Employment situation (N=436)

Employment situation	Count	%
Unemployed	298	68%
Employed - in work	95	22%
Employed - absent from work	32	7%
Self-employed - in work	8	2%
Unemployed - voluntary worker	3	1%

Source: WWIPSPC monitoring data

3.4 The sectors of those in work are diverse and span 24 different sectors. The most common sector is healthcare (21 participants, 15%). Other common employment sectors include retail (19, 13%), cleaning/domestic (15, 11%), and teaching & education (14, 10%). Table 3-2 shows a majority are in full time employment and there are few participants in temporary work.

[26] For almost all participants 'employment situation' aligns with allocation to OOW/IW cohort. There are, however, some participants in employment at the point of joining allocated to the OOW cohort because they subsequently fell out of work or because they are seeking to change employer. Switching to the OOW cohort entitles them to 12 months of support rather than 4 months.

Table 3-2: Starts by contract type (IW only, N=140)

Contract type	Count	%
Full time	80	57%
Part time	55	39%
Temporary	5	4%

Source: WWIPSPC monitoring data

Unemployed participants

3.5 Length of unemployment is varied. Around a third have been unemployed for less than six months, and around two-thirds for less than two years.

Table 3-3: Length of time since last employment (OOW only, N=263)

Length of time since last employment	Count	%
0-6 months	81	31%
6-12 months	40	15%
1-2 years	49	19%
2-5 years	40	15%
5 years+	36	14%
Never employed	17	6%

Source: WWIPSPC monitoring data

3.6 Amongst the unemployed just 4% said they do not believe they can find work. Asked when they believed they could start work, the vast majority believed they could find a job within 3 months which suggests a reasonable fit between the cohort and the IPS model's focus on rapid job search. It also suggests WWIPSPC is not reaching those furthest from the labour market, due to some self-selection based on ability to work.

Table 3-4: Length of time in which client believes they can start work (OOW only, N=306)

Client believes they can start work within:	Count	%
1 month	131	43%
2-3 months	123	40%
4-6 months	30	10%
7-12 months	7	2%
I don't know	15	5%

Source: WWIPSPC monitoring data

3.7 Participants are also asked how confident they feel in starting work. Very few gave the lowest score of 1 out of 6, otherwise there was a spread of scores given showing varying levels of confidence.

Table 3-5: Confidence in starting work (OOW only, N=296)

Confidence in starting work	Count	%
1 (lowest)	13	4%
2	34	11%
3	66	22%
4	61	21%
5	66	22%
6 (highest)	56	19%

Source: WWIPSPC monitoring data

Employed participants

3.8 Most employed participants have been with their current employer for over two years. Less than one in five have been with their employed for less than a year. The rationale for excluding people employed for under six months was queried during the fieldwork. This cohort were seen as similarly standing to benefit from being supported while in work, rather than having to fall out of work to be eligible.

Table 3-6: Length of employment with current employer (employed only, N=126)

Length of employment with current employer	Count	%
6 - 9 months	16	13%
9 - 12 months	6	5%
12 - 18 months	12	10%
18 - 24 months	9	7%
24+ months	83	66%

Source: WWIPSPC monitoring data

3.9 The participants currently in work were asked how frequently they had been absent from work in the last six months. Around three-quarters had been absent to some degree, although around two-thirds said not at all or occasionally. The impact of this starting point will be important to consider against outcomes as they emerge over time.

Table 3-7: Frequency of absence (IW only, N=139)

Frequency of absence	Count	%
Not at all	38	27%
Occasionally	55	40%
Frequently	46	33%

Source: WWIPSPC monitoring data

3.10 The participants who said they were currently absent from work were asked how long they had been absent. For around three-quarters it had been less than six months, and just a couple of participants had been absent for longer than a year.

Table 3-8: Length of time absent from work (employed but absent only, N=31)

Length of time absent	Count	%
0 - 6 months	23	74%
6 months - 1 year	6	19%
1 - 2 years	2	6%

Source: WWIPSPC monitoring data

3.11 A majority of employed participants said they were at risk of falling out of work due to their disability or health condition. However, 39% said they were not. WWIPSPC staff suggested for some of these participants their job was nonetheless detrimental to their health, and they would benefit from changes to their job or alternative employment.

Table 3-9: Risk of falling out of work due to disability/health condition (IW only, N=128)

At risk of falling out of work due to disability/health condition	Count	%
Yes	78	61%
No	50	39%

Source: WWIPSPC monitoring data

Characteristics

3.12 This section considers the data collected on participants' personal characteristics and situation. In places it includes breakdowns by cohort and referral source to consider any differences between them.

Gender

3.13 Overall, 52% of participants are male and 46% female. OOW participants are more likely to be male and IW are more likely to be female.

Table 3-10: Cohort by gender

Gender	OOW	IW	All
Male	56%	41%	52%
Female	42%	55%	46%
Non-Binary	1%	2%	1%
Other	0%	1%	0%
Prefer not to say	0%	1%	0%

Source: WWIPSPC monitoring data

3.14 Referrals from primary care and self-referrals are fairly evenly balanced by gender, whereas referrals from JCP skew more towards male which likely reflects the gender balance of those seen by Work Coaches more regularly.[27]

Table 3-11: Referral routes by gender

	Male	Female	Non-Binary	Prefer not to say	Out of:
Primary care	48%	50%	2%	1%	185
Self-referral	46%	49%	1%	0%	69
Jobcentre Plus	63%	37%	0%	0%	54
Community care	54%	43%	2%	0%	46
Voluntary/charity sector	47%	50%	0%	3%	32
Other signpost	60%	40%	0%	0%	25

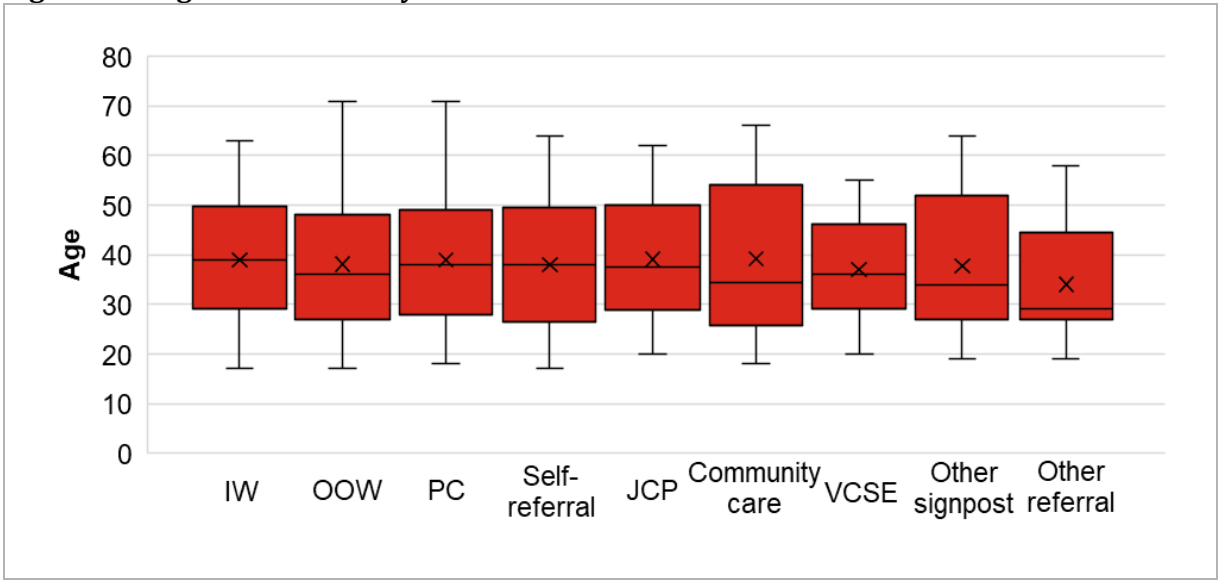
Source: WWIPSPC monitoring data

Age

3.15 The average age of participants is 38. The chart below shows that age distribution is broadly similar between the cohorts and the most common referral routes.

[27] See the chart on gender and conditionality regime from DWP: Universal Credit statistics, 29 April 2013 to 11 January 2024

Figure 3-1: Age distribution by characteristic[28]



Source: WWIPSPC monitoring data

Ethnicity

3.16 Over two-thirds of participants are White, and the other participants a spread of ethnicities. There is little difference between the cohorts.

Table 3-12: Participant ethnicity by cohort

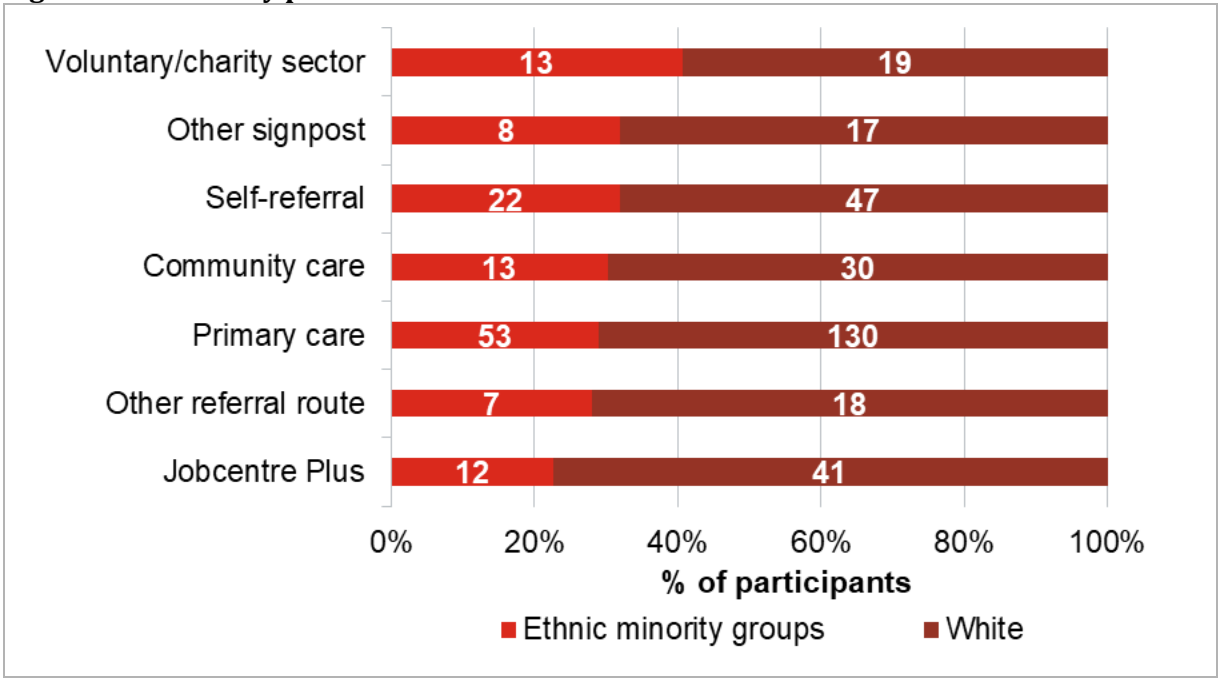
Ethnicity	OOW	IW	All
White	68%	72%	69%
Asian/ Asian British	13%	13%	13%
Black/ African/ Caribbean/ Black British	8%	9%	8%
Mixed/ multiple ethnic groups	5%	3%	4%
Other ethnic group	4%	3%	4%
Prefer not to disclose	2%	1%	1%

Source: WWIPSPC monitoring data

3.17 There is greater variation in referral routes, albeit with the caveat that some numbers are small, hence ethnic minority groups being grouped together. The chart below shows certain routes were more likely to make referrals for white participants, such as Jobcentre Plus, and some more likely to make referrals for ethnic minorities, particularly the voluntary/charity sector.

[28] Guidance on how to interpret this chart: the top and bottom lines represent the highest and lowest values; the top and bottom lines of the boxes represent the upper and lower quartile ranges; the middle line represents the median value; and the crosses represent the mean value.

Figure 3-2: Ethnicity per referral route

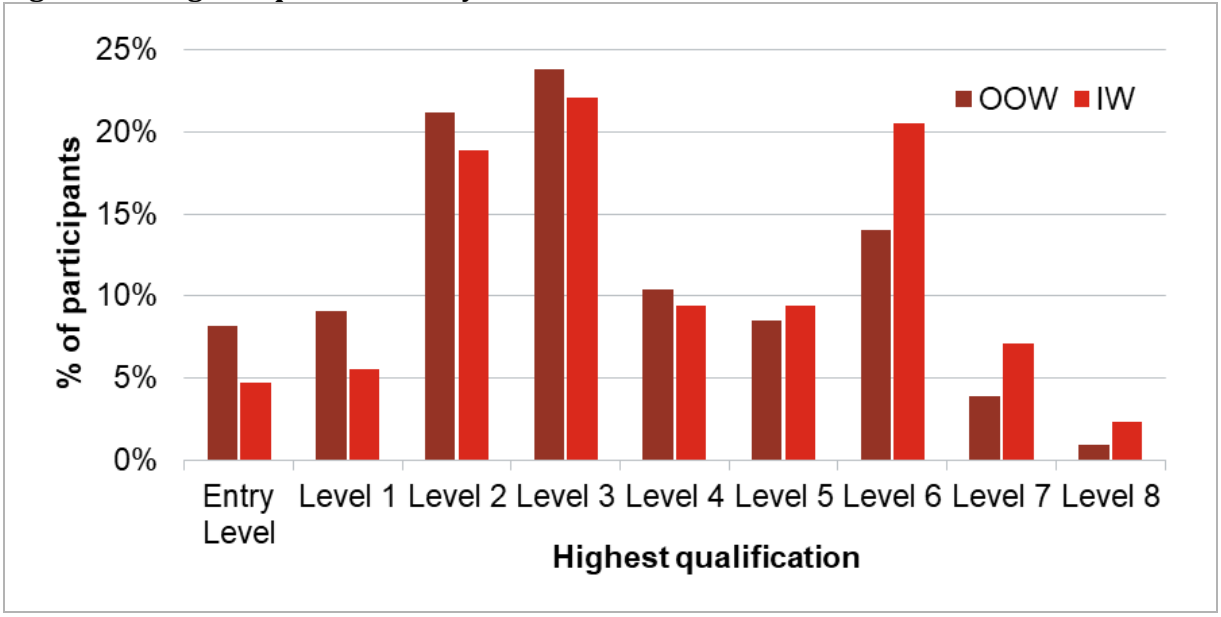


Source: WWIPSPC monitoring data

Qualifications

3.18 The IW cohort are much more likely to be qualified to above Level 4 than the OOW cohort, with around half educated to Level 4 or above. Overall, there is a fairly low prevalence of participants qualified Below Level 2 but it is more common for the OOW cohort.

Figure 3-3: Highest qualification by cohort



Source: WWIPSPC monitoring data

Other characteristics

3.19 Further analysis set out in full in Table A-1 to Table A-5 in Annex A provide various other insights into participants characteristics, most notably that:

- 38% live in a jobless household
- 21% are experiencing or have experienced domestic violence
- 19% are the primary caregiver to dependent children and 9% live in a single adult household with children
- The most common housing situation is living with friends/relatives (32%) which is far higher amongst those aged 18-34, followed by private renting (24%), amongst a mix of other housing situations
- Three participants (1%) have had no fixed abode while 32 (7%) are at risk of homelessness.

Disabilities and health

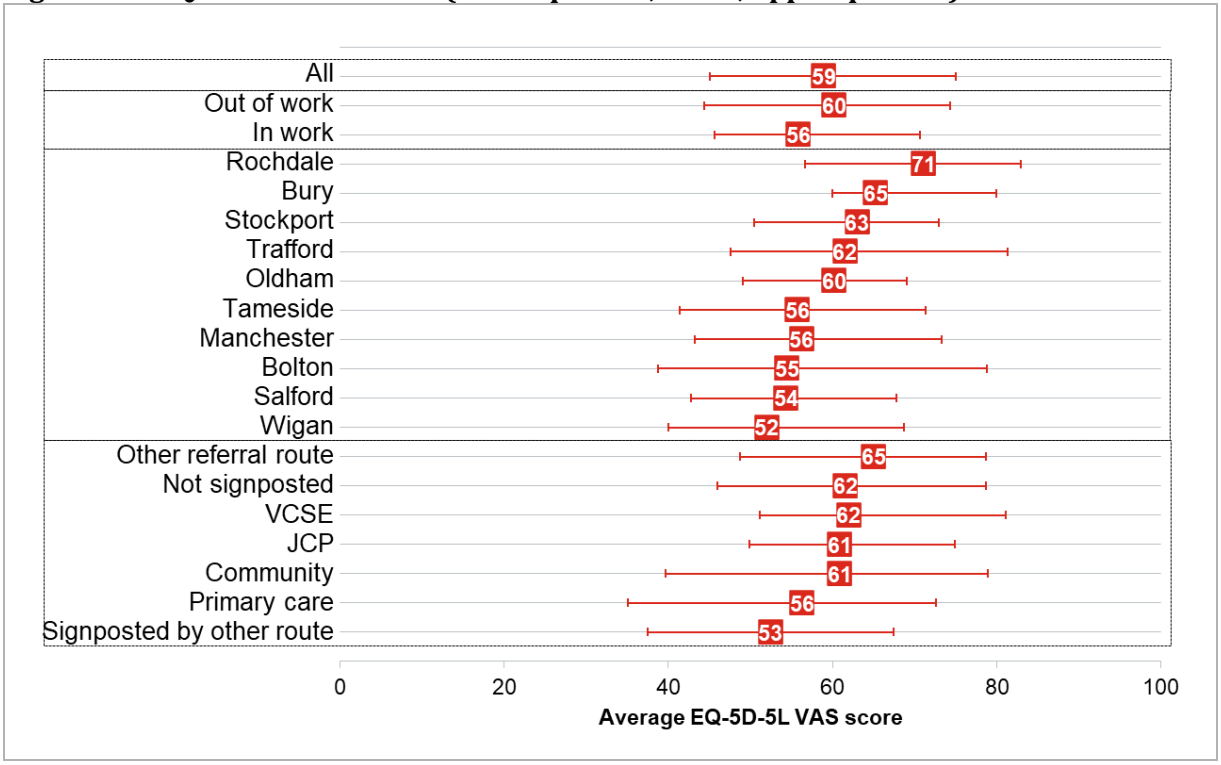
3.20 Various data is collected at onboarding to understand the nature, impact and severity of disabilities and health conditions of participants. This is particularly important given the programme is testing the IPS model with a different disability/health cohort which is expected to come through different referral routes.

Overall health

3.21 WWIPSPC uses the validated EQ-5D-5L tool. It includes visual analogue scale (EQ VAS) which asks participants to score their overall health from 0 to 100 (equivalent to 'the worst health you can imagine' and 'the best health you can imagine' respectively). Overall, participants gave an average score of 59. Comparing different cohorts, areas and referral sources in Figure 3-4 shows:

- The IW cohort (56) reported slightly worse health than the OOW (60)
- There is quite wide variation by LA with Rochdale having the highest average score (71) (which might reflect the impact of Get Rochdale Working's inclusion as a referral route) and Wigan the lowest (52)
- 'Other' signposts have the worst health (53) (with the caveat that numbers are low, and noting that the precise nature of these signposts is unclear) and primary care is second lowest (56), but otherwise there is quite limited variation by referral source

Figure 3-4: EQ-5D-5L VAS scores (lower quartile, mean, upper quartile)



Source: WWIPSPC monitoring data

Health dimensions and severity

3.22 EQ-5D-5L also captures data on the five different dimensions of health and their severity. Table 3-13 reflects the status of participants' health at onboarding, showing:

- Anxiety/depression is far more common than the other dimensions (and more prevalent than the 'health conditions' data suggested). Nearly two-thirds reported that it was a moderate issue or worse, including 15% who reported it as an extreme issue.

- Less than half of participants report issues with each of the other dimensions of health. Amongst them, pain/discomfort is most common (46%), followed by problems with usual activities (44%), mobility (34%) and self-care (21%). For participants with issues three-quarters or more reported them as slight to moderate issues, with severe and especially unable/extreme uncommon.

Table 3-13: Participant health severity by dimension (N=431)

	Mobility	Self-care	Usual activities	Pain/ discomfort	Anxiety/ depression
No problems (1)	66%	79%	56%	54%	16%
Slight problems (2)	15%	0%	15%	21%	22%
Moderate problems (3)	11%	17%	18%	16%	39%
Severe problems (4)	6%	3%	10%	8%	6%
Extreme/ unable (5)	0%	0%	1%	0%	15%
Blank	1%	1%	1%	1%	1%

Source: WWIPSPC monitoring data

3.23 Table 3-14 considers what proportion of participants had one or more issue rated at the different levels of severity, finding 31% reported at least one issue as severe or extreme, 20% reported slight issue(s) at most, and just 10% reported no issues.

Table 3-14: Proportion of participants with at least one health dimension ranked at each level of severity (N=431)

At least one...	Count	%
Extreme	31	7%
Severe	102	24%
Moderate	169	39%
Slight	86	20%
None	43	10%

Source: WWIPSPC monitoring data

3.24 Considering the combination of different health issues, Table 3-15 shows:

- Almost all participants with one health issue had at least one other (e.g. just 1% of those with mobility issues reported only mobility issues while 89% also reported issues with anxiety/depression)
- Those reporting anxiety/depression are most likely to report it as their only issue (35% reported just this issue) but the vast majority of participants reporting other issues also reported anxiety/depression.

Table 3-15: Relationship between health dimensions

Of those with…	Also have issues with… (grey = only issue)					Out of (no. with issue)
	Mobility	Self-care	Usual activities	Pain/ discomfort	Anxiety/ depression	
Mobility	1%	44%	82%	86%	89%	145
Self-care	74%	0%	99%	85%	94%	86
Usual activities	62%	45%	0%	70%	92%	191
Pain/ discomfort	62%	37%	67%	4%	88%	199
Anxiety/ depression	36%	22%	48%	48%	35%	361

Source: WWIPSPC monitoring data

3.25 Table 3-16 considers scores given by cohorts. It shows the IW cohort have been more likely to report all health issues, and more likely to have severe/extreme issues. This is perhaps unsurprising, given this cohort have sought out support while already in work. Almost all have at least a slight issue with anxiety/depression.

Table 3-16: Participant health severity by dimension and cohort

	Mobility	Self-care	Usual activities	Pain/ discomfort	Anxiety/ depression	Out of (no. with issue)
Mean score						
Overall	1.6	1.4	1.8	1.8	2.7	432
IW	1.7	1.6	2.1	1.9	3.0	127
OOW	1.5	1.4	1.8	1.7	2.6	305
% with issue						
Overall	34%	20%	44%	46%	84%	432
IW	43%	26%	54%	52%	93%	127
OOW	30%	17%	40%	44%	80%	305
% severe/extreme/unable						
Overall	6%	3%	11%	8%	21%	432
IW	9%	3%	16%	12%	24%	127
OOW	6%	2%	9%	7%	20%	305

Source: WWIPSPC monitoring data

3.26 Table 3-17 similarly considers how scores vary by referral source. Cautioning that numbers are currently small, this shows:

- Primary care has the highest proportion of participants reporting issues with anxiety/depression, and the highest average score.
- Self-referrals are generally amongst the least likely to report the different issues, except for with self-care.

Table 3-17: Participant health severity by dimension and referral source

	Mobility	Self-care	Usual activities	Pain/ discomfort	Anxiety/ depression	Out of:
Mean score						
Primary care	1.6	1.5	1.9	1.8	3.0	185
Self-referral	1.6	1.5	1.7	1.8	2.4	69
Jobcentre Plus	1.7	1.4	1.8	1.9	2.6	54
Community care	1.6	1.4	1.7	1.9	2.7	46
Voluntary/charity sector	1.5	1.2	1.8	1.8	2.5	32
Other signpost	1.4	1.3	2.0	1.5	2.8	25
Other referral route	1.5	1.3	1.9	1.9	2.4	25
% with issue						
Primary care	36%	22%	48%	45%	91%	185
Self-referral	28%	24%	37%	41%	72%	69
Jobcentre Plus	35%	20%	46%	52%	78%	54

Source: WWIPSPC monitoring data

Types of conditions

3.27 Table 3-18 below considers the type of disabilities and health conditions participants have. It uses high-level categories requested for capture by DWP which align with guidance around the Equality Act 2010 on defining disabilities.[29] Participants are asked for their 'primary' condition and 'other' conditions.

3.28 Reflecting findings from EQ-5D-5L it shows the high prevalence of mental health conditions, with nearly two-thirds reporting it as an issue (further data shows 27% of participants reported being

[29] Government Equalities Office (2022) Disability: Equality Act 2010 - Guidance on matters to be taken into account in determining questions relating to the definition of disability

diagnosed with a serious mental illness). There is then a spread of other types of conditions. The high prevalence of 'other' may reflect the list not being intuitive for ES and participants.

Table 3-18: Types of disabilities and health conditions (N=410)

Type of health condition	% primary condition	% primary or other
Mental health condition	57%	64%
Other	13%	23%
Learning disability	6%	7%
More than one of the above	4%	6%
Progressive and/or chronic	3%	5%
Restrictions arising from bodily injury, including to the brain	3%	3%
Recurring or fluctuating condition	2%	4%
Sensory impairment	2%	4%
Auto-immune	1%	2%
Developmental	1%	1%
Organ specific	1%	2%

Source: WWIPSPC monitoring data

3.29 Data is also captured on the specific disabilities and health conditions participants have as shown in Table 3-18. Unfortunately, it suffers from lower completion than data on types of conditions does and has been captured for just 56% of participants. A contributing factor is likely the exclusion of specific mental health conditions which appears to have led to high use of 'other'.

Table 3-19: Specific disabilities and health conditions (N=410)

Specific condition	% primary condition	% primary condition or other
Other	23%	28%
Aspergers/Autistic Spectrum	6%	8%
Neurological	6%	8%
Arthritis - Osteo	2%	4%
Difficulty in hearing	2%	2%
Epilepsy	2%	3%
Learning difficulties	2%	3%

Specific condition	% primary condition	% primary condition or other
Problems with back	2%	3%
Arthritis - Rheumatoid	1%	1%
Chest/breathing problems	1%	2%
Emotional Unstable Personality Disorder	1%	1%
Fibromyalgia	1%	2%
Heart/blood pressure	1%	2%
IBS - Irritable Bowel Syndrome	1%	1%
Long Covid	1%	2%
Problems with legs	1%	2%
Addictions - Other	<1%	<1%
CFS - Chronic Fatigue Syndrome	<1%	1%
CP - Cerebral Palsy	<1%	1%
Diabetes	<1%	2%
Eating disorder	<1%	1%
MS - Multiple Sclerosis	<1%	<1%
Problems with arms	<1%	1%
Problems with feet	<1%	1%
Problems with kidney/liver	<1%	<1%
Problems with neck	<1%	<1%
Skin conditions/allergies	<1%	<1%
Stroke/TIA (Transient Ischemic Attack)	<1%	<1%

Source: WWIPSPC monitoring data

3.30 The shortcomings in data on types of conditions means the evaluation will not have the full set of anticipated evidence on the prevalence of different conditions, including differences between referral sources that, and how effective the IPS model is for those with different conditions. That said, the data captured via EQ-5D-5L has almost full completion and will be useful for exploring these points of interest, which mitigates some of this impact.

3.31 Lastly, data has been collected on oral health. This is intended to support the Working Well: Roots to Dental scheme, which is due to provide dental support to participants. It shows around one fifth of participants would like to see a dentist and overall 20% reported one or both of the oral issues captured.

Table 3-20: Starts reporting problems with their oral health (N=436)

	Count	%
Would you like to see a dentist?	91	21%
Have you any problems with your teeth or mouth that stop you smiling or speaking without embarrassment?	57	13%
Do you have any problem or pain in your mouth at the moment?	51	12%
At least one problem with oral health	86	20%

Source: WWIPSPC monitoring data

Wider barriers to finding and sustaining employment

3.32 During onboarding participants are asked to give score of 1 - 6 for a list of 21 different barriers to employment. A score of 1 represents no issue and a score of 6 means a significant issue. Table 3-21 shows:

- The most prevalent and severe barriers are health (mental more than physical) and general confidence and self-esteem
- Next most prevalent are travel to work, work experience, qualification/skillset and local labour market. These are all more directly related to work than other issues on the list.
- The various other issues are less common, but they are nonetheless being reported by some participants.

Table 3-21: Barriers to work scores (N=436)

Barrier	Mean score	% an issue	% severe (scored 5-6)
Health: mental health	3.7	86%	38%
General confidence and self-esteem	3.5	86%	29%
Health: physical health	2.7	60%	19%
Access to private transport to travel to work	2.7	49%	26%
Lack of work experience	2.4	57%	13%
Lack of qualifications/skillset	2.4	60%	11%
Local labour market	2.3	54%	10%

Barrier	Mean score	% an issue	% severe (scored 5-6)
Debt/finances	2.2	45%	11%
Family support	2.0	39%	11%
Access to public transport to travel to work	2.0	40%	9%
Chaotic family lifestyle	1.9	36%	9%
Age	1.8	35%	6%
Bereavement	1.8	27%	10%
Care responsibilities for children	1.6	22%	8%
Care responsibilities for other family members or non-family individuals	1.6	25%	7%
Housing issues	1.5	20%	6%
Divorce/relationship break up	1.5	19%	6%
Domestic violence	1.3	11%	4%
Substance misuse	1.2	9%	2%
Convictions	1.1	4%	0%
Unspent convictions	1.1	2%	1%

Source: WWIPSPC monitoring data

3.33 Table 3-22 considers the differences in issues reported by the OOW and IW cohorts. The OOW are more likely to identify issues around experience, skills, job access and wider barriers, while the IW are more likely to identify issues with health and relating to family life. This reflects the OOW facing challenges in securing work, while the IW are facing issues that make sustaining work challenging.

Table 3-22: Barrier to work scores by cohort (N=436)

	% with issue		% with severe issue (4-5)	
	OOW	IW	OOW	IW
General confidence and self-esteem	86%	86%	25%	37%
Health: mental health	84%	90%	35%	45%

	% with issue		% with severe issue (4-5)	
	OOW	IW	OOW	IW
Lack of work experience	65%	38%	13%	12%
Lack of qualifications/skillset	64%	50%	11%	11%
Local labour market	59%	42%	9%	13%
Health: physical health	57%	67%	15%	30%
Access to private transport to travel to work	52%	41%	29%	18%
Debt/finances	45%	45%	10%	13%
Access to public transport to travel to work	42%	37%	9%	10%
Family support	39%	39%	11%	9%
Age	37%	32%	7%	4%
Chaotic family lifestyle	35%	39%	8%	10%
Bereavement	27%	28%	9%	12%
Care responsibilities for other family members or non-family individuals	24%	29%	6%	9%
Housing issues	22%	15%	7%	5%
Care responsibilities for children	20%	25%	7%	11%
Divorce/relationship break up	17%	23%	6%	6%
Substance misuse	12%	4%	2%	1%
Domestic violence	10%	15%	3%	5%
Convictions	5%	1%	1%	0%
Unspent convictions	2%	2%	1%	1%

Source: WWIPSPC monitoring data

Motivations and ability to work

3.34 During the fieldwork delivery staff were asked about the motivations of those who join the programme. There was a consensus that almost all have joined because they want to find or sustain their employment – as opposed to people joining because they wanted support for their health or other issues without it being through the lens of employment. Staff identified only very rare instances where they felt a participant's health issues were so extreme they would struggle to work.

"I lost all confidence and I couldn't build myself back up. I felt helpless. I couldn't have cared more or less if I was alive or dead. I went to my GP, and was having depressive thoughts and suicidal. I just wanted to get better. They referred me to a mental health nurse who offered medication, but I didn't want that – I needed structure, I needed to re-join life and I felt work was a good option." – Participant

3.35 It was suggested the referral sources least likely to result in participants with a genuine motivation to work were JCP and outreach at places like Job Fairs which were frequented by similar people. Some of these participants were seen as more motivated by JCP requirements around searching for work than they were to actually find work.

3.36 The initial conversation prior to signing a participant onto the programme has been key to ensuring participants are motivated to work. Where a prospective participant did not yet consider themselves ready or needed support for other issues (e.g. access to training, addressing issues in their family life) they would be referred elsewhere by the ES rather than being started on the programme.

Reflections

3.37 The key messages from the monitoring data and fieldwork are:

- Participants have mixed employment situations, both for the OOW and IW cohorts. For the OOW, while many but not all are short-term unemployed the vast majority think they can go into work soon, albeit confidence around entering work is mixed (but very few expressed the lowest level of confidence). The common attribute of the cohort is the motivation to work – which was almost always viewed as feasible – so participants can be considered be appropriate for the programme on this basis.

- Mental health issues are very prevalent. To some extent this will reflect the targeted referral routes having a mental health focus, so this might change if other referral routes are developed. Doing so could help generate learning around whether the IPS model is as effective for people with physical rather than mental conditions.

- Around one in three participants report severe/extreme health issues, one in five report severe/extreme anxiety/depression, and around a quarter report being diagnosed with a Serious Mental Illness. Consultees said frequently participants had levels of need that ought to qualify them for secondary care, but that they had not yet reached the part of the system (sometimes due to waiting lists) or had been discharged from secondary care. The expectation of the IPS model is that participants are able to access the health support they need because they are already engaged with mental health services. For WWIPSPC there is a question of whether participants are accessing the health support they need, and how adequate or effective it is.

- Comparing the two cohorts, the IW cohort has greater health issues and issues around family life, while OOW still have high levels of health issues but are relatively more likely to report

issues relating to experience, skills, transport and wider barriers. This shows common support needs around health, but otherwise the needs of the cohorts differ in a way that reflects their different employment statuses.

- Self-referrals have signed themselves up for the programme and on average have some of the less severe health issues, which suggests those joining through this route may be amongst the most motivated and work ready.

Comparisons with other Working Well programmes

3.38 Preliminary analysis comparing WWIPSPC to GM's WWWHP and WW: Pioneer programmes did identify points of difference between the participants on WWIPSPC and these other programmes. This included:

- A higher proportion of women have been engaged on WWIPSPC
- Using EQ-5D-5L scores WWIPSPC participants are broadly similar on physical dimensions of health but more severe for anxiety/depression
- The OOW cohort are more likely to have been unemployed for less time
- WWIPSPC participants are higher qualified on average, with considerably fewer with low qualification levels and far more highly qualified participants.

3.39 The evaluation will return to this next year when numbers are higher, to understand whether the programmes are accessing different types of people based on referral routes and target cohorts, particularly the IW cohort. Based on the differences between the cohorts so far it is likely the WWIPSPC cohort are more employable so higher levels of outcomes should be expected.

4. Support

4.0 The main stages and components of support expected to be delivered through WWIPSPC are:

- Programme onboarding
- Employment Specialist support, consisting of
  - Employment-focused support to secure work and sustain employment
  - Integration and signposting to support wider needs including but not limited to health.

4.1 These elements are considered in this chapter. Also covered are the extent to which the programme is meeting participant needs and reflections on WWIPSPC's implementation of the IPS model.

Programme onboarding

4.2 Participants are allocated to an ES in one of two ways. Referrals are sometimes sent direct to ES in instances where a relationship has been developed with the referrer. Otherwise, referrals made via the online referral form are received centrally and allocated out, prioritising the ES linked to the referral source (where relevant) and with consideration to caseload sizes.

4.3 The ES undertakes an eligibility check, generally by phone call, with eligible participants then enrolled to the programme. The eligibility check call was initially undertaken by a Referrals Administrator for TGC, however this was changed so that the ES is involved in all stages of the participant journey from the outset.

4.4 The ESs spoken to for the fieldwork identified instances of 'warm handovers' from referral partners, occasionally involving three-way appointments between the ES, participant and referral partner. This is only possible where there is an identifiable referral partner, and has been more likely to occur where an ES is co-located with that referral partner.

4.5 Once signed up to WWIPSPC the first appointments consist of:

- Collection of extensive onboarding information.
- Undertaking vocational profiling and developing a vocational action plan (VAP) (Fidelity Measure 14). This entails discussing the participant's household situation, means of travel, strengths and skills, work history, job preferences and requirements (e.g. role, sector employer, hours, location, reasonable adjustments), restrictions or issues influencing this (e.g. children, health issues, convictions) and employment-related and wider support needs to achieve job goals (e.g. health, access to training, work experience).

4.6 The onboarding process was widely seen as time consuming, generally taking two appointments, but positively it was considered comprehensive and useful for understanding participants' needs and goals to enable support to be tailored and participant-led. This is in line with the principles of the IPS model.

"The initial assessment was really clear. It told me what I could get, looked at what I needed, and discussed about how it would all be at my pace. This was quite comforting." – Participant

4.7 Going forwards there may be a case for reducing the amount of onboarding information captured. WWIPSPC is capturing extensive information around health and wider issues, which in part reflects the interest in generating evaluation learning. However, some ES reported that it was creating issues, including:

- Shifting the focus away from employment and onto these wider issues, and the barrier they present to work
- Bringing up trauma for participants, for example by asking about domestic violence, without the ES being able to offer sufficient support for the issue beyond signposting outwards.

4.8 Slimming down the data collection on wider issues for future delivery beyond the 'test and learn' phase could support a narrower focus on employment more in line with the IPS model. The trade-off would be less insight into the nature of the participants and who the programme is working more or less well for, and a risk that other issues are not surfaced and so not addressed, which could lead to problems at a later point.

The Employment Specialist role

4.9 The ES is responsible for all aspects of the support journey since the changes to the onboarding process (Fidelity Measure 3) and ES reported mostly being able to maintain a focus on employment while supporting participants (Fidelity Measure 2). This was considered a reflection of participants being motivated and feeling able to find employment as evidence in the previous chapter. Participants with more severe mental health issues or other significant issues have been more likely to draw ES time onto issues other than employment, but the interviewed ESs clearly recognised the need to maintain an employment focus as far as possible.

4.10 ES caseloads include a mix of OOW and IW participants. The following sections consider the support to secure work and support to sustain work sequentially. That said, the Fidelity Measures focus only on supporting people in to work, reflecting the historic focus of IPS on those out of work.

Support to secure employment

4.11 OOW participants seeking to secure employment broadly receive the same types of support. This is tailored to the participant, and both informed and structured using the Vocational Action Plan (Fidelity Measure 14), which is expected to be revisited at least monthly. The support provided includes:

- Developing and updating their CV
- Identifying employment options that suit the participant's aspirations, abilities and requirements
- Providing a 'Better Off Calculation' and benefit advice to help the participant understand the financial implications of entering employment (Fidelity Measure 12)
- Support with job searching, including via job sites and more proactive employer engagement based on preferences (Fidelity Measure 16)
- Support with job applications and dealing with rejections
- Support with interviews and work trials which includes mock interviews and accompanying participants to interviews and work trials
- Advice around disability and health in relation to employment, including the pros and cons of disclosing conditions to employers (Fidelity Measure 13), reasonable adjustments, and support available through the Access to Work scheme
- Signposting and liaising with wider support services to support with wider needs including health, housing, domestic violence and debt
- Preparing participants prior to commencing a job including developing their understanding of employer expectations
- Discretionary funding for purchases that remove possible financial barriers, such as covering travel expenses and purchasing work clothes.

"The job market is very big, it's very complex to find the right job, and get applications done. I needed professional help to find work … I had been doing everything independently, but I was getting demotivated with it all. It was more a case of being told there was someone who could help me navigate that space, to get some support from people who know the market better than me." – Participant

"Just having the regular meetings did wonders for my mental health – previously I would get rejected and think 'what is the point?' Having those regular conversations stopped that from happening, [my ES] would help me work through it. It was motivational, and having that support there was brilliant in me not losing enthusiasm and getting dejected." – Participant

4.12 The frequency of some of this support is summarised in Table 4-1.[30] It shows support with job applications, CVs and interview preparation is most common. The proportion of the IW cohort

[30] Some participants only started recently so will have less time to receive these different types of support. It is also possible there is some under-recording of support based on the prevalence of blanks.

receiving this support is notable, as it shows the prevalence of IW participants receiving support aimed at finding alternative employment.

Table 4-1: Support provided to participants

Support	All	%	OOW	IW
Job Applications	245	56%	59%	47%
Interviews Preparation	240	55%	57%	46%
CV Writing	225	52%	53%	46%
Mock Interviews	167	38%	41%	29%
None (blank)	134	31%	29%	33%
Work Taster	97	22%	26%	12%
Working Interview	83	19%	21%	13%
Other	61	14%	11%	21%
Out of:	-	56%	59%	47%

Source: WWIPSPC monitoring data

Identifying job goals

4.13 ESs emphasised the importance of identifying realistic job aspirations in discussion with participants (Fidelity Measure 14). This entails helping participants to understand:

- The types of roles that align with their interests, employment history and skills, and helping to identify transferable skills
- The practical considerations around what is feasible for the participant given their personal situation and health condition(s)
- Any requirements and considerations relating to the jobs themselves, such application processes, competitiveness, training requirements, physical requirements and shift patterns.

"Having someone else there to point you in different direction, think about things in ways you haven't before. [My ES] saw potential in my skills in areas I hadn't considered." – Participant

"I was looking for something which was right for me. I have had loads of jobs in the past which I've left because of my mental health condition, so I wanted to find one which I could stay in." – Participant

4.14 While some participants have a very specific job goal, generally ESs had found participants were open to considering different options. The refinement of job goals is iterative as participants find, apply for and get insights into different jobs.

"We might look at their hobbies and employment history, interests and skills. We have lots of conversations about how we will get there. If we have to get back to the drawing board we will." – WWIPSPC staff

"One participant really wanted to work as a policeman so we looked into the role requirements, and once they realised how much work was involved they backed down and I found them a 7.5hr per week job at Iceland. This was a better starting point for that person." – WWIPSPC staff

Rapid job search

4.15 The expectation is that participants commence job searching soon after they start on the programme, and the first face-to-face contact with an employer is on average within 30 days of starting the programme (Fidelity Measure 15). Individual ES viewed this timeframe as appropriate for some or many of their caseload, but not all, which does fit with the expectation as it is an 'on average' target. Amongst the OOW cohort on programme for at least a month, 32% had started applying for jobs and 15% had their first face-to-face contact with employers within 30 days of starting. Of those OOW that had started applying for jobs and had face-to-face contact with an employer, this took on average 22 days and 38 calendar days respectively.

4.16 Reasons that some participants were not considered ready included low confidence, taking time to establish job preferences, and having wider support needs (such as health, housing, etc) that participant and/or the ES were of the view needed to be resolved first.

"These are fundamental issues for participants and if I don't help them there won't be meaningful change." – WWIPSPC staff

4.17 The data on the IW cohort is more difficult to interpret (because it contains a mix of those wanting to find a new job and wanting to sustain their current job) but ES reported that those already in work were more likely to be ready to start applying for jobs immediately.

Employer engagement

4.18 A key part of the ES role is the engagement of employers to support with job placement (Fidelity Measure 3) tailored to participants' interests (Fidelity Measure 16). It should include six or more face-to-face contacts per week (Fidelity Measure 17) and relationships should be built through multiple in-person visits (Fidelity Measure 18). The intention of this engagement is to identify appropriate vacancies for individual participants, promote the participant to the employer, discuss reasonable adjustments to recruitment processes and the role (dependent of participant's desire to disclose their condition) and communicate the support that the ES offers around recruitment and retention.

4.19 ESs described how employer engagement varied depending on participant job preferences and how open participants were to the ES contacting prospective employers on their behalf:

- Some participants are already keen to work for a particular employer so the ES has been able to approach them directly. More commonly, ES and participants have started by searching for vacancies and employers online, with the ES then approaching the employers that participants indicated an interest in. In some instances participants have prioritised a particular location

so the ES have proactively approached employers in that area. ES have also been undertaking less targeted outreach to meet employers, for example by attending job fairs.

- Not all participants have wanted their ES to approach employers on their behalf (the prevalence of this is uncertain due to a lack of data on it). Reasons included not wanting to disclose their health condition to their employer and concerns about how their employer would perceive them being engaged with WWIPSPC. In these cases, the ES has focused on empowering participants to approach employers in the same manner the ES would.

"I'm encouraging participants to do their own searching, getting them to come up with employers in their area. I ask them to keep their eyes and ears open, to think about where they would love to work, so I can go knock on their door." – WWIPSPC staff

4.20 Challenges for ES have been:

- The amount of time it takes to engage employers compared to the time available. ES have allocated two days per week for employer engagement, but pressures from other aspects of their role meant this was not always possible. Difficulties managing workload are considered further below. Guidance from IPS Grow was that six face-to-face employer meetings should require just one day per week, which WWIPSPC staff suggested was not feasible.

- Confidence and skills of ES around engaging employers. Many of the ES have worked in similar roles before but those roles lacked such a strong employer-facing aspect, although a minority of ES have come from a recruitment or sales background. Skills and confidence have been developed through extensive internal and external training sessions, and by linking ES with lower confidence to more confident ES for shadowing and mentoring.

"Employer engagement is the hardest part: fitting it in, getting meaningful interactions, especially when my caseload is getting high. I'd never done it before. We have had training on it, which encouraged us to take a sales approach almost. Some ES are good at this – but I am better at client engagement."

"Once I get to the point of getting a full caseload I may not have enough time to do meaningful employer engagement – fitting in 6 engagements per week is tricky with a full caseload." – WWIPSPC staff

"There isn't enough time in a week to source that many employers meaningfully." – WWIPSPC staff

4.21 The ES have also been supported to identify vacancies and employers through other routes.

4.22 TGC have an Employer Engagement Team (EET) in place for its delivery of wider provision across GM, including other Working Well programmes. The ES have been able to draw on this team, including through weekly meetings. The benefit has been access to leads with 'warm' employers, often with an understanding of how accommodating they are likely to be as an employer around reasonable adjustments, and many of them Disability Confident.

4.23 The EET have also been promoting WWIPSPC as part of the broader suite of support that TGC offer to employers, which could result in referrals to the IW cohort. In May, a WWIPSPC-specific Employer Engagement Consultant was recruited to provide more targeted support for the programme.

4.24 In some areas the local councils have been proactive in sharing vacancies and employers with the ES.

4.25 Drawing on these other routes could be perceived to deviate from IPS Fidelity. However, it could still be in line with fidelity provided ES efforts are informed by participant preferences, the ES is directly involved with the employer, and the volume of engagement by ES is sufficient.

4.26 Factors that ES identified as influencing receptiveness of employers were mindset (around inclusion), employer size (in larger employers it has often been challenging to reach the right person with responsibility for recruitment) and the ability of the ES to sell the benefits of engaging (in particular with recruitment and retention). Some did report pushback from employers who felt they were being approached by too many programmes similar to WWIPSPC.

"A lot of people want to work in retail – but these businesses are big national establishments – and it is hard for us to get an entry point within a local store. We constantly get deferred to HR, so it has been challenging because the local stores don't have control over who they can hire. So that's been a barrier for retail and it is hard than expected to get into those." – WWIPSPC staff

"They have got to know what is in in it for them: reducing recruitment costs and improving retention." – WWIPSPC staff

"Employers know how time consuming and expensive recruitment is, so going there and having someone who is passionate, it is great." – WWIPSPC staff

4.27 Engaging with employers was considered to have generated positive results for participants. This included job starts, securing adaptations to recruitment processes and job roles, making employers aware of any particular needs the participant would have in a job role, and giving participants greater confidence in their new role. Directly engaging employers has given ES a better sense of whether employers are likely to be understanding and accommodating.

"For autistic participants it is finding them a role where the employer is open to understanding autism, so for one person it could be sensory, for another it … could be whether they would let them have additional breaks, whereas for another they may not understand social dynamics, so letting them know they need to give them specific instructions." – WWIPSPC staff

Exploring why those in the IW cohort want to change job

4.28 The various ESs spoken to during the fieldwork said that amongst their IW caseload many, most or all wanted to change job. Reasons given for participants changing job have included the following, each of them with some level of overlap:

- Difficulties coping in the role due to their disability or health, or wider issues
- Difficulties coping or dissatisfaction with their role due to their work environment, role requirements, hours and shift patterns amongst other reasons
- A desire to find a job more in line with their aspirations and preferences, including the type of role, better hours or better pay.

4.29 This is explored by the ES in jointly developing a Vocational Action Plan. Sometimes this discussion has resulted in participants agreeing a better course of action would be to try and resolve the issues in their current role, recognising the issues they face might persist in a new job. Depending on participant's preference they will either receive support to find a new job (as detailed above) or to sustain their current job (as detailed below). Where a participant initially in the IW cohort has fallen out of work they have moved into the OOW cohort and can receive up to 12 months of support to find new employment.

"A lot of the time it isn't work in general that's the problem, but rather a specific position/employer." – WWIPSPC staff

Support to sustain employment

4.30 The IPS model includes individualised in-work support (Fidelity Measure 22) that is time-unlimited but likely to reduce in intensity over time (Fidelity Measure 23). For the IW cohort the maximum length of support to sustain employment is four months. The OOW cohort who move into work receive in-work support for the remainder of their time on the programme. This is equivalent to 12 months minus the time spent on the programme so far, or until the end of March 2025 – meaning the length of in-work support is dependent on how quickly the participant moves into work and when they joined the programme. Some participants may therefore receive very little in-work support. These limits reflect IPSPC being a modified IPS model.

4.31 The in-work support offer for sustaining employment includes:

- Keeping in regular contact with the participant to discuss and support with any issues as they arise
- Advice around managing health and wellbeing in employment
- Advice around the pros and cons of disclosing disabilities and health conditions to their employer (Fidelity Measure 13)
- Advice around employment rights including in relation to health, such as the entitlement to reasonable adjustments and the Access to Work scheme, but also on any broader issues
- Assistance around returning to employment for those currently absent from work, for example by developing a back to work plan

- Support and encouragement around career progression
- Engaging directly with employers to advocate for the participant, and support with any of the issues in this list.

"I have liked how [my ES] is a partner for me outside of the job. Especially on the days I might have struggled ... We were communicating every step of the way." – Participant

4.32 Delivery staff and participants emphasised the value of an independent and impartial perspective on the issues IW participants were facing within work, and empowering participants with knowledge to better manage their situation.

"When you're struggling and you have someone neutral to turn to, you have got someone who can guide you, they know what the law is, they know what adjustments they can ask for, they have got contacts. They know the industry better than I do. You've got a lot more options than if you were on your own." – Participant

"For a lot of the IW cohort it's about just offloading to someone. Helping them understand what is and isn't normal from ES perspective – an independent viewpoint." – WWIPSPC staff

"They use me as a sounding board, just having someone who is impartial. It is advice and security." – WWIPSPC staff

4.33 There was a strong view amongst delivery staff and referral partners on the need for this type of support for people in employment, to avoid them falling out of work. A preventative approach, rather than responding only once an individual had fallen out of employment, was seen as less costly for the individual, employers and society.

Engaging with and disclosure to current employer for those in work

4.34 Participants are reported to have been mixed in their openness to:

- Disclosing their condition(s) to employers (Fidelity Measure 13) – 23% of IW and 12% of OOW indicated they were not open to disclosure
- Asking for reasonable adjustments
- Their ES engaging directly with their employer.

4.35 The ES is led by the participant's preferences on all of these points as per the IPS model. Where participants have been reluctant, it is seen as resulting from concerns about how employers will react. Some participants have wanted to disclose their condition and/or ask for reasonable adjustments without involving their ES, in which case the role of the ES has been to equip them with the information and confidence to do so.

"Some say no to disclosure. Then my hands are tied, as they won't let us speak with employer. Some are concerned about how it would look to their employer; worried they might get sacked asking for reasonable adjustments." – WWIPSPC staff

"I've got someone who is being bullied in the workplace, so I am communicating with their union rep." – WWIPSPC staff

"Sometimes people just want their employer to know they have a condition, not necessarily do anything, it gives them the confidence to tell them." – WWIPSPC staff

4.36 Amongst the ESs who had been permitted by participants to engage with employers some had experienced resistance or barriers with the employers. In some instances employers were simply not receptive to engaging or to making reasonable adjustments. In others, the challenge was reaching the right person within the employer. Generally larger employers were seen as more difficult in this respect, with local managers often lacking the ability to make changes for participants, although multiple examples were identified where large employers had been successful engaged and made accommodations. ES emphasised the need to sell the benefits of engaging to the employer, such as reducing an employee's time off work and avoiding having to re-recruit, to get their buy-in.

Support and integration around health and wider needs

Health needs

4.37 The IPS model is premised on the ES focusing on employment support (Fidelity Measure 2) while being integrated with health services to help participants get the health support they need and enable responsiveness to their health situation (Fidelity Measure 5 and 8).

"We're mainly focused on the job searching, but [my ES] is aware of my mental health and she keeps an eye on me during our catch-ups. She knows if I'm not answering my phone, that it might just be that I am having a bad day."

4.38 Positively, in many cases participants with health needs are already getting the support they require – enabling the ES to focus on employment-related support. Where participants have been in need of support, this has been provided via:

- Collaboration with health partners. As established in Chapter 2 the level of integration with the health system is mixed, but in some areas the ES have been able to become embedded or form working relationships with partners. This has been more effective in where the ES is attending joint meetings and co-located, most commonly with Living Well teams and other MDTs. There were examples during the fieldwork of regular, ongoing discussions with partners about participants. Such examples were limited, however. Others were providing email updates to referrers around key milestones, or requesting support with disengaged participants, but lacking deep and frequent engagement. Some ES were not able to work in partnership with health services beyond taking referrals, or at all, for example because

referrals came via non-health routes such as Get Rochdale Working. In line with the findings in Chapter 2, levels of embeddedness and collaboration with health partners does appear to be increasing over time as trust and understanding is built with partners.

"It feels like lack of good spaces gets in the way of developing personal relationships [with the ES]" Health referral partner

"We do try to keep in close contact, but not a weekly update, naturally the participant will update the referral partner." – WWIPSPC staff

"I have had check-ins with referral partners, but no joint meetings outside the initial introduction." – WWIPSPC staff

"I had a participant who wasn't using the sessions properly and didn't seem work ready, so the referrer spoke to me about how they used those sessions, and was held accountable." – WWIPSPC staff

"I make sure I am in contact with anyone referred over, every two to three weeks, to nip any issues in the bud that they may be having, or to provide the encouragement to keep going." – Health referral partner

- Signposting to wider health support. This has been more common for participants not already engaging with health services and/or where the referral was from outside of the health system so the ES lacked a direct link to the participant's health support. Most commonly these signposts have been to GPs and the VCSE sector to access support around mental health. ES can support signposted participants by accompanying them to appointments and by paying for travel. It is anticipated that in the coming months it will also be possible to signpost participants to the Working Well: Roots to Dental initiative for participants to get support for oral health issues from the University Dental Hospital of Manchester.

4.39 As has been the case for generating referrals, the capacity of health partners has presented a key barrier to working in an integrated manner. Often there is an incentive for partners making a referral to finish treatment or close their case. This may be a key point of difference in applying the IPS model to primary care versus secondary care. Similarly, the capacity of ES to engage with health services has sometimes been limited due to workloads. Some partners indicated a desire for more regular contact around participants they referred to enable more integrated support.

"The participant just goes onto the programme and we lose touch with them. We can't keep this many cases open, realistically." – Health referral partner

"We are open to more contact where a patient is struggling but we've not got the capacity to initiate, nor to maintain contact about all participants." – Health referral partner

"If we refer a participant to IPS where work is the main priority we can disengage them and fill spaces for other participants." – Health referral partner

4.40 There was concern expressed by WWIPSPC staff that not all participants are receiving the level of health support they need. Particularly those with more severe mental health issues, high levels of need related to neurodiversity and displaying challenging behaviour. Waiting lists for diagnoses and support, and the intensity and effectiveness of the support available through the NHS, were both cited as concerns. Where ESs lack a link to health services for a specific participant the management of their health needs becomes more of a responsibility for the ES.

"Access to therapy is really limited … with long waiting lists" – WWIPSPC staff

"The gap in support is free counselling. The support offer from GPs is either six sessions of CBT – which is less effective for women, and doesn't work very fast – or anti-depressants." – WWIPSPC staff

"Support with [learning disabilities] is only if you're diagnosed, but they're waiting for diagnosis." – WWIPSPC staff

4.41 These issues point to disadvantages from opening the IPS model up to non-health referral routes and the limited or lack of integration with health partners which can follow. Aiming for greater fidelity on these points could remedy the disadvantages created, albeit at the cost of numbers joining the programme. Alternatively, some of those interviewed questioned whether there is a need to augment the IPS model with access to more dedicated health support. If there are shortcomings in the support accessible in the wider landscape and the scope for integration (as delivery staff have suggested) there could be a case for this – because the IPS model is premised on participants having access to the health support they need. A further advantage may be that it provides an incentive for health partners to refer, albeit with a risk it creates an incentive to refer/join for health support rather than finding employment.

Wider needs

4.42 Chapter 3 highlighted the range of other barriers to work that some participants face, such as with housing and debt. Mostly these do not present severe barriers to work, enabling the ES to focus on employment support, although in some cases they have been more severe. ES have generally provided help with these wider barriers by signposting to relevant services. ES reported an awareness of the wider support landscape through training and access to a directory, and through their outreach activities and networks. In a small number of instances, the ES has needed to be more involved in handholding and advocating for participants dealing with such issues.

"If they're presenting with anything that our programme can't help with, we will signpost them elsewhere." – WWIPSPC staff

"A lot of participants we see are slipping through the net of other support services, so when they come to ESs they need help with everything, not just work." – WWIPSPC staff

4.43 There is regular contact with Jobcentre Plus staff around participants (Fidelity Measure 6), particularly via Disability Employment Advisors. However, some issues were highlighted with this relationship:

- Concern that engaging with JCP staff is generating referrals, at the expense of referrals from health partners which would better align with the IPS model. This issue arises from applying Fidelity Measure 6 in a programme that also permits referrals from JCP. The wider parameters of IPSPC has created a tension between different aspects of fidelity.

- Disagreements with Work Coaches about the needs of participants and their employment requirements. It is worth highlighting that the threshold for a job outcome on IPSPC is 7 hours per week, which conflicts with the Universal Credit threshold equivalent to working 18 hours per week below which a claimant would need to increase their hours and earnings. This increases the scope for disagreement between ES and Work Coaches on what is appropriate employment for individual participants. There were a small number of examples of disagreements between ES and Work Coaches.

- Negative perceptions of JCP amongst some participants and referral partners, which creates a risk to how WWIPSPC is perceived by participants/partners if seen to be working in partnership with JCP.

Frequency, format and location of support

4.44 The Minimum Service Delivery Standards (MSDS) for WWIPSPC establish the requirement that 100% of participants are to be contacted each week and 100% of actively engaged participants are to review progress against their VAP at least monthly. The mandating of weekly contact is in contrast to the participant-led, flexible nature of the IPS model, for which intensity should be determined by the participant. That said, weekly contact was broadly considered appropriate for those out of work.

"Because everyone is so different, we need to make sure that we are going at their pace. This isn't necessarily an issue, rather something that might impact timelines." – WWIPSPC staff

4.45 Considering those in work, weekly contact is contrast to Fidelity Measure 23 which says in-work support should be "at least monthly … as desired by clients" following the first month of support. ES reported that participants who had secured employment or felt more secure within work often did want less frequent contact.

4.46 Some participants have required more frequent contact – especially around starting the programme, and at points when dealing with a job application or a particular issue – which ES accommodate. Participants with higher levels of need, particularly those with more severe mental health, very low confidence, neurodivergent participants and those aged 16-18, have tended to need this greater intensity of support.

4.47 The format of contact varies. It can consist of in-person meetings, phone calls, video calls, emails and/or texts. Again, this is largely participant led. Some participants request to always meet in-person but more commonly participants have preferred semi-frequent in-person meetings in combination with remote catch-ups by other means. The preference for some of the support to be remote was due to its convenience – particularly for those in-work who wanted to meet during a

break or before/after work. ES indicated a preference for in-person meetings for onboarding, for the regular reviews of progress against the VAP, and to support practical tasks such as job searching and applications. The remote catch-ups generally function as quicker check-ins.

4.48 ES spend much of their time delivering the programme from community settings (Fidelity Measure 24) and, to a lesser extent, from health settings. In some cases this involves co-location alongside health and non-health partners, for example in Living Well Hubs or with Get Rochdale Working, but often this has not yet proved possible. As noted in Chapter 2, the ability to co-locate with health partners in particular has been limited by the availability of space by information governance concerns and seemingly a lack of willingness, even where the relationship is otherwise good. As a result, ES are more commonly working from non-health hubs, libraries and cafes. In line with IPS expectations there is a prioritisation of settings that participants feel comfortable with. However, some ES did report having to undertake sensitive appointments in spaces such as libraries that lacked privacy, which they felt was not appropriate.

Caseload sizes and workload

4.49 The expected maximum caseload per ES for WWIPSPC is 24 participants. This is above the threshold of 20 needed for a maximum fidelity score of 5 out of 5 on Fidelity Measure 1, but it is within the range of 21-25 that gives a score of 4 out of 5. The caseload sizes for IPS fidelity are based on all participants initially being OOW though rather than both OOW and IW, and some of the IW do appear to require a lower intensity of support.

4.50 Some of the ES spoken to who were at the maximum caseload of 24 described it as challenging in terms of the workload involved. Notably (and perhaps concerningly) staff with experience of delivering other IPS programmes felt this programme was more demanding and suggested WWIPSPC was 'not a true IPS programme.'

"24 is a lot … I would say around 20 is ideal for delivering individualised support. I have some colleagues … who have over 24 who are swamped." – WWIPSPC staff

"Being at maximum caseload is difficult … it is difficult to fit in quality engagements with all 24 participants, especially if they all want different types of work, and then also do the employer engagement." – WWIPSPC staff

4.51 Various aspects of WWIPSPC delivery appear to be contributing to this concern about workload pressure:

- Generating referrals: ES are responsible for generating referrals and have been tasked with generating them in an exploratory fashion through liaising with a high number of partners and extensive outreach. This is in contrast to the expectation for a high-fidelity service which is integrated with and takes referrals from just one to two teams. The approach taken for WWIPSPC is likely to be more time-consuming. The service is also new, and establishing new relationships is time-consuming.

- Levels of need and support:
  - The most intensive period of support has been around onboarding and the early stages of delivery. The start profiles have required a lot of onboarding during the early phases of the programme, so ES have been delivering high volumes of more intense support.
  - Many participants have high levels of need, perhaps more than might have been anticipated given the intended focus on primary care. However, links with health services to draw in the support needed are still being developed or are not in place. Developing these relationships and sourcing support without this integration already in place is time-consuming.
  - More participants are searching for employment than anticipated (because many of the IW are wanting to find a new job) and those searching for work generally require more intensive support than wanting support to sustain work.

- Engagement of employers: Undertaking six meaningful employer engagements per week is time-consuming, and not viewed as feasible within a single day as suggested by IPS Grow.

- Administration and contractual requirements:
  - GMCA are committed to monitoring and evaluating WWIPSPC to enhance their insights as a commissioner and generate learning for future programmes. This has, however, increased the amount of administration required by ES. Similarly, MSDS requirements increase the administration workload. Some ES with prior IPS experience expressed surprise at the target-driven nature of WWIPSPC.
  - There is less flexibility and more intensity in delivering IPS due to the MSDS, in a way that at times clashes with IPS fidelity. For example, the MSDS require weekly contact for all participants whereas a high fidelity model recognises less frequent contact may be required after a month in work. Requiring more contact for the IW cohort means a greater workload, and is at times in conflict with participant preferences, who have stated a preference for less frequent contact or for texts rather than phone calls. Failure to achieve MSDS requires supporting evidence, which adds to the workload.

4.52 To summarise, in many ways WWIPSPC is more resource intensive than a traditional, high fidelity IPS model. Decisions around design and strategic priorities have contributed to this. Notably, the pressure to achieve ambitious programme starts profiles, to seek them from a wide range of sources, and to build in additional administration, means other aspects of delivery appear to have suffered. In particular, some ES reported not having the time to deliver the level of support and employer engagement they ideally would.

"It doesn't feel like it's IPS. It's a mainstream programme copied and pasted … [The profile] is affecting quality of service, the impact is huge … staff are providing a light touch IPS service." – WWIPSPC staff

"The biggest challenge for this programme is the MSDS, targets and profiles are at loggerheads with being a customer-led service, and with fidelity to an extent." – WWIPSPC staff

"We need more time in the day or smaller caseloads." – WWIPSPC staff

"I have people on my caseload who are autistic, who need face-to-face support, and turn up every week. If I was to have 24 face-to-face every week I would struggle." – WWIPSPC staff

4.53 Over time, some of these pressures may ease and caseloads could become more manageable: as ES become more competent and efficient across all aspects of their roles; as lower start profiles mean less time spent on generating referrals and the administration requirements of onboarding; as integration with health services improves, meaning less time spent on cultivating relationships and better, more efficient access to health support. The programme's short lifespan is a disadvantage in this respect, as by the time the programme has matured there will be limited delivery time left.

4.54 Some of the pressures on workload may not abate with time though. It might be that the focus and design of WWIPSPC is more time-consuming. Most notably, it might be that integrating with primary care simply is more time-consuming. This, and implications for workload and the trade-offs ESs are reporting, should continue to be considered as the programme matures. Returning to the potential natural experiments identified in Chapter 2, it may be that there are observable differences between areas which achieve stronger integration with particular parts of the health system (such as Living Well) in line with a high fidelity model compared to those which do not.

4.55 Lastly on caseloads, at the time of the fieldwork in May, Groundwork were facing challenges with their caseload sizes with an average caseload of 32 and maximum caseload size of 35. This was the result of challenges with staffing (recruitment, someone leaving and illness), the timeline for participant recruitment and inflexibility around this. For a team with just 10 ES, a small number of unfilled roles and absences has a greater impact on average caseload sizes. In parallel, there was limited flexibility on participant recruitment, with pressure to continue generating referrals and starts despite already high caseloads – and despite the potential implications for the quality of support and pressures on staff.

Disengagement

4.56 There is a small minority of participants who have stopped engaging. For WWIPSPC a participant that misses an engagement and cannot be contacted after four follow-up attempts (within 24 hours, and then at least three times on different days, at different times of the day and via different media) they can be discharged. Again, this reflects IPSPC being a modified IPS model, as Fidelity Measure 25 requires support to not be terminated because of missed appointments or fixed time limits. That said, if a participant did seek to re-engage they are able to do so and be supported for any time remaining.

"When you're trying to contact someone who is socially anxious, we have to contact them every day, and it feels a bit like harassment" – WWIPSPC staff

4.57 The process for discharging participants is understood not to have been followed strictly, allowing more flexibility. It was well recognised by ES that participants can and do suffer from bad days

and setbacks, and that engagement could suffer due to this. Therefore, participants are usually not discharged for at least a month, following multiple attempts to re-engage, and working with referral partners where possible.

4.58 There is a risk of pressure to discharge participants in order to free up caseloads to prioritise more programme starts. This returns to the issue of prioritisation between programme numbers supporting individuals.

Participant satisfaction

4.59 A rolling survey of participants has been established to capture ongoing feedback on the programme. The results from this will be considered in the next Annual Report. In the meantime, six participants were interviewed for this report. These participants were identified by the providers and so are not necessarily representative of the broader caseload. More participant interviews are planned going forwards with participants sampled using the monitoring data.

4.60 Amongst the participants spoken to the feedback was strongly positive about the support model, the start process, the frequency and nature of support they had received, and particularly their ESs. The features of the programme that stood out as particularly valued or instrumental to their progress were:

- The support spanning the full process of identifying job goals, applying for jobs and sustaining employment
- The personalised and nurturing approach of their ES, with participants feeling supported, understood and motivated as a result.

"Before the programme I was not in a good place – the worry was immense, and just having someone to guide me was nearly a lifesaver. I felt like I had to continue with where I was or risk leaving and being in debt … It was just about going through my CV and opening those doors, they're up to date with everything in terms of the job market, they give you that boost to do things." – Participant

"[My ES] phoned up before the interview to give me a boost beforehand and reassure me, and I found that really helpful. It was showing that it was proper support, and she was invested in me trying to find a job. I've been understood and listened to, we have always talked things through and discussed things. I found it incredibly supportive." – Participant

"It is very compassionate, and I feel that sometimes people don't often get that when looking for jobs, it can be draining when you keep getting rejected. And the energy [the ES] put into it helps you feel supported." – Participant

"Sometimes you feel so alone with conditions like this, and difficulties with work. These support workers are really good at listening, and helping you understand job opportunities, and then if I want help communicating to employers I know I can get it – so I would really recommend it." – Participant

Reflections on what works

4.61 This chapter has considered various challenges in operationalising the IPSPC model. Despite the challenges, overall, the IPS model and support offer was regarded as appropriate for those joining the programme. The features most commonly highlighted as important during the fieldwork were:

- Its flexible, individualised and participant-led nature, which has meant it is appropriate across the varying levels of need amongst those joining the programme.

- The role of the ES in being there for participants to talk issues through, with a particular focus on employment and building confidence, but also supporting wellbeing throughout the process of securing and sustaining employment, and drawing on wider services as needed.

It's important that there's someone there who believes in you." – WWIPSPC staff

"A lot of these people don't have someone to talk to, they may have been out of training, education or work for a while. They lack confidence and don't really know where to start with employment." – WWIPSPC staff

Some are de-motivated by lots of rejections. I can provide perspective around process of securing a job – around rejection rates, the time it takes." – WWIPSPC staff

4.62 These features are also present and seen as important in the other Working Well programmes, despite the programmes being different in other ways. This similarity underlines these being core principles of good practice across different models of employment programmes. WWIPSPC does differ from WWWHP in having lower caseloads, however, meaning these principles being delivered with greater intensity.

4.63 It is worth noting that those joining to date have been more likely to have poor mental health and wellbeing, rather than physical conditions, so this is more a reflection the fit for this cohort who are similar to the cohort IPS is known to work for. If, going forwards, the proportion with physical health needs increases, the evaluation will be better placed to consider the appropriateness of the IPS mode for this alternate cohort. Similarly, insights into the differences in support needs between the IW and OOW cohort – and how well the support offer meets those needs – are expected to be clearer as time progresses.

5. Outcomes

5.0 This chapter considers the evidence around outcomes achieved to date, predominantly employment but also health and more broadly. The evidence on this is relatively limited due to the time it takes for participants to achieve outcomes. Next year's Annual Report will be able to consider them in greater depth.

Employment outcomes

5.1 The programme has achieved a range of employment outcomes including job starts and the sustainment of employment. More specifically, the types of outcomes achieved, and ways ES have enabled this, include:

- Moving participants from OOW into employment and moving IW participants into a new job that better aligns with their interests and requirements (including requirements related to health conditions), has more appropriate hours and/or higher pay
  - Helping participants identify appropriate roles including through proactive employer engagement
  - Supporting participants through the entire application process
  - Securing reasonable adjustments to the process e.g. sharing interview questions in advance

"I worked closely with [the employer's hiring manager] to make sure they understood the participant's position and application requirements – they were really receptive and made sure the interview conditions were suitable. The participant then got the job, which was a good outcome." – WWIPSPC staff

"One of my participants got a job in admin with a charity organisation. I met the employer at a jobs fair, and I made sure the application went directly through her and that the hiring manager understood the wider details. The participant has done really well, and just promoted." – WWIPSPC staff

"We found her a remote role for an insurance claims company, which suited her preference as she had mobility barriers." – WWIPSPC staff

- Enabling participants to sustain or return to their current employment
  - Liaising directly with employers to advocate for participants
  - Listening to and coaching participants around dealing with challenging work situations and managers
  - Securing changes and reasonable adjustments from their employer e.g. different working hours and changes to breaks

- Helping participants to move role or department where that role or environment had been causing difficulties

"I can access the line manager and have been able to focus on breaking down their tasks – looking at what has been impacting their mental health to help them return to work." – WWIPSPC staff

"I have a client who is in-work sick, and has long-Covid. We developed a plan to go back to work. She's currently doing three days in the office, working 3hrs per day. It was helping her understand the reasonable adjustments she needs and then balancing this with what the employer can do." – WWIPSPC staff

"One person suffering from a bad back and arthritis was working long eight hour shifts over two days, we so asked to split it over three days to make it more manageable." – WWIPSPC staff

- Supporting participants to progress in employment
  - Encouraging and supporting participants to apply for a new position
  - Supporting participants to access opportunities such as training

"One participant's confidence was so low, she wasn't sleeping, and had mental health issues … after having been made redundant from her previous role after the pandemic. She was so upset and worried that no-one would want to employ her again. We managed to find her a job as Head Teacher's PA within about two months … I knew she was well aligned to it, and the school was a good employer … [After getting the job] I was texting and keeping in contact, and built her confidence further. She told me about another, more senior opening that came up – and she was initially interested but nervous to apply. I encouraged her to, as looking at the requirements I knew she could do it, and she did, and she got the promotion to Business Manager – she has flown. Really come into her own. No mention of those issues again." – WWIPSPC staff

5.2 The rest of the chapter considers the programme's outcome targets and monitoring data on the outcomes being achieved.

Programme targets

5.3 The table below provides a summary of the programme's targets for job starts and sustainment ('job outcomes'). It includes targets for the IW and OOW cohorts in GM, and for IPSPC overall based on DWP expectations.

5.4 A 'job start' can be claimed once a participant has undertaken 7 hours of paid work in a single week which could be either: starting a new job, a return to their current job, or an in-work participant self-certifying they are no longer at risk of falling out of work. The 'job outcome' thresholds are met by sustaining a job for 13 and 26 weeks.

Table 5-1: WWIPSPC outcome targets[31]

	% of starters			% of those with a Job Start		
	OOW	IW	DWP	OOW	IW	DWP
Job Start – working 7hr in a single week	48%	45%	40%	-	-	-
Baseline Job Outcome – working 7hrs a week for 13 weeks in a 16-week period	36%	34%	30%	75%	75%	75%
Higher Job Outcome – working 7hrs a week for 26 weeks in a 32-week period	31%	28%	20%	65%	62%	65%

Source: WWIPSPC profiles and DWP IPSPC provider guidance

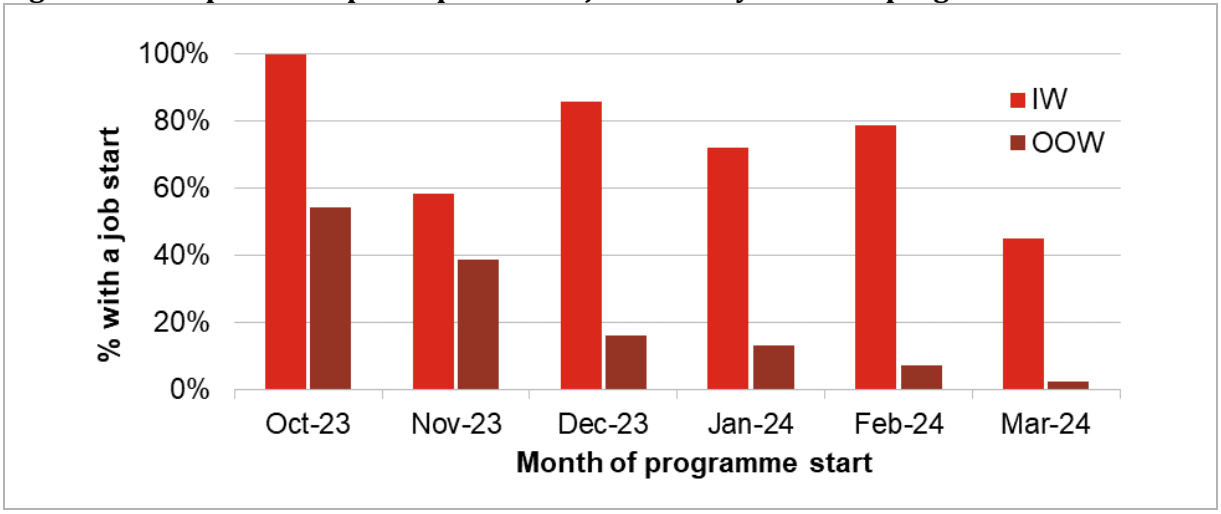
Job starts

5.5 There were a total of 124 job starts recorded by the end of March 2024. These have consisted of the following:[32]

- 41 job starts by OOW participants – versus a target to date of 115 (36% of target to date)
- 83 job starts by IW participants – versus a target to date of 33 (252% of target to date).

5.6 Figure 5-1 shows the proportion of participants going into work by cohort and month of programme start. The IW cohort have achieved high levels of job starts, with the caveat that the number of IW participants is quite small in individual months. This difference is probably to be expected given the IW cohort are already in-work and the low threshold for claiming a job start.

Figure 5-1: Proportion of participants with job starts by month of programme start

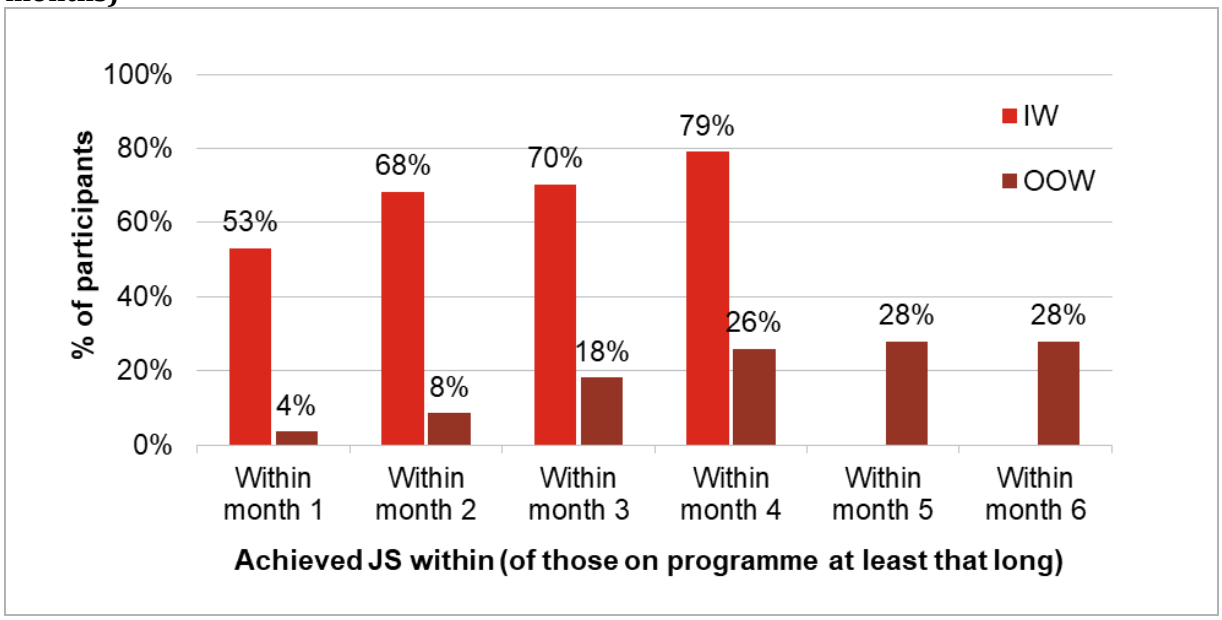


Source: WWIPSPC monitoring data

[31] These targets are based on profiles proposed by TGC. These were set higher than the targets for IPSPC as a whole which DWP will assess GM's performance based on. The DWP targets for the OOW and IW cohorts are identical whereas TGC anticipate different performance for the two cohorts.
[32] Please note the targets are based on the programme's original profiles. They therefore do not account for recruitment being lower than profiled during the early months of delivery.

5.7 Figure 5-2 provides further insight into the time taken for participants to achieve a job start. It shows that, of all participants 53% of IW and 4% of OOW are achieving a job start within their first month. Of the participants who started 3-4 months ago 79% of IW and 26% of OOW have achieved a job start. This difference will be important to monitor in the coming months to ensure that the OOW cohort move closer to achieving their outcomes target. At the same time, it may be worth exploring how much support has been given to the IW cohort to help them sustain or return to work, and the implications for the additionality and value for money of this element.

Figure 5-2: Time to achieve a job start (for those on the programme for at least that many months)



Source: WWIPSPC monitoring data

5.8 Table 5-2 shows most of the in-work starts have been a return to the same job and employer (90% of all IW job starts) – further data shows 59 of these have been job sustainments (72%) and 15 have been a return to work (18%). The table shows a small proportion of the IW job starts have been the result of participants changing job and employer (9%).

Table 5-2: Job starts by category and cohort

Job start category	IW	OOW
Same job & same employer	74	9
Different job & same employer	1	0
Different job & different employer	7	32
Out of:	82	41

Source: WWIPSPC monitoring data

How jobs were sourced

5.9 The source of jobs gained is shown in Table 5-3, which shows three-quarters have come from an application to an employer advert identified by the participant or ES, with a further 13% identified via the hidden job market.

Table 5-3: How new jobs were gained

Route	All	IW (new job only)	OOW
Participant applied (employer advert)	40%	57%	43%
Participant applied (advert identified by employment specialist)	33%	29%	32%
Other	13%	14%	13%
Hidden job market (via employment specialist)	10%	0%	9%
Hidden job market (via participant)	5%	0%	4%
Out of:	40	7	47

Source: WWIPSPC monitoring data

Types of jobs started

5.10 The characteristics of participants' job starts are summarised in Table 5-4. It shows the majority are full-time and permanent, although the OOW are more likely than the IW group to have gone into fixed-term, temporary or zero-hours roles, with nearly a third going into those types of roles. Around 80% of IW and OOW participants are earning real living wage.[33]

Table 5-4: Nature of jobs started by participants

	All	IW	OOW
Employment type			
Full time	58%	57%	61%
Part time	38%	42%	29%
Seasonal	1%	0%	2%
Temporary	3%	1%	7%
Contract type			
Fixed-term	6%	4%	12%
Permanent	77%	86%	59%
Temporary	6%	1%	15%
Zero-hours	6%	4%	12%
Varies	4%	6%	0%
Missing	1%	0%	2%
Earning Real Living Wage			

[33] Equivalent to £12.00 an hour in 2023/24. See Living Wage Foundation: What is the Real Living Wage?

	All	IW	OOW
Yes	81%	81%	80%
No	19%	19%	20%
Earnings Cycle			
Weekly	16%	12%	25%
4 weekly	5%	3%	10%
Monthly	78%	84%	65%
Other	1%	0%	1%
Out of:	124	83	41

Source: WWIPSPC monitoring data

5.11 Table 5-5 shows the most common sectors of employment. Retail, Sales and Customer Service were the most common sector for both the IW and OOW cohorts. Comparing sectors of employment against sectors of interest expressed during initial assessment, 39% of the OOW cohort had entered a sector they initially expressed interest in.

Table 5-5: Top seven most common sectors of employment

Sector	All	IW	OOW
Retail, Sales & Customer Service	17%	17%	17%
Healthcare	12%	16%	5%
Cleaning/Domestic	9%	12%	2%
Hospitality & Food	9%	6%	15%
Administrative/Clerical/	6%	5%	10%
Government Services	6%	2%	15%
Teaching & Education	6%	7%	2%
Out of:	124	83	41

Source: WWIPSPC monitoring data

5.12 Considering the nature of the 41 jobs started by the OOW cohort against the fidelity measures on job types and variety, and recognising that we are not qualified to undertake an audit, it appears that:

- For Fidelity Measure 19 on the diversity of job types the programme would score 4 out of 5 based on 78% of job starts appearing to be 'distinct' jobs
- For Fidelity Measure 20 on the diversity of employers the programme would score 5 out of 5 based on 97% of job starts being with distinct employers
- For Fidelity Measure 21 on competitive jobs the programme would score 1 out of 5 as the scale is written because 59% in permanent employment is below the threshold of 64%. However, we have been told IPS Grow only intend to assess whether jobs are competitive rather than also permanent. If so, then it is understood the programme would score 5 out of 5. The

prevalence of non-permanent employment may reflect the speed with which participants can move into non-permanent roles, so may change over time.

5.13 This is a very early assessment given low job start numbers for the OOW cohort so is subject to change. For now, it is positive on the diversity of roles and employers, but the prevalence of permanent roles is low albeit with the caveat that this might be expected to improve with time.

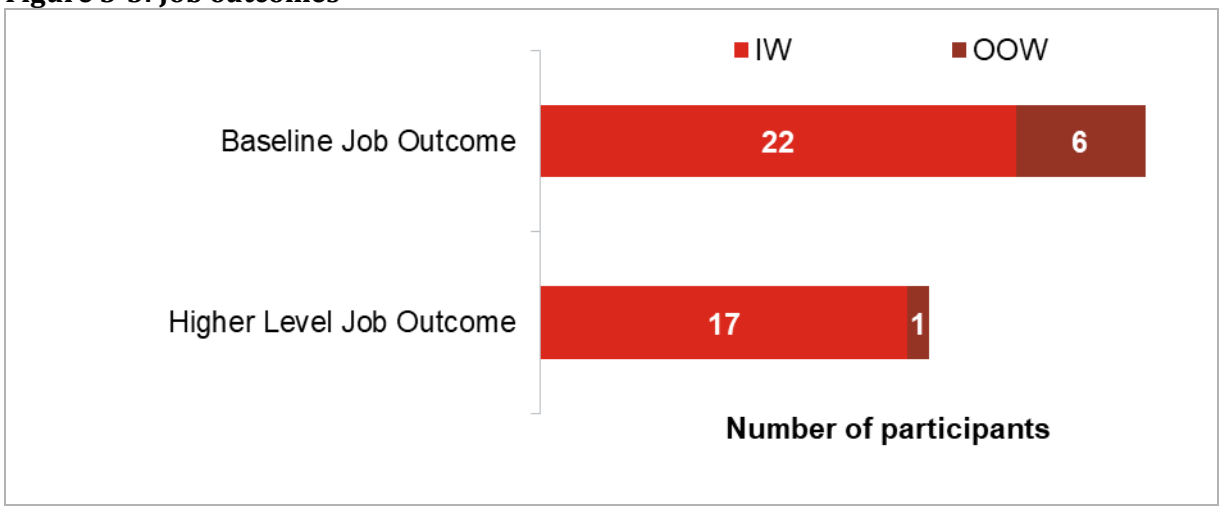
Job Outcomes

5.14 The programme also captures the sustainment of job starts by recording:

- Baseline Threshold Job Outcomes – equivalent to working 7hrs a week for 13 weeks in a 16-week period
- Higher Level Threshold Outcomes – equivalent to working 7hrs a week for 26 weeks in a 32-week period

5.15 Due to the time period required to achieve the Job Outcomes, there have been relatively few to date, as shown in Figure 5-3. Positively, sustainment of jobs starts is understood to be good to date, with just two participants reported as having fallen out of work by the end of May.

Figure 5-3: Job outcomes



Source: WWIPSPC monitoring data

Wider outcomes including health

5.16 During the fieldwork ES and participants identified examples of participants experiencing improvements in the health, wellbeing and wider barriers to employment. They reported:

- Improvements in wellbeing, mental health and confidence as a result of:
  - Being able to discuss their issues or 'offload' on someone independent.
  - A greater sense of direction and understanding the practical steps needed to achieve their goals.

- Success in finding employment, moving towards employment or resolving the issues they were facing in employment. Particularly due to the focus on ensuring employment is appropriate for the participant.

"This programme worked for me. I needed structure to my life, not medication. I'd absolutely recommend this programme – and getting to work – for anyone who was lost. I absolutely felt a pit for despair. Work provides structure and focus. I know if I have a routine and structure, I am not going to dwell on bad things. It gave my life meaning again – IPS is helping me get there." – Participant

"My kids have a happier mum." – Participant

"Just believing in yourself – when someone comes forward and helps you realise your skills and when you have that support, it really helps." – Participant

- Remedying challenging situations in participants' personal lives such as health problems, becoming homeless and facing debt issues. Resolving these issues had improved their wellbeing, and was anticipated to improve the likelihood that in due course those participants could be supported into employment. Participants also reported improved mental health as a result of finding suitable employment.

"There have been a few who are no longer seeing the Mental Health Practitioner because they have made progress in their personal life, and some are very open in that they feel the progress and that they feel so much better." – WWIPSPC staff

"They are improving in their mental health if they reach employment – it has often been that we have found the right employer and a strong fit of role." – WWIPSPC staff

"Being able to verbalise/vocalise their issues help participants to feel better." – WWIPSPC staff

5.17 There was one example given by an ES of an IW participant with mobility issues who was supported to make adaptations to their working hours, to make their job more accessible. That participant subsequently fell out of employment because their health issues worsened. It is just one example, but there is an important question around how well the IPS model works for those with physical health conditions. This will be considered as more evidence emerges.

5.18 Data is being captured at later stages in the participant journey to help evidence health outcomes. The amount of data available at the end of March 2024 is limited so it will need to be considered in the next Annual Report.

6. Conclusions

Context and early implementation

6.1 The relatively short timeframe for the implementation and delivery of WWIPSPC, and the resulting pressures, has been a key contributor to the challenges encountered in the early stages of delivery. Much of this report has focused on the implications timelines have had for generating referrals, integration with the system health and the broader implementation of the IPS model.

6.2 Key people involved in the implementation and delivery of WWIPSPC reported a steep learning curve. TGC had not delivered an IPS programme before, while Groundwork had but in a different part of the health system. Understanding and experience of working with primary care was limited.

6.3 The pre-launch period involved extensive stakeholder mapping and engagement by GMCA to support delivery of the IPS model in this new space. This work was viewed as valuable, but not sufficient. Indeed efforts to improve engagement are still ongoing in several places and with a range of services, indicating the scale of the challenge.

6.4 These issues and consequences all highlight the importance of having sufficient timeframes for programme design, commissioning and delivery, particularly those intended as 'test and learn' programmes. The report has noted that the short delivery timeframe means by the time the programme reaches a more 'mature' state there will be limited delivery time remaining.

6.5 WWIPSPC was one of multiple new programmes launched within GM during around the same time, alongside Working Well: Pioneer and Working Well: Support to Succeed, which are also recruiting via outreach and building relationship with referral partners. This has meant a significant increase in the level of outward engagement by local employment support programmes, which could create some reluctance from some referral routes to engage in 'another programme' or confusion about which people should be referred to which programme. It also has had an impact on the capacity of key people involved in commissioning and supporting the programmes.

Referrals and starts

6.6 WWIPSPC has recently managed to reach its profiled start numbers following a challenging few initial months. Some of the challenges reflect the usual issues of rolling out and embedding a new programme which are being resolved over time. Others point to some of the tensions arising from implementation of the IPS model in the primary care space and the programme's competing priorities.

6.7 Most significantly, there has been a tension between generating start numbers and fidelity. This tension arises from the challenges of integrating with primary care, the inclusion of other referral

sources and time and resource pressures – in particular the intensive start profiles and difficulties recruiting and onboarding staff. This tension has seen start numbers prioritised at the expense of fidelity.

6.8 More specifically, the prioritisation of starts has meant recruitment has been from a breadth of referral sources and at the expense of deeper integration with the health system. This appears to have had implications for the workload of delivery staff and the support provided to participants. The prioritisation of start numbers is also in tension with the 'test and learn' approach – with performance prioritised over learning what does and does not work. The latter requires a willingness to try things that might fail and patience, and not creating pressure or incentives to sacrifice that approach for performance.

6.9 Integrating with primary care has proved difficult, and variable across areas. It has required a considerable investment of time and resource for mixed success. This has generated extensive learning around what works and what the barriers are. A key challenge comes from the primary care system being diverse and diffuse, with high levels of autonomy. Successes and barriers around integration have been highly dependent on individual localities and partners, with successes and solutions not easily replicated with other areas and partners – even despite success in engaging senior health stakeholders.

6.10 Above all, investing time and resource appears to be most important –to persist in linking with the right people (going beyond strategic leads to front line staff), to develop buy-in and trust, and to work through barriers to co-location and joint meetings so as to better align to fidelity. There are areas where progress is positive and promising, but even in those areas relationships and embeddedness still need time to mature.

6.11 Primary care is in some ways very different to the secondary care system that the IPS model is well aligned to. Certain parts of the primary care system have characteristics that mean they appear to be more promising than others for implementing a high fidelity IPS model, namely Living Well and PCN MDTs.

6.12 Individual areas have so far had varying success and approaches to integrating with different partners in the health system and with non-health partners. Accordingly, individual areas appear likely to achieve different degrees of alignment to fidelity. This may offer a series of natural experiments for the evaluation – with comparisons between the areas providing insights about the key drivers of outcomes.

6.13 The report also posed a series of points to consider going forwards around how to manage excess demand, alternative approaches to generating referrals and how to manage the transition and continuity with a successor programme. Additionally, the parameters on WWIPSPC means some people who could benefit from the support are ineligible. Most notably, people in work for less than six months and those in zero hour contracts. These may warrant consideration in designing and commissioning future provision, or as targets for other provision.

Participant needs and support

6.14 The people who have joined the programme most commonly have some level of mental health issue, with a majority reporting it as moderate or worse. To an extent this reflects the referral routes that have been targeted. The IPS model is proven for people with SMI and therefore is likely to be well-suited to supporting this group. The beneficial impact of appropriate employment on mental health and wellbeing means that the employment-focused support that IPS provides can lead to positive health outcomes.

6.15 There has, however, been a lower prevalence of participants with physical health conditions, for whom evidence of the IPS model is limited. Going forwards it would be beneficial to WWIPSPC as a test and learn programme if more participants with physical health conditions could be recruited. This would provide insights into whether the IPS model is also effective for these groups, and what the link is between securing appropriate employment and outcomes for physical health and wellbeing. Efforts are ongoing to link with referral routes, such as musculoskeletal services, that would refer participants with physical health issues.

6.16 While participants face health challenges, in many ways those on WWIPSPC appear reasonably well placed to find employment: amongst the OOW cohort many are short-term unemployed; relatively few participants are qualified to a low level and many are education to degree level or higher; almost all believe they can find work and very few express very low confidence in starting work; and all voluntarily signed up or even self-referred to a programme focused on finding employment rapidly indicating a level of motivation. This suggests the programme should perform well on outcomes compared to other Working Well programmes that have targeted people further from the labour market.

6.17 Comparing the OOW and IW cohorts, they have common needs around health and confidence, but there are differences apparent that reflect their employment status: OOW are more likely to report barriers associated with accessing and securing work (experience, skills, transport and wider barriers); and those IW are more likely to report issues that could affect sustainment of employment (health issues and issues with family life).

6.18 Support for the IW cohort was viewed positively amongst referral partners as a distinctive offer in line with a preventative rather than reactive approach. That said, amongst the IW cohort there has been a higher prevalence of people seeking to move job than anticipated. This has implications for the level of support this group is requiring compared to expectations, possibly with further implications for assumptions around unit costs and workload. Against that, there is also a group of the IW cohort who appear to move to an outcome very quickly.

6.19 The intensive and personalised nature of the IPS model was well regarded. It appears to be appropriate for almost all who have joined. Participants with more severe mental health issues, high levels of need related to neurodiversity and displaying challenging behaviour were identified as more challenging, but there is considerable flex within the IPS model to accommodate this.

Where there were shortcomings this has tended to be due to issues with the adequacy or understanding of health support being provided in parallel.

6.20 The IPS model is premised on integration with the health system so that participants are receiving health support in parallel as needed. The ES can play a role in this by liaising with health services. Yet health integration is weak in many instances so far. This partly reflects the time to develop relationships and embeddedness, but also the various practical barriers to integration identified around referrals. Going forwards the evaluation will consider how important levels of integration with the health system are to progressing participants once they are on the programme. The report highlighted suggestions made by some of augmenting the IPS model with additional health support, as an alternative if close integration with health services proves too difficult or to address shortcomings in the wider landscape. However, in doing do there would be a clear move away from our understanding of the core of the IPS model.

6.21 The report highlighted concerns about ES workloads, and that WWIPSPC was seen to differ from traditional IPS programmes in how the amount of work required. Factors contributing to this include caseload sizes, the approach taken to generating referrals, participant support needs, difficulties with engaging employers and administration and contractual requirements. In the early phase of delivery, the prioritisation of certain aspects of the ESs role, particularly generating starts, appears to have entailed trade-offs with the delivery of support and employer engagement.

6.22 Over time, some of these pressures may ease – although the programme's short lifespan means by the time the programme has matured there will be limited delivery time left. It is also possible that some pressures will not abate. Some might simply reflect the focus and design of WWIPSPC, and in particular the focus on primary care. There may also be observable differences between areas based on the approaches taken.

6.23 A concern is that at the time of the fieldwork over half of the programme's profiled participants had joined the programme. The IPS model is intended to be intensive, and based on rapport and understanding between the ES and participants, with the first month of the participant's time on the programme therefore particularly important. Given this, there is a risk that programme performance will suffer as a result of the extent to which generating starts was prioritised throughout that time.

Outcomes

6.24 The evidence around outcomes is limited for this report due to the time needed for outcomes to emerge, particularly on the sustainment of job starts and on health outcomes. The insights at this stage are therefore based on early observations around job starts, and subject to change as more outcomes emerge which could change the trends observed to date.

6.25 The job start rate for the IW cohort is very high and being achieved quickly. This is perhaps unsurprising, given the low threshold for a job start and that the IW cohort were already in employment. There are also OOW participants on the programme whose support needs may be relatively low given in many ways they appear employable, as considered earlier in the

conclusions. There may be a case for quick, reactive, simple support for these groups, but this does raise questions around additionality and value for money. The lack of a counterfactual will limit assessment of the level of impact support from WWIPSPC is having on these groups.

6.26 Job starts for the OOW cohort are quite limited to date so it is challenging to assess performance, and monitoring this should be a priority over the coming months given concerns about the trade-offs between generating starts and support. Amongst the job starts recorded so far for the OOW cohort there is quite a high prevalence of non-permanent employment. This may reflect a timing issue, with non-permanent jobs being secured more quickly. Otherwise, there is a good prevalence of jobs paying the Real Living Wage and a diversity of jobs and employers.

6.27 It has been challenging to gauge the strength of outcome performance due to data on the other pilot areas not being made available to GMCA by DWP. This has meant GMCA cannot benchmark their performance, and limits scope for generating learning in line with the 'test and learn' ethos.

Reflections on application of the IPS model

6.28 This report has considered the learning generated around implementing the IPS model. There is good buy-in the value of the fidelity model amongst delivery staff, but also widespread concern about the viability of implementing it within the primary care space. We have suggested that many of the challenges in implementing a high fidelity model have arisen due to a series of tensions between fidelity and other things – namely start profiles and the programme timeline – which have seen fidelity de-prioritised in places. It also appears to be the case that different parts of the health landscape are more able to accommodate a high fidelity model. To date, this has included Living Well and PCN MDTs, although more may be identified as delivery progresses. Some of the difficulties in implementing the model reflect the programme testing the model with parts of the landscape less suited to an IPS model.

6.29 We have suggested the different approaches taken between areas and partners provide natural experiments around implementation of the IPS model. Comparing areas that achieve greater success with fidelity around integration with the health service against those with lower fidelity will provide evidence on the relationship between fidelity, support, workloads and performance. Achieving high fidelity looks likely to still require some time though, even where positive progress has been made. This is in line with the expectations of IPS Grow that a high fidelity service takes time to establish. As a result, high fidelity delivery may only be in place for a limited window – the implication being that the short timeframe for WWIPSPC delivery may limit the learning that can be generated from these natural experiments.

6.30 Finally, fidelity reviews for each of the two providers are scheduled for November and December 2024. It is understood that these will be very narrow on their focus, covering just two ES and a manager in one locality. Given the variation in set-up across GM the findings on certain fidelity measures (particularly integration with health services) the findings are unlikely to be representative of the entire programme. That said, they should provide useful insight into levels

of fidelity in those areas and provide steer around how to improve aspects of fidelity that are less area-specific.

Annex A: Additional data tables

Table A-1: Benefits being claimed at the start of the programme by cohort (N=436)

	All	IW	OOW	All %
Universal Credit	232	41	191	53%
Universal Credit - Limited Capacity for Work	29	8	21	7%
ESA Support Group	19	2	17	4%
Job Seekers Allowance	13	0	13	3%
Universal Credit - Limited Capacity for Work or Work Related Activity	8	1	7	2%
ESA Other Incapacity Benefit	8	0	8	2%
ESA Work Related Activity Group	3	1	2	1%
Incapacity Benefit and Income Support	3	1	2	1%
Income Support	5	1	4	1%

Source: WWIPSPC monitoring data

Table A-2: Time since participant last engaged in education or training (N=436)

	All	IW	OOW	All %
Less Than 1 Month	38	8	30	9%
1-6 Month	25	6	19	6%
7 - 12 Months	19	4	15	4%
1-3 Years	72	27	45	17%
Over 3 Years	280	82	198	64%
Unknown	2	1	1	0%

Source: WWIPSPC monitoring data

Table A-3: Starts profile by other characteristics (N=436)

	All	IW	OOW	All %
Living in a jobless household	164	6	158	38%
Experienced domestic violence	91	32	59	21%
Primary caregiver to dependent children	84	28	56	19%

	All	IW	OOW	All %
Lives in a single adult household with dependent children	39	10	29	9%
At risk of homelessness	32	4	28	7%
Been in care	32	10	22	7%
Criminal conviction	25	6	19	6%

Source: WWIPSPC monitoring data

Table A-4: Housing status (N=436)

Housing situation	All	IW	OOW	All %
Living with friends/ relatives	140	31	109	32%
Privately renting	106	34	72	24%
Own with mortgage	56	30	26	13%
Social renting - housing association	52	12	40	12%
Social renting - local authority	48	9	39	11%
Own outright	31	11	20	7%
No fixed abode	3	1	2	1%

Source: WWIPSPC monitoring data

Table A-5: Living situation (N=436)

Housing situation	All	IW	OOW	All %
Living on own	129	33	96	30%
Living with family	110	34	76	25%
Living with parents	91	17	74	21%
Living with partner	78	35	43	18%
Living with friends	15	5	10	3%
Other	11	3	8	3%
Unknown	2	1	1	0%

Source: WWIPSPC monitoring data

SQW

Contact

For more information:

Graham Thom
Director, SQW
T: 0131 243 0736
E: gthom@sqw.co.uk

2nd Floor
14 - 15 Mandela Street
London
NW1 0DU

www.sqw.co.uk