LEARNING AND WORK INSTITUTE

# Working Capital

## Third Evaluation Report
## January 2019

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**Learning and Work Institute**
Patron: HRH The Princess Royal | Chief Executive: Stephen Evans
A company limited by guarantee, registered in England and Wales
Registration No. 2603322 Registered Charity No. 1002775
Registered office: 4th floor, Arnhem House, 31 Waterloo Way, Leicester LE1 6LP

Published by National Learning and Work Institute

4th Floor Arnhem House, 31 Waterloo Way, Leicester LE1 6LP

Company registration no. 2603322 | Charity registration no. 1002775

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# Contents





# Executive Summary

## The Working Capital programme

Working Capital is an innovative, pilot programme of integrated employment and health support for people with disabilities and/or health conditions who have been out of work for more than two years. It was designed by Central London Forward (CLF), working with eight central London local authorities, the Mayor of London and central government. It is funded by the European Social Fund (ESF).[1] The programme is being delivered under contract by Advanced Personnel Management UK (APM), following a competitive tendering process. The programme began delivery in 2015. It is currently in its fourth year of running. Job starts and sustainment rates will continue to be measured until 2020.

The pilot programme has been designed to support Employment and Support Allowance (ESA) claimants in the 'Work Related Activity Group' (WRAG) who had been through the government's Work Programme without securing sustained employment; and to test the effectiveness of providing more intensive and specialised support for this group.

This third evaluation report compares experiences of delivery of Working Capital between summer 2017 and summer 2018, considering good practice and challenges encountered. It builds on our previous reports to explore, in greater detail, outcomes achieved on the programme as well as providing an update on the Randomised Control Trial. The report data draws on interviews with Working Capital participants and frontline delivery staff, findings from the observations of support sessions in Jobcentre Plus and data analysis of administrative data obtained from both the Working Capital provider and Department for Work and Pensions (DWP).

# Findings

### Programme participant needs

Throughout the evaluation it has been evident that programme participants have a range of complex needs that often interact, and which create significant barriers to them entering and sustaining work. Health issues were perceived as the most significant barrier to entering work amongst participants interviewed. However, several other issues revolving around life circumstances were also identified as barriers. These included participant age, a lack of basic skills, and having qualifications and experience obtained abroad which were not recognised in the UK. Many Working Capital participants are in low income households, and often reported housing problems, whilst financial issues and debt caused some participants considerable concern. Caseworkers and local authority leads also highlighted the prevalence of social isolation, which was felt to impact participants' resilience to cope with setbacks.

[1] Priority Axis 1: Inclusive Labour Markets under Investment Priority 1.4

### Participation rates

The actual number of referrals made up to June 2018 was 60 per cent lower than had been expected, despite action being taken to increase volumes. The number of ESA WRAG claimants who had completed the Work Programme without a job on completion, and who were therefore eligible for Working Capital fell significantly after December 2015. Reasons for this included the increase in employment outcomes for Work Programme participants, and because of a Work Capability Assessment (WCA) reassessments. Only around a fifth of reassessments in the Working Capital boroughs resulted in individuals staying in or moving to the ESA WRAG group, from which eligible participants were identified. Staff turnover and the introduction of the Work and Health Programme (known as Central London Works in Working Capital boroughs) was also felt to negatively impact referral rates.

However, there have been improvements to the rate of effective referrals as well as the attachment rate. For example, 89.1 per cent of referrals attended an initial meeting, and of those individuals, 78.2 per cent accepted the support offer. This represents 65.2 per cent of all Jobcentre Plus (JCP) referrals.

### Participant journey

The randomisation process continued to be unobtrusive, and the process of organising initial appointments seemed to have become more efficient due to experience and the relationship between APM staff and JCP work coaches. Although many participants remained unaware of why they were referred to Working Capital, it was more common that they could recall being told details about the programme at the point of referral. Nonetheless more information was desired, for example on the format of the support.

There was consensus that the voluntary support helped to distinguish Working Capital from other programmes, however some individuals remained convinced that their participation was mandatory. The nature of the referral, views of JCP and previous experience of DWP mandated employment support programmes contributed to this perception.

Views and experiences of the first meeting were largely positive, participants had good initial impressions of the APM caseworkers and thereafter felt more relaxed about participation. An action plan was used to decide ongoing support, which was tailored according to individual needs and circumstances. Respondents reported receiving support (from APM caseworkers and externally, following a referral) to increase their employability skills, identify relevant employment and skills opportunities and address their health and wellbeing barriers. Fewer respondents than in previous waves of research had attended sessions with a health and wellbeing adviser (potentially reflecting the APM restructure). Nonetheless, where they had done so, they gave positive feedback. Some who chose not to take up this support offer were reluctant to discuss personal health issues with someone other than their GP, whilst others believed that their health needs were already being adequately addressed.

Participants also received in-work support. Those who had received this, liked that there was someone available to support them where required, this included with financial advice, health and wellbeing advice and guidance on how to address issues in the workplace. Some individuals were being supported to find more suitable and/or better paid or additional roles.

### The APM restructure

Since the last wave of research, APM have undergone a restructure. This reduced the number of staff working on the programme and resulted in caseworkers being responsible for employer engagement. Linked to this there were concerns about health and wellbeing advisers' capacity to adequately support participants, as the remaining two health professionals were spending a lot of time travelling and were less able to work intensively with participants.

### Outcomes

The significantly lower than estimated participation rates are having knock on effects on the outcomes the programme can achieve. As of April 2018, 11 per cent of programme participants were verified as entering work. Further cohort-based analysis suggests that verified job outcomes can break 14 per cent, which is within the parameters of the 3-5 per cent stretch the programme aims to achieve. Interestingly, many of the participants we interviewed that had entered work since being on Working Capital were now seeking additional hours or better paid roles. There were also examples of individuals who had left the job that they found through Working Capital either because they had found it too stressful or different to what they expected.

Other outcomes reported included improvements to individual health and wellbeing, feeling more confident and/or motivated, gaining employability skills or qualifications and addressing their training needs. Factors which were seen to enable outcomes included the sequenced nature of the support, whereby immediate concerns were addressed first, and the relationship that participants were able to develop with their caseworker. Gaps in support sessions and changing caseworker (sometimes multiple times) were perceived as shortcomings of Working Capital for those participants affected.

### Service integration

A key aim of Working Capital has been to deliver better participant outcomes through service integration. Local authority involvement in the delivery of Working Capital was felt to benefit participants as they had access to a wider range of support options as a result. The research identified examples of local authorities becoming more aware of residents' support needs because they had been identified through

Working Capital, and of local authorities supporting participants to address barriers and make progress towards their ambitions.

Factors that were felt to enable local service integration included Working Capital delivery being co-located with other local services and APM staff involvement in local forums and networks. However, staff changes proved to be a barrier in maintaining good working relationships, and low referrals made it difficult to keep momentum up about the programme in some boroughs. Furthermore, the inability to track action plans over time to better understand participant's journeys was felt to be a shortcoming which prevented greater integration between local authorities and Working Capital.

## Conclusions and recommendations

The programme is trying to engage and support a high need, diverse group whose needs vary over time. A strength of Working Capital is that it has offered a personalised delivery model whereby support can be adapted to address individual needs.

Having significantly lower referrals than anticipated has impacted every part of the programme, including maintaining programme momentum, encouraging service integration and the outcome rates. APM have also had to restructure the core delivery team, and staffing changes have had a negative impact on those individuals whose caseworker changed during the support.

Nonetheless, the programme has been able to deliver a broad range of employment, skills and health and wellbeing outcomes, and learning about integrating health and employment support informed the implementation of Central London Works.

To address issues raised in the research and ensure referrals and outcomes are achieved, we recommend that:

- Following provider staff turnover, efforts should be made to re-establish relationships with Jobcentre Plus, local authority partners and other local partners.
- Greater efforts should be made to advertise Working Capital in Jobcentre Plus to support the referral process.
- Efforts should be made to highlight the unique elements of Working Capital so that the value of the programme is recognised, and appropriate claimants are still referred, regardless of the introduction of Central London Works.
- APM should continue to monitor job quality and suitability to ensure that outcomes are sustained.
- APM should continue to celebrate success and promote case studies which demonstrate how people have been supported on the programme.
- There should be a continuation of the tailored approach to supporting participants to overcome barriers and enter and sustain work.



In terms of the randomisation control trial (RCT) we have raised concerns around data sharing, the introduction of Central London Works and DWP's impact analysis. It is envisaged that robust approaches are taken regarding the RCT (and quasi-experimental methods more generally) to ensure that impact assessments can deliver credible results.

We have also made recommendations regarding future programme development. This includes that:

- Commissioners for future local programmes should set out not just a central projection for the volumes of referrals and attachments, but also and upper and lower bound estimates.
- Consideration should be given to the use of a more sophisticated payment model incorporating both Payment by Results (PBR), to deliver programme outcomes and a service level payment to deliver activities.
- The payment model should reflect the aims of the programme. With PBR models, what ends up being tested is what is commercially viable and not what was intended from the outset.
- Data collection processes should be considered during the programme design stage to ensure that delivery and evaluation activity can be effectively supported, and that progress and outcomes can be monitored.
- There needs to be a robust IT system to store participant data which is understood amongst staff so that data is collected appropriately and consistently.

# 1. Introduction

Working Capital is an innovative, pilot programme of integrated employment and health support for people with disabilities and/or health conditions who have been out of work for more than two years. It was designed by Central London Forward (CLF), working with eight central London local authorities[2], the Mayor of London and central government.[3] It is funded by the European Social Fund (ESF)[4] and was part of the London Growth Deal. The programme is being delivered under contract by Advanced Personnel Management UK (APM), following a competitive tendering process. The programme began delivery in 2015. It is currently in its fourth year of running. Job starts, and sustainment rates will continue to be measured until 2020.

The pilot programme has been designed to support Employment and Support Allowance (ESA) claimants in the 'Work Related Activity Group' (WRAG) who had been through the government's Work Programme without securing sustained employment; and to test the effectiveness of providing more intensive and specialised support for this group. The success of ESA claimants on the Work Programme was particularly low, and the design of Working Capital builds on the evidence around the benefits of integrated and intensive support.

The programme is being delivered during a time of significant change; in the approach to and funding of active labour market programmes from central government, and in the benefits system. For example, the Work and Health Programme (known as Central London Works in the Working Capital boroughs) has been refocused to target specific high need groups, with 75 per cent less funding than its predecessor programme. This shift will increase the onus on Jobcentre Plus and local employment programmes to support claimants effectively. Further, the introduction of Universal Credit is overhauling the way in which work related benefits are administered and managed, and in doing so this has created new procedural pressures. It has also smoothed the transition between in and out of work benefits receipt and introduced in-work conditionality for some, changing the nature of the relationship between a claimant and Jobcentre Plus.

The programme is being run as a 'Randomised Controlled Trial' (RCT), meaning that eligible participants are referred randomly into either a 'treatment' or 'control' group, with the difference in outcomes between these groups being used to measure the impact of the intervention. Those in the treatment group are referred for a mandatory initial appointment where the support offer is explained, and participants are encouraged to take part. After the initial meeting, further participation in the programme is voluntary. Those that do not take part are referred back to Jobcentre Plus for support.

[2] City of London, Camden, Islington, Kensington and Chelsea, Lambeth, Southwark, Wandsworth and Westminster
[3] Department for Work and Pensions (DWP), HM Treasury and the Cabinet Office
[4] Priority Axis 1: Inclusive Labour Markets under Investment Priority 1.4





The funding for Working Capital is significantly higher per participant than has been the case in comparable recent programmes.[5] This has allowed for much smaller caseloads (25 per adviser), and greater funding of additional, specialist provision where existing support is not available.

Learning and Work Institute (L&W) has been commissioned to evaluate the trial, comprising assessments both of its impact and how it has been implemented. More detail about the progress of the RCT can be found in Annex B of the report.

The first report published as part of this evaluation reviewed the commissioning and procurement strategy, and early implementation of the programme.[6] The second built on this to explore the delivery of Working Capital and provide an update as to the implementation of the RCT.[7]

This report compares experiences of delivery of Working Capital between summer 2017 and summer 2018, considering good practice and challenges encountered. It also explores, in greater detail, outcomes achieved on the programme as well as providing an update on the RCT. (This is presented in two technical annexes. Annex A covers the implementation of the RCT and Annex B outlines the balance between the two arms of the RCT).

[5] £2,650, compared with estimated funding for ESA claimants within the Work Programme of just £675 per participant. This is based on a figure of £630 from the 2014 NAO report on the Work Programme uprated to allow for inflation (using the GDP deflator) between 2014/15 and 2018/19.
[6] Patel et al. (October 2016), *Working Capital Evaluation Report 2016*, Learning and Work Institute http://centrallondonforward.gov.uk/wp-content/uploads/2018/01/LWI-Working-Capital-Year-1.pdf
[7] Bennett et al. (November 2017), *Working Capital Second Evaluation Report 2017*, Learning and Work Institute http://centrallondonforward.gov.uk/wp-content/uploads/2018/11/Working-Capital-Evaluation-Report-2017.pdf

# 2. Methodology

This evaluation uses a mixed method, multiphase evaluation design, to address the following research questions:

1. How effective has the commissioning process for the Working Capital intervention been?
2. Has the process of delivering the Working Capital intervention achieved its intended objectives, including greater local service integration and providing specialist support for very disadvantaged groups?
3. Have the Randomised Control Trial (RCT) arrangements been set up and executed in a robust way?
4. How well has Working Capital performed in delivering employment-related outcomes?
5. How well has Working Capital performed in achieving non-employment related outcomes?
6. What is the cost/benefit case for the Working Capital intervention?

Table 2.1 below demonstrates how the research elements combine to address the research questions.

**Table 2.1: Evaluation framework**

| Research element | Research question | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| Desk research and literature review | ● | | | | | |
| Scoping interviews | ● | | | | | |
| Longitudinal participant research and user focus groups | | ● | | ● | ● | |
| Frontline staff interviews | | ● | | ● | ● | |
| Local authority interviews | | ● | | ● | ● | |
| Observation of randomisation and post-hoc assessment of randomisation process | | | ● | | | |
| Analysis of provider MI, DWP and HMT data | | | ● | ● | | ● |
| Cohort Survey (control and treatment group) | | ● | | ● | | ● |





Interviews with participants, frontline staff and local authority staff helped to address research question 2, in relation to the delivery of Working Capital and the extent to which it has achieved local service integration, as well as employment and non-employment related outcomes (research questions 4 and 5). Qualitative findings on outcomes were then compared with Management Information (MI), to explore in greater detail the profile of participants and their progress on the programme. To learn more about the set up and implementation of the RCT, we conducted observations of meetings with claimants who were likely to be eligible for the trial.

Though originally anticipated, the cohort survey (highlighted in red in Table 1) is unlikely to proceed due to ongoing data sharing and privacy issues, prohibiting the sharing and use of contact details for Working Capital trial participants. Alternative methods are subject to ongoing discussion between CLF, DWP and the evaluators.

## Participant interviews

Ten follow-up (longitudinal) interviews were carried out with programme participants that had been interviewed approximately twelve months prior to the most recent wave of research being completed, to find out whether they had made progress on Working Capital and to explore the reasons why.

A further sixteen standalone (non-longitudinal) interviews were conducted with individuals who had joined the programme since the last round of research (completed in spring 2017). These interviews provided additional data on participants views and experiences of Working Capital, focussing particularly on early interaction and service delivery, to aid our assessment of the effectiveness of the delivery model.

Participants were drawn from across all the boroughs involved in Working Capital, and with varying lengths of unemployment, including people who had entered employment recently and those who had not been in work for over five years.

The age of participants interviewed ranged from 31-64 and there were of a range of ethnicities, reflecting the diversity of London. Many had varied work histories, but most were currently claiming Employment Support Allowance (ESA). Other benefits claimed by interviewees included Personal Independence Payments (PIP), Tax Credits and Housing Benefit (HB). Further, some participants have made the transition to Universal Credit after finding employment/ becoming self-employed.

Interviews were conducted using a semi-structured topic guide. This had a list of questions and probes, which could be used flexibly based on the respondent and their experiences. This gave the discussions focus whilst enabling researchers to explore areas in more detail where possible.

## APM staff interviews

Overall, seven members of the APM team involved in the delivery of Working Capital were interviewed. This included caseworkers, health and wellbeing advisers and an

administration lead. As with the participant research, staff interviewed for this evaluation covered all the boroughs involved in the programme.

These interviews were conducted to gain an insight into the delivery of the programme; specifically, the key enablers and barriers to outcomes being achieved. They also explored service integration, and provided insight into the implementation of the RCT. Again, a semi-structured topic-guide was used.

### Local authority interviews

Staff leading on or contributing to the Working Capital programme at six of the eight local authorities involved were interviewed. The interviews reflected on programme delivery over the past year, from the local authority perspective; specifically, what was working well and where challenges had been encountered. Lessons learnt from involvement were also discussed, considering that the DWP Central London Works programme has now begun delivery in London.

### Support observations

In line with the process evaluation tied to the RCT, four observations were conducted across participating Jobcentre Plus offices. Following the observation, where possible, we took the opportunity to speak to work coaches about their views of the Working Capital programme and their experiences of the randomisation and referral process.

### Data analysis

Quantitative data was obtained from APM, the Working Capital contracted provider and from DWP.

The data from APM related to the referrals and people attached to the programme. Individual level data was provided regarding 1,206 referrals and 1,076 individuals with whom initial meetings were conducted. Variables included in this dataset were agreed by CLF and satisfy ESF management information reporting requirements.

DWP provided aggregated profile information about the participants involved in this trial, split by those in the treatment group (e.g. the group of people referred onto the Working Capital programme to receive the 'intervention') and the control group (e.g. those who would otherwise be eligible for Working Capital support, but are not referred to the programme who would receive 'business as usual support' via Jobcentre Plus).



# 3. Working Capital Participants

### Programme Eligibility

As outlined in previous evaluation reports, the Working Capital programme is aimed at people falling into the ESA WRAG claimant group living within the eight CLF central London boroughs, who have completed the Work Programme without going into sustained employment. Being in the ESA WRAG group means that the claimant has completed a Work Capability Assessment and are considered able to undertake activity to prepare for work.

Around the time of the Working Capital programme becoming operational (2014-15), L&W estimated that on average each month around 250 people in the ESA WRAG group in Central London were completing the Work Programme and were not in work, and so were eligible for Working Capital. A year later this figure had fallen markedly to around 80, and in late 2018 we estimate this figure is around 70 per month.[8]

Initially, programme eligibility was limited to those who completed the Work Programme and returned to Jobcentre Plus for the first time (flow claimants), and our estimated numbers above refer to such cases. However, due to lower than anticipated footfall, eligibility was extended to include central London ESA WRAG claimants who had also completed the Work Programme without entering into sustained employment but had already re-established their relationship with Jobcentre Plus (stock claimants). The use of stock claimants provided a welcome boost in Working Capital referrals for a time, though the use of stock claimants has now ceased to top-up referral numbers, which are again solely dependent on rates of flow.

### Programme Participant needs

Throughout the evaluation it has been evident that programme participants have a range of complex needs that often interact, and which create significant barriers to them entering and sustaining work.

*'I lack confidence in myself... I don't think I can do certain things…being a single parent where I didn't have childcare, I found it really hard to like, go out and try and find a job because who would look after the children...My back wasn't helping me neither.'* (Female, 39)

Confirming findings from previous years, analysis confirmed that more than four out of every five participants (83.2 per cent) who had attached to the programme had not worked for at least four or more years. Given the nature of the eligibility criteria (focussing on Work Programmes completers, which in itself requires two-years to complete) this level of prolonged work absence is to be expected. However, many

[8] L&W estimates based on Work Programme data

had been out of work for significantly longer - just under a quarter (24.3 per cent) reported that they had not worked for 20 or more years, if at all. Understandably, the thought of returning to the labour market was daunting for many participants as the nature of employment had changed so much since their last job.

*'I kind of don't know where to even start because the world has changed so much since I last worked... It's quite difficult to know where to look or what to do.'* (Female, 60)

Participants recalled previous work experience across a range of sectors including retail, customer services and the care industry. Some had held professional roles within the civil service and health sector, whilst others had undertaken physical roles such as bricklaying– which were no longer possible due to health reasons. Reasons for leaving work or being dismissed given by participants included health issues, substance dependency and caring responsibilities.

## Presenting health issues

Health issues were perceived as the most significant barrier to entering work amongst participants interviewed. Possibly indicating the complexity of the health issues Working Capital participants experience, more than half (61.3 per cent) of all referred to Working Capital reported comorbidity, though this falls notably shorter than the 74.7 per cent previously reported.[9] It is unclear why this drop has occurred, as perceptions around client health needs have remained relatively consistent.

Programme participants presented a range of health conditions, including (but not limited to):

- mental and behavioural disorders
- diseases of the Musculoskeletal system and Connective Tissue
- chronic neurological conditions
- drug and alcohol dependency (which had appeared to become more common over the past year of delivery)
- arthritis
- cancer

For some, the prospect of work seemed distant due to their physical health issues. Participants recalled struggling with limited mobility, constant or regular pain and/ or having a fluctuating condition, which made their ability to enter stable employment a challenge.

*'I can't tell you from one day to the next how I'm going to be, so some days I can't even get up so I can't exactly go and say, "Hey, I'm going to work today," if I can't move…So, that's the biggest problem...I can't guarantee that I can turn up for work five days a week, continuously.'* (Female, 37)

Mental health issues such as depression and anxiety were highly prevalent, even where the participant had not received a formal diagnosis or declared this. For some, this had prevented them from working in the past, which made them worry about their ability to compete for a role in the future.

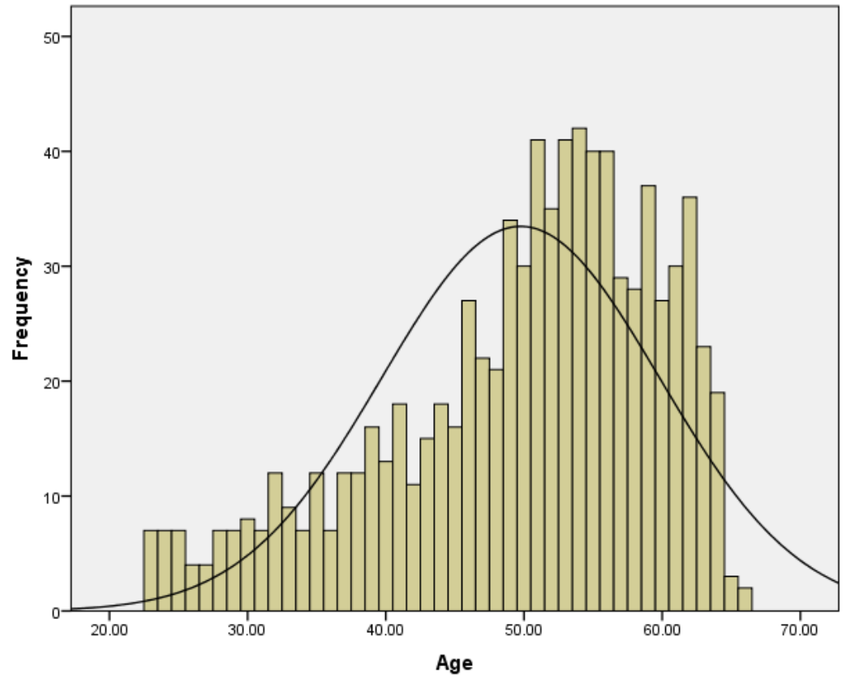
In addition, some longitudinal respondents explained that their health had deteriorated since they last took part in the research. For example, one individual who previously felt that their mental health was under control, explained that they were now suffering from depression again. Another participant, who found work on the programme, had been signed off work for the past month due to a kidney infection. Someone else was now receiving support from daily carers for an undiagnosed issue that was causing dizziness, weight loss and mobility issues.

Several other issues revolving around life circumstances were also identified as barriers to the labour market, these are discussed in more detail below.

## Participant age

The median age for Working Capital participants is 52 (mean=49.6). As can be seen by Figure 3.1, the age distribution of Working Capital participant is skewed towards older claimants.

**Figure 3.1: Age distribution of Working Capital participants**




[9] However, APM caution that the data provided are likely to belie the true extent of participants' health challenges, as data is gathered on the presenting issue at the point of referral and not once the full health and wellbeing assessment is conducted as part of the programme offer.

In earlier waves of research, older participants' low confidence regarding their chances in the labour market was partly related to their age, which they felt made them unattractive to employers. As 13.4 per cent of Working Capital participants were in their 60s and therefore close to the state pension age, they sometimes lacked motivation to move closer and/or into work.

It was interesting to note that age was not discussed as a barrier amongst this cohort in the most recent wave of research, but that longitudinal respondents continued to refer to this as the biggest factor (alongside their health issues) preventing them from finding employment. Such respondents believed that there was a lot of competition for jobs from younger candidates, who employers preferred to hire. Such concerns are reflected in numerous studies which found that ageism is the most commonly experienced form of prejudice and discrimination in the UK.[10]

## Skills, training and qualifications

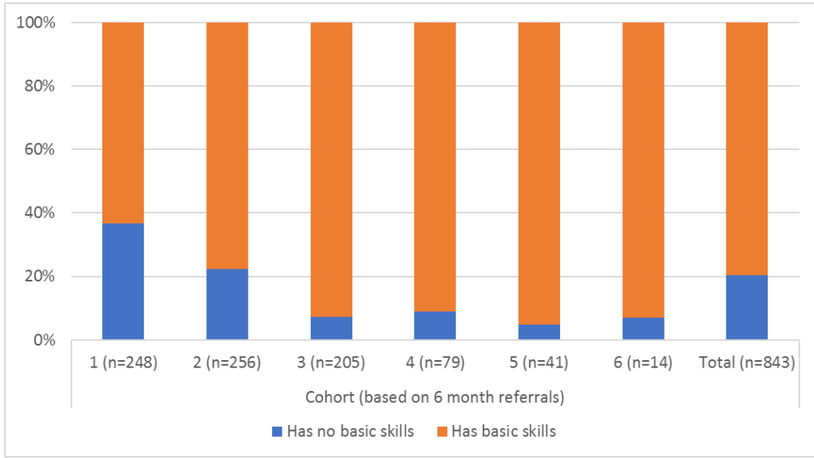
A fifth of Working Capital participants (20.5 per cent) were identified as not having basic skills. However, as can be seen in Figure 3.2, when looking at rates of basic skills by referral cohort (grouped into 6-month groups determined by the date the participant was referred to the programme), there is a marked reduction in the rate of reporting no basic skills over the first three six-month cohorts, with the rate stabilising thereafter. Consequently, it appears the high volume of participants reporting no basic skills within the first two cohorts considerably inflates the group rate when looking across all cohorts. This finding is supported by analysis of highest educational attainment which shows that for the first two six-month cohorts, those reporting only receiving a primary education or lower varied between 60.5 and 68.0 per cent respectively. Those reporting likewise for the following four six-month cohorts, ranged between 17.7 and 38.0 per cent.

[10] See Age Concern, 2005; Ray et al., 2006; Abrams et al., 2009, 2011b; Sweiry and Willitts, 2012; Abrams et al., 2011a





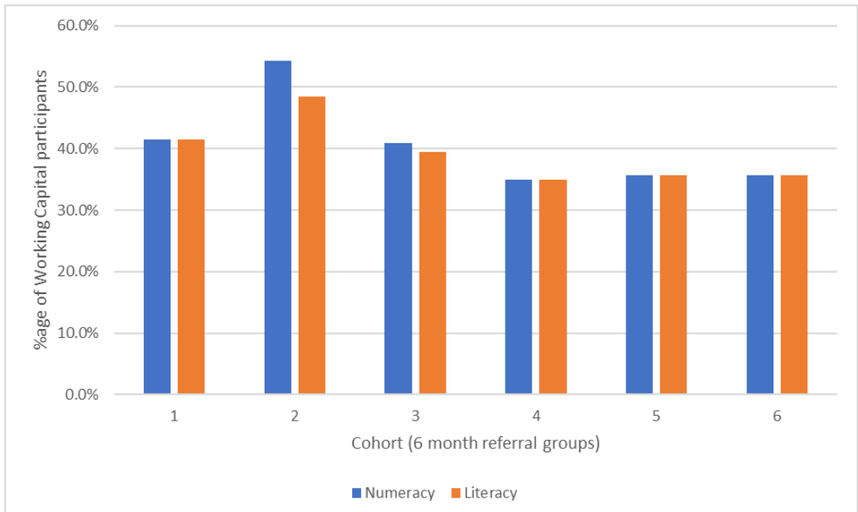
**Figure 3.2: Basic skills by cohort (grouped into 6-month cohorts based on referral date)**




It may be entirely plausible that this is an artefact of reporting. Indeed, when looking at the rates at which participants reported having a lower than Level 1 qualification for numeracy and/or literacy (Figure 3.3), reporting was broadly consistent across cohort groups (though there was a visible spike in the second cohort).

The variation did coincide with the introduction of 'stock' clients and may indicate an interdependency there.

**Figure 3.3: Percentage of participants with lower than Level 1 qualifications in numeracy and/or literacy (grouped into 6-month cohorts based on referral date)**



An emerging theme from the most recent wave of qualitative research concerned participants who had obtained qualifications and work experience abroad, which were not recognised in the UK. Some participants suggested that addressing this skills and qualification need would in part help entry into work. Unfortunately, it is not possible to quantify this as there is no marker for country of birth or ESOL (English for Speakers of Other Languages) need within the management information being used here.

## Housing, financial stability and social isolation

Many Working Capital participants live in low-income households, and interviewees reported housing problems, such as residing in unsuitable or poor-quality housing and/ or being at risk of eviction or homelessness. Analysis of management information suggests that the experience of homelessness affected 4.2 per cent of participants attached to the Working Capital programme – when looked at over time, this rate appears to be increasing. While only 1.2 per cent of those recruited in the first six months of the programme reported experiencing homeless, in the most recent complete six months for which data is available, the rate had increased to 5.0 per cent and 7.6 per cent in the preceding six-month period (a statistically significant increase)[11]. This issue was also reflected in the caseworker interviews, as some APM staff had noticed a rise in people on their caseload experiencing homelessness.

Financial issues and debt were causing some participants considerable concern. For example, one participant was worried about being evicted after their housing benefit had been reduced, which meant that they could no longer afford to pay the rent. Such concerns took precedent and meant that finding work was not a priority.

The prevalence of social isolation was a significant issue identified by caseworkers and local authority leads, and this was felt to impact participants' resilience to cope with setbacks.

*'People who are very isolated really, people who kind of have just come to rely on family, have come to rely on like a fairly narrow circle of friends and they tend not to almost… it's like a cut off life I would say.'* (Local authority lead)

Most local authority staff explained that the characteristics of participants were largely what they would have expected for this cohort. However, in one local authority Working Capital participants were thought to be noticeably older on average and much further away from the labour market than their overall ESA WRAG population, due to their length of unemployment. Likewise, in another local authority it was acknowledged that Working Capital participants in the borough had often been unemployed for over 20 years, and that these were the claimants that they had previously struggled to engage with their local employment provision.

[11] $\chi^2_5$=13.930, p=.016





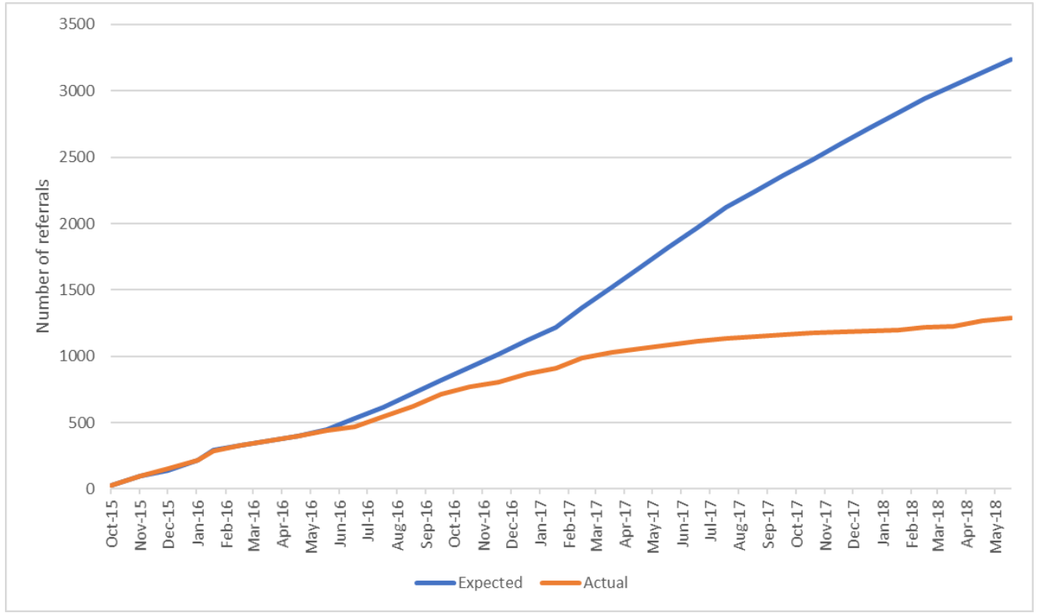
In addition, local authority partners sometimes questioned whether some claimants referred to the programme would be able to work due to their health condition, and therefore potentially in the wrong benefit group. Some APM caseworkers also felt that individuals currently being referred by Jobcentre Plus may not have been referred a year ago, due to the significant barriers that they faced.

*'There's hardly any referrals left now. I think they're also referring people who they probably wouldn't have done in the first place, but now because they're the only ones left, they seem to have more health complex problems now, than the beginning.'* (Caseworker)

# 4. Participation rates

Participation on the Working Capital programme remains significantly lower compared to initial estimates, having knock on effects on the outcomes the programme is able to achieve. As can be seen from Figure 4.1, which cumulatively compares the expected and actual number of referrals made to the programme, the actual number of referrals made up to June 2018 was 60 per cent lower than had been expected, despite action being taken to increase volumes.

**Figure 4.1: Cumulative expected and actual Working Capital referral volumes**




Two principle reasons help to explain the gap between expected and actual referral volumes. Firstly, the increase in employment outcomes for Work Programme participants, including those in receipt of ESA, was not factored into the expected profile of workless Work Programme completers. This reduced the number of individuals eligible for participation in Working Capital. Secondly, and probably most importantly, there was a transfer of ESA WRAG claimants to the ESA Support Group (and less markedly onto Jobseekers Allowance (JSA) i.e. deemed fit for work) during the course of the Work Programme. This was because of a Work Capability Assessment (WCA) reassessments, which made such individuals ineligible for Working Capital. In part this was due to the changing management of the Work Capacity Assessments contract, including the change in contractor from Atos to Maximus.

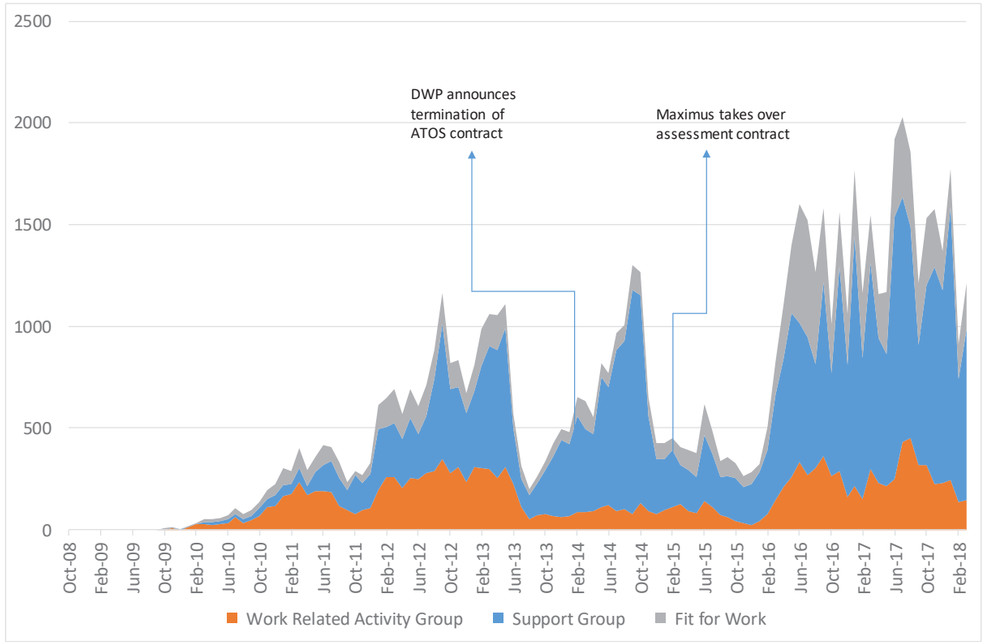
Figure 4.2 below illustrates the scale of the second of these factors. It shows WCA reassessments for the area covered by Working Capital. It includes, but is not limited





to Work Programme participants, according to individuals' 'destination' after reassessment to either the ESA Support Group, ESA WRAG, or Fit for Work (JSA). At any one point in time the proportions ending up in these three groups varied considerably. However, it is evident that for the period that Working Capital was in operation, a significant majority of reassessed individuals ended up outside the ESA WRAG group. Overall for the period October 2015 to March 2018; 60 per cent of reassessments resulted in people being in the Support Group, 18 per cent in the WRAG group, and 22 per cent as Fit for Work. Hence, only around a fifth of reassessments resulted in individuals staying in or moving to the ESA WRAG group, the group from which individuals eligible for participation in Working Capital are drawn.

**Figure 4.2: Work Capacity Reassessments by Destination, Working Capital area**




Based on the most recent Work Programme data, Figure 4.3 below shows actual ESA WRAG Work Programme completers without a job on completion (the blue line) and our estimate for the number of completers based on data for current Work Programme participants. This assumes a 7 per cent rate of 'missing'[12] claimants (average for the entire Work Programme to date), and a 9 per cent job outcome rate (weighted average for the entire Work Programme period) (the orange line). As can

[12] Being 'missing' can be due to a range of factors including, for example, moving out of London, death, emigration and starting full-time study.

be seen, the number of individuals in this group, and therefore eligible for Working Capital fell significantly after December 2015.

**Figure 4.3: ESA WRAG Work Programme completions in Working Capital boroughs without a job on completion, by completion date**

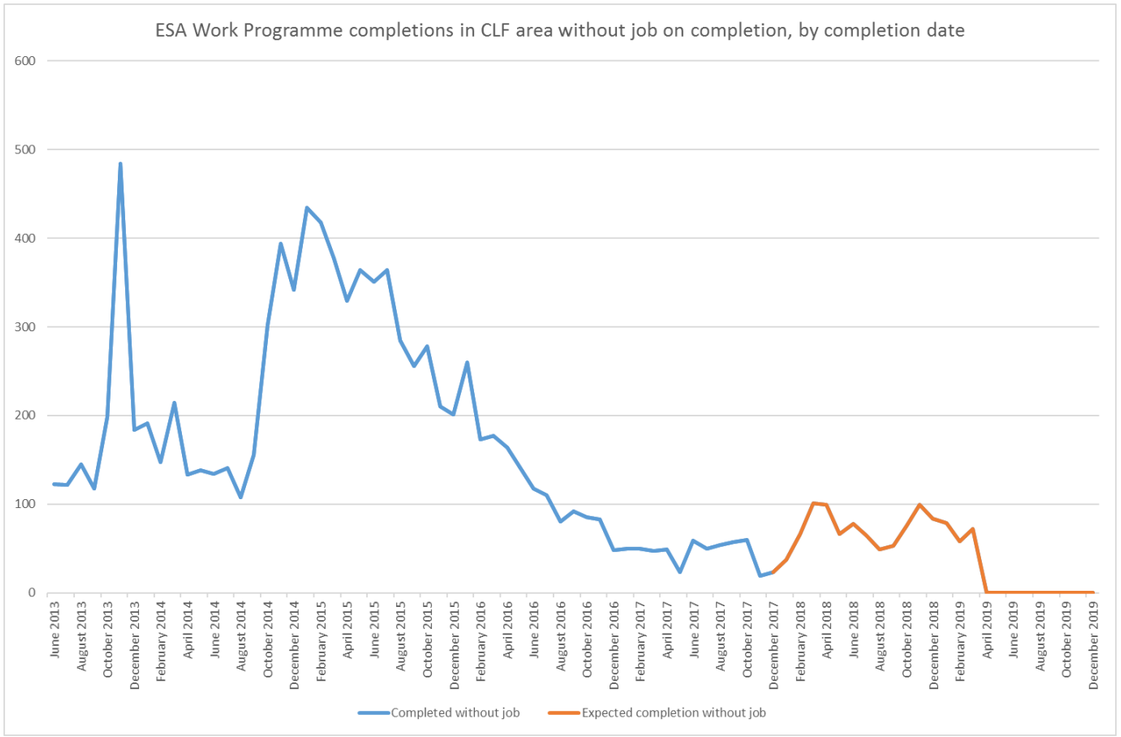



Figure 4.4 below takes the Work Programme completers data presented in Figure 4.3 and uses it to calculate an expected number of Working Capital referrals. This is done by multiplying the Figure 4.3 numbers by 0.67 to replicate the randomisation process and then lagging the data by three months to allow for a transition period from the Work Programme to Working Capital. These estimates are then compared against the actual number of referrals to Working Capital. As can be seen, there is a more reasonable match between this expected number of referrals based on the latest Work Programme data and the actual number of referrals to Working Capital.

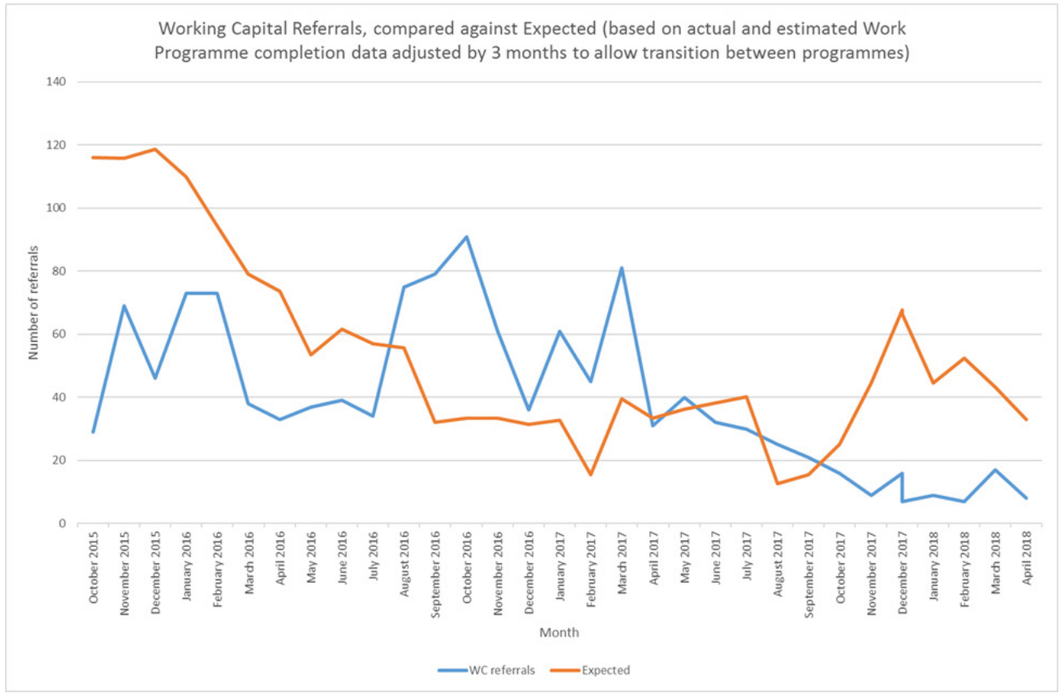
There are a couple of factors to note here:

- The 'orange' line in Figure 4.3 is a projection based on starts data for the Work Programme and so is inherently uncertain.
- The increase shown in actual referrals to Working Capital shown in Figure 4.4 between May 2016 and March 2017 is likely to reflect the 'stock clients' that were bought into the programme.





**Figure 4.4: Working Capital referrals compared against expected referrals (based on actual and estimated Work Programme completion data[13]**



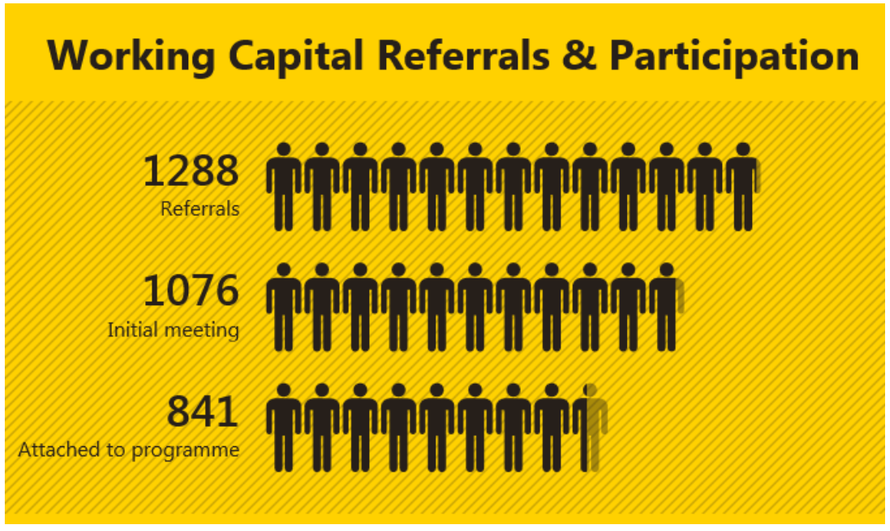

Between the Working Capital programme going live and June 2018, the programme has received 1,288 referrals from Jobcentre Plus. Of these, 1,076 people referred to the programme had an initial meeting, providing an effective referral rate of 89.1 per cent (an increase on the previous year's rate of 86.2 per cent). This transfer rate is likely to be slightly lower than the actual rate as the figure presented does not account for those who had been recently referred but had not had their initial meeting with the Working Capital caseworker. As such it may be marginally better than the 10 per cent 'drop-out' rate originally anticipated.

Of the 1,076 individuals who were referred to the Working Capital programme and had attended an initial meeting, 841 had accepted the Working Capital offer, and had, or were in the process of attending a full assessment, providing an attachment rate of 78.2 per cent, or 65.2 per cent when viewed in relation to the total number of referrals made by Jobcentre Plus.

This is marked improvement when compared to the rate reported in the previous evaluation report, which reported the attachment rate at 65.4 per cent and 56.4 respectively.

[13] Adjusted by three months to allow for transition between programmes

**Figure 4.5: Referral and programme participation volumes (to June 2018)**




Looking at attachment by borough over time, attachments have decreased across the geography of the programme. While some caution should be observed with regards to the two most recent cohort groups (those who joined between April 2017 to September 2017 and October 2017 to March 2018) due to lags in attaching to the programme, the overall trend is clearly downward.

Unfortunately, as it has not been possible to obtain detailed socio-demographic data about those referred to the Working Capital programme, it has not been possible to fully explore the characteristics and circumstances of those who did and did not attend the initial meeting after being referred. This would have been a useful exercise as it may have enabled the identification of individuals least receptive to receiving employment support.



# 5. Participant journey

The participant journey through the Working Capital has been illustrated in previous reports, and recent experiences of this are discussed below.

## Referrals

Individuals are referred to the programme during an appointment with a Jobcentre Plus (JCP) work coach. The process of randomisation continued to not appear to make an impression on participants, with no one recalling the event in the most recent wave of research.

If someone is assigned to the treatment group, their work coach then contacts the APM central booking team to arrange an initial appointment by telephone in the presence of the participant.[14] Our most recent observations of referrals found this process to be relatively short, and so not too much of a burden on the participant. Furthermore, as the work coaches now have a rapport with the APM staff they speak to, these phone calls were often of a friendly nature.

Most participants continued to be unaware of why they were referred to the programme. However, in the latest wave of research, there was an increase in participants being able to recall details about the programme that they were told at the point of referral. This included that the support was delivered by a separate organisation to JCP and that it provided support to help people get back into work. Some individuals were told that the programme could help them with their health barriers or that it targeted people 'like them' who had health conditions. Those participants who were aware of the aims of the programme and who it was designed for were more positive about the referral.

However, there was still a desire for more information – for example on the format of the support and how it could help participants. This was because some people did not know what to expect and so were apprehensive about engaging, often as they expected Working Capital to be like the Work Programme. One suggestion was to have more written information, as a few respondents spoke about having a bad memory and so would have liked something to refer to. Those individuals who were negative about the referral emphasised that they were not ready to work, and therefore felt the programme was unsuitable for them.

In addition, some caseworkers highlighted that they no longer receive additional information from JCP about participants prior to the first appointment. This previously included details about individual's health conditions which they found beneficial.

[14] There would usually be contact between the Caseworker and client via telephone between the point of referral and the initial meeting, to make introductions, confirm the appointment and place, as well as any items (such as some form of identification) required to complete the enrolment.

## Low referrals

Low referrals to Working Capital has been an ongoing issue. The main reasons given for this by local authority leads and caseworkers were that the projections at the outset were inaccurate, and that many potential participants had completed their Work Capability Assessment, and either been placed onto JSA or moved into the support group – which no longer made them eligible for the programme. Staff changes, both at APM and JCP, and the introduction of Universal Credit was also seen to impact engagement with Working Capital. Furthermore, the introduction of the DWP Central London Works programme was felt to have resulted in potential programme participants being referred to this instead of being considered for Working Capital.

*'A lot of people were being reassessed as JSA, and this was an ESA programme, so unsurprisingly the pool of residents that we could work with shrank, just as coincidentally the second Working Health Programme came on...it's not quite the perfect storm but there's lots of stuff going on…'* (Local authority lead)

Linked to this, when conducting observations of the randomisation process in JCP offices during the last wave of research, the advertising for Central London Works was noticeable. In contrast, there was a lack of reminders about Working Capital in JCP offices (e.g. leaflets and posters): an issue which was exacerbated by the reduced presence of APM caseworkers in some offices due to the organisation's restructure. Hence, a work coach explained that having more information leaflets about Working Capital would be 'wonderful'. This was because information leaflets can be referred to when discussing the programme and are something that potential participants can take away with them to find out more about the provision.

## Initial meeting

The initial appointment with an APM caseworker is mandatory. This involves being introduced to the programme and invited to participate. Interviewees largely did not distinguish between the mandatory initial appointment and voluntary ongoing support. Throughout the evaluation we have spoken to individuals who believed that participation was also mandatory, and that their benefits would stop if they disengaged. The nature of the referral, views of JCP and previous experience of DWP mandated employment support programmes contributed to this.

Some respondents wanted additional employment support so were indifferent about the nature of support and referral; some individuals expressed relief when they realised that ongoing support was voluntary; whilst others felt that the mandatory first appointment was a good thing as they have benefited from the support but might not have engaged otherwise.

*'I think it is exactly what is needed really, because there are lots of people that are not ready to go back to work and they need a bigger push and they need organisations like that…'* (Male, 37)



Nonetheless, there was consensus that the voluntary support helped to distinguish the Working Capital from other programmes.

## Assessment process

Needs were assessed during a face-to-face appointment, which involved a depth discussion of a range of areas including participants' health and wellbeing, their personal situation, and their aspirations.

Most interviewees had their first appointment at JCP, whilst a few had the appointment in public places, such as cafes or local authority buildings. The flexibility to deliver support in a range of locations based on participant preferences was recognised as a significant benefit of the programme by caseworkers. Some participants liked having appointments in JCP because it was easy to get to and familiar, whilst others disliked the lack of privacy or complained about previous bad experiences there.

*'I had some reservations really because certain things I wanted to say, I didn't want the other people ear-wigging... It was convenient for me because where I live, from the Job Centre I could walk from my house to the appointment… But I would have more preferred in a private room.'* (Male, 60)

Caseworkers and local authority leads both spoke about the difficulties in identifying suitable community locations for the support to be delivered. Some community hubs had also closed in recent months.

*'Yes, it just lacked, this contract, a hub for each borough or the hub in the south and the hub in the north, somewhere you can meet up.'* (Caseworker)

Views and experiences of the first meeting were largely positive. One of the main reasons for this was the APM caseworkers, who were described as friendly and good listeners. This meant that participants often felt more relaxed about being on the programme thereafter.

## Action plan and deciding on support

Caseworkers and participants worked together to create an action plan to decide on ongoing support. Action plans go through a quality assurance process that includes being signed-off by the relevant local authority, which then triggers a payment to APM for programme attachment.

Where participants remembered completing this, it was usually regarded as a helpful activity. Reasons for this included that it gave participants support journey structure, goals to aim towards, and means of achieving these. One respondent also felt that this process helped them to understand their capabilities and limitations, whilst someone else believed that it was a useful tool to reflect on their progress and consider what else they could do.

*'Well it's just actually having it all down on paper, really. Being able to see it and see that actually, yes, there is something there. I know what my strong points are, I know what my weak points are, I can try and work on those.'* (Female, 37)

As previously found, some participants felt like the suggestions on their action plans were unhelpful or inaccurate. This was usually because they were not ready to consider employment or because they were already receiving support similar to what was suggested. There were examples of this improving over time as relationships were established and participants felt able to discuss sensitive issues. Hence, caseworkers spoke of amending the document over time and building on progress.

Local authority leads are still approving most action plans. The term 'generic' continued to be used to describe the action plans. However, one local authority lead felt that this was to be expected due to the similar nature of the client group, and another felt that this was better than having too much detail – which could be demotivating for participants. This concern was reflected by a respondent who found the action planning process quite 'intense':

*'It felt a bit intense because it felt like I had to prove myself, but at the same time they gave me goals that I had to do where I didn't have it before.'* (Female, 39)

In contrast, one local authority lead felt that the quality of action plans had improved as caseworkers became more familiar with the programme and participant needs. Previous concerns about having to approve a high number of action plans, which was resource intensive, were not raised on this occasion due to the low numbers of participants joining the programme.

The Maytas IT system was introduced in 2017. It was a system used by APM to store participant data and claim funding, which local authority leads could access to approve action plans and check information. The IT system was largely thought to have been working well. However, local authority leads expressed frustration that they only saw the initial action plans when they signed them off and were unable to track action plans over time. This meant that they could not get a broad understanding of whether participants were making progress, and identify where local provision was being taken up, or where there were gaps. Hence this was felt to be a shortcoming of the process which prevented further integration: (caseload reviews often focused in on particular individuals and occurred infrequently).

*'Being able to follow a case through to find out what's been going on, you know, where we might be able to help. But it ended up being pretty much the same as in we just read the action plan and then either approve it or not.* (Local authority lead)

**Case study: Desmond**

Desmond* is 59 years old and he lives alone. He has suffered with stress, anxiety and depression, which has made it difficult for him to sustain work in the past.





These conditions have also resulted in him becoming angry and upset. At the time of the research, Desmond had been supported by Working Capital for nearly a year.

*'My main barriers are that from day to day I don't know what mood or what I am feeling like… all it takes is a person to upset me and I am liable to burst into tears or be argumentative…I can't take being ordered and all this sort of thing which is a really tough situation.'*

He liked having meetings with his caseworker in less formal environments, as this suited his mental health conditions and he liked getting '*out and about'*. When he joined the programme, Desmond recalled creating an action plan with his caseworker where he thought about what he would like to achieve in the next five years and what steps he would need to take to do this, which he thought was good motivation.

As Desmond is interested in working with animals, his caseworker has been giving him advice about necessary qualifications to do this and supporting him to look for opportunities to gain relevant experience.

*'She is looking around for places and she is ringing round different catteries, veterinary clinics, and all that kind of thing'*

He was grateful to receive guidance with making job applications and contacting employers and he explained that he felt 'less alone' during the process as a result. Hence, he wished he had been referred to the programme when he was put on ESA.

*'Yes, that would be better because that would help a lot more people settle down into finding out what they can do and what they can't do.'*

Desmond was also supported by a health and wellbeing adviser who referred him to an anger management course, and he thought this would be helpful to better controlling his temperament.

Overall, he valued the individualised approach of Working Capital, was less stressed and had moved closer to entering employment because he was being supported to identify suitable opportunities.

*'With Working Capital, they listen, they help you with the support, they take you as a friend and not just as a statistic.'*

## Ongoing support

Participants reported receiving support (face-to-face and by telephone) at different frequencies, ranging from weekly to monthly. Participants also gave examples of

their caseworker ringing or emailing them in between appointments, to help them to update their CV or let them know about job opportunities. Further, one respondent explained that they had the telephone number of their health and wellbeing adviser, and they were grateful to know that they could contact them if they needed support.

The frequency of the support was seen to be suitable by most participants. However, in the most recent wave of research inconsistent appointments and gaps in support were reported by some participants, which meant that they had negative views of the programme.

*'But nobody had told me what was going on from June till September and it was like that a lot, I didn't really hear from [caseworker] unless they needed paperwork filled in to be fair…It was a lot of me giving to them, but them not giving me anything back in return.'* (Female, 37)

Support was intended to be tailored based on individual needs and circumstances. Participants recalled discussing topics including their barriers to employment, their training needs, their home life and their career aspirations. They also completed numerous activities[15] with the support of their caseworker such as:

- updating their CV
- looking for job opportunities
- getting support with applications for paid and voluntary roles
- discussing interview techniques
- identifying relevant adult learning opportunities
- changing their benefits
- identifying resources and funding options to help with their goal of self-employment

## Referrals to other services and provision of support

In addition, caseworkers made referrals to a range of other internal and external services, so that participants could receive specialist support to address their needs. As well as the health and wellbeing support (described below) respondents had been referred to an APM Business Adviser for guidance with becoming self-employed. Respondents had also been referred to courses to support with confidence, mindfulness, literacy, numeracy and IT.

There were examples of warm handovers such as a caseworker accompanying participants to the first appointment. However, some participants expressed frustration at having to wait a long time for a referral – to health and wellbeing support and from the business adviser. Where participants had not taken up support this was often because they were 'not in the right frame of mind', they had limited time, or because they thought it was unsuitable.

[15] See the second evaluation report for a more detailed discussion of ongoing support activities



## Health and wellbeing support

APM health and wellbeing advisers (who are health professionals) also deliver Personal Wellbeing Sessions to discuss participants' physical and mental health needs. Participants can choose to take up the support and/ or referrals as this is voluntary. This health and wellbeing offer was thought to improve the delivery model, as specialist staff could address more complex health concerns and ensure that support was tailored and appropriate. Local authority leads also reported that learning about integrating health and employment support had informed the implementation of Central London Works.

However, concerns about the team's capacity to adequately support participants remained, as there were now only two health professionals providing support across all eight boroughs. This meant that the health and wellbeing advisers were spending a lot of time travelling, rather than providing support, and were less able to work intensively with participants, which was the intended support model. They were also having to now work in new areas, re-establishing relationships and learn about available provision, which was time consuming. Hence, contact with and familiarity of the health and wellbeing adviser's role varied from borough to borough.

There no longer appeared to be uncertainty amongst local authorities about the level of integration between APM's health and wellbeing provision and the caseworkers, in fact one local authority lead highlighted evidence of joint working. A reason for this may be that there are now fewer staff working on the programme, as some caseworkers felt that this had led to greater team work.

*'I think the health lead was aware enough of the health needs of the cases that the caseworkers were going through [in the caseload review] ...So that was good, that was reassuring that he actually kind of knew so that kind of joined up work between them was reassuring.'* (Local authority lead)

Fewer respondents than in previous waves of research recalled attending sessions with a health and wellbeing adviser, which could reflect staffing changes. Where they had done, they had been supported with their mental health needs, referred to relevant external services – such as counselling and anger management courses, or had been accompanied to GP and hospital appointments. Participants who had taken up the support gave positive feedback about their experience. For example, a participant with ESOL needs valued his health and wellbeing adviser's support in explaining what health professionals were saying in appointments and advocating on his behalf.

*'Sometimes I don't speak English… And she is ringing and calling to hospital… I am very happy, it's very good for me because I don't have anyone [to do this].'* (Male, 60)

As we have previously found, not all participants were positive about the health and wellbeing offer. There continued to be reluctance amongst some individuals to

discuss personal health issues and be referred to additional support by anyone except their GP. Others felt that they were receiving adequate support with their health issues from multiple channels, and so they did not feel this additional support was necessary. Reflecting this, a caseworker felt that there was a good network of mental health support in some boroughs, so some participants were already being well supported – and did not feel the need to 'explain themselves again and again.'

'*I told her that I was seeing my hospital consultant and the gastroenterology consultant and my GP and basically, I had all of that covered so I didn't need any more help.'* (Female, 60)

## In-work support

In-work support on Working Capital lasts for up to six months. It is intended to support participants to deal with the (often daunting) transition back into work so that they can sustain employment.

*'That changeover period it is very important for us to be with them step by step to make sure that everything's transitioned smoothly and even when they're in work to know that we're still there, we don't leave them… we're giving them that support once a week or once a month…'* (Caseworker)

Caseworkers highlighted the importance of 'Better-Off' calculations and supporting participants to apply for different benefits – as this helped to motivate participants to enter work and support themselves financially. Keeping in touch to find out how participants were getting on with colleagues, coping with their role and managing their condition also helped to identify any issues that needed addressing.

Unlike earlier research, there was less emphasis on employer liaison about how they could support a participant to enter or sustain employment, instead there was greater emphasis on individual support once someone entered work. One participant was encouraged to speak to her employer when issues arose, and they appreciated their caseworker's encouragement to remain in the role.

*'At one point I was ready to just quit. but she was very encouraging and just helped me to look at it from, you know, different angles.... and how I can obviously benefit from being in work and… by talking to management, those changes being made.'* (Female, 61)

Similarly, another participant had been encouraged to find a more suitable role rather than 'just give up' and leave her current job.

*'She just advised me really… trying to see if… other jobs that suit my needs, something that's less demanding and things like that but then also as well to not drop a job. You know, just don't quit work just like that. Try and see if there are other things first.'* (Female, 34)



Participants who had received in-work support liked knowing that there was someone who cared about how they were that they could *'turn to'* if they had any concerns. One individual also acknowledged that the advice their caseworker gave in response to their experiences of the workplace was personalised, because their caseworker knew them and their situation very well. This meant that the guidance was tailored to their health condition, which they appreciated.

Other benefits of receiving in-work support referenced by respondents included being supported to make the financial transition from ESA. For example, one participant received vouchers and help with transport costs until they received their first pay cheque, which meant that they did not have to worry about money when they started working. Another participant was supported to begin claiming Universal Credit, by getting help from her caseworker with filling out the relevant forms.

Others were receiving health and wellbeing advice, such as a participant who was now pregnant, whose caseworker was advising her on how to look after herself in the workplace.

One respondent who had become self-employed expected more advice and guidance around funding and compiling tax returns which they did not receive. However, they had been supported to get a laptop to help them set up and run their business. A previous concern about in-work support being unavailable for self-employed participants was not raised by those interested in this route in this wave of research.

There were examples of individuals who were being supported to find more suitable and/ or better paid or additional roles, in the catering, health and social care and hospitality sectors. However, there were also examples of individuals who had left the job that they found through Working Capital either because they had found it too stressful or different to what they expected.

**Case study: Benjamin**

Benjamin* is 34 and lives alone. He was born abroad and has lived in other countries. After divorcing his wife, he returned to England and completed literacy, numeracy and NVQ qualifications. He has been suffering from depression since 2015, and previously experienced post-traumatic stress disorder (PTSD). When Benjamin first participated in the research he felt that his mental health was under control, however more recently, he felt that it had got worse again.

Benjamin had been supported by Working Capital for about two months before finding full-time work for a cleaning company. Through Working Capital, Benjamin had taken part in a confidence-building course, had appointments with the health caseworker to discuss his sleeping issues and having a healthy lifestyle and was supported to look for work. He was also accessing external support to improve his wellbeing that JCP and his GP had referred him to.

Although he wanted to work part-time hours to ease himself back into employment, his employer insisted that he completed full-time hours. Benjamin stayed in this job for the probation period, which was three months, however he left after this because he found the experience to be stressful and overwhelming.

*'It all got too much, yes, instead of going, starting with a part-time job, I went straight into the deep end and... Because there were no part-time chances...I think it was almost 40 hours.'*

Benjamin liked his caseworker, he explained that the support gave him 'a sense of value' and motivated him to find work as he previously lacked confidence to do this. He also found it useful to have someone to talk when he got a job, and his caseworker was easy to contact. However, he believed that his caseworker was more focused on trying to get him into work rather than understanding and addressing his health needs. He explained that despite speaking to his caseworker about the difficulties he was experiencing at work, his caseworker did not seem to understand and encouraged him to stay in the position.

*'They just wanted me to get a job and I guess they were not looking at my main condition they just wanted me out there and just working and not caring what is the matter, I will be honest, that is the way I saw it.'*

After leaving the cleaning role, Benjamin was told that he could continue being supported by APM. However, he disengaged with Working Capital because he did not feel that he was in the right frame of mind to engage with support and because he wanted some space.

*'At that time, I just went blank, I just wanted some breathing time and some space.'*

Benjamin is now claiming ESA again and receiving employment support from a local provider that his housing officer referred him to. He preferred the approach of this organisation, which he felt was more person centred as they *'treated everyone individually'* and better understood the impact mental health conditions have on people's ability to sustain work. He has taken part in training and voluntary work and is working towards obtaining a CSCS card. He hopes to find part-time work in the construction industry in the future, and his long-term goal is to be site-manager.





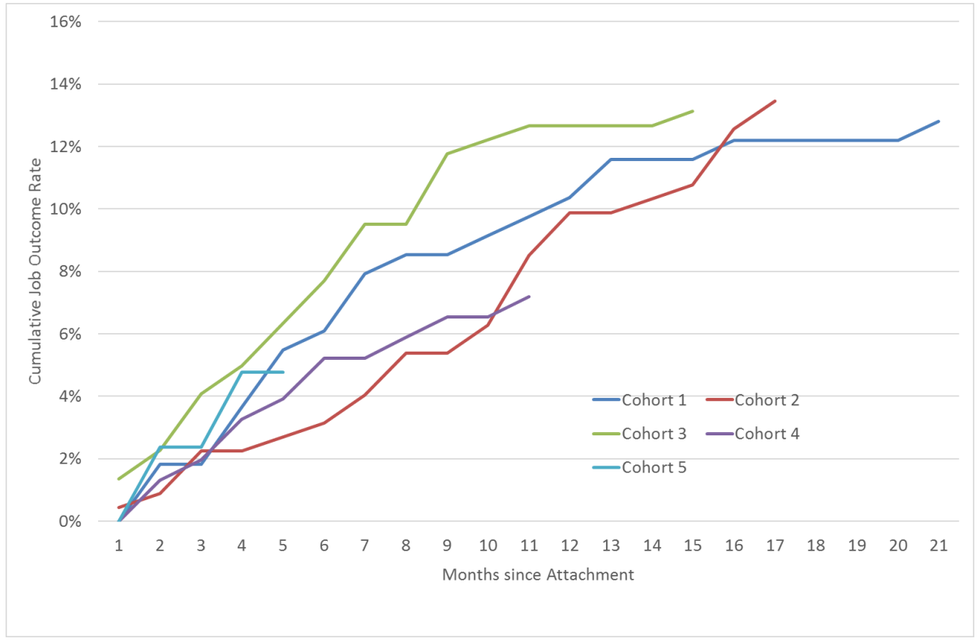
# 6. Outcomes

This chapter presents an initial assessment of outcomes achieved through the Working Capital programme, in particular job outcomes.

## Employment outcomes

Overall, between October 2015 and April 2018, 93 Working Capital participants were verified as entering work, accounting for 11.0 per cent of the 841 participants on the programme. In order to compare job outcome rates from different cohorts who joined Working Capital at different times, it is necessary to control for the amount of time different cohorts have spent on the programme. This is because earlier cohorts will have spent longer on the programme and so, all other factors equal, will have a greater likelihood of obtaining a job. Figure 6.1 shows the cumulative job outcome rates for the those joining the programme between October 2015 and March 2016 (Cohort 1), April 2016 to September 2016 (Cohort 2), October 2016 to March 2017 (Cohort 3), April 2017 to September 2017 (Cohort 4) and October 2017 to March 2018 (Cohort 5) by the length of time since their attachment on Working Capital.[16]

**Figure 6.1: Cumulative Job Outcome Rates by Cohort**




[16] In four cases participants started a job after their referral date but before their attachment date. In two of these cases the attachment date was around four months after their referral date. For these four cases we measured 'time to job entry' from their referral date rather than their attachment date. Our understanding is that participants can receive support from Working Capital before they become formally attached to the programme when such attachment is delayed by the sign off of their individual action plan.

Figure 6.1 also reveals some notable differences in performance across the five cohorts. Cohort 3 appears to be the best performing cohort; achieving the highest job outcome rates compared to the other cohorts from around four months on Working Capital. Cohort 4 appears likely to end up as the poorest performing cohort. This is because for the period for which data is available, it performs worse than Cohorts 1, 3, and 5. Cohort 2 initially performs worse than the other cohorts, but there is an acceleration in performance from around 10 months since attachment, and by 15 to 16 months on the programme this cohort is achieving a cumulative job outcome rate broadly in line with Cohorts 1 and 3.

For Cohorts 1 and 3, there is a noticeable slowdown in the increase in the cumulative job outcome rate after the 12 months out of work support period ends. This is not apparent for Cohort 2. Part of this slowdown will most likely reflect the fact that participants closer to the labour market are likely to move into work earlier than those who are further away. However, it also raises a question of whether a longer out of work support period would have resulted in higher post-12-month job outcome rates. This was the view of some participants and staff, who felt that 12 months was not long enough to address then complexity of barriers to work that participants faced. Regardless, the benefits of a longer support period would need to be weighed against the extra costs this would create.

**Figure 6.2: Cumulative Job Sustainment Rates by Cohort**

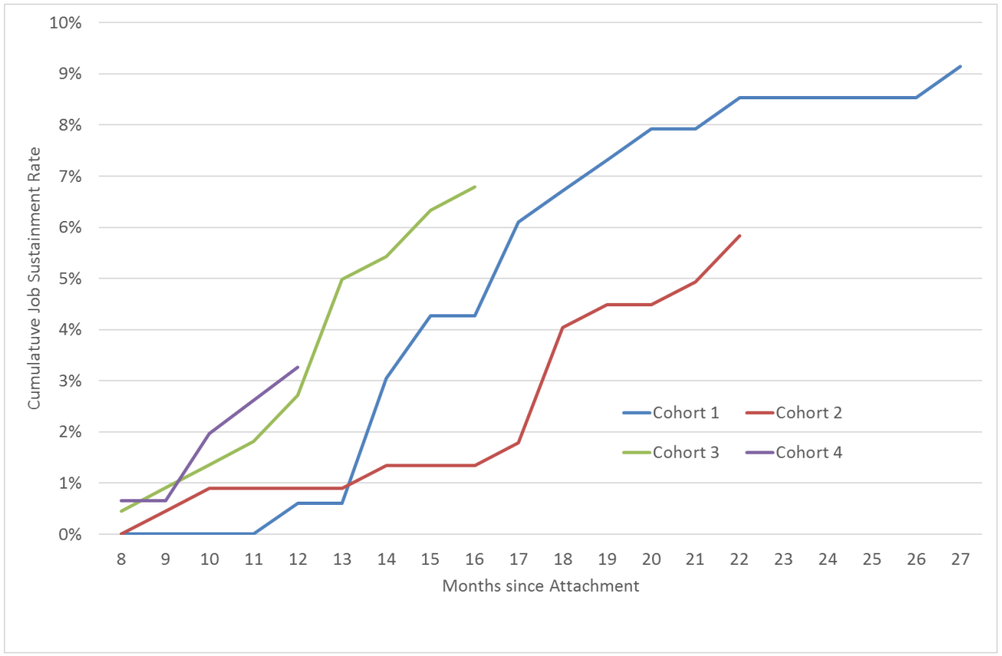



Figure 6.2 shows the same analysis as in Figure 6.1, but for job sustainment rates. Data is only shown for Cohort 1 to 4 as no members of Cohort 5 had achieved a





sustained job outcome at the time of analysis. (This is not surprising given this cohort joined Working Capital between October 2017 and March 2018). The later cohorts, (Cohorts 3 and 4), achieve higher job sustainment rates than the earlier cohorts, (Cohorts 1 and 2), for the time periods for which there is data available. Cohort 2 in particular has especially low job sustainment rates from around 13 months on Working Capital, compared to both Cohorts 1 and 3. It may be that the later acceleration in job outcomes for Cohort 2, as demonstrated in Figure 6.1 will also, in due course, also come through in job sustainments. In the present set of data, Cohort 4 has not been on Working Capital long enough to have sustainment rates beyond 12 months on the programme.

Around a quarter of participants interviewed were currently in employment. It was interesting to note that many of these individuals were now seeking additional hours or better paid roles. This included someone working part-time as a personal assistant on a school bus for children with special needs and someone with a part-time role in a hotel who wanted another part-time role to complete alongside this. Both participants were being supported by their caseworker to identify opportunities.

Similarly, since their last interview, one respondent had a found a part-time role in an art gallery where they had hospitality and cleaning responsibilities. They also had another part-time job lined up, which their friend had told them about – as a crafts facilitator for people with dementia. This participant wanted to move into a full-time role or to have numerous part-time roles so that they no longer had to claim benefits.

A longitudinal participant who was on their probation period as a retail assistant in the last wave of research has since been made a permanent member of staff. They explained that they were surprised how quickly they found work after joining the programme and that they continued to find working part-time hours manageable alongside their mental health condition. Another longitudinal participant was still working for a care home company but found the fluctuating hours and need to travel to numerous different locations at the last minute difficult to manage.

Some of the participants who had achieved employment outcomes found out about the opportunities that they were fulfilling through organisations that were already supporting them when they were referred to Working Capital or which they were referred to by their caseworker. This included Remploy and CamdenAbility.

In the last wave of research a few participants held voluntary roles, which they valued because this reduced their isolation and enabled them to socialise. A few respondents in the latest wave of research hoped to find voluntary work in the near future, as they thought that this would be a good step towards employment.

*'I think voluntary work for me right now would be a bit okay because it's slowly getting me back into the outside. It's, I think that one day a week is not too bad or two days a week…to take on a job, at the moment, it would be a bit tricky because I know there's a lot more commitment to it than the voluntary work.'* (Female, 39)

The option of self-employment was particularly popular amongst participants as this enabled them to work their preferred hours, in a comfortable environment.

*'I needed something that was creative and something that I could do from home because with my IBS, it was really bad at one point, so, yes, working from home was a good option and to be able to work around my daughter and stuff like that…'* (Female, 37)

One participant had set up a business as a craft demonstrator and they were also selling products on Amazon, another was being supported by her caseworker to invent a new product linked to their interest in recycling and one individual was working to develop a business plan as they wanted to become a motivational speaker.

**Case study: Sarah**

Sarah* is a 58-year-old female who lives alone. She has had depression for the past few years, which she still takes medication for, and because of this she had been out of work for approximately six years when she engaged with Working Capital. Sarah left school at 15 and did not have any qualifications, however she had worked for most of her life, including in factories and the retail sector.

When she was first interviewed, Sarah was on her probation period as a part-time retail assistant. She has since been made a permanent member of staff. Sarah found this role after her caseworker suggested it before referring her to Remploy - as they had a close relationship with the organisation that Sarah now works for.

*'She said, "We're not pushing you" …but she thought that I'd be going back to work just part-time or whatever would be good for me and she was actually right… I do feel like I'm in a better place now.'*

Before finding her temporary role, Sarah completed a work placement where she undertook tasks such as till training. This was helpful in giving her confidence in her ability to work.

*'I think it gave me back a bit of confidence, I thought, I can do this.'*

Sarah explained that although Remploy helped her to find the role and supported her by giving her interview techniques and interview clothes, her APM caseworker helped her with her travel costs before she got paid. They also kept in touch with her by telephone and face to face – which she was grateful of.

*'It's just nice to know that they were making sure that I was alright, that I was happy in the job…it was just nice to have that support, that if it wasn't going well, that I had somebody there to turn to.'*



Although her caseworker recommended speaking to a health and wellbeing adviser, Sarah was already receiving counselling that her GP had referred her to, so she did not think this was necessary.

Sarah has had a very positive experience of employment. As well as increasing her confidence, this has reduced her social isolation as she has made friends with colleagues. She reflected that she would probably still be out of work if she had not engaged with Working Capital. She has also been able to reduce the amount of medication she takes, which she felt was a result of both working and receiving support from a counsellor.

*'A good impact. Because I don't think I would…I probably still wouldn't be working now, I'd probably be slipping deeper into depression or something. I'm even starting to lower my dose of medication.'*

## Health and wellbeing outcomes

For a few participants, the support from their health and wellbeing adviser was perceived as having the most impact. This included support to help individuals manage their physical and mental health conditions, which meant that they could focus on other things.

*'How I think and portray myself and outside really. Instead of thinking negative all the time, thinking more positive and helping me maybe take my steps to go forward instead of staying stuck where I am at the moment.'* (Female, 39)

This support, or the resulting referrals proved particularly significant when participants had not addressed their health issues through primary care provision. For example, one respondent reflected that they wished they had got help to manage their temperament sooner – as this would have helped them to succeed in the workplace. Their health and wellbeing adviser referred them to an anger management course.

Another outcome reported by some participants was feeling more optimistic about the future because they had made progress and/ or had things to look forward to. For example, one participant was excited to take part in training and felt happier.

*'I think it has done a lot of good, I feel happy, just really happy and excited to do this thing [training], I really want to do it and I am getting excited to do it.'* (Male, 49)

## Improvements in confidence and motivation

Caseworkers and participants alike felt that increased confidence and motivation was a key outcome that resulted from engaging in Working Capital. Entering employment or gaining work experience was found to be a reason for this, because

participants had been able to better understand their capabilities and learn new skills.

Importantly, taking part in training or entering work also enabled participants to meet and work alongside new people, which helped to reduce social isolation.

*'Because I'm working with the public, so you're interacting with people and you're meeting new people all the time. Yes, it's just nice to be... and I've made friends there and we go out for drinks sometimes. So yes, I think it's helped my social life as well.'* (Female, 58)

Engaging in the programme, speaking to someone about their needs and completing activities had also given some participants more confidence in their ability to communicate effectively and make steps toward the labour market.

*'It was definitely worthwhile doing, in the way that it gave me more confidence, I suppose… sort of, like, independent, and confidence learning more… actually going for interviews and confidence meeting people, talking to people straight rather than getting in a muddle...'* (Female, 55)

## Skills and qualifications

Several participants had moved closer to the labour market after gaining employability skills or qualifications through Working Capital. This included improving their CV, gaining interview skills and being more aware of how to complete a successful application.

Participants had also been supported to address training needs. For example, one participant was about to start a college course to help with their literacy and numeracy. As well as making them more employable, they also hoped that this would help them to support their children.

*'It will give me better skills with my reading, my spelling, my handwriting, definitely my maths because I know the basics, but I don't know a lot and I've also got two children that, like, every so often come over to me and ask me to help them with their homework, if they're not too sure on something.'* (Female, 39)

Other examples of skills gained included IT, photography, web-design and business admin after participants were referred to adult-learning provision related to their interests. Furthermore, there was evidence of outcomes being achieved after participants had left the programme. For example, one individual had gained a CSCS card after engaging with further employment support.

## Factors which enabled outcomes

Having sequenced support, delivered by an understanding and approachable caseworker were factors identified as key to outcomes being achieved. Participants valued having a caseworker that was flexible, who listened to their concerns and who they could talk to about their wider needs.

*'About my daughter sometimes, you know, with my personal problem, you know, my family problems which has affected me, my health...Well, because, you know, I don't have any friends and I need someone.'* (Female, 56)

Participants particularly liked that they did not feel 'forced' to complete activities or look for jobs, when they had more pressing concerns. The importance of sequenced support was also recognised by caseworkers and local authority leads alike as enabling sustainable outcomes to be achieved.

*'I think where the case workers have had success, you can see that it's because they've worked through X, Y, Z problems with a client before gearing them up for employment…and it kind of helps, hopefully, into sustainable employment and not just getting someone to the point of work and then realising, you know, the financial issues that I had are still hanging about and therefore work isn't as appealing.'* (Local authority lead)

Caseworkers recognised that building up a trusting relationship was vital in participants remaining engaged and making progress. Other factors highlighted by caseworkers were work placements and permitted hours as these options allowed participants to get a taste of the working environment, without having to commit to signing off benefits. They often then wanted to increase their hours once they had gained this experience (as evidenced by the individuals interviewed most recently).

*'Permitted hours is very good, working a few hours a week…They're not going to go into a full-time job, sign off. They're not going to do it. This is a perfect way to get them into it slowly.'* (Caseworker)

## Factors preventing outcomes from being achieved

Gaps in support sessions and changing caseworker (sometimes multiple times) were perceived as shortcomings of Working Capital for those participants affected. For example, one participant disengaged after their caseworker changed for the third time. Since the last wave of research, APM have undergone a restructure. This reduced the number of staff working on the programme and meant that caseworkers were now responsible for employer engagement as there is no longer an employer liaison lead. Hence, caseworkers now have larger caseloads and increased responsibilities.

In addition, some participants did not feel that they were able to enter employment or make significant progress because of their health condition. For some, this meant that they were not particularly engaged with the programme, whereas other's conditions had deteriorated, or they had received an additional diagnosis since joining.

*'It's not because of the programme, it's because of my health [it] would have been helpful if I was a different person. If I hadn't had my accident…I would have been all over there. I would have been working by now.'* (Male, 36)

In the last wave of research, older participants specifically felt their age was a barrier to achieving employment outcomes, despite making progress more generally. Although this issue did not come up in the participant research more recently, caseworkers acknowledged that it was harder to achieve outcomes for those over 60 because of the complexity of their health conditions and their mindset – as they were less willing to consider retraining or volunteering.

Housing issues were found to be particularly difficult to overcome, and in some boroughs, there were long-waiting lists for therapy services aimed at people with severe mental health needs. There were also examples of local authority leads being able to signpost caseworkers to relevant local services, but participants not being able to access support because of the eligibility criteria.

Lastly, some participants suggested that the programme should be longer to increase the likelihood of them succeeding. They expressed disappointment that the support ended after 12 months– in some cases caseworkers were able to extend the length, but this was not always possible.

*'Lengthen it a bit because a year was definitely not enough, for me anyway… in that year I was sick so many times I wasn't really able to do stuff.'* (Female, 60)

## Integrated delivery

A key aim of Working Capital has been to deliver better participant outcomes by more effectively combining support through local council, health and voluntary sector services, and other specialist services.

Different factors were credited for enabling Working Capital to integrate more successfully into the participating borough. Firstly, co-location with other local services was found to be beneficial as this facilitated communication with relevant staff members and enabled warm handovers where relevant. Having pre-existing local employment programmes was also thought to help integration as caseworkers were linked in with these, and so could find out more about local services and job opportunities that were available.

*'So, I think the co-location works when you've got like these small little hubs…Especially when you've got like a brokerage function present there...if they've got a client that they're seeing, and the brokerage person is right next to them, then they might you know, introduce their clients… It just allows them to put them towards opportunities a bit easier I think.'* (Local authority lead)

Furthermore, several local authority leads invited APM caseworkers to be part of local employment forums or networks, which was intended to raise awareness of



Working Capital locally and help caseworkers to better understand local issues and services.

*'APM was invited to present at that forum about the programme and become part of that partnership and forum...And so we would introduce them to other partners that we thought it would be good for them to work with… there was synergy.'* (Local authority lead)

However, keeping wider local services engaged proved problematic when the expected numbers were not realised because they were not receiving referrals.

There was consensus amongst local authority leads and caseworkers that a key benefit of local authority involvement was the local authorities' awareness of available provision in the borough, and their ability to help with the referral process.

*'We know where to turn to. We know who to go to and it's having that relationship with that person to be able to pick up the phone or email and say, "I've got this client. This is what they need." It's just a simple referral and they're able to get the support for the client"* (Caseworker)

Involving APM staff in local authority training was also found to be beneficial, to share knowledge and good practice. For example, the health and wellbeing caseworkers were invited to training run by a recovery college in one borough which they found helpful.

Across different borough's, different decisions were taken about where the responsibility for Working Capital should sit. Where the local authority lead had a more strategic role (for example in the council economic development team) this was felt to benefit the programme because they were able to put the caseworker in touch with council staff to support their clients and had a good overall understanding of the local landscape.

*'It's been easy for us to put APM in contact with the right people and kind of broker those relationships from a strategic point of view… on our side it's helped us because we're responsible for employment commissioning and skills commissioning and wider conversations…so it means that we've got that oversight and that link into a frontline service.'* (Local authority lead)

Hence, this joint-working and local authority involvement in the delivery of the Working Capital programme was felt to benefit participants as they had access to a wider range of support options as a result, and hopefully a better experience of the referral process.

*'I think probably for the residents, it's better for them because they're getting a much better, all round service than they would if there was just APM delivering it completely separate from the local authority.'* (Local authority lead)

There were also examples of councils becoming aware of issues facing their residents as a result of their involvement in Working Capital. This included being informed of tenants that were in rent arrears or individuals who were facing issues in relation to their housing and benefits.

In addition, in one borough they had been able to support self-employment outcomes by linking participants in with local initiatives, finding workshop space and helping participants to get 'their idea out there'.

An issue felt to reduce the level of integration was staff changes – at APM, but also within local authorities and Jobcentre Plus (JCP). Once a main contact changed, it took a long time to rebuild relationships and identify the staff member that could provide the relevant support or guidance. There were examples of local authorities and JCP being unaware of who their local APM contact was, and likewise caseworkers being unsure of their local authority lead. This issue prevented Working Capital from remaining at the forefront. Likewise, as previously mentioned, low referrals made it difficult to keep momentum up about the programme in some boroughs.

Whilst progress had been made in integrating Working Capital with council teams, including housing, economic development and adult social care – it was felt that linking in with health services remained challenging.

*'I think some of the services, the teams here, have been more receptive to that approach than others. I don't think we've by any means cracked it with health yet, it's kind of a long way off.'* (Local authority lead)

However, there were good examples of joint-working between caseworkers and wider health teams. This includes caseworkers having meetings with a participant and their support worker, referrals being prioritised from APM for a local mental health pilot and instances of health and wellbeing advisers linking up with GPs and encouraging participants to speak to them about their needs.

Finally, as previously discussed, the inability to track action plans over time and see what provision was taken up and where there were gaps was felt to be a shortcoming to the model which prevented greater integration between local authorities and Working Capital.

**Case study: Priti**

Priti* is 39 and lives with her two children. She did not have any qualifications but had recently completed some vocational courses. She stopped working in 2004 when she gave birth to her son.

Priti experiences mental and physical health problems and was concerned about managing work and her childcare responsibilities.





*'I was struggling to cope with day-to-day life, struggling with the children.'*

She explained that she lacked confidence to enter the workplace but felt more motivated to do so since joining Working Capital. Hence, her caseworker was currently supporting her to begin a voluntary retail placement.

Although she was nervous about her first meeting, she was reassured after meeting her caseworker who provided suitable suggestions based on the issues that she raised when they put together an action plan.

*'She was taking it down and she actually was interested in what was going on. She didn't just like, "Oh okay, well that's that then." You know, she actually took her time, she spoke to me, she told me that, "We're going to see what we can do.'*

Priti also saw a health and wellbeing adviser who referred her to counselling, which she thought would help to reduce her negative thoughts. Her APM caseworker referred her to a local community centre, which offered a range of services including literacy courses. Although her adviser had attended with her when she first visited, she cancelled her first appointment as she did not feel in the 'right frame of mind'. However, she hoped to reengage in the future, as she thought this would be a good way to meet new people and learn new skills.

Overall, Priti now thought that she had more self-belief, and she attributed this change to having a 'mentor' who understood her needs and could support her accordingly. She did not think her experience would have been as positive if her caseworker changed as she would not have had the opportunity to develop this relationship.

*'For myself personally, I find it difficult for change and I've managed to talk to [caseworker] about things that she understands me, where if I had to change again I'd have to go through that whole thing and I'd get nervous…So, having that one person, it's has been absolutely amazing.'*

# 7. Conclusions

This report updates findings from the two previous reports, paying particular attention to outcomes and service integration.

It is apparent from several perspectives including APM caseworkers, local authority stakeholders and the participants themselves, that the programme is trying to engage and support a high need, diverse group. Many participants experienced multiple disadvantages, and a significant majority had multiple health problems (often concurrently with other forms of social and economic disadvantage). However, while this appears to be a broadly consistent theme, findings presented here suggest that programme participants' backgrounds and needs are not static and vary, both across individuals and over time. For example, proportionally fewer recent programme participants lacked basic skills needs compared to earlier cohorts. While this may suggest a reduction of need in one sense, there was at the same time a growing proportion who had experienced, or were in threat of, homelessness and over-indebtedness.

Consequently, programmes akin to Working Capital require fluidity in their support offer to adjust to these changes in the needs of their client base. To its strength, the deeply personalised delivery model and relationship between the participant and caseworker, provides this by allowing support to be easily adapted to individuals' circumstances.

The programme continues to struggle to achieve the volume of referrals and attachments that had been originally estimated, with referrals being around a third of where they were expected. Naturally, this has consequences on the number of outcomes the programme can achieve. To the programme's credit, both the initial meeting and conversion to attachment rates have been improved, recouping some of the shortfall in participation due to the low footfall. This in part is due to a more embedded process to transit people between Jobcentre Plus (JCP) and APM. However, the consequence of the low footfall has impacted every part of the programme, including maintaining and resourcing the partnership, encouraging service integration and co-location. Moreover, the commercial implications for APM have led to the restructuring of the core delivery team, and staff turnover. For programme participants, staff retention has most directly shaped their experience of the programme, with less positive programme experiences being associated with losing or not having a single caseworker to provide support throughout their Working Capital journey.

The implementation of the Central London Works may also have an indirect influence over Working Capital and it is likely the two programmes, which share common aims and service features, occupy the same space. Feedback from JCP work coaches indicates that referrals to Central London Works may be being prioritised over Working Capital, thereby partially choking the flow of participants to the latter programme. This may explain the lower than expected flows seen in recent quarters and warrants further exploration. As well as potentially reducing Working Capital's eligible population, the overlap between the two programmes is also likely to affect the RCT (see Annex A, for more detail).

Little has changed regarding the client journey to, and through, the programme, though APM caseworkers have continued to refine the support offer. There does appear to be a change with regards to in-work support, with less emphasis on direct employer engagement by caseworkers and greater direct support to programme participants.

Local authority involvement appears to be mixed. Some leads were closely involved in the delivery of the programme, while others maintained a more limited involvement than originally envisaged due to the low number of referrals. However, overall sentiment about Working Capital appeared more positive, with a greater understanding of the challenges of delivering this type of provision within a sub-London region. Though their role in the action plan process provided limited insight on the support needs of Working Capital participants, it appeared that other processes, such as case conferences and partnership forums were being used to get a better understanding of local resident needs.

Critically, the evaluation is at a point at which it is able to assess job outcomes. While the overall job entry rate is 11 per cent, cohort-based analysis presented here suggests that verified job outcomes can break 14 per cent, which if realised would be within the parameters of the 3-5 per cent stretch that the programme aims to achieve. However, compared to the contract target of achieving 32 per cent job entry rate, Working Capital performance falls short, and this ambitious target is almost certain to be missed during the course of the programme. Although easy to conclude in hindsight, this contract target was high for a programme which has a mandatory initial appointment and a particularly hard to help client group.

The evaluation also reaffirmed the programme's ability to deliver a broader range of outcomes, such as improved confidence and wellbeing, reduced isolation, and improved housing circumstances. For example, respondents reported a better understanding of how to manage their condition, engagement with primary health services and increased optimism. The programme is also often regarded very positively by those receiving support. Reasons for this include the personalised and flexible support offer, and the trusting relationship that participants often developed with APM staff.

# 8. Recommendations

Recommendations in relation to ongoing service delivery and the implementation of the randomised control trial are included below. We have also considered lessons learnt from Working Capital to make recommendations about the future development of similar employment programmes.

## Service delivery

- **Provider staff turnover means that efforts should be made to re-establish relationships.** The Working Capital team needs to reconnect with other partners such as Jobcentre Plus and local authority teams, but likewise partners need to ensure that their own staff turnover is handled to ensure that the Working Capital team are still connected to the service if someone leaves. This would help Working Capital to maintain momentum, whilst ensuring that participant needs can be addressed efficiently through wider support (where relevant).

- **Greater efforts should be made to advertise Working Capital in Jobcentre Plus,** especially considering that there are currently many posters and leaflets available advertising Central London Works. Both Jobcentre Plus work coaches and participants suggested that leaflets would be a useful way to inform potential participants about the programme. Participants felt that this would help to refresh their memory and liked the idea of having something to take away with them following the referral. Work coaches explained that this would help to remind them of the key elements of the programme when describing it to claimants. This may also help to legitimise the programme, especially if such advertising includes examples of the support or outcomes achieved.

- **Due to the introduction of Central London Works, efforts should be made to highlight the unique elements of Working Capital so that the value of the programme is recognised, and appropriate claimants are still referred.** For example, Central London Works is aimed at numerous claimant groups, unlike Working Capital which is purely for ESA WRAG claimants; and Working Capital is delivered separately from Jobcentre Plus / DWP, whereas Central London Works is a national government employment programme (albeit devolved).

- As some research respondents that had been supported into employment expressed a desire to progress into a better paid role and others had negative experiences with their employer, **it is important that APM continue to monitor job quality and suitability to ensure that outcomes are sustained**. This is also important to participant wellbeing, views of the programme and views of employment more generally.



- **APM should continue to celebrate success and promote case studies which demonstrate how people have been supported on the programme**, as this helps to demonstrate the benefits of involvement to potential participants, whilst recognising outcomes that have been achieved.

- A key part of the delivery model was personalised support based on individual circumstances and needs. This was well-received by participants and identified as good practice by local authority leads and APM staff. Therefore, **there should be a continuation of the tailored approach to supporting participants to overcome barriers and enter and sustain work.**

## The randomised control trial (RCT)

- **Data sharing is a key issue, which needs to be resolved**. This requires a commitment from central government to localism and devolution. Despite political commitment to do so, the Government has not made the structural, and procedural changes necessary to support this.

- **Central London Works poses a risk the to the fidelity of the Working Capital trial, and this should be monitored**. From evidence provided by Jobcentre Plus work coaches, there appears greater emphasis on making referrals to Central London Works. This issue should be raised with DWP, and if necessary specific training should be provided formalising the process of assessing eligibly and completing the randomisation for both Working Capital and Central London Works. Some notion about the level of cross over between the two programmes would be useful.

- **The DWP analysis on the impact of the programme raises some questions that merit consideration.**
  - Firstly, around the quality of the analysis and underpinning assumptions. For example, that the small, but statistically significant difference in work history is not of concern, and their approach which analyses the data based on the treatment and control groups that individuals should have been assigned to – not those which the work coaches actually put them in. (DWP describe this as an intention to treat approach which is not our understanding of the technical meaning of this term).
  - Secondly, concerning the adequacy of randomisation by Jobcentre Plus work coaches. This is because of the relatively high-level mis-allocation to the treatment and control groups, which suggests issues, and potentially the need for ongoing monitoring (this would ideally be monthly, but quarterly would suffice).

## Future programme development

The shortfall of actual from expected referral numbers pervades the performance of Working Capital. Although some potential shortfall in referrals should be mitigated against by any provider; the current shortfall of Working Capital referrals is hard to mitigate against. The unanticipated movement of individuals out of the WRAG group due to Work Capacity Reassessments was a significant reason behind this shortfall. External factors are likely to influence future programme eligibility and referral numbers. Therefore:

- **Commissioners for future local programmes should set out not just a central projection for the volumes of referrals and attachments, but also and upper and lower bound estimates**. Responses from contractors should be assessed against this range of volume projections and their proposed mitigation strategy if volumes turn out to be different and in particular, lower than anticipated. One way to address issues of commercial viability in the light of lower than anticipated programme volumes is to guarantee minimum volumes up front by committing to widening the eligibility for participation in the programme in such circumstances.

- **DWP should support local areas both with the development of initial volume forecasts for local programmes and the review and revision of such projections in the light of subsequent events**. In developing its own policies and programmes, DWP should also consider any potential competition for participants in areas where devolved programmes already exist, and the impact this may have on the volumes of referrals and attachments flowing through to such local devolved programmes.

Furthermore, the predominance of a payment-by-results (PBR) based model makes it difficult for the programme to deliver its other core aims. The payment model is in itself generous and designed to be as 'up front' as possible to encourage investment in tackling more structural issues, in particular improved service integration and tackling on multiple/severe disadvantage. Therefore:

- **Consideration should be given to the use of a more sophisticated payment model incorporating both PBR, to deliver programme outcomes, coupled with a service level payment to deliver activities** (such as referral network building, service integration, service user consultation). Doing so will ensure wider programmes aims can be achieved, even if core performance is not achieved. Currently the programme appears ill equipped to fully cross-subsidise these wider aims through the PBR arrangement. Service Level Agreements will also ensure that performance is taken seriously, and that participants are suitably supported.



- Related to the above point, **the payment model should reflect the aims of the programme**. For instance, if the aim of a programme is to test a particular service model (which Working Capital seems to be) then a PBR model is not appropriate. This is because what ends up being tested is what is commercially viable (e.g. a smaller team, working in a more conventional way, staff working across several Borough Council's) and not what was intended from the outset. From a purely research perspective we are learning less about what this service model can deliver, and more about what this commercial model delivers. Ideally, this should be tested in two stages – the first testing the service model (delivered via a Service Level Agreement, and heavily audited/project managed by the commissioners), the second testing the payment model, introducing PBR to see if it increases performance. There are political challenges around this, but in order for commissioners to learn about what works there needs to be precision about the questions that are asked.

Lastly, in order to effectively monitor and evaluate Working Capital and other employment programmes more generally, it is important that good quality management information (suitable for both performance payment and evaluation purposes) is collected regularly and consistently. Therefore, building on lessons from Working Capital:

- It is important that **data collection processes are considered during the programme design stage**. This will ensure that delivery and evaluation activity can be effectively supported, and that progress and outcomes can be monitored.

- There also needs to be a **robust IT system to store participant data which is understood amongst staff so that data is collected appropriately and consistently.**

# Annex A: Implementation of the randomised control trial

As previously noted, the Working Capital programme has implemented a Randomised Control Trial (RCT) as part of the programme design. As such, over the longer term it will be possible to fully measure whether the delivery model leads to higher rates of employment (re)entry and sustainment compared with existing provision. Monitoring and ensuring the correct implementation of the RCT will enable robust and quantifiable impacts to be measured between those assigned to the programme (the treatment group) and those receiving 'business as usual' support through Jobcentre Plus (the control group). RCTs are regarded as providing the strongest standard of evidence within social policy research.

The primary measurement demonstrating the impact of the programme will be the differential in the rate at which Working Capital participants achieve job outcomes and benefit off-flows compared to those who receive business as usual support. The key outcome measure will be to achieve a substantial performance 'stretch' of increasing job finding and sustainment rates of participants by at least 3-5 percentage points for the treatment group as compared to the control group. It is too early to assess the impact of the programme at this point, but it remains critical to the success of the RCT that the processes and allocation of participants to the Working Capital programme are consistent.

The use of an RCT also helps to unlock other critical elements of programme evaluation to demonstrate their impact beyond claimant numbers. For instance, the results from the RCT design will enable a full economic impact evaluation, including a cost benefit analysis (CBA) to demonstrate, what, if any, the savings are to the exchequer and to provide a cost benefit ratio.[17]

It was originally anticipated that L&W would receive pseudo-anonymised data from DWP on an annual basis for the duration of the evaluation to monitor the RCT and conduct impact analysis in-house. However, due to data sharing issues this has not been possible. To work around this, DWP colleagues have supported the evaluation by agreeing to run annual analysis (presented in Annex B).

## Progress on the RCT

Data received from DWP shows that in the period between the programme going live and May 2017, 1450 ESA claimants had been considered for participation in the Working Capital trail. Of these, 165 were exempt. Of the remaining 1285 claimants, 70.0 per cent were assigned to the treatment group and 30.0 per cent were assigned to the control condition. The design of the randomisation process should provide a 2:1 split in favour of the treatment group; although assignment to the treatment group is slightly higher than would be expected, this fell short of significance.[18]

While the split between treatment and control was broadly in-line with expectation, the DWP analysis note reveals significant errors in the allocation into the groups, suggesting an issue in the randomisation process. The note suggests that approximately 7.6 per cent of trial participants were incorrectly allocated. This rate appears slightly lower than previous years which was estimated as being between 9-10 per cent[19], but is still concerningly high.

It remains unclear whether the misallocation to the groups is purely random or whether there is any systematic bias being introduced. Data received from DWP and observations of the randomisation process conducted by the evaluators do not indicate any clear cause for the difference, though a balance check of the profile of the two groups did highlight some differences.

However, in previous waves of the participant qualitative research there was a suggestion that in some limited instances, it was perceived that they were being referred to the programmes after either indicating an interest in working or being told that they were ready for work. Due to recall issues and asymmetries in understanding the processes that underlie referrals to the Working Capital programme, this does not in itself indicate that the process of randomisation is not being applied. Qualitative interviews conducted with Jobcentre Plus work coaches did not reveal any indication of non-random assignment, with all demonstrating some level of understanding about the importance of randomisation. Examples were provided during these discussions about having to assign people to the control group even where the work coach believed they could benefit from the programme. While this is reassuring, it does possibly reveal a potential source of bias. Further, the fact that nearly twice as many participants were incorrectly assigned to the treatment group suggests at least some level of selection occurring.

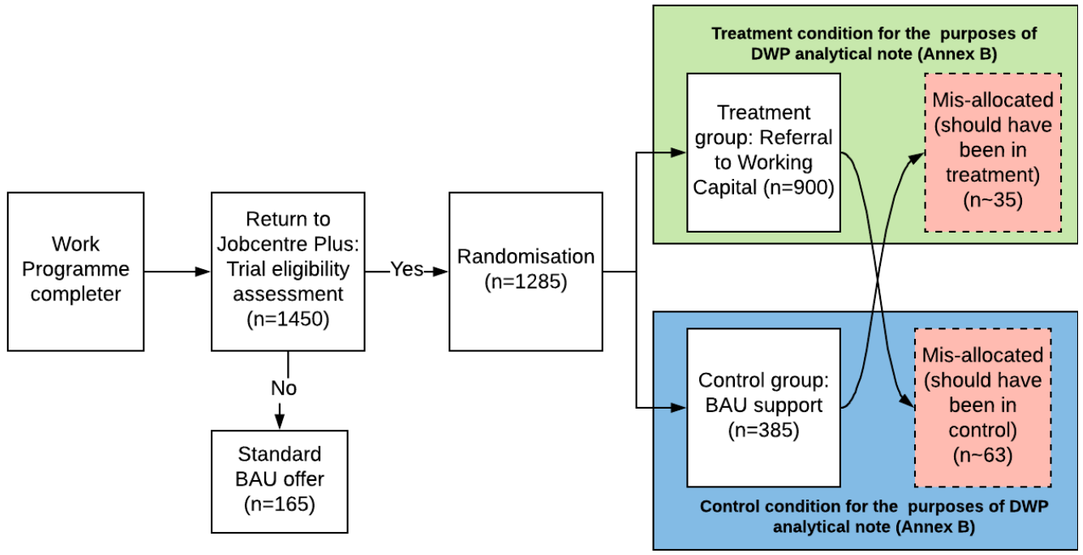
It should also be noted that the analysis presented in Annex B in based on *intended* assignment (that is to say, on the assumption that all trial participants were allocated into the correct arm of the trial). The Department note that this is attributable to the 'intention to treat' approach to analysis; this is an unconventional interpretation to intention to treat and caution should be observed when interpreting the analysis presented in Annex B. Figure A1 presents the flow of participants through the trial.

[17] It is also anticipated that programme participation will lead to other improvements across a range of other measures, including health and well-being, confidence and motivation, and other social issues 0(such as housing stability and financial resilience).

[18] $\chi^2_1=3.841$, p=.062

[19] It should be noted that due to DWP data protection and privacy policies data provided has not been provided as actuals so are subject to minor errors in.

**Figure A1. Participant flow through the Working Capital trial, including actual assignment and designation for purposes of analysis contained in Annex B (as at May 2017)**




## Trial Balance

Balance between the treatment and control groups has been assessed using data presented in Annex B. Differences in the balance of the groups were observable. The most concerning difference can be seen in Figure B3 of the Annex B, which suggests that control group participants had marginally better work histories in the two years prior to entering the Working Capital RCT. It is not possible to precisely state what the difference is, as access to the data underpinning the figure has not been made available, though it appears to fluctuate between 1-2 percentage points above the treatment group. The difference was statistically significant at the 5 per cent level[20].

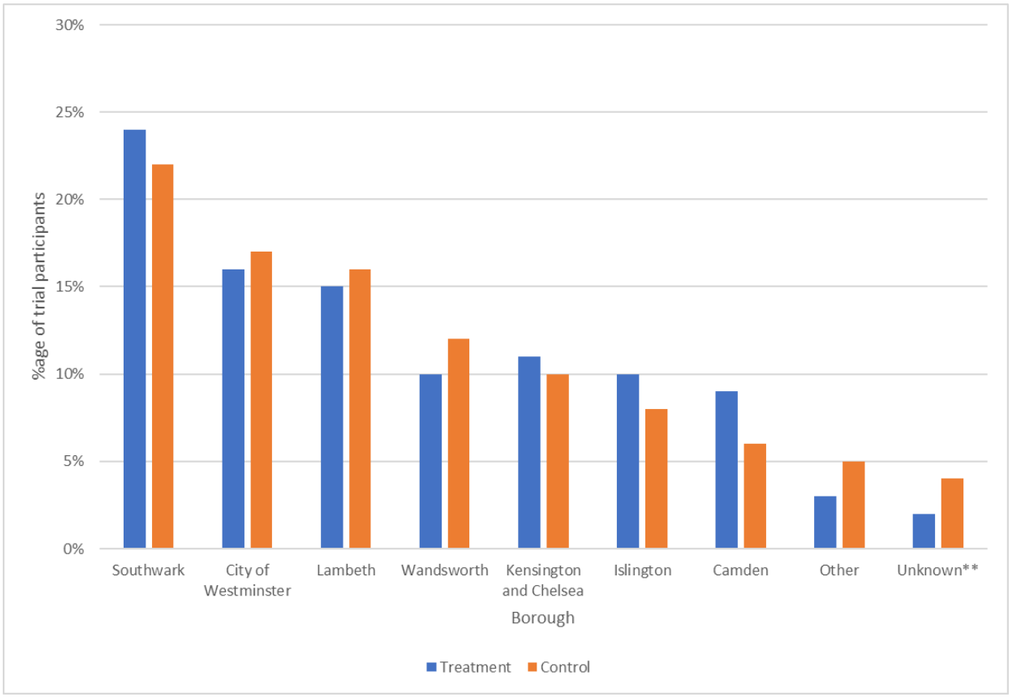
When looking at assignment between London boroughs (Figure A2), there were no significant differences in condition assignment, with the exception of those whose residential borough was 'unknown'[21].

Elsewhere, the balance between the two groups remained largely similar, with a few exceptions.[22] However, these exceptions did not indicate any bias in the randomisation process and would be expected given the comprehensive list of variables compared.

[20] Test statistics have not been made available.
[21] z=-2.064, p=.039
[22] With regards to ethnicity, there was a significant difference between the groups by individuals who were identified as 'Asian' being more likely to be in the treatment group (z=2.058, p=.040). There was also some difference by age, with those identified by 'unknown' age being more likely to be assigned to the control group (z=-2.064, p=.039). Finally, there were some differences in the ICD code, though given the comprehensive list of codes, and issues around small numbers this is neither surprising or concerning in and of itself (test statistics provided here based on supplementary analysis of DWP data conducted by L&W).



**Figure A2. Percentage of trial participants assigned to groups by borough[23]**




## Trial sample size and power

In order to determine the viability of the RCT, power[24], and sample size calculations were conducted in R. The aim of the impact evaluation is to test the null hypothesis that the job outcome rate between the treatment and control group are the same. The purpose of these calculations is to estimate whether the RCT is sufficiently *powered* to show an impact and calculate how many trial participants would need to be involved to detect a 3 per cent difference in the primary outcome measures (sustained job outcome) between the treatment and control group.

[23] Statistically significant differences denoted by '*'
[24] The power of any statistical test is the probability that it will reject a false null hypothesis (which in this case is the hypothesis that participation in Working Capital does not increase participants' chances of securing a sustained job outcome) i.e. that a study will detect an effect when there is an effect there to be detected. The higher the statistical power the lower the chances of concluding there is no effect when, in fact, there is one (a false negative, or type II error). Statistical power depends on the size of the effect and the sample size. Larger effects are easier to detect than smaller ones as they require smaller sample sizes to be statistically significant.

Previous calculations were presented in the first evaluation report. The summary table from that report is shown in Table A1. A 1-tailed test was applied with significance set at .05, and power at .80[25], with the proposed sample of 1920 in the control group (the smaller of the two trial arms). Under such a scenario, a difference of 2.6 per cent would need to be detected, for it to be significant. Assuming that control group sustained, job entry rates are 11.0 per cent, 14.0 per cent of the treatment group would have achieve a similar outcome to disprove the null hypothesis.

**Table A1. Power and sample size calculations based on 2:1 split in trial arms**

| Percentage of trial participants vs expected | No. in control group | No. in treatment group | Probability of sustained job outcome: Control Group | Probability of sustained job outcome: Treatment Group | Difference in probability required to identify significant difference |
|---|---|---|---|---|---|
| 100.0% | 1920 | 3840 | 0.11 | 0.136 | 0.026 |
| 75.0% | 1440 | 2880 | 0.11 | 0.141 | 0.031 |
| 50.0% | 960 | 1920 | 0.11 | 0.148 | 0.038 |
| 45.3% | 870 | 1740 | 0.11 | 0.150 | 0.040 |

Acknowledging that referral rates to the programme are the lower than anticipated Table A1 also presents detectable effects size by lower trial participation (75 per cent and 50 per cent of expected trial participants entering into the trial), as well as highlighting the sample size required to detect a four percentage-point stretch over the control group (anticipated at 45.3 per cent).

These calculations were based on an assumption of 2:1 split between the treatment and control group. The previous evaluation report suggested that the true split between treatment and control was 28.7 per cent. However, this most recent update shows the allocation rate has improved with 30.0 per cent being allocated to the control group. Revised power calculations are provided in table A2 based on 30.0 per cent of trial participants being assigned to the control group. These revised calculations assume that this proportion between the two groups will stay constant throughout the duration of the Working Capital programme.

[25] This means that we can be 80% certain that we can reject a false negative finding i.e. concluding that Working Capital has no positive impact on participants' sustained job outcomes when, in fact, it does. This 80% threshold has become the conventional benchmark for power calculations.



**Table A2. Power and sample size calculations based on prevailing trial arm assignment rate (30.0 per cent going into control)**

| Percentage of trial participants vs expected | No. in control group | No. in treatment group | Probability of sustained job outcome: Control Group | Probability of sustained job outcome: Treatment Group | Difference in probability required to identify significant difference |
|---|---|---|---|---|---|
| 100.0% | 1726 | 3840 | 0.11 | 0.1378845 | 0.0279 |
| 75.0% | 1294 | 2880 | 0.11 | 0.1424399 | 0.0324 |
| 50.0% | 863 | 1920 | 0.11 | 0.1502762 | 0.0403 |
| 50.4% | 870 | 2465 | 0.11 | 0.15 | 0.0400 |

As would be expected, as the sample size decreases, the required effect to prove programme impact increases. Hence, if expected trial participation rates are realised, the minimum detectable effect size is equivalent to 2.7 percentage points. In contrast, if the trial only achieves 50% participation, the effect size increases to 4.0 percentage points.

Given that referral rates are 70.2 per cent lower than expected, the minimum detectable effect size would be 4.9 percentage points; this falls just between the 3-5 per cent stretch target the programme is hoping to achieve. Below this point the RCT will be underpowered to detect a statistically significant difference. If the assumed effect size is taken to be 4 per cent (mid-point of the stretch target range), the RCT is currently underpowered under current participation rates.

## Review of randomisation process

As part of the process evaluation, a number of observations were conducted of the randomisation process itself, to ensure RCT procedures are correctly implemented across Jobcentre Plus and the Working Capital provider. Most of the Jobcentre Plus work coaches found the randomisation and referral process relatively easy, and the use of the Random Allocation Tool (RAT) straightforward. As noted the process has bedded down, and, from the observations at least, work coaches appeared to be conducting randomisation competently. It is in particular notable that the time taken to introduce the trial and conduct the randomisation has been reduced significantly, which appeared to be well received by trial participants.

Typically, an observed session broadly followed the process highlighted in previous reports.

The first stage of the process was consistently followed, with work coaches welcoming the customer back and (where relevant) discussing their experience of the Work Programme and often confirming personal details were up to date. This was followed by a brief introduction to Working Capital and the trial. Potential participants were verbally asked if they would like to participate in the trial. If they agreed to do so, the trial participants number was run through the RAT.

If the participant was allocated to the treatment group, the work coach would call the Working Capital appointment line to arrange an initial appointment. Unlike previous years where the work coach would hand the phone the participant, observations suggest that exchanges with the Working Capital appointment line were entirely by the work coach. The overall effect was to reduce the amount of time spent arranging the initial appointment; this appeared to be welcomed by the participant.

## Implication of Central London Works

Interviews with work coaches have suggested the recent roll out of Central London Works may have implication for both the referral flows to Working Capital as well as for the RCT. Within the CLF sub-region, there may also be implications for the impact evaluation of Central London Works.

With regards to the first issue concerning referral rates, Jobcentre Plus work coaches stated that they were given guidance to assess eligibility and prioritise referrals to Central London Works over other initiatives. Though not entirely the same, participant eligibility for Central London Works did overlap with Working Capital; therefore, assuming the sequencing of programmes eligibility is applied across the CLF region, this may in part choke participant flows to the Working Capital trial.

The second issue, related to the impact evaluation of both Working Capital and Central London Works, stems from the abrupt change in 'Business as Usual' (BAU) support for the control group. Both programmes implement an RCT design, with a similar 2:1 split between treatment and control allocation. As both programmes are being run across the CLF region, individuals allocated to the control group for one study may, in some instances, be entered into the second trial and allocated into the treatment group.

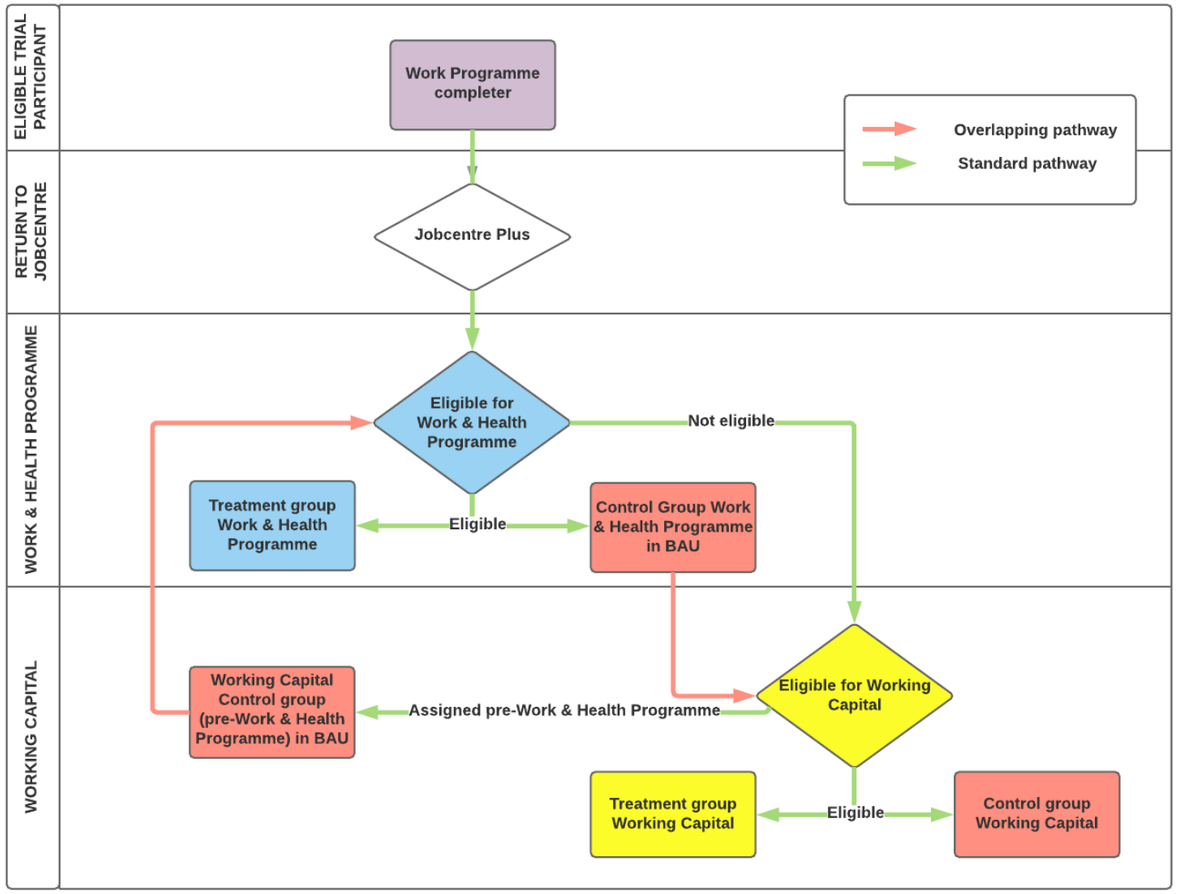
Figure A3 shows how participants may flow from the Central London Works RCT into Working Capital, and vice versa. Overall, creates a risk in the fidelity of the trial by:

- Exposing the control group of Central London Works to Working Capital
- Exposing Working Capital Trial participants who had been allocated to the control condition prior to the implementation of Central London Works to enter into the later trial





**Figure A3. Trial recruitment and randomisation processes**




Technically this does not affect trial fidelity for either trial as the control group is provided BAU support which would include alternative provision. Indeed, it was acknowledged early in the delivery of Working Capital that BAU for the control group could include the successor to the Work Programme as and when it ended. However, given the similarities in the delivery of both programmes there is a realistic risk that some in the control group for both programmes will be provided support that closely resembles the respective interventions being tested as part of BAU.

At this moment in time, it is not possible to assess the level of overlap that is occurring. It would be advisable that the evaluation for both Working Capital and Central London Works closely monitor this. If possible, the Department for Work and Pensions should flag within its administrative data, participants that are included as part of both trials. This would indicate the level of overlap between the trials and may allow the overlap to the statistically controlled during analysis.

# Annex B: Summary statistics based on DWP data

## Background

The figures used in chapters 3,4 and 6 and Annex A are based on administration data held by the Department for Work and Pensions (DWP). This annex presents the full data tables underpinning the figures and provides further information about the source. This annex provides summary characteristics on the Working Capital participants broken down by their pilot status.

Other than providing data, DWP has not been involved in the evaluation of Working Capital.

The DWP National Statistics Data is a frozen data source produced every three months. To capture the characteristics data for the Working Capital participants we examined the National Statistics Data scans between August 2015 and May 2017. We combine these scans into one dataset which is used to find information on the participants from the time they were recruited onto the pilot.

While the National Statistics data is published quarterly by DWP through Stat-Xplore, in its published form it is a single benefit database and it is not possible to cross tabulate benefits i.e. it is not possible to produce the numbers of ESA claimants that are also claiming DLA.

We have linked the various National Statistics datasets to provide this information for the Working Capital participants. These statistics therefore cover only Working Capital participants and no inferences should be drawn to the general population of the UK.

Details on the pilot participation come from the Labour Market System. This system is used to administer benefit conditionality and claimant support. It houses a range of markers that we have used to identify people who have been recruited to the Working Capital pilot and to the groups they have been assigned to.

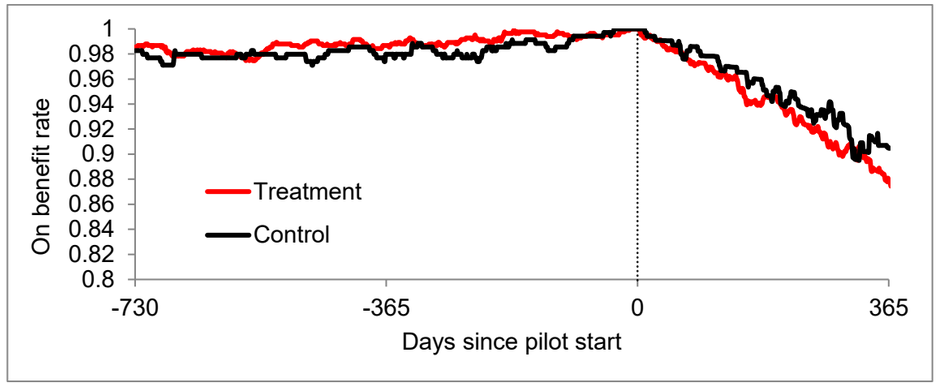
## Benefit dependency

Figure B1 below shows the proportion of claimants in the treatment and control groups who were on benefits since they were recruited to the pilots. The percentage point difference between the treatment and control group benefit dependency rates is also shown with confidence intervals in figure B2. A negative difference in this figure indicates the treatment group are less likely to be in receipt of benefit than the control group on a particular day.

The wider margins of error to the right-hand side of the chart are because our data is 'censored'. This simply means that fewer people contribute to the longer-term outcomes because fewer people joined the pilot early enough for us to measure their longer-term outcomes. For example, we cannot measure a yearlong outcome for somebody who only joined the pilot in January 2017 (recall the analysis is based upon data up to and including May 2017). If a data point is based upon fewer people, the margin of error associated with that data point is wider.

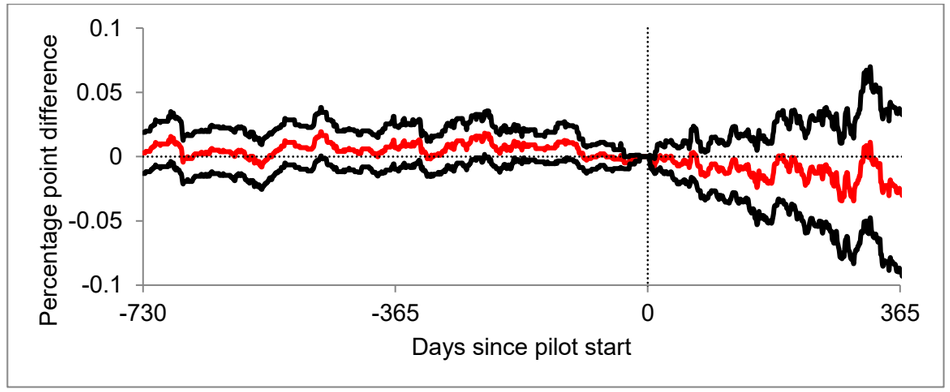
The second figure indicates that there is no statistically significant difference between the benefit dependency rates of the treatment and control groups.

**Figure B1: On benefit rates by allocation**




*Source: DWP National Statistics Data, May 2017*

**Figure B2: Difference in on benefit rates between allocations**




*Source: DWP National Statistics Data, May 2017*

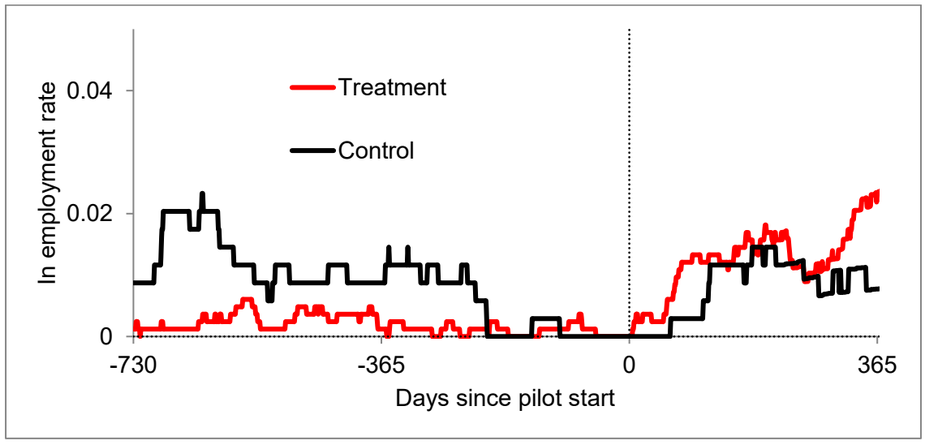
## Employment outcomes

We use HMRC's P45 data to identify employment start and end dates. This data is subject to considerable time lags and generally only approaches completeness some six months after the event. As well as being a relatively out of date source there are known shortcomings in the HMRC data. For example, many employment start and end dates are set to the beginning and end of the tax year respectively and do not

reflect the true employment period. Many employment records do not have end dates which may be because the jobs are ongoing, but it is also possible that some jobs have ended without our knowledge. There is also a known and significant under-representation of self-employment as well as jobs where the earnings are lower than the tax threshold (and therefore do not need to be declared to HMRC). We use the July 2017 scan of the data.

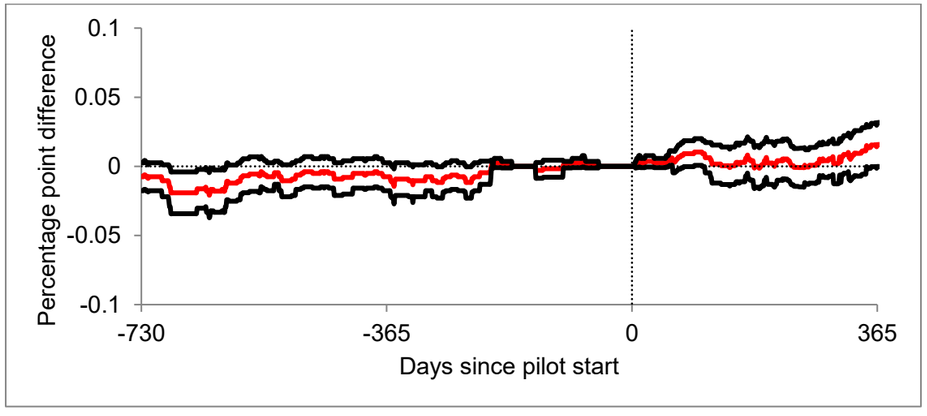
The figures below portray the employment rates (subject to the caveats above) of the treatment and control groups and the differences between these groups. A positive difference indicates the treatment group is more likely to be in employment than the control group.

**Figure B3: Employment rates by allocation**




*Source: HMRC P45 Data, July 2017*

**Figure B4: Difference in employment rates between allocation**




*Source: HMRC P45 Data, July 2017*





## Characteristics

In the table below people are allocated to the (treatment or control) group that they should have been allocated to, on the basis of their national insurance number.

The following rounding rules have been applied to the figures presented in this table:

i) The group sizes have been rounded to the nearest 5.

ii) Percentages have been rounded to the nearest whole number.

In addition to the Treatment, Control and Exempt groups there is a fourth group comprising of 30 individuals (subject to rounding) who refused to take part.

T-tests to detect statistically significant differences (5% significance level) between the treatment and control groups were carried, where a characteristic has been shown to differ significantly between the groups that characteristic has been marked with two asterisks. These tests were carried out before the rounding rules were applied.

| | Treatment | Control | Exempt |
|---|---|---|---|
| **Total People** | 900 | 385 | 165 |
| | | | |
| **Random Allocation** | | | |
| Correct Allocation** | 93% | 91% | 100% |
| Incorrect Allocation** | 7% | 9% | 0% |
| **Gender** | | | |
| Male | 50% | 53% | 55% |
| Female | 50% | 45% | 45% |
| Unknown | 0% | 0% | 0% |
| **Ethnicity** | | | |
| White | 49% | 53% | 61% |
| Black | 5% | 4% | 3% |
| Asian** | 7% | 4% | 3% |
| Mixed | 23% | 19% | 18% |
| Chinese/Other | 9% | 10% | 6% |
| Prefer Not To Say | 7% | 9% | 9% |
| Unknown | 1% | 1% | 0% |
| **Age At Start of Pilot** | | | |
| Under 18 | 0% | 0% | 0% |
| 18 to 24 | 2% | 3% | 3% |
| 25 to 29 | 4% | 4% | 3% |
| 30 to 40 | 15% | 13% | 18% |
| 40 to 50 | 26% | 23% | 24% |
| 50 to 60 | 41% | 40% | 33% |
| Over 60 | 10% | 10% | 15% |

| | | | |
|---|---|---|---|
| Unknown** | 2% | 4% | 3% |
| Average Age | 47 | 46 | 46 |
| **Number of Dependents At Start of Pilot** | | | |
| No Dependents | 81% | 79% | 82% |
| 1 Dependent | 12% | 10% | 9% |
| 2 Dependents | 5% | 6% | 3% |
| 3 or More Dependents | 3% | 5% | 6% |
| **Age of Youngest Dependent At Start of Pilot** | | | |
| 0 to 4 | 2% | 3% | 3% |
| 5 to 10 | 5% | 4% | 3% |
| 11 to 16 | 6% | 8% | 9% |
| 17 or Over | 7% | 6% | 3% |
| **Other Benefit** | 3% | 3% | 9% |
| Adult Dependent Allowance | 8% | 8% | 6% |
| Lone Parent | 4% | 3% | 3% |
| On DLA | 13% | 10% | 18% |
| IB Migration Case | 32% | 31% | 33% |
| **Duration of Most recent ESA Claim** | 1% | 1% | 3% |
| Under 1 Year | 12% | 13% | 6% |
| 1 to 2 Years | 8% | 9% | 12% |
| 2 to 3 Years | 9% | 10% | 15% |
| 3 to 4 Years | 15% | 16% | 18% |
| Over 4 Years | 54% | 52% | 52% |
| **Status At Start of Pilot** | | | |
| Assessment Phase | 3% | 3% | 9% |
| Support Group | 15% | 13% | 27% |
| Work Related Activity Group** | 79% | 77% | 61% |
| Unknown** | 3% | 6% | 6% |
| **Most Recent Status** | | | |
| Not on ESA | 18% | 18% | 12% |
| Unknown (but on ESA) | 1% | 1% | 3% |
| Assessment Phase | 5% | 5% | 6% |
| Support Group | 17% | 16% | 27% |
| Work Related Activity Group | 59% | 60% | 52% |
| **Local Authority** | | | |
| Camden | 9% | 6% | 9% |
| Islington | 10% | 8% | 9% |
| Kensington and Chelsea | 11% | 10% | 9% |
| Lambeth | 15% | 16% | 12% |
| Southwark | 24% | 22% | 30% |
| Wandsworth | 10% | 12% | 6% |
| City of Westminster | 16% | 17% | 12% |
| Other | 3% | 5% | 9% |



| | | | |
|---|---|---|---|
| Unknown** | 2% | 4% | 3% |
| **Marker Value** | | | |
| On Programme** | 92% | 9% | 0% |
| Completed Programme | 0% | 0% | 0% |
| Became Exempt | 0% | 0% | 0% |
| Ceased Other** | 1% | 0% | 0% |
| Refused | 0% | 0% | 0% |
| **Time Since WP End** | | | |
| No Prior WP Spell | 1% | 0% | 6% |
| WP Ends After WC marker | 1% | 0% | 3% |
| Under 1 month | 28% | 27% | 21% |
| 1 to 3 Months | 18% | 17% | 21% |
| Over 3 Months | 52% | 55% | 52% |
| Average Time Difference (Days) | 402 | 411 | 434 |
| **ICD Code** | | | |
| Certain Infectious and Parasitic Diseases | 1% | 1% | 3% |
| Neoplasms | 1% | 1% | 0% |
| Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism | 1% | 1% | 0% |
| Endocrine, Nutritional and Metabolic Diseases | 2% | 1% | 0% |
| Mental and Behavioural Disorders | 49% | 47% | 55% |
| Diseases of the Nervous System | 4% | 3% | 6% |
| Diseases of the Eye and Adnexa | 1% | 0% | 0% |
| Diseases of the Ear and Mastoid Process | 1% | 0% | 0% |
| Diseases of the Circulatory System | 2% | 3% | 6% |
| Diseases of the Respiratory System | 3% | 3% | 3% |
| Diseases of the Digestive System | 1% | 1% | 0% |
| Diseases of the Skin and Subcutaneous System | 1% | 1% | 0% |
| Diseases of the Musculoskeletal system and Connective Tissue | 14% | 17% | 12% |
| Diseases of the Genitourinary System | 0% | 1% | 0% |
| Pregnancy, Childbirth and the Puerperium | 0% | 0% | 0% |
| Certain Conditions Originating in the Perinatal Period | 0% | 0% | 0% |
| Congenital Malformations, Deformations and Chromosomal Abnormalities | 0% | 0% | 0% |
| Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified | 13% | 10% | 6% |
| Injury, Poisoning and certain other consequences of external causes | 4% | 5% | 3% |
| Factors influencing Health Status and Contact with Health Services** | 2% | 0% | 0% |

| | | | |
|---|---|---|---|
| Unknown** | 2% | 4% | 3% |
| **Left ESA**<br>No longer on ESA | 18% | 18% | 12% |

*Source: DWP National Statistics Data, May 2017*

Notes:

i) Where someone receives the 'Adult Dependent Allowance' that dependent is not necessarily their partner (in the sense of 'Living Together as Husband and Wife').

ii) Not everybody who has a partner (in the sense of 'Living Together as Husband and Wife') will receive the Adult Dependent Allowance.

iii) We have defined Lone parents as 'not receiving the Adult Dependent Allowance' and having a dependent aged under 16.

iv) International Classification of Disease is the standard system used for classifying disease. We have categorised the disease codes beside on their prefix as outlined below.

| ICD prefix | Category |
|---|---|
| A00-B99 | Certain Infectious and Parasitic Disease |
| C00-C99 | Malignant Neoplasms |
| D00-D99 | Other Neoplasms, Diseases of the Blood and Blood forming organs and certain disorders involving the immune mechanism |
| E00-E99 | Endocrine, Nutritional and Metabolic Disease |
| F32 | Depressive episode |
| F30-F49 (ex F32) | Mood, Neurotic, Stress Related and Stomatic Disorders |
| F00-F99 (ex F30-F49) | Mental and Behavioural Disorders |
| G00-G99 | Diseases of the Nervous System |
| H00-H99 | Diseases of the Eye or Ear |
| I00-I99 | Diseases of the Circulatory System |
| J00-J99 | Diseases of the Respiratory System |
| K00-K99 | Diseases of the Digestive System |
| L00-L99 | Diseases of the Skin and Subcutaneous Tissues |
| M54 | Dorsalgia |
| M00-M99 (ex M54) | Diseases of the Musculoskeletal system and Connective Tissue |
| N00-N99 | Diseases of the Genitourinary System |
| O00-O99 | Pregnancy, Childbirth and the Puerperium |
| P00-P99 | Certain Conditions Originating in the Perinatal Period |
| Q00-Q99 | Congenital Malformations, Deformations and Chromosomal Abnormalities |





| | |
|---|---|
| R00-R99 | Symptoms and signs involving the Circulatory and respiratory systems |
| T00-T99 | Injury Poisoning and certain other consequences of external causes |
| U01-U21 | Injuries to unspecified part of trunk, limb or body region |
| U22 | Surgical Treatment |
| U23 | Terminally Ill |
| Z00-Z99 + misc | Other |

Notes

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