LEARNING AND WORK INSTITUTE

Working Capital

Second Evaluation Report 2017

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Executive Summary

Working Capital is an innovative, pilot programme of integrated employment and health support for disabled people and those with 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,[1] the Mayor of London and central government[2]. The programme became operational in October 2014. It is currently in its second year of running and will continue to do so until 2019. The programme has been designed to support Employment and Support Allowance (ESA) claimants in the 'Work Related Activity Group' (WRAG) who have 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 funding for Working Capital is significantly higher than has been the case in comparable recent programmes, allowing for smaller caseloads and greater specialist provision.

This second evaluation report builds on a previous report to fully understand the delivery context and operation, highlight learning about what has and has not worked in the delivery of the Working Capital programme and provide an update as to the implementation of the randomised controlled trial built into this programme of work. The report draws on interviews with Working Capital participants and frontline delivery staff, findings from the observations of support sessions and data analysis of administrative data obtained from both the Working Capital provider and Department for Work and Pensions (DWP).

Findings

Working Capital Participants

Working Capital participants' needs and barriers to entering and maintaining employment are complex and wide-ranging. Just under three-quarters of participants reported a secondary health issue, and nearly a quarter had not worked for 20 years or more. A high proportion also reported not having basic skills (29.9 per cent). The age distribution of participants was skewed towards older age groups, with the median age being 51 years (this distribution is unsurprising given that the eligibility requires a prolonged period out of work and the interaction between health and age). Age appeared to be a significant barrier with claimants reporting low levels of self-confidence as they perceived reluctance amongst employers to hire older staff. There was also reduced motivation to work among those who were approaching retirement age.

[1] City of London, Camden, Islington, Kensington and Chelsea, Lambeth, Southwark, Wandsworth and Westminster

[2] Department for Work and Pensions (DWP), HM Treasury and the Cabinet Office

Given the length of time participants had been out of work, a number of other issues revolving around life circumstances, household and financial stability were also prevalent, and required addressing.

There appeared to be an amplified need for work and support to be delivered both flexibly and locally due to health needs (which may increase the friction of distance) and care commitments. Naturally this restricts the number and types of jobs that they felt able to apply for.

Participation rates

Despite taking steps to increase participation (i.e. extending eligibility to DWP 'stock' ESA WRAG participants), the number of referrals and attachments to the programme remained significantly lower than originally expected. In turn, this has supressed the number of outputs and outcomes that can be achieved and the overall success of Working Capital. Unfortunately, it has not been possible to obtain detailed socio-demographic data about those referred to the Working Capital programme to fully explore the characteristics and circumstances of those who did and did not attend the initial meeting after being referred. There was evidence that personal characteristics and circumstances did in part influence whether an individual 'fully' attached to the programme, with recent experience of homelessness and living in a jobless household with caring responsibilities reducing the likelihood of an individual fully engaging with programme.

Participant journey

The participant journey on the programme was in line with what was anticipated. The randomisation process was unobtrusive, though differences in the level and manner in which Work Coaches provided information appeared to have influenced participants' decision to attach. Despite often being told by Work Coaches and the APM caseworkers that involvement in Working Capital programme was voluntary, participants still perceived that it was a mandatory. Underpinning this belief was the involvement of Jobcentre staff in the referral process and the mandatory first appointment, which created a persistent perception that the programme itself was mandatory.

The action planning process was largely well received with participants feeling involved in the decision-making process. Despite this, local authority leads suggested that action plans were more 'generic' rather than high-quality at the point that they were required to review them (action plans were subsequently updated following the Personal Wellbeing Session, and provided more detailed information about the health and welling needs of participants – which local authority leads were not required to review).

Participants reported receiving a mixture of employment and skills support as well as health and emotional support. Although a unique aspect of the programme, the health and wellbeing offer was not as enthusiastically taken up as initially

anticipated. In part this was due to the association with Work Capability Assessments, which APM appears to have addressed. However, for some, health issues were a deeply personal matter, and they preferred the advice and support of their own GP.

In-work support was also well regarded by participants as it gave them the confidence and motivation to stay in work. A range of internal and external support (e.g. benefits advice, income maximisation, health support etc.) was provided to participants as they moved closer into the labour market, enabling the participant to focus on their new job.

Outcomes

Although it is not yet possible to quantitatively assess the impact of Working Capital due to low job starts and sustained job outcomes, the qualitative research has demonstrated soft outcomes for clients. This includes improved confidence and wellbeing as well as more stable financial and housing situations. Participants also reported being closer to entering employment because they had better CVs and applications as well as more of a sense of what they wanted to achieve, and how to do this.

There is also evidence to suggest Working Capital has encouraged more integrated service provision, though the extent of this integration is unclear. An important factor in the progress made is the lower than anticipated participant numbers, which has impacted local authorities' ability to maintain engagement in Working Capital amongst local providers and develop further partnerships.

A number of recommendations to improve the support were suggested by participants, these included operational issues, such as:

- notifying participants of any change to their caseworkers,
- paying for out-of-pocket expenses,
- extending the 12-month duration of out of work support,
- clearer communication of the mandatory nature of the first meeting, but voluntary participation thereafter.

However, several of the recommendations relate to structural issues, and included:

- more effective housing support,
- finding suitable alternatives to provision that is oversubscribed,
- getting 'quicker' referrals to wider services.

Conclusions

Overall, the programme has started to become established, with progress being made on the process of engaging participants and integrating and co-ordinating with local authority provided services. Recent steps taken by both the provider and local authorities is promising and may increase the pace of integration in the coming period. This interim evaluation has highlighted some key issues, and provides challenge to some of the assumptions made about the employment support needs of long-term out of work disabled people. In particular, findings illustrate the deep-rooted barriers some face to entering the labour market as well as the role of personal autonomy in accepting health services. It also highlights how operational issues, such as the low attachment rate, impact not only on the ability to deliver outcomes at volume, but may also effect sustaining the engagement of wider services.

Introduction

Working Capital is an innovative, pilot programme of integrated employment and health support for disabled people and those with 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,[3] the Mayor of London and central government[4]. The programme is being delivered under contract by Advanced Personnel Management UK (APM) following a competitive tendering process. The programme became operational in October 2014. It is currently in its second year of running and will continue to do so until 2019.

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 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 funding for Working Capital is significantly higher 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.

The programme is being run as a 'Randomised Control Trial', 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. Learning and Work Institute (L&W) has been commissioned to evaluate the trial, comprising assessments both of its impact and how it has been

[3] City of London, Camden, Islington, Kensington and Chelsea, Lambeth, Southwark, Wandsworth and Westminster

[4] Department for Work and Pensions (DWP), HM Treasury and the Cabinet Office

[5] £2,650, compared with estimated funding for ESA claimants within the Work Programme of just £700 per participant

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. This second evaluation report builds on the previous report to fully understand the delivery context and operation, highlight learning about what has and has not worked in the delivery of the Working Capital programme and provide an update as to the implementation and participation of the randomised controlled trial built into this programme of work. The report sets out:

- In Chapter 2, the methodology used to conduct the research;
- Chapter 3 outlines the profile and needs of programme participants;
- Chapter 4 outlines programme participation rates;
- In Chapter 5, a discussion of participants' journey's through the support;
- In Chapter 6, an overview of participant outcomes; and,
- Chapter 7 provides interim conclusions.

The report also includes two annexes which present technical information regarding the implementation of the RCT (Annex A) and the balance between the two arms of the RCT (Annex B).

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 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?

The table below demonstrates how the research elements combine to address the research questions.

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		●		●	●	
Obvs. of randomisation and post-hoc assessment of randomisation process			●			
Analysis of provider MI, DWP and HMT data			●	●		●
Cohort Survey		●		●		●

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 5 and 6). 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.

Further information on the methodology that was applied to conduct the research outlined in this particular report is included below.

Participant interviews

We conducted a total of sixteen interviews with programme participants across all the boroughs involved. The purpose of these interviews was to capture their views and experiences of the services being delivered to them to aid our assessment of the effectiveness of delivery. Interviews were conducted using a semi-structured topic-guide, this gave the discussions focus whilst enabling participants to explore areas in more detail where possible. The age of participants interviewed ranged from 31-65 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). Two interviewees were now claiming Jobseekers' Allowance (JSA) after being found 'Fit for Work', though one had subsequently successfully appealed this decision, and returned to ESA. Other benefits claimed by interviewees included Personal Independence Payments (PIP), Housing Benefit (HB) and Income Support (IS).

Frontline staff interviews

Overall, eight frontline staff were interviewed. As with the participant research, we ensured that we spoke to staff who covered all the boroughs involved in the programme. These interviews were conducted to gain an insight into the delivery of the programme; specifically, what was working well, what could be improved, factors affecting delivery and the significance of service integration. They also provided insight into the outcomes achieved on the programme, and the implementation of the RCT. Again, a semi-structured topic-guide was used.

Local authority interviews

We interviewed staff leading on or contributing to the Working Capital programme at six of the eight local authorities involved. The interviews sought to find out more about the action plan and caseload review processes, from the local authority perspective, and to explore whether the programme had impacted processes or policy within the local authorities. Partnership working was also discussed.

Support observations

In line with the process evaluation tied to the randomised controlled trial, four observations were conducted across three participating JCP's. In one instance, a potential claimant likely to be eligible for the trial, did not attend their meeting. In this instance, the research took the opportunity to talk through the Working Capital eligibility and check the referral procedure with the Work Coach.

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 920 referrals and 793 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 the Jobcentre Plus).

3. Working Capital Participants

Programme Eligibility

As set out in the first evaluation report, 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, there were 11,850 claimants in the ESA WRAG group in central London; over the course of a year, this figure steadily fell to 10,160[6]. Depending on their prognosis for being ready for work, WRAG claimants are either referred into the Work Programme for two years of support, or supported by Jobcentre Plus Work Coaches.

Initially, programme eligibility was limited to those who completed the Work Programme and returned to Jobcentre Plus for the first time (flow claimants). 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).

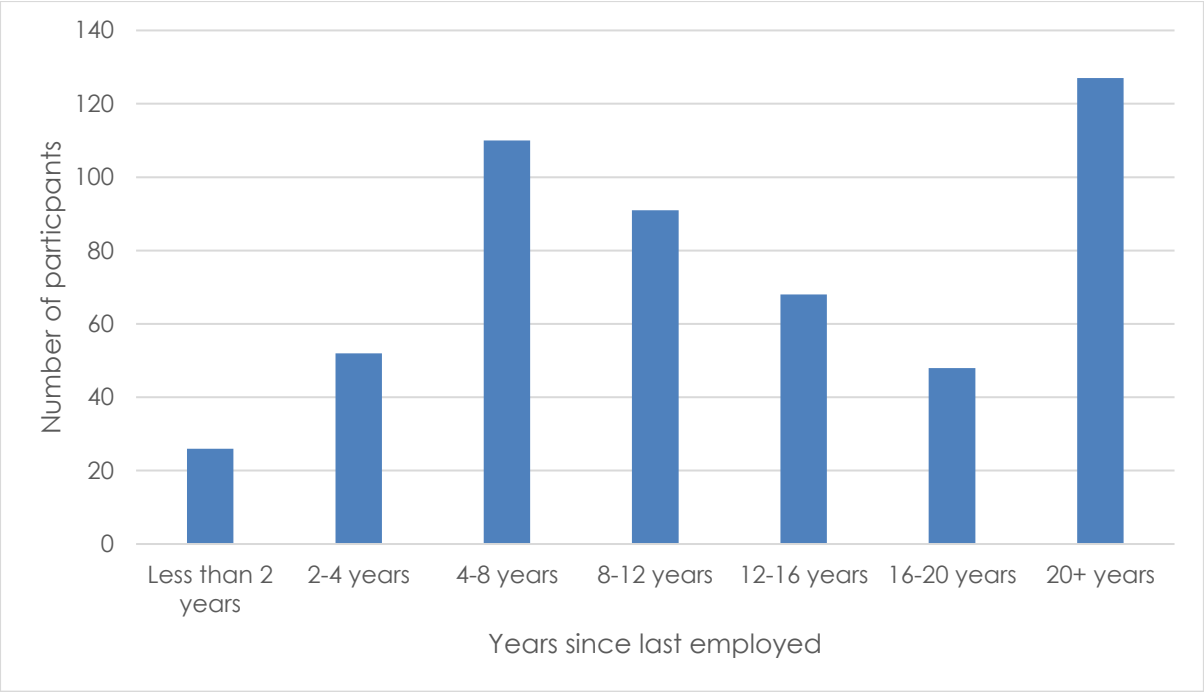
Programme Participant needs

It was clear from both the participant themselves and the Working Capital caseworker, that programme participants' needs were multiple, and varied, and presented a significant barrier form them entering the labour market. The nature of the eligibility criteria meant that all had been out of work for a significant period and many had not worked for extended periods, if ever. Figure 1, below, shows that most of the participants who had attached to the programme had not worked for at least four or more years, with just under a quarter (24.3 per cent) reporting that they had not worked for 20 or more years.

Interviews with participants who had previously worked revealed that among some other reasons, health issues or substance dependency were a key driver in their leaving work or being dismissed; the other reasons for leaving work that was notable among those interviewed related to caring responsibilities.

[6] Data extracted from NOMIS (2 July 2017) for the period November 2015, February, May, August and November 2016.

Figure 1. Participant length of unemployment



Participants appeared to have had previous work experience across a range of sectors including retail, sales, customer services and the care industry, as well as some with professional roles within the civil service and health sector. A few currently held voluntary roles, which they valued and enjoyed, as it reduced the level of isolation they experienced by getting them out of the house and meeting other people.

Presenting health issues

Data provided by DWP and presented in Annex C, shows that claimants eligible for Working Capital support presented a range of health conditions. Most common were mental and behavioural disorders (reported for 47 per cent of people referred to the programme), diseases of the Musculoskeletal system and Connective Tissue (reported by 15 per cent of people referred) and Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified (accounting for 14 per cent of people referred). Management information from the Working Capital provider identifying symptomatic markers claimants have also indicated mental health issues as the most significant health issue for the programmes participants, with 43 per cent reporting such issues as a primary health condition and further 24.3 per cent as a secondary issue. Interviews with local authority leads and APM caseworkers also suggested that mental health and musculoskeletal were the most common issues faced by Working Capital participants.

Possibly indicating the complexity of the health issues Working Capital participants experience, nearly three quarters of participants (74.7 per cent) reported having a secondary health issue. 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.

Participants interviewed reported a variety and wide range of physical and mental health conditions, including chronic neurological conditions, arthritis, depression, drug and alcohol dependency, and a rare blood condition. They commonly had complex and multiple conditions, some of which were long-term. Others had recovered from health conditions that they were previously claiming ESA for, such as cancer and Post-Traumatic Stress Disorder (PTSD). In many instances, the true extent of health needs was not initially apparent, and mental health issues were highly prevalent, even where the participant had not disclosed this or been formally diagnosed with such issues.

> *"All of my clients probably have an element of hidden long-term health conditions… We're not practitioners and we can't diagnose it, however, we can see it in one way, shape or form … perhaps where being around people, feeling uncomfortable with travelling, so anxieties as well as being able to make independent, informed decisions. Yes, I would even go as far to say that every single one of my clients has a sort of mental health issue."*
> (Caseworker)

For some, the prospect of work seemed distant due to their health issues, with participants reporting being in in regular or constant pain, lacking confidence and having limited mobility because of their condition. For others, the unpredictable nature of their condition made their ability to enter stable employment a challenge.

> *"I don't know if I want to go into a work environment because I feel that my ailments are so sporadic that I feel unhappy to be a hindrance to an employer"*
> (**Female, 59**)

Participants also mentioned mental health issues such as depression and anxiety as preventing them from working in the past, which made them worry about their ability to complete for a role in the future. In other instances, participants were wary of their ability to undertake more physical roles, which some had done in the past, due to the combination of having a physical health condition and their prolonged unemployment – it was not always clear whether this was an actual inability due to their health condition, or one that was perceived.

> *"Some of the time I feel very competent, but there are other instances where I just feel so bewildered and lost, and I work hard to picture myself in work and I have been applying for roles, but I kind of feel like I fall between two stools "*
> (**Female, 45**)

The concern among participants about their ability to work was also shared by local authority partners who questioned whether some claimants referred to the

programme were actually able to work due to their particular health condition, and therefore potentially in the wrong benefit group.

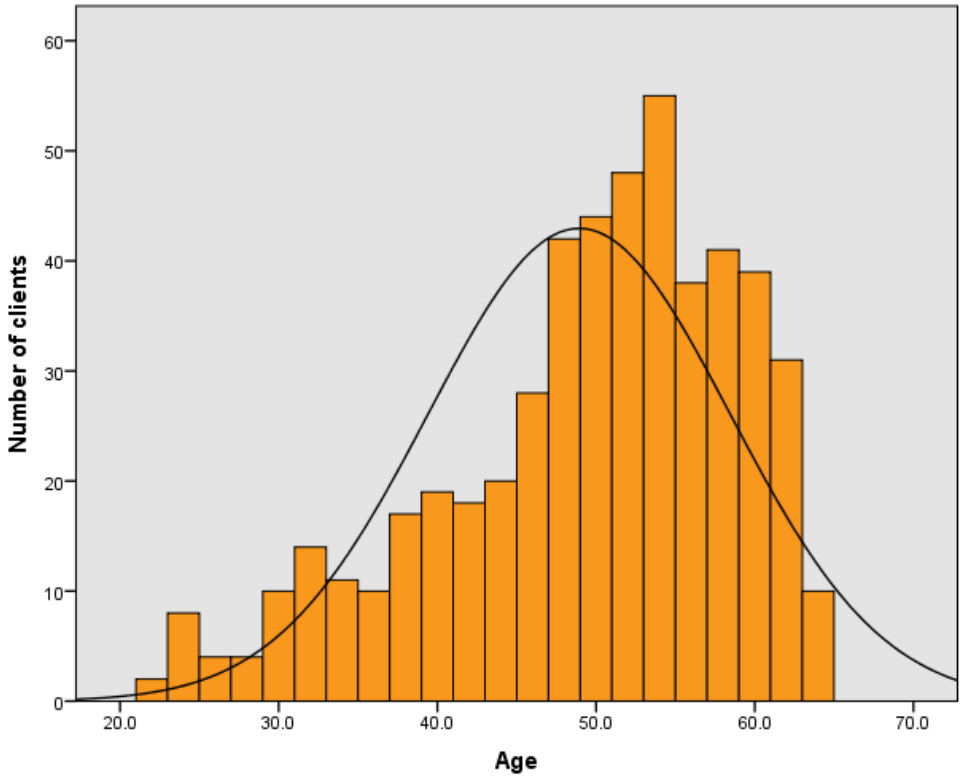
> *"Sometimes it was really the opposite and I thought 'why is this person not in a support group, they are really not going to be able to work?' So I think it raised a lot of issues around were people on the correct benefits"* (**Local authority lead)**

Local authority staff explained that the characteristics of participants were largely what they would have expected for this cohort, and that some programme participants had previously taken part in local authority run employment support programmes. However, their involvement in the Working Capital programme (in particular the reviewing and sign off action plans discussed below), has highlighted the true extent of the challenge faced by post-Work Programme ESA WRAG claimants due to their health conditions.

Participant age

Participants interviewed were universal in their perception of health issues as their most significant barrier to entering work. However, they were not the only challenges they reported. Given the length of time participants had been out of work, it is not surprising that a number of other issues revolving around life circumstances, household and financial stability, and relevance of past employment experience and skills were also identified as barriers to the labour market.

Figure 2. Age distribution of Working Capital participants



As can be seen from figure 2, the age distribution of Working Capital participants was skewed towards older age groups, with the mean age being 48.9 years (the median age was 51 years). This distribution is unsurprising given eligibility criteria which requires a prolonged period of time out of work and the interaction between health and age.

Participants coming to the programme in later years felt that this made them unattractive to potential employers because they would not be working for the organisation for more than a few years.

> *"They prefer an employee who can progress and work for long time, but I'm 61 now"* (**Male, 61**)

Echoing this, others were more explicit in their perception that their age put them at a distinct disadvantage to younger jobseekers; something to which they had reconciled to (*"Well, at the age of 58, I'd leave it to the young ones myself"* (**Female, 58**)). This self-perceived disadvantage due to age, combined with their health issues appeared to directly contribute to older participants' low levels of confidence about entering employment.

Further, nearly a tenth of Working Capital participants were in their 60's and therefore close to the state pension age. This again appeared to affect the level of motivation they had to look for work.

Skills, training and qualifications

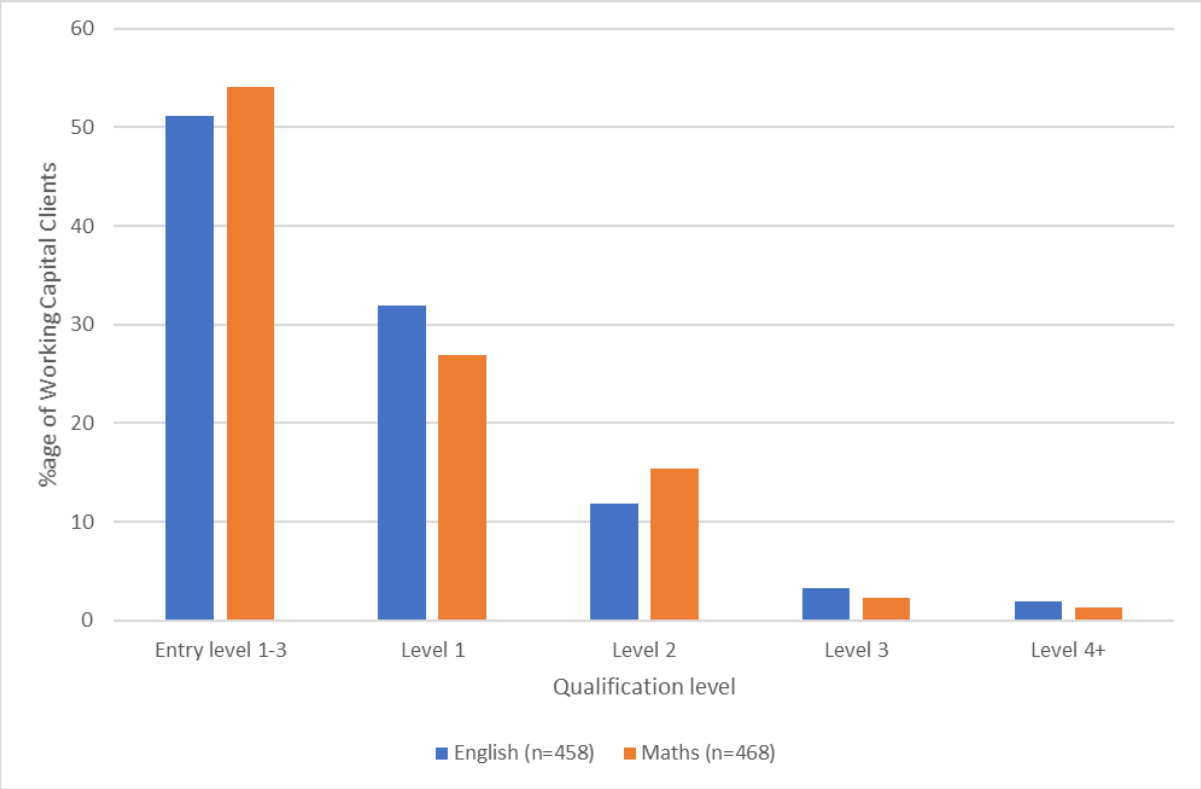
The lack of appropriate skills, training and relevant qualifications was a significant barrier to employment. Nearly a third of Working Capital participants (29.9 per cent) were identified as not having basic skills (self reported and assessed on attainment of qualification). As can be seen from figure 3, where maths/numeracy and literacy qualifications were held by participants they tended towards lower levels, particularly entry level qualifications. It was suggested that addressing this skills and qualification need would in part help entry into work.

> *"I don't think I've got the right qualifications. I'm not very well educated at all, but with the right training it would be all right."* (**Female, 55**)

When comparing the highest level of qualification held by Working Capital participants to the broader population, they are noticeably less more likely to hold an Entry Level qualification (particularly with regards to literacy). While 14.9 per cent of the population of England hold Entry Level qualifications for literacy, 51.9 per cent of Working Capital did likewise. While not as marked, Working Capital participants were more likely to hold an Entry Level numeracy qualification as their highest qualification

compared to broader population; respectively rates were 54.1 per cent compared to 49.1 per cent.[7]

Figure 3. Highest literacy and maths related qualifications[8]



Local and flexible employment

Often related to a participant's health issue or caring commitments was a desire to work locally or under flexible working arrangements. When explored, a number of more detailed reasons were provided, including not wanting to be too far removed from one's home or their child's school to reduce the travel time; concern about travelling on public transport due to discomfort, particularly in peak hours where seats are less available; and the unpredictability of their own health condition.

Naturally this narrows the scope of work participants find acceptable. It also led a number of participants to express an interest in self-employment, which they believed would be a more suitable option considering their situation and health, specifically they were drawn to the ability to work from home and during hours that suited them.

[7] Rates for the population of England were obtained from Dept. of Business Innovation and Skills (2013) *The 2011 Skills for Life Survey: A Survey of Literacy, Numeracy and ICT Levels in England*. London: Dept. of Business Innovation and Skills (available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/36000/12-p168-2011-skills-for-life-survey.pdf#page=66)

[8] Respectively 10.6 per cent and 11.9 per cent of Working Capital clients held some 'other' qualification, that were not recognised and/or aligned to educational levels.

Housing, financial stability and social isolation

Many Working Capital participants live in low income households, and often face housing problems. Data from APM suggest that four per cent of Working Capital participants were experiencing homelessness at the point of arriving to the programme.

> *"I was couch surfing... I mean my time in the hostel didn't last very long, I was moved on quite rapidly"* (**Female, 45**)

The experience of unsuitable or poor-quality housing, being at risk of eviction or experiencing homelessness naturally affected participants' ability to focus on other issues, including finding work, outside of their immediate wellbeing needs.

> *"I had a flood, I've got another one now. I had a leak in the toilet and the process of them coming to me and how long it took, and I just thought it was ridiculous, but I've had heating problems."* (**Female, 59**)

Similarly, financial concerns and debt also squeezed participant's mental bandwidth to focus on non-monetary issues. One respondent explained that after having their benefits stopped, they were unable to pay their utility bills, which they described as distressing and confusing and was their immediate priority to resolve.

While not apparent from participant interviews, a significant issue identified by caseworkers was the prevalence of social isolation and the impact that can have on one's resilience.

> *"I think some of the stuff, like I mention this fear [and anxiety] it's a lot of the clients don't have that kind of network in terms of family support – it's they're on their own"* (**Caseworker**)

The consequences of this isolation could be quite profound, with some participants being unable to cope with minor setbacks or everyday events, irrespective of how well other things were going for them.

Summary and implications

Working Capital participants' needs and barriers to entering and maintaining employment are complex and wide-ranging. The majority of participants reported a secondary health issue, nearly a quarter of participants had not worked for 20 years and nearly a third of participants were reported as not having basic skills. Further, age appeared to be a significant barrier with claimants reporting low levels of self-confidence as they perceived reluctance amongst employers to hire older staff. There was also reduced motivation to work among those who were approaching retirement age.

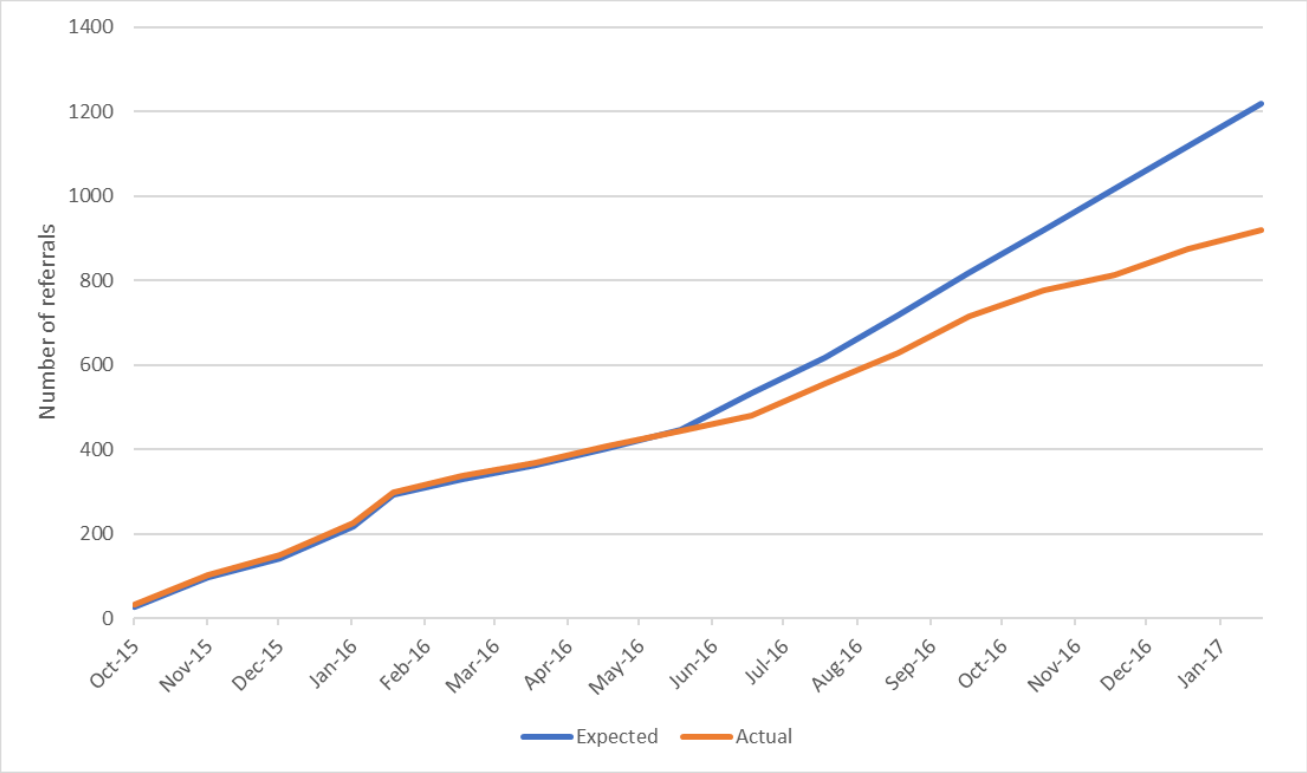
This would support the case for intensive support, over an extended period to support participants to overcome these often entrenched and persistent barriers and help them focus on employment and training.

Once participants feel ready to apply for work, the desire for flexible and local work due to health and care commitments restricts the number and types of jobs that participants feel able to apply for.

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 5, which cumulatively compares the expected and actual number of referrals made to the programme, the actual number of referrals made is 24.5 per cent lower than had been expected, despite action being taken to increase volumes (discussed below).

Figure 5. Cumulative expected and actual Working Capital referral volumes



Several reasons may help to explain this including:

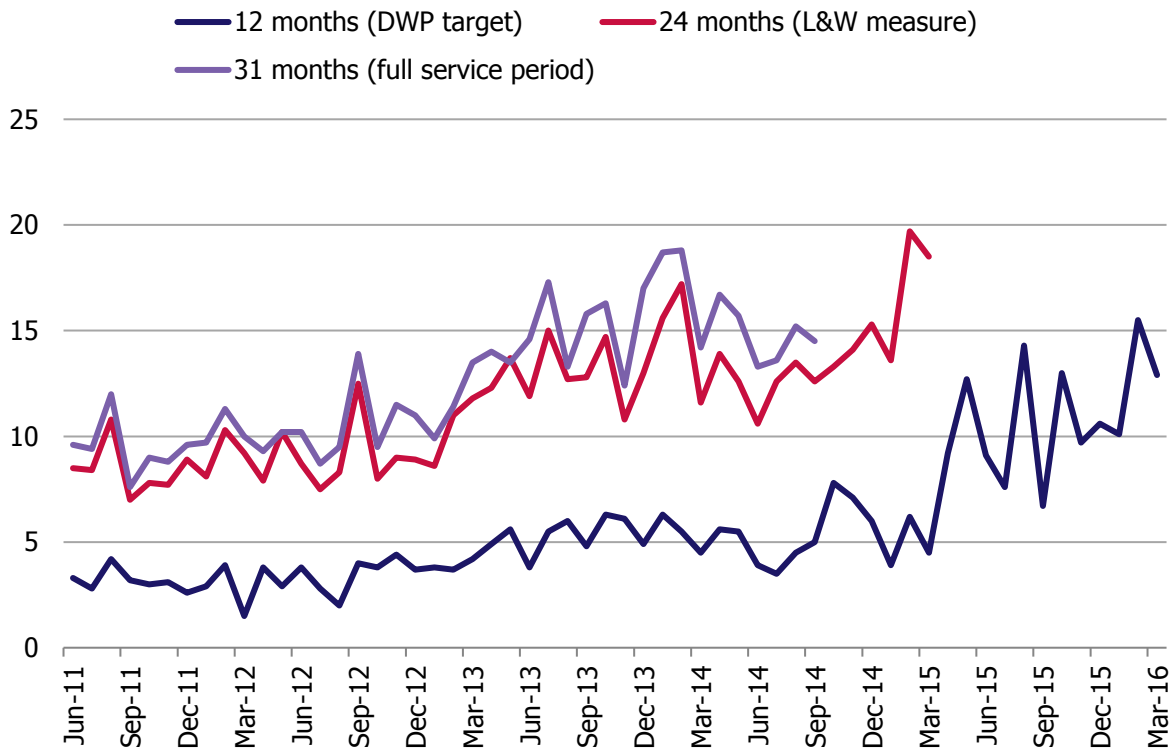
- the increase in employment outcomes for Work Programme participants, reducing the number of unemployed Work Programme completers;
- the move of ESA WRAG claimants to the ESA Support Group (and less markedly onto Jobseekers Allowance) during the course of the Work Programme following a subsequent Work Capability Assessment, making them ineligible for the Working Capital programme; and;
- errors in the estimated made at the outset of the programme which were based on the data and projections available at the time.

The first two points are particularly salient given the extent to which they divert individuals who started the Work Programme from fully completing it (and thereby becoming eligible for Working Capital). Though difficult to demonstrate through the

available data, the increase in job outcomes achieved by the Work Programme for ESA WRAG claimants may mean the remaining cohort (who are ultimately eligible for Working Capital support) are relatively further away from labour market.

With regard to the original estimates, predicted volumes expected to be referred to the programme were originally based on the minimal service targets set by DWP for the Work Programme (expected to be less than five per cent). However, as can be seen by figure 6, there has been a progressive increase in the Work Programmes job outcome rates in recent years. At the point of developing the Working Capital programme (around March 2013), 12 month job outcomes were at below five per cent, while 24 month job outcomes were just over ten per cent. The 24 month job outcome rate for potentially eligible claimants entering the Work Programme two years later (March 2015) had increased to around fifteen per cent, with the trend continuing to rise overall.

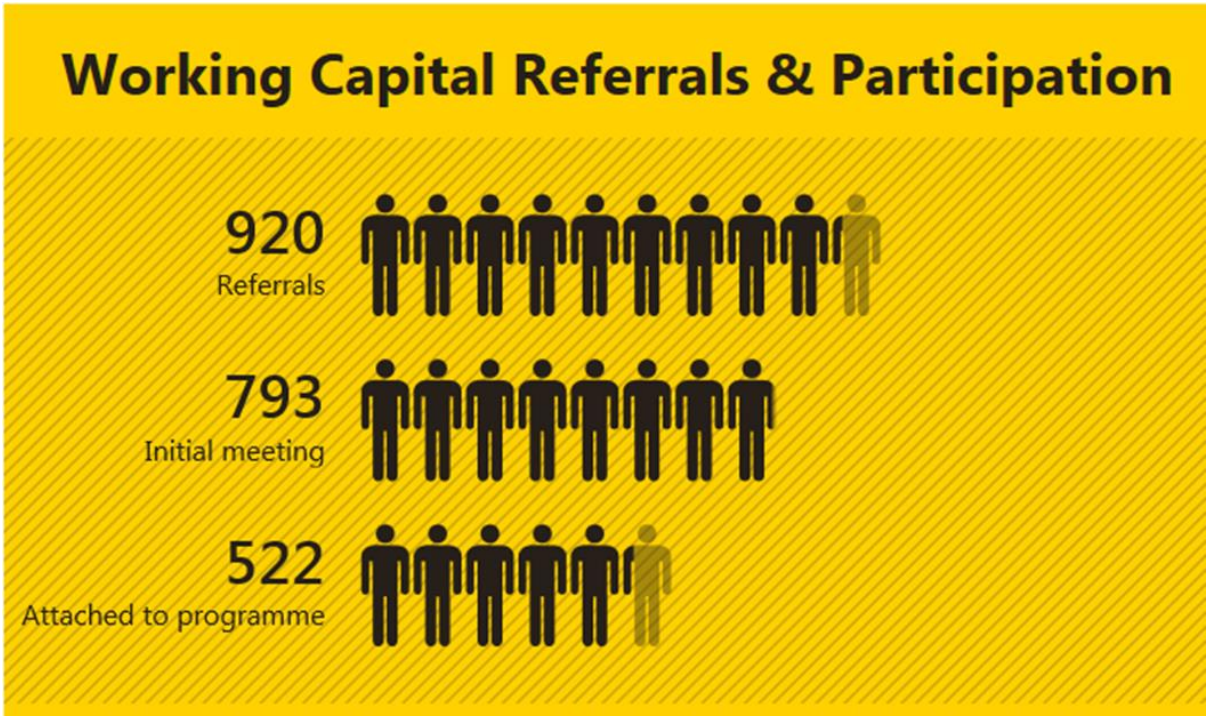
Figure 6. Work Programme job outcome by cohort (separated by month of start on programme)



Between the Working Capital programme entering into live running and April 2017, the programme has received 920 referrals from Jobcentre Plus. Of these, 793 people referred to the programme had an initial meeting, providing an effective referral 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 is broadly in line with the 10 per cent ‘drop-out’ rate originally anticipated.

Of the 793 individuals who were referred to the Working Capital programme and had attended an initial meeting, 522 had accepted the Working Capital offer, and had, or were in the process of attending a full assessment, providing an attachment rate of 65.4 per cent (or 56.4 per cent when viewed in relation to the total number of referrals made by Jobcentre Plus). However, while 522 had nominally attached to the programme, 41 claimants had yet to attend or complete their full assessment, were awaiting local authority attachment approval or had disengaged between the initial meeting and the assessment meeting.

Figure 7. Referral and programme participation volumes (to February 2017)



Comparing the socio-demographics and circumstances between those that did formally attach, and those who did not (or were going through the process) showed some interesting differences. First, those who were identified as not having basic skills were proportionately more likely to fully attach to the programme when compared to participants with basic skills; respectively, 98.0 per cent attached, compared to 89.9 per cent who did not[9].

While there was no notable difference in attachment rates between participants who lived in jobless households and those that did not, differences did become statistically significant when looking at those who lived in jobless households with dependent children. Participants from such households were almost twice as likely to not to fully engage with the programme when compared to those living in other household circumstances (respectively, 13.0 per cent compared to 6.7 per cent[10]).

[9] $\chi^2_1=9.556$, p=.002
[10] $\chi^2_1=4.493$, p=.034

Being homeless appeared to most significantly affect fully attaching with the programme, with 33.3 per cent of those identified as being homeless not attaching compared to only 6.8 per cent of those not considered homeless[11].

Qualitative interviews with caseworkers suggested there were other reasons for not engaging with the programme, or disengaging at an early point. Participants with very severe health complications, or those whose health had recently deteriorated were identified specifically as being less likely to engage. While substance addiction was not seen as a barrier to taking up the initial Working Capital offer, it was associated with earlier disengagement by one caseworker.

Being out of work for extended periods could also act as a barrier, as participants could sometimes be intimidated by the programme and prospect of work.

> *"Like, they haven't been in work for such a long time just the idea of work alone can be quite a scary process. It becomes a culture almost of staying away from that side of things, so I think they find it a challenge [to engage]".* (**Caseworker**)

Summary and implications

Significantly lower numbers of referrals and attachments to the programme originally expected has supressed the number of outputs and outcomes that can be achieved and the overall success of Working Capital. 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 individual least receptive to receiving employment support.

There was evidence that personal characteristics and circumstances did in part influence whether an individual 'fully' attached to the programme, with recent experience of homelessness and living in a jobless household with caring responsibilities reducing the likelihood of fully engaging with programme. Increasing awareness of the factors that are more likely to result in participants not engaging and attaching could shape how information about Working Capital is relayed to potential participants going forward. For example, emphasising that the support can be flexible and that participants can be supported to enter volunteering or part-time work may be beneficial for those with dependent children.

[11] χ^2_1=19.626, p<.0.001

5. Participant journey

The participant journey through the Working Capital was illustrated in the first evaluation report, and is out lined here again, in figure 4.

Referrals

Referrals were initiated by Jobcentre Work Coaches. Most participants interviewed recalled being referred to the Working Capital by the Work Coach in person, and in some instances, this was followed up with a letter from DWP asking them to attend an appointment.

The process of randomisation did not appear to make an impression on participants, with none recalling the event. When asked about why they felt they had been referred, reasons given included that their Work Coach felt that they were ready for work or that they thought it would benefit them, as a response to demonstrating an interest in working or becoming self-employed, or simply as a follow-on programme after completing the Work Programme. However, most participants appeared to be passive parties to the referral, who were unaware why they were being referred to the programme.

Information provided by Jobcentre Work Coaches was viewed as important to whether an individual ultimately took up the Working Capital offer. As one caseworker explained:

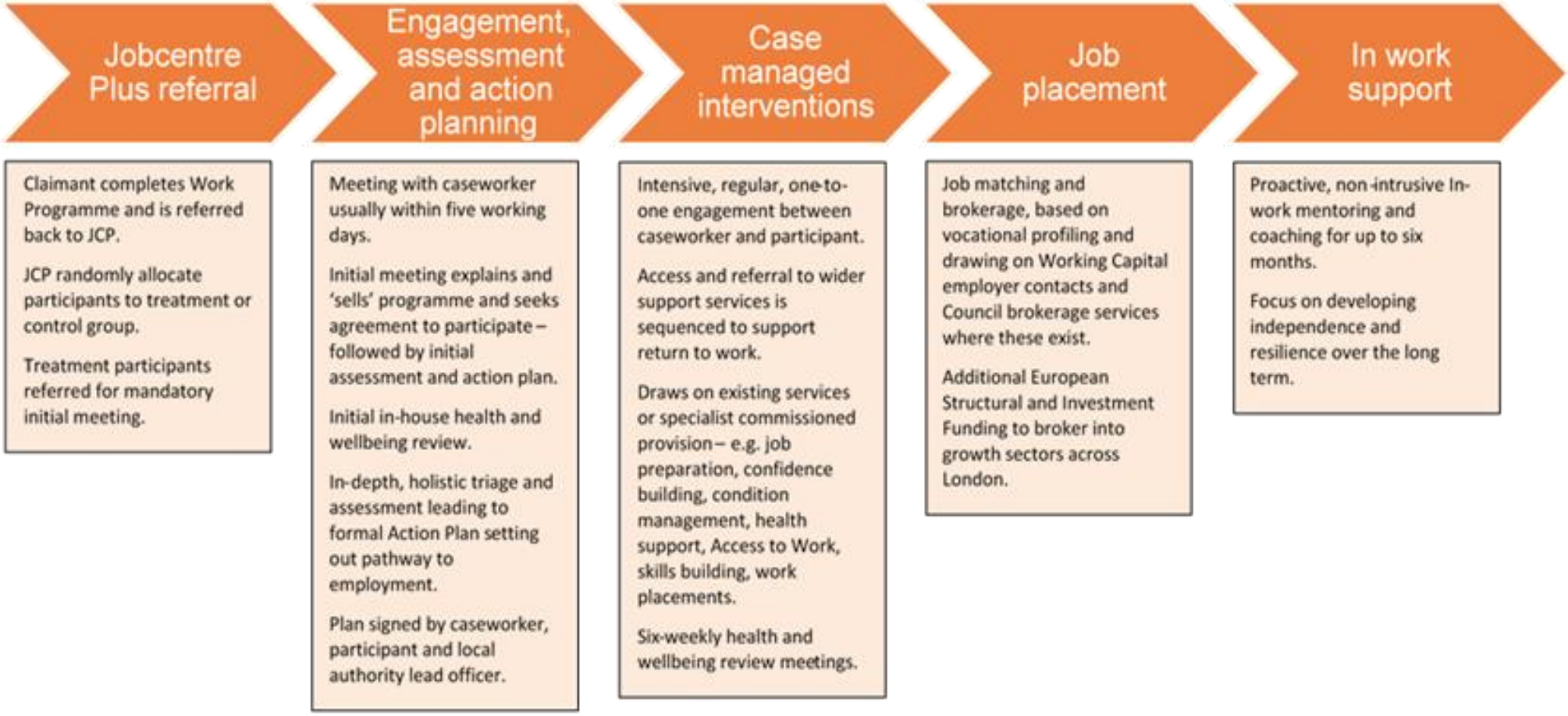
> *"We've got a really great Jobcentre contact in one [borough] and the way he almost sells it to the clients makes them want to show up for the first appointment. And it's really that meeting the caseworkers allows them to buy into it a little bit more. Whereas other Jobcentres I have covered now and again…the Jobcentre adviser just says, 'you have to go to this'…So some of it [deciding to participate in Working Capital] has to do with the Jobcentre"* (**Caseworker**)

When explored further with caseworkers, it was suggested that jobcentres which used *"really small, dedicated team of advisers"*, who had greater working knowledge of Working Capital and managing referrals, made more effective referrals.

Interviews with participants echoed how initial information about the programme varied depending on the Jobcentre Work Coach that referred the participant. Some participants appeared to be clear on the nature of the programme and what it would involve.

> *"I was told that it's the sort of programme to help me and support me back into work, and give me like more one to one type of assistance, and just to really help me to return back to work in a supportive type of way."* (**Female, 40**)

Figure 4. Working Capital participant journey



More often, however, participants appeared to have received little upfront information about Working Capital, and what would be expected of them on the programme. Though not experienced by all, the lack of information created a degree of apprehension about attending the initial appointment, which was particularly detrimental for individuals who already suffered anxiety and depression.

> *"I was apprehensive...Well, I wasn't quite sure what my responsibilities would be and I think in terms of my confidence in my skills package, it was particularly low"* (**Female, 45**)

The lack of clarity at the point of referral made claimants feel that Working Capital was another programme that they would have to attend, irrespective of their own needs and circumstances or their preparedness for work. For those who did not feel they were ready for work, the lack of information about the project meant that Working Capital was viewed negatively at this point.

> *"I didn't feel I had a say in where I'm going to go…In the beginning, I was reluctant to go, I was, I have to admit every time I went in I'm thinking, "Argh," because I feel sometimes that, when you go to these programmes, it's just a ticking of boxes and nobody really cares, but that's how I felt."* (**Female, 59**)

Despite being a key feature of the programme, health and wellbeing support was rarely discussed when participants were told about the programme prior to the referral, with emphasis being firmly on getting participants into employment. There were exceptions to this with one claimant explaining that they were told that the programme might be able to help them with their anxiety.

As per the participant journey figure, once a referral was made participants had to attend a mandatory initial appointment with a Working Capital casework, where they would be introduced to the programme and invited to participate. The meeting would be arranged by the Jobcentre Work Coach who would contact a central booking team via telephone in the presence of the participant and a suitable time for a meeting would be arranged[12].

Initial meeting

The purpose of the initial meeting is to *'sell'* and reassure the participant about their involvement in the Working Capital programme. Although attendance at these initial appointments is mandatory, participation in the programme is not, so the onus on getting a potential participant to commit to the programme falls to the caseworker.

> *"If you're able to convey all the positive support that you're able to offer and to just, kind of, reassure that client as well that 'we're working at your pace,*

[12] 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.

nothing's mandated, you're not going to be sanctioned this is our journey together' and it's just trying to get the most out of it" (**Caseworker**)

However, interviewees largely did not distinguish between the initial appointment and ongoing support when they were asked about their understanding of the nature of the referral. Participants reasoned that because the referral was mandatory, participation in the programme was as well: previous experiences of DWP mandated employment support programmes also contributed to this view. Consequently, some interviewees believed that their benefits would have stopped if they chose not to join the programme, or that they would no longer be able to receive ESA.

"With the previous two programmes I've had to do it.... You know it was mandatory, you know, you had to do it otherwise it may affect my benefits." (**Male, 55**)

Caseworkers were also aware that despite trying to emphasise that participation on the programme is voluntary, participants attended because they were unable to disassociate it from Jobcentre Plus and therefore presumed that their involvement was mandatory; not because they actually wanted to be there.

A few people did explain that they knew that the programme was voluntary, and that they did not have to take part. For example, one individual explained that they were told that they could leave the programme if they did not think it would be helpful, or that they did not have to agree to join if they did not want to. This ability to disengage was positively received.

"They said you don't have to sign their contract, if you don't like what you're seeing or you're not feeling comfortable … then you can always leave it" (**Female, 32**)

Some respondents did not mind this perceived mandatory nature of the programme because they felt ready for work or wanted employment support, and so were willing to take part.

Assessment process

Participants recalled this first face-to-face assessment, whereby their APM caseworker would ask them questions on topics including their health and wellbeing, their personal situation and the challenges they face when looking for work. The discussion was mainly described as conversational rather than having a rigid question, answer structure. The majority of interviewees recalled their first appointment taking place in their local Jobcentre Plus offices. Caseworkers were often positive about arranging the initial appointment in Jobcentre Plus, as in some cases this helped to professionalise the programme. Likewise, participants appeared to like this because it was a local and familiar location that was easy to get to. However, there were sometimes issues with room bookings, which caused confusion

and delays to the appointment. Caseworkers also raised this issue explaining that in some instances appointments were not always held in private spaces.

> *"We weren't able to have the right room…A lot of people had to come in and sort of try to start the interview"* (**Female, 55**)

There were also examples of initial appointments occurring on an outreach basis on public places, such as cafes, and when this had happened participants referred to the relaxed and informal nature of the appointment. Hence, having different options for the location of appointments appears to have worked well to date. This flexibility was particularly valued by caseworkers, as it enabled them to adapt to participants' needs and personal preference. The ability to use 'other spaces' was also useful to break the perceived connection between DWP/Jobcentres and the Working Capital programme, as it made the programme more distinct.

Despite being a long and involved process (often taking more than two hours) some participants were positive about the assessment process because it was focused on what they wanted to achieve and how this could be made possible; they often found the caseworker to be a good listener.

> *"I think it was really good because she really asked me what I wanted to get from it, and where I wanted to go with my future as well, and then she told me how they were able to support me and met all my needs.…She gave me a lot of time to talk, she listened, so I felt it was good"* (**Female, 40**)

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, professional and empathetic. Participants often felt more settled and reassured about joining Working Capital after this meeting because they became more aware of the nature of the programme, its holistic nature and the fact that it was independent from DWP/Jobcentre Plus. Consequently, they described being more confident that the programme would be able to support them.

Action plan and deciding on support

Ultimately, the assessment meeting was used to identify a participant's aspiration, circumstance and support needs in order to draw up an action plan. While the message did not penetrate with all participants, who in some cases were unsure how the information collected as part of the assessment was being used, caseworkers all used the same broad approach to explain the purpose of the assessment and were unanimous in the view of the process of drawing up an action plan being a joint endeavour with their participants.

> *"I always warn clients in advance I'm going to ask you a lot of personal questions, but it really is, you know, the more information you give me, the more I'll be able to support you. The information you give me, I will identify any support needs and I'll put it in our plan. You'll have a chance to look at it,*

[and] if you don't agree, if you want me to edit it, add anything else, you have the opportunity before you sign it" (**Caseworker**)

Most participants interviewed recalled feeling involved and engaged in the decisions about what activities they would complete or what referrals could benefit them during the action planning process. Positive feedback included that individuals did not feel forced to agree to anything, and that the options put forward were responsive to participants' needs. One participant added that it was useful to undertake an assessment and consider next steps early on in the support because it meant that they could access relevant support as soon as possible.

Not everyone remembered completing an action plan, but where participants did this was usually regarded to be a helpful activity as it gave participants goals to aim towards, and steps to reach them. The process also made participants more positive about their aspirations and provided a manageable and clear pathway towards the labour market.

"It made me look into the future in a positive way so whatever I'm saying it's not just word of mouth…so I think it's a great idea to have an action plan so you know the steps so if you forget certain steps that you make you can always go back and look over it, evaluate it and then go forward. " (**Female, 32**)

However, there were examples of participants who felt like the activities and referrals on their action plans were unhelpful or inaccurate based on the discussions that had. For example, one health and wellbeing referral made was viewed as unsuitable because it was perceived as a service for people with much more complex or greater needs than the individual in question.

Participants who had been on the programme for longer periods reported referrals and suggested support options improved over time, once their caseworker got to know them better. Part of this, it appears, is also related to the participant themselves becoming more trusting of their caseworker and in turn more open about their needs and their views.

The plans could take a few days to complete after a full assessment had been carried out. Once a draft was completed a follow-up appointment with the participant would be made to share the action plan with them and get their views on it. Participants were given the option of reading there and then, or taking it away to read. However, feedback from caseworkers suggests that most participants appreciate going through the action plan together with them.

Once agreed and signed off by the participant, the action plans go through a quality assurance process, which includes being signed-off by the relevant local authority; a requisite for the initial payment to APM for programme attachment to be triggered.

Feedback about the action plans from local authority leads reflected that they rarely did not sign-off an action plan. Where they did not sign off a plan, it was usually due to minor technicalities, such as missing information, or lack of clarity about how an issue identified would be addressed. However, action plans were felt to be adequate for the purpose, though not necessarily high quality.

> *"I would have said the quality is relatively generic. I mean some of them still come through with, for example, some sections maybe missed, some sections may not be filled in as you would hope"* (**Local authority staff member**)

The use of the term 'generic' also echoed the sense that action plans were standardised, and, in the extreme, viewed as being a *"cut and paste job"* by some local authority leads. One interviewee queried whether tying the action plan to the initial payment to APM, acted as a perverse incentive to submit lower quality action plans, as this encouraged caseworkers to submit quickly prepared plans in order to get the payment sooner. Further, as someone responsible for quality assuring the plans, local authority leads appeared to have been provided little steer as to what a high-quality action plan should look like, or be assessed against.

However, others were more forgiving to the challenges of drafting a detailed action plan and believed that the local authority sign off stage ensured that there was due oversight and quality to the action planning process. In particular, they were aware that at this early stage, participants would not have had a full health and wellbeing assessment, meaning that the resources and actions available to the caseworkers were relatively generic at this point.

> *"the quality of the case worker is that they actually got an enormous amount of personal information off people in that first [assessment]… this is the result of a conversation that lasted for three hours and they would get an enormous amount of personal stuff off people and then the way the action plan was set up was that all they could do in desperation was say, we will provide one-to-one coaching, we will write a CV, we will do fairly boring generic things"* (**Local authority staff member**)

There was consensus that checking every single action plan was resource intensive, and it was questioned whether a less onerous approach would be more appropriate. (e.g. reviewing one in every ten plans selected at random instead). However, there was broad agreement that the current process added an important level of oversight and quality.

The action plan can be subsequently updated following a 'personal wellbeing session' which, if required, usually occurs within six weeks following the initial interview. Following this, a full action plan is drafted and agreed with the participant.

A new IT system (known as Maytas) for this process has recently been introduced. The system is intended to enable more efficient transfer of information between APM

cseworkers and local authority leads. Early feedback on the system has been positive and an overall improvement to the previous process. Specifically, an issue with the previous system was that once action plans are approved, local authority staff did not get sight of them again, limiting the ability to monitor participant progress.

Ongoing support

Interviews with caseworkers and participants suggested that ongoing meeting (whether face-to-face or over the telephone) tended to be held weekly or fortnightly, and the length would vary based on what needed to be discussed or completed. Participants also explained that their caseworker would ring them in between appointments about job opportunities, and in turn appeared to be comfortable about telephone contact if they needed to talk to the caseworker. The frequency of the support was seen to be suitable by most participants. However, one participant originally found the weekly appointments stressful as they were also receiving additional support elsewhere, which could be quite exhausting.

> *"It's stressful because I have been seeing different people and explaining my personal things, it really drains me."* (**Male, 34**)

While initially meetings tended to be done in person, it appeared that over time appointments had become less frequent or increasingly telephone-based as participants got more involved in external activities, such as volunteering or training; despite the reduction in intensity of their involvement with their caseworker, this was not felt to be an issue, and appeared to appropriate to the progress they were making.

Caseworkers explained that there was no distinct pathway through the programme based on characteristics of participants because there was such great variation between each individual and their circumstances. This was reflected in the interviews with participants, as the content of their meetings and topics discussed differed by individual. The range of areas covered in meetings included participants' barriers to work and how these could be overcome, wellbeing advice, participants' training needs, and how they are feeling. Examples of activities completed during meetings included checking participants' progress against their action plans, updating their CV and completing a 'wellbeing plan' that included advice on diet and exercise, and attendance at group sessions designed to increase confidence and provide practical advice about how to address their time out of work with a potential employer.

Support was also provided by an Employment Liaison Consultant. The consultant has previous experience in this field and therefore bought and extensive professional network of employee contacts and support providers. Caseworkers described the consultant as providing quite intensive support, for example helping participants to prepare for interviews and attend interviews with them. Importantly, participant's

reported that the consultant's enthusiasm about the roles available and the overall programme energised and motivated them to find work and stay in work.

An issue raised by several participants, particularly those who had started the programme earlier, was staff turnover. One participant interviewed explained that they had, to date, had three different Working Capital caseworkers. Although they were positive about each of those staff members, the constant change impacted the progress they could make, and left them feeling like they had to go back to the beginning and explain their situation every time their caseworker changed. Caseworker turnover also left to people experiencing gaps in the support they received. In one instance, a participant who had two different advisers on the programme, had experienced a two-month wait before meeting the second caseworker.

Health and wellbeing support

A core component of the Working Capital programme is the offer of a Personal Wellbeing Session (PWS), delivered by an in-house health and wellbeing team. This involved meeting a health professional where factors such as physical and mental health are discussed. The resulting actions and referrals are voluntary, so the participant may choose to take up the suggested support offer or not.

This health and wellbeing offer was viewed as improving the support offer and giving the programme a unique selling point. It also supported caseworkers to further tailor the action plans and ongoing support.

However, at the time this research was conducted, there were three health professionals providing health and wellbeing support across all eight boroughs. As such, there was some concern about the team's capacity as much of their time appeared to be spent travelling rather than providing support. Further, there was some uncertainty among local authority about the level of integration between the provider's health and wellbeing provision and their caseworks.

Despite the perceived benefit of the health and wellbeing offer by both caseworkers and local authority leads, there remains reticence among participants to attend these sessions. The sessions were previously referred to as Health and Wellbeing Assessments, though were renamed to PWS, after it became apparent to caseworkers that the participants were associating the sessions with Work Capability Assessments. The change appeared to have a near immediate effect on the acceptability of the offer, with caseworkers being clearer in their communication and presentation of the offer in a non-threatening way.

> *"Selling the idea of it was originally a challenge for me. I think just the wording, because you've got a Work Capability Assessment and then you've got your Health and Wellbeing Assessment, and so I think sometimes those words got misconstrued. And as a team … we sort of got our heads around that. So it's just selling it in a way, it's like 'let's break it down so it's about*

addressing your health conditions, it's about providing whatever support you may need from a medical professional and giving you all the advice'." (**Caseworker**)

Most of the participants interviewed recalled attending sessions with a health and wellbeing adviser, and feedback about the experience of this was largely positive. Participants appreciated that the advice given was sensitive to their needs and circumstances.

The positive participant sentiment about PWS was not universal. For some, the issue of their health was deeply personal and they preferred not to speak so anyone except their GP about it. Similarly, participants were reluctant to take up referrals made by the Health and Wellbeing team as they felt this was a role for their GP.

In-work support

Those individuals who had found employment, as a result of the programme or through other means, also discussed receiving in-work support from their APM caseworker. In-work support on Working Capital lasts for up to six months. During this time participants could receive mentoring and coaching support aimed at increasing their independence and resilience so they are able to sustain employment. For example, caseworkers interviewed explained that supporting participants with their finances and any benefit changes was key, to ensure that they did not go into arrears and could focus on their new job, instead of worrying about wider circumstances.

The frequency of contact varied depending on participant need and circumstances. As would be expected, contact is more regular during an individual's first few weeks in the workplace, as participants often needed most support while transitioning into employment. As one participant explained, their caseworker gave them the motivation to re-enter employment and reduced the anxiety they had about this. The support they received helped them to sustain employment, and gave them a *"clear"* understanding of their employment rights and obligations.

Importantly, Working Capital caseworkers and in particular the Employment Liaison Consultants reported providing support and guidance to employers about how they can support a participant into work and making in sustainable.

> *"It's just basically speaking with the employer, making them understand exactly where they are in terms of it [their obligation] … but it's just more working with the employer to make sure that they better understand the client's need and then they have that support around them, rather than just putting them somewhere"* (**Caseworker**)

One participant expressed a concern that in-work support would not be available for individuals who became self-employed. Therefore, they were worried that they would

not be adequately supported once they started their business and recommended that in-work support was extended to cover self-employment.

> *"I still need that support or at least keep an eye on me for a good three months to see if I'm okay. If I'm okay then they can go, but not just to basically go and leave you to get on with it"* (**Female, 32**)

Referrals to other services and provision of support

The caseworkers themselves provided a range of support, from providing careers advice and guidance, practical advice on applying for jobs, training, to importantly being contactable should a participant need them. In some instances, this offer extended beyond the participant themselves.

> *"[The client's] married with two young children…so I've worked with the entire family to make sure things are on the straight basically. And I've liaised with the wife, and she's assured me that if anything comes up that she's concerned about, relapsing [into substance misuse] or anything like that, she'll give me a call."* (**Caseworker**)

Where support needs were beyond a caseworkers capability, they were able to make referrals to an extensive range of other services (both internal and external), training courses and interventions. Among these, interventions included:

- Arranging voluntary work and work placements. In one case, APM arranged a part time voluntary office role after this was recommended by the participant's GP to build up their strength while the participant prepared for fully entering the labour market. During this time, the participant was also supported to complete a Business Administration course as she wanted a regular office job;
- Getting access to an Occupational Therapist to advise and support participants and identify reasonable adjustments that could be made with a participant's home and potential work environment;
- Referral to a foodbank and support with problems relating to over-indebtedness - *"Talking about wellbeing, he's sorted a lot of stuff out for me. I was in a lot of trouble.... Bills and things like that. He sorted all that out.... Well, I'm on low pay, aren't I…so I have to go to food banks sometimes as well, so he introduced me to that."* (**Female, 58**);
- Access to a financial adviser, to help a participant draw up a business plan, as she wanted to start their own business;
- Facilitating access to local and internally run courses, such as IT training courses, and confidence and motivation courses.

Building participants' confidence was a key task for caseworkers, and underpinned their role in providing pastoral support to their participants.

> *"Getting them interview clothes as well is really important; it builds their confidence. If a client turns up in a suit or a really nice outfit, they're beaming and they're smiling, so I work with Dress for Success as well, that support women with interviewing clothes…So anything to build their confidence – if they need travel to get to work, we support that, sign it off; lunch food; if you need a uniform; some clients might need tools…it really depends on what they need"* (**Caseworker**)

As noted, participants were also referred to confidence courses to help them overcome personal insecurities they may have accumulated after being so long out of work. Those able to attend the course reported good experiences and noticed the benefits in themselves. However, one individual referred to the course, reported being disappointed to find that it was cancelled after no other participants turned up.

> *"She sent me the details, I turned up.… The trainers were there and I was there, it didn't run because none of the other participants turned up... ultimately, they turned to me and said, "Sorry, because of the way this works," I'm paraphrasing, "You won't get the full benefit if you're just doing it by yourself."* (**Female, 45**)

There were also challenges in drawing on other support. There was consensus amongst caseworkers that while there was locally available health and wellbeing provision, it was often disjointed and not easily found, and in the case of local mental health services, very long waiting lists. However, having an in-house health practitioner that caseworkers can rely on has been useful in mitigating this challenge by facilitating referrals (*"I might ask the [client's] GP to do a referral if I'm not able to do it"* (**Health and Wellbeing caseworker**)).

Another participant was referred to a specialist self-employment adviser, but found the approach off-putting because they felt that the practitioner was rushing her to sign-off benefits, something that they did not feel ready for.

> *"They referred me to someone that does small businesses, but to be honest I wasn't happy with him because he said I had a good idea, but he just pushed me to say I'm ready to sign off benefits which I wasn't ready then, and start work and I was thinking that's the wrong advice"* (**Female, 32**)

Reasons why participants did not take up or continue support that they were referred too were mainly due to personal circumstances and because they did not think that they had the time to participate.

When participants were referred internally to specialist staff within APM, they recalled having a warm handover, which they appreciated, especially when meeting new people was difficult for them.

Summary and implications

The randomisation process appeared to go unnoticed by participants who seemed to be unaware of why they were referred to the programme, though information provided by Jobcentre Plus Work Coaches appeared to have played an important role in participants' decision to attach to the programme.

Initial meetings with caseworkers helped participants to understand the programme and addressed their concerns. The flexibility to arrange appointments in a suitable location for the individual also appeared to work well. However, due to the link with Jobcentre Plus and because of their previous experience of the Work Programme, many participants still perceived that it was a mandatory, rather than voluntary programme.

The action planning process was largely well received because participants felt involved in the decision-making process and as if the suggestions made were suitable. They particularly appreciated the opportunity to identify goals that they could aim towards and ways to achieve them. Despite this, local authority leads suggested that action plans were more 'generic' rather than high-quality. Though signing-off the action plans was seen to provide an important element of quality assurance, looking through each one was considered disproportionately resource intensive: an issue that could be exacerbated if programme numbers rise.

Participants reported receiving a mixture of employment and skills support as well as health and emotional support. Although a unique aspect of the programme, the health and wellbeing offer was not as enthusiastically taken up as initially anticipated. In part this was due to the association with Work Capability Assessments, which APM appears to have addressed. However, for some health issues were a deeply personal matter, and they preferred the advice and support of their own GP.

In-work support was also well regarded by participants as it gave them the confidence and motivation to stay in work. A range of internal and external support (e.g. benefits advice, income maximisation, health support, etc.) was provided to participants as they moved closer into the labour market, enabling the participant to focus on their new job.

5. Outcomes

As discussed in the following chapter, it is too premature to quantitatively assess the impact of the Working Capital programme as numbers against the primary outcome measure (job starts and sustained job outcomes) are currently low. Data from APM suggests that by February 2017, only 26 jobs starts had been achieved. A few participants interviewed were currently in employment. One individual had secured a part-time cleaning job with help from their APM adviser, and hoped to progress into the construction industry in the future, while another was working in a care role, but was considering other, more flexible roles.

However, qualitative evidence suggests positive outcomes are being achieved across a range of soft outcomes. Participants and caseworkers alike felt that there had been improvements in Participant's soft outcomes. This included communication skills, socialising more and making more efforts in their appearance and dress. Improvements in participants' confidence were also seen to be noticeable.

Critically, there was also some limited evidence that Personal Wellbeing sessions could also lead to positive health outcomes, that may not have been realised through usual primary care provision. This included learning about stress management and coping with their anxiety, advice with their sleeping issues and having a healthy lifestyle.

> *"I've had quite a few sessions with her [the Health and Wellbeing practitioner] and she's given me a lot of training, on pacing myself and stress management and handling anxiety, and things like that. It's been very helpful"* (**Female, 40**)

A number of participants reported feeling more confident as a result of participating on the Working Capital programme. This was attributed to the three-day confidence course run by APM, the pastoral support provided by caseworkers and feeling less socially isolated as a result of increase interactions with others and *"getting out of the house more."*

Participants also reported more stability in the housing and finance. Caseworkers were proactive in supporting participants to reduce their outgoings or increase their income.

> *"[My Caseworker] helped me with my gas. He's looked at my meters, he took my bills, looked at what I'm paying and he phoned up to get my meters changed and we're in the process of changing it again, to get the best result... he take[s] on a situation and phone[s] them himself, so it gets a quicker reaction than me phoning and waiting for someone to come out."* (**Female, 59**)

There were a number of positive outcomes related to moving closer to the labour market. As well as being better prepared to look for and apply for work through CV workshops and guidance on interview techniques, involvement in the programme

appeared to help clarify what participants wanted to achieve in the future, and how they intended to achieve this. For example, by raising awareness of the qualifications they wanted to obtain and what type of job they eventually wanted to enter. Similarly, participants valued the caseworkers advice about relevant support options or training courses that they could sign-up to, which they felt would improve their chances of getting into work.

> *"I can sort of improve on my IT skills, couldn't I? Right, it will keep me occupied and also it'd help improve my chances of finding work as well…"* (**Male, 55**)

Voluntary work provided a good option for those participants who were considering employment to test and develop their preparedness. Unsurprisingly, supporting participants to access voluntary roles was particularly appreciated, and was viewed as an important and beneficial step by participants who were volunteering, or who had done so through their involvement with Working Capital. These opportunities reduced social isolation and made participants feel more ready for work because it increased their confidence and enabled them to gain new skills or refresh their skills.

Participating on the programme also gave participants a sense of structure to their lives, and someone who they could talk to regularly. Many were grateful to have a supportive caseworker to encourage and reassure them through their journey, as it made them feel as if *'someone cares'*.

Success of the programme was seen to be a result of the model of support, which ideally involved a continuous caseworker who has a small caseworker and therefore can provide intensive support, which is sequenced to remove key barriers first, rather than solely focusing on employment. An aspect of the programme that numerous participants identified as important in leading to progress was the sequencing of the support, which meant that their most prominent needs could be addressed. This was particularly important for those individuals who did not yet feel ready to enter employment, and who had numerous issues that they felt required more immediate support with, such as debt and their health and wellbeing needs.

However, not all participants felt they were able to achieve the same outcomes as others. Older participants specifically felt their age was a barrier to achieving employment outcomes, despite making progress more generally.

> *"I am doing interview, they are saying okay, you are excellent at everything then they don't call me so that's why I told you at the beginning maybe this is the age problem."* (**Male, 61**)

While there were no apparent adverse or negative outcomes from participating on the programme, for some participants there was frustration when they were told that their support was ending, because they had been on the programme for 12 months. These participants reported not being aware of the duration of the programme, and

in a few instances claimed that their caseworker had not informed them of this. The participants felt that they would have benefited more from Working Capital if it had lasted longer.

> *"I'm grateful for it but, to be offered things, as in a way forward where it was pleasing to me and I was excited about going forward … This is why I'm frustrated now, if you understand? If it had concluded, I would be singing their praises, it hasn't concluded to me…"* (**Female, 59**)

Further, one of the participants interviewed reported that some of the employment suggestions put forward by the Employment Liaison Consultant were unsuitable.

> *"The job, it started at five o'clock, they wanted me to take two buses… it is like two hours or whatever, an hour and a half, they wanted me to take a night bus and then… just walk for like ten minutes…I said that is not the kind of job I want to do, and they were just like forcing me to do something."*

However, it should be noted this was a singular experience, and not reported elsewhere.

Integrated delivery

Effective service integration is a key aim of Working Capital. The programme was designed to deliver better participant participants outcomes by more effectively combining support through local council, health and voluntary sector services, and other specialist services.

As well as reviewing action plans, the local authority staff also worked with caseworkers to review and monitor their caseload and discuss existing provision that could support Working Capital participants. This was intended to facilitate integrated delivery through making caseworkers aware of available local provision and networks, and providing warm handovers when required.

> *"We have regular caseload reviews with our borough leads so that allows them to really understand our clients and basically advise us on any services that we could use that we didn't know of. Islington, in particular runs an employment practitioners network every six weeks so that gives us a real opportunity to mingle and mix with everybody that works within Islington"* (**Caseworker**)

In some instances, local authority leads had put caseworkers in touch with other local authority staff who could support them to address a participant's specific needs. For example, after caseload reviews in one borough, housing emerged as a significant issue preventing participants from progressing towards the labour market. Consequently, caseworkers were put in touch with the borough's housing options team, who they can contact directly as and when required.

> *"One of the relationships we've brokered is sort of our housing options team on Working Capital, so they can now go through to [staff member] and the team and he will do what he can to help, so the communication is there"* (**Local authority lead**)

Local authority leads explained that caseworkers were able to work from their offices whenever deemed this suitable. This optional co-location helped with relationship building and improved communication. In one borough, caseworkers were co-located in the local mental health and wellbeing hub, that is based in Jobcentre Plus, which was seen to encourage integration with local community services.

The timing and format of reviews differed across the boroughs. Intervals between reviews ranged from monthly through the quarterly reviews, and involved direct liaison with caseworkers themselves, or more senior APM managers. While one borough scheduled regular monthly reviews, another appeared to maintain an open door between to caseworkers and the local authority lead to raise issues as they became apparent. The caseload reviews were valued by both the local authority leads and the caseworkers.

> *"I think that is absolutely fantastic, that is a really strong part of the process. It has been really helpful and again it has given us a real understanding of the challenges that [caseworkers] face and certainly I've come out of those meetings thinking these guys are doing a great job in a really tough environment."* (**Local authority staff member**)

As part of this review, local authority leads also monitored caseworkers workloads to ensure that any one caseworker did not exceed their maximum caseload. However, this was not always as straightforward as would first appear, due to participant disengagement over time. The direct engagement between the local authority and caseworkers allowed the local authorities to directly explore why maximum caseloads appeared to be exceeded.

> *"There was also an issue with caseloads which were never supposed to exceed 26 and that was part of the thing at the beginning … so all those people [the clients] will get everything they need. But then our caseload went up to 55, 60…But I think the goalposts have changed so when I speak to the case worker they say, "Oh, but that person isn't engaged with me and so they're not active on my caseload.""* (**Local authority staff member**)

A challenge for some local authority leads in more fully engaging with the Working Capital programme has been that they are less directly involved than they had originally envisaged due to the low numbers coming through. As a result, the initial momentum to draw in authority led services and partners, somewhat waned.

> *"If we'd have had sufficient numbers and sufficient attachments, and sufficient referrals into other services, which is quite important, I would have envisaged*

a lot more of my time linking into those partners, and bringing them on board really." (**Local authority lead**)

As one interviewee explained, this has had a detrimental effect in mobilising local service provision to more effectively integrate as the benefits partners may have realised through the scale of the programme has not materialised, with few onward referrals being made to wider partners.

> *"You get stakeholders engaged and you get them excited about the programme, and then when the numbers aren't there and the programme has been delivered, it's really hard to keep them on board and with you because they're like, "Well, how is this important to me right now? I'm giving up…" Some of them are small organisations…"* (**Local authority lead**)

Despite this, there was consensus that Working Capital had demonstrated that there is scope for increased integrated working, and that it was somewhat successful in building relationships and developing a more coordinated way of delivering support.

> *"The conversation is being had and those relationships are being built, and I think that can only be a positive thing and that came out of Working Capital."* (**Local authority lead**)

On a more strategic level, local authority leads valued to the quarterly Operations Steering Group meetings, which brought them together with CLF and APM staff. There was consensus amongst those interviewed that although there are different contexts and delivery models in each borough, it was useful to share learning and establish relationships.

A suggested improvement was to focus more on generating a collective understanding of the issues and how these could be overcome, rather than solely discussing the current issues. Hence, one interviewee felt that the concentration on addressing the low numbers of referrals and attachments to the programme took away the focus from achieving good outcomes for participants.

Comparisons with other support

Although all participants would have had to have completed the Work Programme, a few had no memory of this or recognise the name.

Where involvement in the Work Programme was recalled, participants expressed frustration that their needs were not met on past employment programmes due to the relentless focus on finding work; something that they were expected to do *"straight away"*.

> *"They weren't helpful because all I had to do is just talk about if I'm looking to find work, but I didn't find they were supportive to be honest. I felt that I was wasting my time… [there was] no push unless you are looking to go into work*

but any training and anything like that, there was nothing there for me." (**Female, 32**)

One notable and preferred difference with Working Capital and previous support that participants had received on the Work Programme was the offer of more intensive one-to-one support. Working Capital was viewed as more tailored by participants because caseworkers had the opportunity to get to know their caseload and personalise the support accordingly. Caseworkers interviewed echoed this view with several who had direct experience of delivering support on the Work Programme noting the difference in the Working Capital offer.

> *"[On the Work Programme] It's only five minutes and then you're out the door whereas [Working Capital caseworkers] spend an hour with you talking about any issues, any change of circumstances, things like that where you feel that you're a bit more appreciated, it's not a rush thing where you just sign, whereas like you have to sign or they won't pay you…"* (**Female, 32**)

Another significant benefit of the Working Capital programme was the flexible nature of the support, whereby appointments could be rearranged when participants had health appointments or were on a course was also liked, and seen to be different to other employment support. As was the choice to have appointments in public places.

Finally, the voluntary nature of Working Capital was seen as unique, and in some instances made participants feel more relaxed about attending appointments and taking up referrals. It also changed the relationship between participants and Working Capital staff who were seen to be more understanding of participants' circumstances and needs.

In contrast to Working Capital support, where participants recalled attending the Work Programme they felt that Work Programme appointments were held in inaccessible locations and that the overall approach of advisers was generally unsupportive.

Suggested improvements

Based on their experiences of Working Capital participants made a range of suggestions which they thought would improve the programme. These are:

- where a participant's caseworker is due to leave, they are provided advance notice about this, and for an alternative Casework to be in place sooner to prevent gaps in their support journey.
- There was some dissatisfaction with the 12-month length of the programme. Some interviewees felt like they were making good progress on Working Capital, which was halted by their support coming to an abrupt end. They therefore felt that the programme length should be extended, but did not specify what length they thought would be suitable.

- Linked to the duration of support issue, participants felt that onward referrals should be more rapid, and come sooner in order to make progress with the timeframe of the programme.
- Where it is not possible to identify or receive the desired support, it was suggested that caseworkers should present alternative options. This was particularly focused on training courses, such as English, maths and IT, which were often oversubscribed.
- There was some call for additional housing support and advice among participants. This point was echoed by caseworkers who initially expected to have a key contact in each local authority who could support them with housing queries. Caseworkers felt having those key contacts in place within each authority from the outset would have been helpful and reduced some delays experienced by participants in getting this support.
- As numerous participants experienced apprehension about joining Working Capital, it was felt that more detailed upfront information on the programme would have helped to alleviate their concerns, which largely stemmed from misconceptions about it being a mandatory and solely employment focussed.
- Lastly, there was a suggestion for more financial support with travel fares to and from appointments, despite this provision being included in the contract.

Summary and implications

Although it is not yet possible to quantitatively assess the impact of Working Capital due to low job starts and sustained job outcomes, the qualitative research has demonstrated soft outcomes for participants. This includes improved confidence and wellbeing as well as more stable financial and housing situations. Participants also reported being closer to entering employment because they had better CVs and applications and more of a sense of what they wanted to achieve, and how to do this.

There is also evidence to suggest the Working Capital has encouraged more integrated service provision, though the extent of this integration is unclear. An important factor in the limited progress made is the lower than anticipated participant numbers which has impacted local authorities' ability to maintain engagement in Working Capital amongst local providers and develop further partnerships.

The intensive and sequenced model of support was viewed as key to such outcomes being achieved and the subsequent success of the programme. This was compared to the Work Programme, which some participants recalled as too work-focused and impersonal. The flexible and voluntary nature of the programme were also seen as significant and unique. However, some participants expressed dissatisfaction that their support would end after 12 months, something that they were not always aware of.

A number of recommendations to improve the support were suggested by participants, these included operational issues, such as notifying participants of any change to their caseworkers and paying for out-of-pocket expenses, and service design issues, such as the 12-month duration of support and misunderstanding of the mandatory nature of the first meeting, but voluntary participation. However, several of the recommendations relate to structural issues which are likely to be beyond the control of Working Capital caseworkers, such as getting prompt housing support, finding suitable alternatives to provision that is oversubscribed, and getting ‘quicker’ referrals.

7. Conclusions

Research conducted as part of this interim report shows that Working Capital participants' needs and barriers to entering and maintaining employment are complex and wide-ranging, and arguably deeper than had been anticipated. This may in part be a consequence of the improving performance of the Work Programme which may disproportionately lead some of those who are closer to the labour market into work.

Despite dipping into 'stock' participants, the programme continues to struggle to achieve the volume of referrals and attachments as had been originally estimated. Naturally, this has consequences on the number of outcomes the programme can achieve. The attachment rate has been markedly lower than anticipated, with around a third of eligible participants received onto the programme having not attached. Some level of attrition should be expected, but the attrition rate of 10 per cent applied to original estimates is, in hindsight, insufficient. Though limited, analysis presented here suggests that personal characteristics and circumstances (such as experience of homelessness and living in a jobless household with dependent children) influenced whether an individual 'fully' attached to the programme.

Consequently, programmes akin to Working Capital should be more cautious in determining the level of participant attrition to apply when forecasting participation rates. Further, consideration should be given on how to engage particular groups, whose needs may make intensive assessment and engagement challenging and so require tailored approaches.

Overall, the participant journey to the programmes was in line with what was anticipated. The randomisation process was unobtrusive, though differences in the level and manner in which Work Coaches provided information appeared to have influenced participants' decision to attach. Despite often being told by Work Coaches and the APM caseworkers that involvement in Working Capital programme was voluntary, participants still perceived that it was a mandatory. Underpinning this belief was the involvement of Jobcentre staff in the referral process and the mandatory first appointment, which created a persistent perception that the programme itself was mandatory.

Local authority involvement appears to have been less intensive than originally envisaged, with their role in the action plan process providing limited insight on how the support needs of Working Capital participants were being addressed. To address this, local authorities and the provider have changed the way they work together – while initial feedback has been promising, the effectiveness of the case conferencing approach that has been adopted, will become apparent in the coming period.

The programme has been somewhat successful in drawing in wider support that participants require, though the level of integration and co-ordination has varied by caseworker and by local authority area. It appears that the programme has not

achieved the structural changes to the delivery of services within the timeframe that had originally be hoped. Nevertheless, tangible progress had been made in building referral networks and relationships with local service providers as well as more direct liaison and co-ordination with local authority leads as the programme has become more established. Despite local authorities engaging their wider service networks to prepare them to receive Working Capital referrals, the actual number of referrals made has not been sufficient keep their services interested. As such, much of the progress made with regards to integration is likely to reflect the personal effort made by local authority leads and caseworkers themselves.

The research also exposed Working Capital participants' personal barriers to fully engaging with support provided by the programme, in particular services related to health and wellbeing. Specifically, it has highlighted a rational reluctance to engage with the health and wellbeing support provided as part of the programme as they felt in encroached on a role they reserve for their General Practitioner. Given the nature of the target population for this programme, participants may already have high levels of engagement with health services. An implication of this for the provider is to consider how the presentation of the health and wellbeing offer adds value and is distinct from the health services that participants already have relationships with. For service commissioners, consideration should be given to integrating existing health service and not necessarily establishing parallel provision.

Although it is not yet possible to quantitatively assess the impact of Working Capital qualitative research has demonstrated a range of outcomes being achieved, such as improved confidence and wellbeing, financial stability and improved housing circumstances. Importantly, participants also felt closer to the labour market as much of the success of the programme was attributed to the intensive and sequenced model of support provided, which compared favourably to the Work Programme.

Overall, the programme has started to become established, with progress being made on the process of engaging participants and integrating and co-ordinating with local authority provided services. Recent steps taken by both the provider and local authorities is promising and may increase the pace of integration in the coming period. This interim evaluation has highlighted some key issues, and provides challenge to some of the assumptions made about the employment support needs of long-term out of work disabled people. In particular, findings illustrate the deep-rooted barriers some face to entering the labour market as well as the role of personal autonomy in accepting health services. It also highlights how operational issues, such as the low attachment rate, impact not only on the ability to deliver outcomes at volume, but may also effect sustaining the engagement of wider services.

Annex A: Implementation of the randomised control trial

As noted the Working Capital programme has implements an RCT as part of the programme design. As such, over the longer term it will be possible fully measure whether or not 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 provide an incremental cost benefit ratio.[13]

Progress on the RCT

Data received from DWP (and presented in Annex B) show that in the period between the programme going live and August 2016, 995 ESA claimants had been considered for participation in the Working Capital trail. Of these 105 were exempt. Of the remaining 890 claimants, 71.3 per cent were assigned to the treatment group and 28.7 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; however, assignment to the treatment group is significantly higher than would be expected[14]. This would suggest an inconsistency in the randomisation process whereby a greater proportion of participants is being referred to the treatment group.

[13] 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).

[14] χ^2_1=4.21, p=.004

Given the rules applied to data provided by DWP, it is difficult to precisely measure the scale of the overall miss-assignment, though it is likely to be in the region between nine to ten per cent of those participating in the trial.

It is 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, some qualitative data from participant interviews suggested that in at least a couple of 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. However, it does reinforce the need to monitor the possibility of subjective referral decisions being made by Work Coaches in some circumstances.

When looking at assignment between London boroughs (figure A1), while differences between assignment to the two trial conditions were not significant at the five per cent level for most boroughs, there was a significant difference in the proportion assigned in Islington[15] with proportionately fewer participants referred to the control group. While there were nominal differences in other boroughs, these differences did not reach statistical significance.

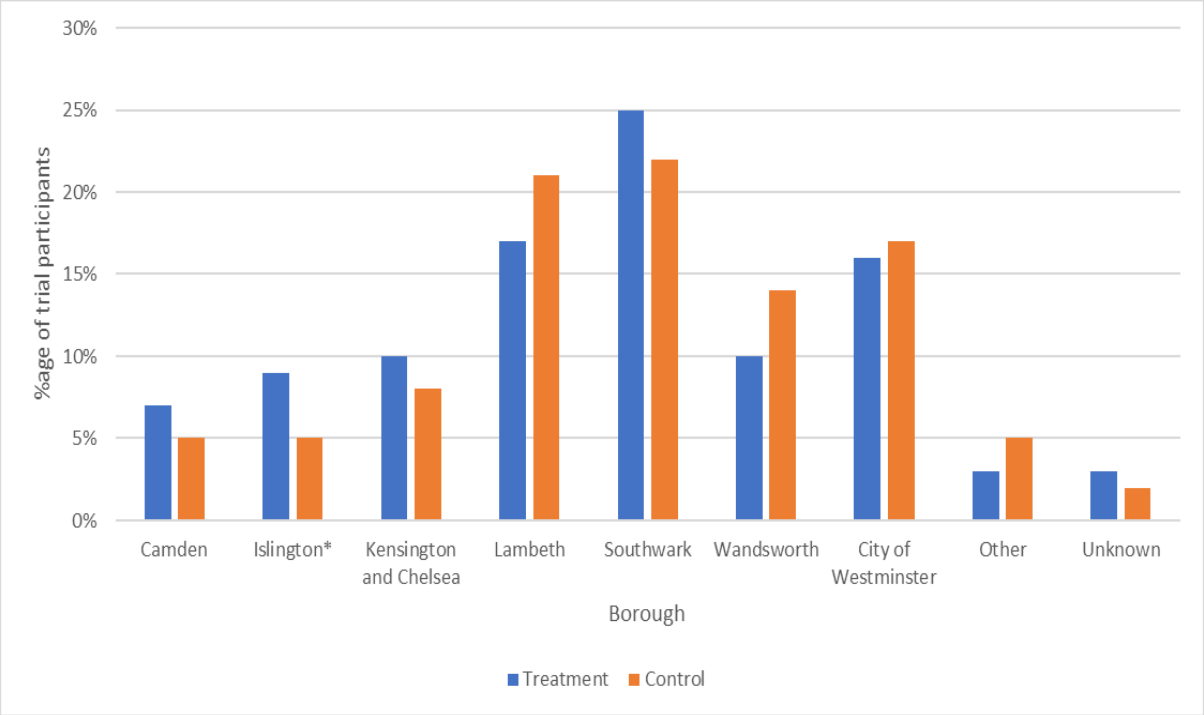
Elsewhere the balance between the two groups remained largely similar, with a few exceptions[16]. However, these exceptions did not indicate any bias in the randomisation process and would be expected given the comprehensive list of variables compared.

In order to determine the viability of the RCT, power, 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 treat group and control 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% difference in the primary outcome measures (sustained job outcome) between the treatment and control group.

[15] z=2.01, p=.045

[16] With regards to ethnicity, there was a significant difference between the groups of individuals who 'preferred not to say' or were identified as being of unknown ethnicity (respectively z=-2.571, p=.010 and z=-2.168, p=.030). There was also some difference in the age of the youngest dependent child with control group being less likely to have children aged 5-10, and more likely to have a youngest child aged 11-16 (respectively z=2.411, p=.016 and z=-2.512, p=.011), though viewed together, these differences balanced out. 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.

Figure A1. Percentage of trial participants assigned to groups by borough[17]



Previous calculations were presented in the first evaluation report. The summary table from that report is shown in table A1. A 2-tailed test was applied with significance set at .05, and power at .80, with the proposed sample of 1920 in the control group (the smaller of the two trial arms). Under such a scenario, a difference of 2.99 per cent would need to be detected, for it to be significant. Assuming that control group sustained job entry rates are 11.0%, 14.0% 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 sig.diff.
100.0%	1920	3840	0.1100	0.1399	0.0299
75.0%	1440	2880	0.1100	0.1448	0.0388
50.0%	960	1920	0.1100	0.1532	0.0432
57.8%	1109	2218	0.1100	0.1500	0.0400

[17] Statistically significant differences denoted by '*'

Acknowledging that referral rates to the programme are the lower then accepted Table A1 also presents detectable effects size by lower trial participation (75% and 50% 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 57.8 per cent).

However, these calculations were based on an assumption of 2:1 split between the treatment and control group. Given the higher than anticipated assignment to the treatment group, these calculations have been revised in table A2 to account for only 28.7 per cent of the trial participants going into 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.

Table A2. Power and sample size calculations based on prevailing trial arm assignment rate (28.7 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 sig.diff.
100.00%	1653	3840	0.11	0.1423	0.0323
75.00%	1240	2880	0.11	0.1477	0.0377
50.00%	827	1920	0.11	0.1568	0.0468
67.06%	1108	2218	0.11	0.15	0.04

As would be expected, as the sample size decreases, the required effect to prove programme impact increases. Hence, if expected trial participations rates are realised, the minimum detectable effect size is equivalent to 3.2 percentage points. In contrast if the trial only achieves 50% participation, the effect size increases to 4.7 percentage points.

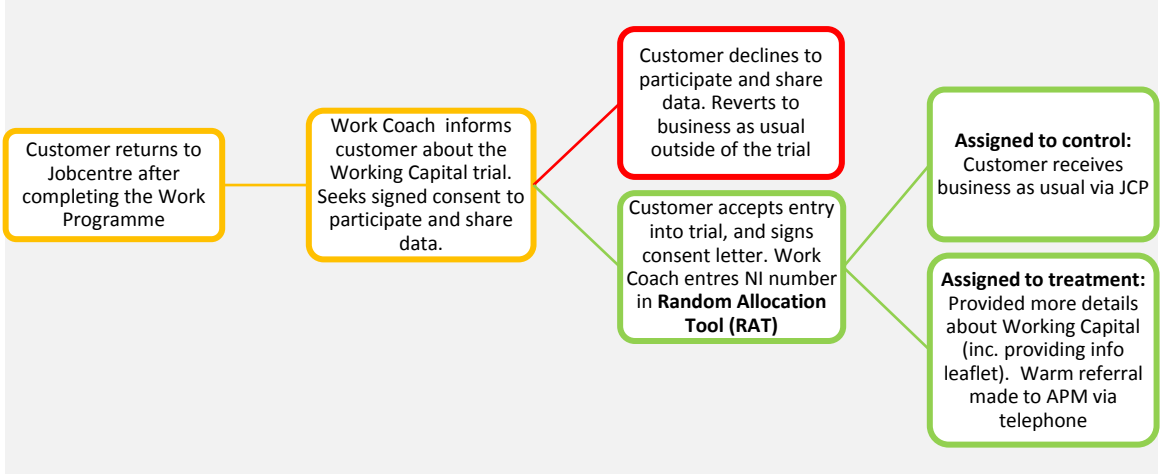
Given that referral rates are around 25% lower than expected, the minimum detectable effect size would be 3.8 percentage points; this falls between the 3-5% *stretch* target the programme is hoping to achieve. Below this point the RCT will be underpowered to detect a statistically significant difference. If the assumed effect size is taken to be 4 per cent (mid-point of the stretch target range), the RCT will not be 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 Work Coaches found the randomisation and referral process relatively easy, and the use of the Random Allocation Tool (RAT) straightforward. Over the course of the year, the process has bedded down, and there was a general feeling among Work Coaches that they were doing this element of RCT competently.

Typically, an observed session broadly followed the process highlighted in figure 7 that should have been followed upon and eligible claimant returning to the Jobcentre from the Work Programme.

Figure 7. Trial recruitment and randomisation process



The first stage of the process was consistently followed, with Work Coaches welcoming the customer back and discussing their experience of the work programme and often confirming personal details were up to date. Though no 'stock' claimants were directly observed, post observation discussions with Work Coaches, suggested that this stage was similar.

However, though the overall process was followed in the majority of the sessions, several issues were identified through the process of observations and informal discussions with the Work Coaches. These are discussed in turn, below.

Failure to obtain the signed consent for *control group* participation and data sharing

There were a couple of instances where Work Coaches were observed informing the claimant about the trial prior to randomisation, but only obtaining signed consent from those individuals allocated into the treatment group; no consent for trial entry and data sharing was obtained from the control group despite them being informed about the trial and taken through the randomisation process. This was confirmed

during a post-observation conversation with the Work Coach. Despite this issue being previously raised, a similar observation was made in more recent sessions.

Implication: This limits DWP's ability to share personal information with Central London Forward (CLF) or L&W without first obtaining signed consent or informing the customer via hard copy letter with an opportunity to opt out of data sharing. While this will not impact the primary impact measures, secondary measures, which are intended to be captured via a survey, will likely need to involve the additional opt-out stage, which may affect response rates.

Randomisation occurring prior to customer attendance

In earlier observations, it was noted that at least one Jobcentre had departed from prescribed process by having a senior manager conduct the randomisation prior to the arrival of the customer (usually carried out the evening before the customer is due to attend). If assigned to the treatment group, a note was placed on the claimant's file so as to alert the Work Coach. The treatment group individuals were then introduced to the Working Capital programme, and invited to participate - confirmed through signing the consent letter. Control group participants bypassed this process so were not informed about the trial or the prospect of data sharing.

Upon identifying this issue, the Jobcentre in question changed its approach to ensure that both treatment and control group participants were informed of the trial and that informed consent for data sharing was obtained from both groups. However, the procedure to carry out the randomisation in advance of a claimant's visit still continued.

Implication: As per the previous issues, the lack from consent from some of the control group limits DWP's ability to share personal information with CLF or L&W. As such an 'opt-out' stage to data sharing may be required.

With regard to the way in which randomisation is conducted, though for the sake of consistency it would be preferable for randomisation to take place in the presence of the claimant, it does not appear to bias the group allocation. It should be noted that this alternative approach to randomisation was adopted following initial errors in the allocation of claimants into the treatment and control groups due to a misunderstanding about how to use the RAT tool. Misallocation within the Jobcentre was felt to have reduced following the alternative randomisation process being adopted. This issue was localised to this Jobcentre, and was not apparent elsewhere.

Annex B: Summary statistics based on DWP data

Background

The figures used in [chapter/para ref] 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 table 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 August 2016. 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 and 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.

Results

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 NiNo.

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.

As the exempt group is small in number we have concealed certain characteristics that may be disclosive.

In addition to the Treatment, Control and Exempt groups there is a fourth group comprising of 20 individuals (subject to rounding) who refused to take part.

	Treatment	Control	Exempt
Total People	635	255	105
Random Allocation			
Correct	92%	88%	
Incorrect	8%	12%	
Gender			
Male	48%	53%	
Female	52%	47%	
Unknown	0%	0%	
Ethnicity			
White	49%	51%	
Black	6%	3%	
Asian	6%	3%	
Mixed	24%	18%	
Chinese/Other	9%	11%	
Prefer Not To Say	6%	11%	
Unknown	1%	3%	
Age At Start of Pilot			
Under 18	0%	0%	
18 to 24	2%	3%	
25 to 29	4%	3%	
30 to 40	15%	15%	
40 to 50	28%	26%	
50 to 60	41%	43%	

Over 60	7%	8%	
Unknown	3%	2%	
Average Age (years)	46	46	
Number of Dependents At Start of Pilot			
No Dependents	78%	79%	
1 Dependent	12%	10%	
2 Dependents	5%	6%	
3 or More Dependents	4%	5%	
Age of Youngest Dependent At Start of Pilot			
0 to 4	6%	7%	25%
5 to 10	30%	22%	15%
11 to 16	32%	41%	50%
17 or Over	32%	30%	10%
Other Benefit			
Adult Dependent Allowance (at start of pilot)[i,ii]	9%	9%	13%
Lone Parent (at start of pilot)[iii]	4%	4%	7%
On Disability Living Allowance (current status)	20%	23%	17%
IB Migration Case	37%	36%	38%
Duration of Most recent ESA Claim			
Under 1 Year	8%	8%	10%
1 to 2 Years	7%	5%	13%
2 to 3 Years	11%	16%	17%
3 to 4 Years	31%	29%	28%
Over 4 Years	43%	42%	32%
Unknown	*0.2%*	*0.4%*	*0.0%*
Status At Start of Pilot			

Assessment Phase	4%	6%	13%
Support Group	2%	2%	25%
Work Related Activity Group	91%	89%	60%
Unknown	3%	3%	2%
Most Recent Status			
Assessment Phase	4%	3%	11%
Support Group	5%	5%	29%
Work Related Activity Group	80%	81%	53%
Unknown (but on ESA)	1%	2%	0%
Not on ESA	10%	9%	8%
Local Authority			
Camden	7%	5%	
Islington	9%	5%	
Kensington and Chelsea	10%	8%	
Lambeth	17%	21%	
Southwark	25%	22%	
Wandsworth	10%	14%	
City of Westminster	16%	17%	
Other	3%	5%	
Unknown	3%	2%	
Marker Value			
On Programme	91%	11%	0%
Completed Programme	0%	0%	0%
Became Exempt	0%	0%	8%
Ceased Other	1%	0%	0%
Refused	0%	0%	0%

Start Date			
Oct-15	68%	69%	74%
Nov-15	13%	9%	12%
Dec-15	0%	0%	0%
Jan-16	0%	0%	0%
Feb-16	0%	0%	0%
Mar-16	0%	0%	0%
Apr-16	0%	0%	0%
May-16	0%	0%	0%
Jun-16	0%	0%	0%
Jul-16	0%	0%	0%
Aug-16	0%	0%	0%
Sep-16	0%	0%	0%
Oct-16	6%	7%	5%
Nov-16	7%	6%	5%
Dec-16	6%	8%	5%
Time Since WP End			
No Prior WP Spell	1%	0%	0%
WP Ends After WC marker	1%	2%	2%
Under 1 month	37%	36%	32%
1 to 3 Months	23%	23%	30%
Over 3 Months	38%	39%	37%
Average Time Difference (Days)	244	234	196
ICD Code[iv]			
Certain Infectious and Parasitic Diseases	0%	1%	
Neoplasms	1%	1%	

Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism	1%	1%	
Endocrine, Nutritional and Metabolic Diseases	2%	1%	
Mental and Behavioural Disorders	47%	46%	
Diseases of the Nervous System	5%	3%	
Diseases of the Eye and Adnexa	1%	0%	
Diseases of the Ear and Mastoid Process	0%	0%	
Diseases of the Circulatory System	2%	3%	
Diseases of the Respiratory System	3%	2%	
Diseases of the Digestive System	1%	2%	
Diseases of the Skin and Subcutaneous System	1%	1%	
Diseases of the Musculoskeletal system and Connective Tissue	15%	16%	
Diseases of the Genitourinary System	0%	1%	
Pregnancy, Childbirth and the Puerperium	0%	0%	
Certain Conditions Originating in the Perinatal Period	0%	0%	
Congenital Malformations, Deformations and Chromosomal Abnormalities	0%	0%	
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified	14%	12%	
Injury, Poisoning and certain other consequences of external causes	3%	6%	
Factors influencing Health Status and Contact with Health Services	1%	0%	
Unknown	3%	2%	
Left ESA			
No Longer on ESA	9%	9%	7%

Source: DWP National Statistics Data, August 2016

Notes:

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

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

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

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