London Work and Health Programmes evaluation

Theme A report

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European Union
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SQW

Contents

Contact:	Peter Farrar	Tel:	020 7391 4141	pfarrar@sqw.co.uk

Approved by:	Graham Thom Director	Date:	29 November 2019

Executive Summary

Background

1. In the UK there are currently more than two million people economically inactive due to ill-health. Sickness absence and worklessness are estimated to cost the UK economy £100 billion a year. Against this backdrop the Work and Health Programme was launched in late 2017. The programme provides employment support for: Jobseekers Allowance (JSA), Employment and Support (ESA) and Universal Credit claimants with long-term health conditions and disabilities; the long-term unemployed[1]; and a range of 'early access' groups[2].

2. In London four sub-regional partnerships have each commissioned their own Work and Health Programmes, with their devolved funding matched by the European Social Fund (ESF). The four sub-regions are: Central London Forward, Local London, South London Partnership and the West London Alliance. The four Programmes are expected to deliver support to a collective total of 50-55,000 individuals. They will receive referrals for up to five years and operate for just under seven years in total (with support continuing for up to 21 months following the last referral).

This evaluation

3. This evaluation will run from October 2018 to November 2022, examining the implementation and impact of each sub-regional Programme. It will explore a range of research questions, which are grouped together as three broad 'themes' of investigation:

   - Theme A - examining the match between participant characteristics and programme design/support available
   - Theme B - participants' experiences, including level of access to relevant support and how well integrated and coordinated different services are
   - Theme C - the quantitative performance of the Programmes and factors influencing any variance.

4. At the time of writing this report we have completed the first fieldwork phase of the evaluation. This phase was primarily designed to address Theme A. It was also an opportunity to begin exploring issues relevant to Theme B, which will examine how effectively different organisations involved in programme delivery are coordinating with each other. This phase included:

   - collection and analysis of monitoring data
   - consultations with participants, providers, JCP staff and external partners
   - systematic qualitative data analysis

[1] Jobseeker's Allowance or Universal Credit claimants who have been unemployed for 2 or more years.
[2] Including ex-offenders, homeless people, ex-armed forces, refugees, care leavers and those with drug/alcohol dependency.

- an analysis workshop to synthesise the findings from the above qualitative and quantitative research.

Conclusions

5. **The programmes have taken some time to reach a steady state**, experiencing similar issues around referral numbers and starts to those experienced in other parts of the country. Overall improvements in referral numbers reflect the efforts of providers to build awareness of the programme amongst work coaches. A coinciding increase in referral quality should reduce the numbers who do not attend/start following referral.

6. **More recently, referral numbers have begun falling again** due to: a declining base of existing JCP customers to refer to the programmes; and some work coaches becoming less willing to make referrals due to negative feedback they had received about the programme from customers. Referral numbers from third party organisations continue to be low, which appears to be due the complexity of the referral process (including the randomised control trial element) and potentially also issues of general awareness.

7. While many participants have health and wider barriers (especially housing) to work, **the mix of people coming on the programme has differed from expectation in two key ways,** which are generally thought to mean that the client group is less employable overall than expected:

   - The proportion of long-term unemployed referrals has been higher. This is the only group whose attendance can be mandated.

   - The number of people aged over 50 has been higher. Over 50s be more likely to face health issues and so be harder to support in to work.

8. **Feedback on the process of referral from Jobcentre Plus to providers was mixed**. Key shortcomings included: limited or missing information about participants; participants not fully understanding the programme, being interested in/aware of only one particular aspect; and time and distance between when people agreed to take part in the programme and first appointments. The increased presence by providers in Jobcentres and arranging appointments while the participant is in the Jobcentre should help to improve this.

9. **Participants' feedback on their first meetings with providers was positive**. These sessions are used to gather information about the person and the barriers that they face and agree how these can be addressed. It is encouraging that the participants we interviewed thought that this was being achieved.

10. Participants are then referred to support, either with the provider or elsewhere. **Provider staff were confident that they knew what support was available and could signpost effectively**. There has been some progress with individual borough councils, which have helped providers identify key contacts with local authority and/or health services to establish external referral pathways. There are some risks around what essentially appears to be an informal and ad hoc process which will need to be explored further as the programme matures.

11. **There was good feedback from participants and key workers about increased confidence and motivation, improved wellbeing and better management of physical health issues** (such as a reduction in physical pain, or sleeping better). Key workers were motivated by this, as were work coaches. This general improvement in well-being should help improve job and earning outcomes in time.

12. **The picture on job and earning outcomes to date is less positive**. The level of people entering work and reaching the earning thresholds was less than expected. Key challenges raised by key workers in each sub-region were the high level of barriers some participants arrive on the programme with, and the unwillingness of some people to look for work. These factors meant that it was difficult to progress participants towards work at a sufficient pace. This is an important issue to revisit in future reports.

Recommendations

13. The evidence gathered points to a number of recommendations to improve program performance. These are set out below.

Programme design

- Review the profile of anticipated referrals.
- Continue to focus on developing links with external organisations that can refer people into the programme.
- Review the impact of the alternative external referral entry route being trialled and roll this out if appropriate.

Engagement at Jobcentre

- Training and/or script for work coaches to guide their first conversations with potential participants.
- Develop good news stories which can be used to promote the programme to JCP staff and potential participants.
- Providers to maintain and, where required, raise their profile in Jobcentres.

Transfer from Jobcentre to provider

- First contact between provider and participants to take place while the participant is in the Jobcentre.
- Ensure claimants are given (and record) the phone number the provider will contact them from.
- Stress to work coaches the importance of providing accurate participant information.

Ongoing support

- Develop close links with councils in their boroughs to support access to other services.

- Develop simple protocols for sharing participant information between support organisations.

Jobs and employment outcomes

- Conduct a short-term, focused exercise reviewing the types of participant coming on to the programme and how they compare to expectation.
- Conduct a review with each provider of the scale and range of vacancies that they offer to participants, and participants' success rate in applying for jobs.
- Ask each provider to re-profile their expected job entry and earnings outcomes over the next six months.

Learning for the design of future programmes

- Revise referral targets, to ensure targets incentivise both volume and quality of referrals.
- Consider revising or lifting caps on referral numbers to focus on starts instead.
- Consider whether a 50% job outcomes target is realistic given participant characteristics.
- Incorporate external referral organisations into initial programme design.
- Explore options for shortening the time between first referral and starting on the programme.

1. Introduction

This is the Theme A report for the evaluation of the London Work and Health Programmes. It details the fieldwork and analysis undertaken by SQW between April and August 2019, the findings of this analysis and the implications of these findings for each sub-region's Work and Health programme and the subsequent stages of the evaluation.

This report has been written for sub-regional commissioners overseeing this study, and any relevant parties they wish to share it with (including their providers).

Background

1.1 In the UK there are currently more than 2 million people economically inactive due to ill-health[3]. Sickness absence and worklessness are estimated to cost the UK economy £100 billion a year[4]. Against this backdrop the Work and Health Programme was launched in late 2017, providing employment support for people with disabilities and the long-term unemployed.

1.2 The Work and Health Programme is a national programme, and in most areas commissioning and management of the Programme is led by the Department for Work and Pensions (DWP). However, in two city regions (London and Greater Manchester) funding for and commissioning of the Work and Health Programme has been devolved[5].

1.3 In London four sub-regional partnerships (illustrated in Figure 1-1) have each commissioned their own Work and Health Programmes, with their devolved funding matched by the European Social Fund (ESF). The four sub-regions are:

- Central London Forward (red)
- Local London (blue)
- South London Partnership (green)
- West London Alliance (purple).

[3] ONS, 2018. *Annual Population Survey.*
[4] DWP & DHSC, 2016. *Improving lives: the work, health and disability green paper.*
[5] Although devolved programmes still have to replicate some elements of the national programme, including aspects of the programme's design (such as referral number caps and outcomes targets) and participation in the national RCT (detailed later in this report).

Figure 1-1: London sub-regional partnerships

Source: London Councils

1.4 The London Work and Health Programmes aims to help address two key challenges that exist within London's labour market:

- A current total of 538,400 people who want to work but are not in employment[6].
- A persistent disability employment gap that has decreased little over the past decade[7], and currently stands at 25.6 percentage points[8].

1.5 The four Programmes are expected to deliver support to a collective total of 50-55,000 individuals. They will receive referrals for up to five years and operate for just under seven years in total (with support continuing for up to 21 months following the last referral). The programmes provide employment support for: Jobseekers Allowance (JSA), Employment and Support (ESA) and Universal Credit claimants with long-term health conditions and disabilities; the long-term unemployed[9]; and a range of 'early access' groups[10].

1.6 Claimants with long-term health conditions and disabilities or who are from one of the early access groups are referred to the Programmes on a voluntary basis by their work coaches in Jobcentre Plus. For long-term unemployed claimants, referral to the Programmes can be mandatory.

[6] ONS, 2018. *Annual Population Survey.*
[7] London Councils, 2018 (here).
[8] 57.1% of disabled residents of London are currently employed, compared to 82.7% of non-disabled residents (*Ibid 6).*
[9] Jobseeker's Allowance or Universal Credit claimants who have been unemployed for 2 or more years.
[10] Including ex-offenders, homeless people, ex-armed forces, refugees, care leavers and those with drug/alcohol dependency.

Purpose of the study

1.7 This evaluation will run from October 2018 to November 2022, examining the implementation and impact of each sub-regional Programme. The specific aims and objectives of the evaluation are to:

- **Generate process learning** by examining the effectiveness of the processes (including contractual mechanisms) used to implement each sub-regional Programme, understanding the context of the implementation and identifying key barriers and enablers to successful implementation.
- **Assess the Programmes' impact** on participants, including on their health and wellbeing, soft skills that will support them in job seeking, and 'hard' outcomes including moving into work and passing different earnings thresholds.
- **Undertake a cost-benefit analysis** examining the overall value for money (VfM) of the Programmes, taking into account the different support received and levels of need across participant groups'.

Strands of investigation

1.8 The evaluation will explore a range of research questions as set out in the Invitation to Tender, which are grouped together as three broad strands of investigation (hereafter referred to as 'themes'):

- **Theme A** - examining the match between participant characteristics and programme design/support available
- **Theme B** - participants' experiences, including level of access to relevant support and how well integrated and coordinated different services are
- **Theme C** - the quantitative performance of the Programmes and factors influencing any variance.

1.9 These themes are described in more detail in Annex C.

1.10 In addressing these themes the evaluation will generate learning to inform the development of the Programmes on an ongoing basis, as well as the design of any subsequent support put in place for the same or similar target groups.

Timeframes

1.11 The activities to be undertaken for this the evaluation are spread across four key phases:

- **Scoping and planning** (November 2018 to March 2019)
- **Theme A data collection and analysis** (April 2019 to August 2019)
  - *Theme A report* (August 2019)
- **Theme B data collection and analysis** (October 2020 to July 2021)
  - *Mid-term review report* (September 2020)

  - *Theme B report* (July 2021)

- **Theme B data collection and analysis** (August 2021 to November 2022)
  - *Theme C report* (November 2022).

Structure of this report

1.12 This report presents the findings of our Theme A research, and is structured as follows:

- **Chapter 2** details the work undertaken by SQW so far
- **Chapter 3** sets out each sub-regional Programme's delivery model, based on a review of documentation and data provided to use
- **Chapter 4** explores the initial engagement of customers at Jobcentres, including the content and effectiveness of the first conversations held with customers about the programmes and the process by which they are referred to their local programme
- **Chapter 5** examines the process of transferring participants from JCP to providers and factors influencing attendance at first appointments and referral-to-start conversions
- **Chapter 6** details the profile of participants starting on the programmes, the quality of support that they are receiving and the outcomes that are being achieved
- **Chapter 7** sets out our conclusions and recommendations.

2. Work undertaken so far

Summary

Since the start of this study in November 2018, we have completed the scoping phase and (now) first fieldwork phase. The scoping phase was designed to produce a detailed understanding of delivery models, progress and challenges to date, and anticipated outcomes or impacts of the Programmes. Scoping activity consisted of a document review, interviews with key programme stakeholders, and scoping of provider monitoring data.

The first fieldwork phase was primarily designed to address one of the three broad strands of investigation (Theme A), examining the match between participant characteristics and programme design/support available. It was also a chance to begin exploring issues relevant to Theme B, which will examine how effectively different organisations involved in programme delivery are coordinating with each other. This phase included:

- a first round of monitoring data collection and analysis
- consultations with participants, providers, JCP staff and external partners
- systematic qualitative data analysis
- a second round of monitoring data collection and analysis
- an analysis workshop to synthesise the findings from the above qualitative and quantitative research.

Scoping phase

2.1 The scoping phase took place between November 2018 and March 2019. It included a review of documentation from each sub-region, consultations with pan-London and sub-regional stakeholders, and a review of the monitoring data available. This section summarises the work undertaken. For full details on the scoping phase please refer to the separate inception report.

Document review

2.2 Each sub-region supplied SQW with background documents on their programme, detailing their programme's background, design and aims. In total, 26 documents were reviewed. We collated information on each sub-regional programme's targets and payments, partner organisations, delivery process and projected participant outcomes.

2.3 The purpose of this review process was to map out each provider's delivery model and the step-by-step process by which participants are being supported by each. Any gaps evident following the document review were explored with sub-regional and pan-London stakeholders during the consultations detailed in the next subsection of this chapter.

2.4 Additional documents received from sub-regions or London Councils following the scoping stage have subsequently been added to this review. Please see Annex A for the full list of documents.

Scoping consultations

Sub-regional consultations

2.5 A total of 11 stakeholders were interviewed across each of the four sub-regions. Insight was gained from the four sub-regional partnerships via interviews with their programme leads and other stakeholders including finance officers, contract managers and departmental leads. We also interviewed the programme leads from each of the providers. In addition, we drew on feedback from commissioners and providers received at the evaluation inception meeting.

2.6 Consultations explored local context (e.g. claimant profile, provider landscape), rationale for the delivery model adopted (especially any variations from the national Programme model); progress to date (including successes and challenges observed so far); anticipated outcomes for participants and local organisations; and any gaps remaining following the documentation review.

Pan-London consultations

2.7 Consultations were undertaken with three pan-London stakeholders, representing London Councils and the Greater London Authority (GLA). We also attended a Joint Governance Board meeting on December 5th (attended by all commissioners, London Councils, the GLA and DWP).

2.8 This activity explored the strategic context and objectives of all four programmes (including the aims and intended benefits of devolving commissioning and delivery), common successes and issues encountered by providers across all four sub-regions, as well as any variation in performance between sub-regions (and possible explanations for this).

Scoping of provider monitoring data

2.9 MI key performance indicators were in place before the evaluation design was finalised. Therefore, our first task was to investigate what MI data would be available. We held a conference call with commissioning leads from the four CPAs to discuss the level and type of MI data collected by each provider, what was (and was not) being collected consistently, and the implications for our analysis.

2.10 We contacted each sub-regional provider requesting copies of all forms used to collect data on individual participants and their journeys. We also requested details on the format in which data is stored and the accessibility of individual-level data. Each form was reviewed on its coverage of participant characteristics**,** issues they present with, support received, distance travelled (i.e. progress), and participant outcomes.

Implications from the scoping phase for the first fieldwork phase

2.11 Our scoping research identified several key issues that influenced each programme's progress with delivery to date. It had also provided us with a more detailed understanding of the level and type of data each provider is collecting on programme participants. The implications of these findings for our subsequent research were that:

- During qualitative fieldwork, we knew to explore the accuracy of referral identification processes used by work coaches, information provided to participants by work coaches, the impact of 'warm' handovers, and the referral process for third party organisations.
- We knew ahead of time which variables included in the MI data would be useable for analysis, as well as the limitations of the data.
- We better identified and mitigated risks around obtaining quality data from providers.

First fieldwork phase

2.12 The first fieldwork phase took place between April and August 2019. It addresses one of the three broad strands of investigation (Theme A) by examining the match between participant characteristics and programme design/support available. This phase consisted of a first round of MI data collection and analysis, qualitative fieldwork, a second round of MI data collection and analysis, and an internal analysis workshop.

First round of MI data collection and analysis

2.13 We collected a first round of MI data from sub-regional providers in early June 2019. This broadly covered data up to and including May 2019. We prompted providers to provide data for a set of core metrics we had identified during the scoping phase, as well as any other data they could provide.

2.14 We carried out an initial analysis of the data to explore the profile/characteristics of participants entering the Programme, the referral to start ratios, and the support different participant groups access, including any variation between sub-regions and individual boroughs. This was in order to:

- assess to what extent provision aligns with participant need, and to what extent implementation matches providers' delivery plans
- highlight any areas for us to explore in the qualitative fieldwork
- identify our intended sample profile for each group of fieldwork interviewees (including across different sub-regions and characteristics), to underpin our discussions with JCP managers and providers.
- Identify in which boroughs to conduct qualitative fieldwork, ensuring a sample which was representative but also varied, allowing us to understand a range of successes and challenges faced by the programme.

2.15 Once we had identified which boroughs to visit for qualitative fieldwork, we consulted each sub-region's provider, their key borough council commissioner, and in one area, the DWP lead, to take their steer on the appropriateness of the boroughs selected.

Qualitative fieldwork

Collection

2.16 From June to August 2019, we conducted consultations with stakeholders in each of the four sub-regions. Each sub-region was assigned to a different evaluation team member, who then undertook all interviews in that sub-region. This enabled that team member to develop greater familiarity and insight into the structure, progress and issues around the Programme in the area they were responsible for.

2.17 All consultations were semi-structured and followed a written topic guide. Separate topic guides were produced for consultations with participants, provider staff, JCP staff and external partners. The topic guides were based on the evaluation's core research questions and informed by our scoping phase and review of monitoring data.

Table 2-1: Number of consultations conducted by consultee type and sub-region

	Participants	Provider staff	JCP staff	External partners[11]	Total
SLP	4	6	5	3	18
LL	8	11	7	4	30
CLF	8	8	6	6	28
WLA	11	6	7	5	29
Total	31	31	25	18	105

2.18 The number of consultations conducted are broadly in line with our expectations set out in the proposal, and for each interviewee group were sufficient for us to explore our research questions.

2.19 Interviews with programme participants were held face-to-face and took place as either one-to-one consultations or focus groups. They were set up by the providers and held on provider premises. The evaluation team asked provider staff to put forward participants for interview who, between them, represented a mixture of groups and lengths of time on the programme (which provider staff achieved). The interviews explored participants' understanding of the Programme, their experience of the referral process, the support provided to them, ongoing barriers to work, and if/ how the Programme likely to benefit them.

2.20 Provider consultations took place with managers and key workers, mostly in person during a site visit and occasionally over the phone. They explored how well the referral and transfer process is working, the appropriateness of referred participants, how well provision aligns

[11] External partners were either support services to whom participants were signposted, or sub-contractors to the main provider who are tasked to deliver key worker support.

with participant needs, relationships with partner organisations and anticipated outcomes for participants.

2.21 Consultations with JCP staff were with managers and work coaches, and were also mostly conducted either in person during a site visit or occasionally over the phone. They covered the consultees' understanding of the Programme, the eligibility criteria, the referral process, and reasons for any participant DNAs/attrition.

2.22 The external partners consulted tended to be organisations that providers would refer participants on to. They included Aspire Education Academy, Inspire, Living Well CIC, Advice4Renters, Brent Hub, Salvation Army, Go train, Lumi Foundation, Strive Training, Camden Borough Council, Richmond and Wandsworth Council, Leonard Cheshire, Renaisi, the Havering Volunteer Centre and the National Careers Service. The consultations explored their links with the Programme, changes in traffic towards their services caused by the Programme, and capacity/ability to provide support to the referred participants.

Systematic qualitative analysis

2.23 All consultation notes were written up into structured templates that followed the format of the topic guides. Provider and JCP staff consultations were analysed using systematic qualitative analysis software, MaxQDA. This software allows for 'coding', where sections of text are grouped under different 'codes' in order to more easily identify key themes. For example, a code named 'good practice' would encompass every mention of good practice identified by the consultees.

2.24 We used the software to automatically pre-coded each question response and manually code each quotation, as well as examples of good practice and ongoing challenges/barriers. This helped us to observe lines of enquiry quickly within large swathes of text, ensure a robust analysis process, and mitigate the risk of recall bias, observer bias and confirmation bias.

2.25 This approach was not taken for the participant and external partner consultations as, due to the manageable number of consultations, it would not be necessary or beneficial to employ qualitative analysis software techniques in these cases. These were analysed via thorough review of the completed structured templates.

Second round of MI data collection and analysis

2.26 In July 2019, the evaluation team collected MI data relating to April - June 2019. We explored our lines of enquiry from the first round more fully, having received more data, and data which 'filled in the blanks' left at the first round. The MI data covered: profile of referrals (group and BME), referral to start ratios, DNA rates, job outcomes, and lower and upper earnings outcomes. We collated the data into frequencies and time series, and compared programme performance between CPAs, and between boroughs within each CPA.

2.27 The purpose of this round of data analysis was to understand how effectively providers are performing against key performance indicators (KPIs), which, when triangulated with insights from other data sources, would explain the reasons behind any variation between CPAs and boroughs, and any metrics above or below profile.

Analysis workshop

2.28 An internal analysis workshop was held in August 2019 and attended by the research team. Its purpose was to explore and share findings from all data sources explored thus far. The team triangulated all data collected against the research questions, explored any gaps or barriers that exist in provision, any deviation from sub-regional plans, and barriers identified by interviewees as contributing to this. The analysis workshop was focused on the task of Theme A: to examine the match between participant characteristics and programme design/support available.

Limitations and caveats

2.29 The analysis and findings presented in this report come with some limitations and caveats, set out below:

- The number of cases included in the quantitative datasets examined was sufficient to enable a comparison of beneficiaries' progress and outcomes in each sub-region, and a comparison between different participant groups[12] across London as a whole. Samples sizes did, however, mean that it was not possible to explore variations in progress and outcomes between beneficiary groups within single sub-regions.

- In examining learning around how the programmes have been implemented and the success of approaches taken by different providers, this evaluation has drawn primarily on self-reported feedback from different stakeholders. To mitigate against any response bias (e.g. unwillingness on the part of any stakeholder to report the shortcoming of their own organisation's approach), such feedback has in all cases been triangulated with: feedback from other stakeholders/beneficiaries in the same sub-region and type of role; feedback from stakeholders in other organisations involved in the same processes[13]; and quantitative data, for evidence of any trend's/issue's likely prevalence.

- Reliance on interviewee feedback posed a particular challenge for exploration of how efficiently and effectively the end-to-end participant journey (including referral to third party provision) is being delivered, as quantitative data was not available to support this strand of investigation. This was not a primary focus of the Theme A fieldwork (the focus of this report) but will be important to explore in more detail during subsequent Theme B fieldwork. Different options for doing so are currently under consideration, including reviewing participant case files and accessing providers' MI on provision access/delivered.

[12] Health & Disability, Early Access and Long-Term Unemployed.
[13] In each sub-region, interviews were undertaken with a selection of commissioners, provider staff, wider partner organisations, Jobcentre Plus staff, and beneficiaries.

3. Provider delivery models

During the scoping research we mapped each sub-regional programme's delivery model, including the minimum support and outcomes they are contracted to deliver. Our findings so far on key consistencies and variation between each programme are as follows:

- For all providers, a proportion of their contract payment is conditional on participants finding employment *and* achieving a minimum level of earnings[14]. Each provider is expected to progress around half of their participants to the minimum earnings threshold. For two providers an additional, higher earnings outcomes target (also linked to payment) has been set.
- The level at which providers' lower and higher earning outcome targets have been set varies. Across the four sub-regions, three different set of targets have been applied.
- Most providers have referral-to-start targets of around 65%, except West London where the target is 100% (but measure differently). There is some, albeit slight, variation in the proportion of programmes' referrals that are expected to come from each participant group (health and disability; early access; long-term unemployed).
- The timeframes within which individual participants are expected to complete the referral and assessment process vary between the sub-regions, ranging between 14 and 20 working days. Contracted key worker-to-participant ratios and minimum participant contact time vary significantly.

3.1 During the scoping research we began mapping out each sub-regional programme's delivery model and the step-by-step process by which participants on each are being supported.

3.2 All devolved programmes must replicate some elements of the national programme. This includes aspects of the programme's design such as:

- referral number caps and outcomes targets
- participation in the national randomised control trial (RCT) as part of the national evaluation, via which individuals assessed as eligible for programme support are (prior to referral to the provider) randomized either onto the programme or into a control group[15].

3.3 These elements are therefore consistent across the four sub-regional programmes. There are, however, elements of programme design that devolved commissioners and providers are free to alter.

[14] This appears to be 70% for all providers, although documentation confirming that this is the case for Local London has not yet been received.
[15] To enable the outcomes of programme participants to be compared to the outcomes of a randomly allocated control group as part of the national programme's impact assessment.

3.4 The following subsections of this chapter set out our key findings from the mapping undertaken, detailing the level of consistency/variation between sub-regional programmes':

- **Payment mechanisms**, including the proportion of providers' payment linked to achievement of outcomes targets (and what these targets are)
- **Referral and start targets,** including a breakdown of referrals and starts expected from each participant group (health and disability, early access, and long-term unemployed)
- **Core delivery standards,** including timeframes for completing referral and assessment processes, and minimum volume/frequency of contact participants should receive.

3.5 Where elements of programme maps could not be completed using the documentation supplied so far, this is marked with an asterisk (*) within the tables. Following submission of this report, further documentation will be requested from the sub-regions and our maps further developed and refined, to be completed prior to our qualitative fieldwork beginning.

3.6 Full copies of each map as drafted so far are included in Annex B.

Payment mechanisms

3.7 From the information we have received, for two programmes the majority of the contract value (70%) comes from participant's achieving earnings outcomes, with the remaining 30% coming from the service fee. All four providers expect around half of all participants to reach their earnings threshold. Two providers have also set an additional, higher earnings outcomes target which has also been linked to their payment, and they are both expecting around 40% of participants to reach this level.

3.8 The levels at which the lower earnings outcome and higher earnings outcome have been set vary across the sub-regions. Three sub-regions have set their lower earnings threshold at the National Living Wage, whilst West London Alliance have set theirs at the London Living Wage. Central London Forward and South London Partnership have an additional higher earnings threshold, set at the level of the London Living Wage. This is mapped out in Table 3-1 below.

Table 3-1: Earnings outcome milestones in each sub-region

	National Living Wage	London Living Wage
Central London Forward	First earnings outcome	Second earnings outcome
Local London	First earnings outcome	-
South London Partnership	First earnings outcome	Second earnings outcome
West London Alliance	-	First earnings outcome

Source: provider documentation

3.9 Three sub-regions have set milestones that differ from the payment milestones used by the national programme (one earnings outcome of National Living Wage). These sub-regions reported having fairly similar rationales for the milestones they had set. The higher first earnings outcome in West London Alliance is intended to encourage their provider to get participants into work that is higher paid (and therefore likely better quality).

3.10 This was also the rationale for Central London Forward and South London Partnership setting a second earnings outcome of London Living Wage, with commissioners in south London noting that London wages tend to be higher and so a higher threshold is needed to encourage providers to find good quality work (as National Living Wage was felt to be easier to hit in London than in other areas). Commissioners in Local London felt that local job and labour markets in the sub-region were not different enough from others nationally (in terms of sectoral breakdown or wages) to warrant different earnings thresholds.

3.11 This variation in earnings targets did not appear to be influencing the type of work that participants are finding through the programmes, with key workers and participants in each sub-region reporting that the type of jobs participants find depends primarily on local labour markets (i.e. what vacancies exist) and participants' preferred types of job and working patterns. This is explored further in Chapter 6.

3.12 A more detailed breakdown of each sub-region's payment milestones, and the proportion of participants expected to achieve these milestones, is set out in Table 3-2 below.

Table 3-2: Breakdown of contract value and outcome payments to provider

		Central London Forward	Local London	South London Partnership	West London Alliance
% contract value paid for	**Service fee**	30	30	30	30
	Achieving employment outcomes	70	70	70	70
Lower earnings outcome	**% of participants expected to achieve**	50	59	50	49
	Level[16]	NLW[17]	NLW	NLW	LLW[18]
	Payment per outcome	£2,696.96	£2,980	£2,838.13	£2,910
Higher earnings outcome	**% of participants expected to achieve**	39	*n/a*[19]	42	*n/a*
	Level[20]	LLW	*n/a*	LLW	*n/a*
	Payment per outcome	£948	*n/a*	£919.19	*n/a*
Self-employment outcome payment to provider	**% of participants expected to achieve**[21]	15%	15%	10% of job starts	-[22]
	Level[23]	182 days	182 days	182 days	182 days
	Payment per outcome	£2,696.96	£2,980	£2,838.13	£2,910

[16] This is calculated as a participant earning the equivalent of someone working at the NLW/LLW for 16 hours per week, for six months.
[17] National Living Wage.
[18] London Living Wage.
[19] Local London and West London Alliance only have one earnings outcome target.
[20] This is calculated as a participant earning the equivalent of someone working at the NLW or LLW for 21 hours per week for six months.
[21] Note: these figures are projections, not targets.
[22] No separate contractual target. The 49% lower earnings outcomes target covers both employed and self-employed.
[23] Self-employment outcomes are based on the length of time an individual spends in self-employment. They are not tied to any level of earnings.

Source: SQW analysis of documentation and consultations

Referrals and start targets

3.13 Most areas expect to start around two-thirds (65%) of those referred. The exception is the West London Alliance, which has a conversion rate target of 100%. However, unlike the other three sub-regional targets West London Alliance's conversion rate is based on referrals that attend their first appointment (excluding referrals who do not attend). West London Alliance's conversion rate from point of referral (at the Jobcentre) to programme start is expected to be the same as in other sub-regions.

Table 3-3: Referrals and conversion rate to starts

		Central London Forward	Local London	South London Partnership	West London Alliance
Profile referrals	**2017/18**	727	500	145	358
	2018/19	7,560	4,500	1,819	3,120
	2019/20	7,992	4,625	1,440	3,336
	2020/21	8,280	6,000	1,440	3,336
	2021//22	4,893	2,750	862	2,004
	2022/23	2,304	1,250	400	952
	Total	**31,756**	**19,625**	**5,582**	**13,106**
Profile conversion rate from referrals to starts	**Total**	**65%**	**65%**	**66%**	**100%***

*Note: * is based on those who attend the first meeting, not all referrals*
Source: SQW analysis of documentation

3.14 Some slight variation is expected between providers in terms of the expected starts from the three groups (health and disability; early access; long-term unemployed) over time. West London Alliance are expecting the same proportion of the three groups to start on the programme each year: 75% Health and Disability, 10% Early Access and 15% Long Term Unemployed. Central London Forward are expecting the proportions to change over time, with the proportion of Long Term Unemployed increasing and the proportion of Health and Disability decreasing.

Table 3-4: Number of profiled starts, by participant group

		Central London Forward		Local London		South London Partnership		West London Alliance	
		No.	%	No.	%	No.	%	No.	%
2017/18	**H&D**	410	91%	300	75%	77	90%	269	75%
	EA	41	9%	50	12.5%	9	10%	37	10%
	LTU	0	0%	50	12.5%	0	0%	53	15%
	All	**450**	**100%**	**400**	**100%**	**86**	**100%**	**358**	**100%**
2018/19	**H&D**	4,158	84%	2,700	75%	1,014	83%	2,340	75%
	EA	495	10%	450	12.5%	116	9%	320	10%

		Central London Forward		Local London		South London Partnership		West London Alliance	
	LTU	297	6%	450	12.5%	97	8%	460	15%
	All	**4,950**	**100%**	**3,600**	**100%**	**1,227**	**100%**	**3,120**	**100%**
2019/20	**H&D**	4,095	78%	2,775	75%	1,014	76%	2,502	75%
	EA	473	9%	461	12.5%	121	9%	342	10%
	LTU	630	12%	461	12.5%	207	15%	492	15%
	All	**5,250**	**100%**	**3,697**	**100%**	**1,342**	**100%**	**3,336**	**100%**
2020/21	**H&D**	3,942	73%	2,850	75%	944	74%	2,502	75%
	EA	486	9%	475	12.5%	117	9%	342	10%
	LTU	972	18%	475	12.5%	207	16%	492	15%
	All	**5,400**	**100%**	**3,800**	**100%**	**1,268**	**100%**	**3,336**	**100%**
2021/22	**H&D**	2,272	71%	1,651	75%	542	73%	1,503	75%
	EA	320	10%	275	12.5%	78	10%	205	10%
	LTU	608	19%	275	12.5%	124	17%	296	15%
	All	**3,200**	**100%**	**2,201**	**100%**	**744**	**100%**	**2,004**	**100%**
2022/23	**H&D**	1,065	71%	750	75%	252	73%	714	75%
	EA	150	10%	126	12.5%	36	10%	98	10%
	LTU	285	19%	126	12.5%	57	17%	140	15%
	All	**1,500**	**100%**	**1,002**	**100%**	**345**	**100%**	**952**	**100%**
Total	**H&D**	**15,942**	**77%**	**11,026**	**75%**	**3,844**	**77%**	**9,830**	**75%**
	EA	**1,965**	**9%**	**1,837**	**12.5%**	**477**	**9%**	**1,344**	**10%**
	LTU	**2,792**	**13%**	**1,837**	**12.5%**	**692**	**14%**	**1,933**	**15%**
	All	**20,750**	**100%**	**14,700**	**100%**	**5,012**	**100%**	**13,106**	**100%**

Source: SQW analysis of documentation

Core delivery standards

3.15 Across the four sub-regions, the expected timeframe for participants to complete the referral and assessment process is broadly the same. Three sub-regions set a time frame between referral and completed assessment of 20 working days, whilst South London Partnership allows up to 30 working days. Other elements of the ongoing engagement with participants also vary between providers. For example, the maximum key worker: participant ratio is smaller in South London Partnership (1:45) than in Central London Forward (1:65 average), with the latter setting their ratio higher due to anticipating a higher proportion of support being delivered via group sessions.

Table 3-5: Referral, assessment and ongoing engagement

	Central London Forward	Local London	South London Partnership	West London Alliance
Warm handover	Yes	Yes	Yes	Yes
Time from referral to first meeting with provider	7-10 working days	10 working days	10 working days	15 working days
Assessment and action plan	Within 10 days of first meeting, assessment must be completed	Within 20 working days of referral, assessments must be completed	Within 20 working days of start[24], assessment and plan must be completed	Within 20 workings days of referral, assessment must be completed
Key worker: participant ratio	1:65 average, 1:85 maximum	1:45 maximum	1:45 maximum	1:40 rolling 12-month average 1:48 maximum
Minimum contact frequency	One hour per week (face-to-face or telephone), at least 50% with the key worker Four hours per week in group activities	Four hours face-to-face per month pre-work, then two hours when in work	Weekly interaction, fortnightly face-to-face meetings & monthly action plans review (each lastly at least 30mins or 40mins for Disability/EE groups).	8.5 hours every 4 weeks
Key worker, case conferencing or 1:1 support	65 hours over 15 months (at least 32.5 with key worker)	Contact listed above is all key worker contact time	16hrs 31mins total (12hrs 3mins face-to-face, 4hrs 28mins phone/email) Additional support for participant: 3hrs 6mins case conferencing	As above
Other/group support	260 hours of group activities	No contractual requirement (although is provided)	Group activities delivered but no minimum time specified	No contractual requirement (although is provided)

Source: SQW analysis of documentation

[24] Documentation provided so far does not define 'start' (which might be the point of referral, or the participant's first meeting with the provider).

4. Engagement at the Jobcentre

Following a slow start, referrals built quickly through 2019 and are now ahead of target in three of the four areas, and close to target in the forth. However, the volume of referrals has declined in recent months.

The work undertaken by providers to enhance work coaches' understanding of the programme was widely held to have been important in growing the number and quality of referrals.

While improved quality was one positive factor behind the decline in referrals, other factors were less positive: a reduction in the rate at which unsuitable referrals (people not seeking work and so not who the programme was designed for) were being included alongside eligible customers: a declining base of existing JCP customers to refer to the programmes; and some work coaches becoming less willing to make referrals due to negative feedback they had received about the programme from customers.

Providers in all four sub-regions are now receiving a higher-than-profiled proportion of LTU referrals. As H&D and EA referral numbers have fallen, the volume of LTU referrals has remained relatively stable (except in CLF where LTU numbers have risen).

Some work coaches also reported that the RCT process put them off making referrals. The allocation tool, which is an important part of the national evaluation, was also perceived to be a barrier to wider organisations referring to the programme.

The offer of support with health and wider barriers, rather than a narrow focus on work, was seen as a key attraction of the programme. However, sometimes the health and employability elements of programme support are not emphasised equally, and participants who have understood less about the whole programme are perceived to be more likely to disengage (due to the programme not meeting their expectations).

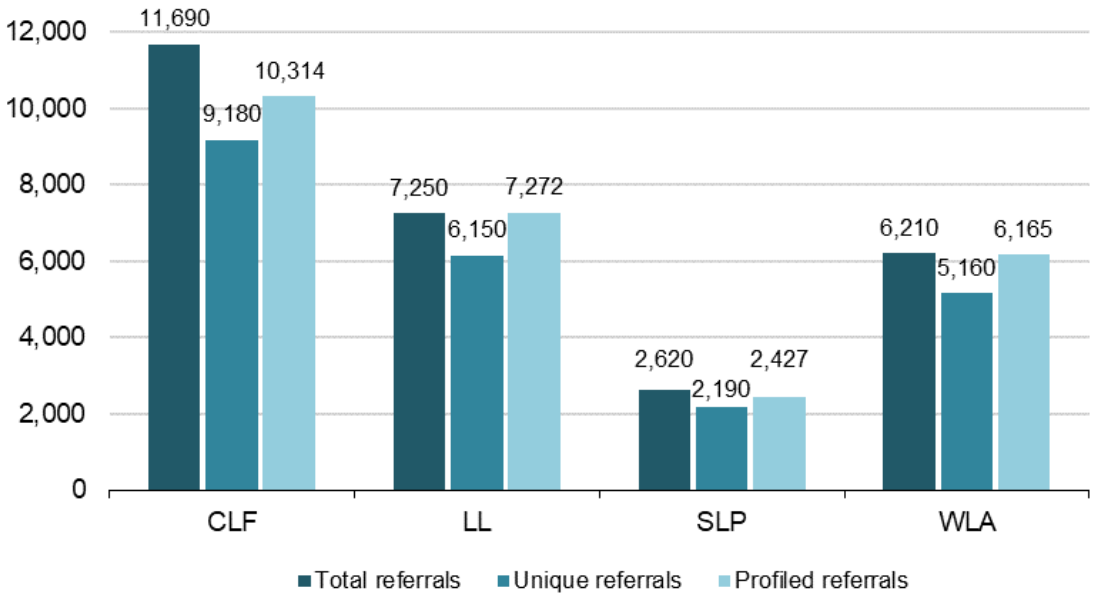
The number of steps involved before starting the programme was said to be off-putting for external organisations. They are meant to refer people to JCP, which then refers to the provider. WLA is trialling an approach whereby organisations first refer to the provider, with JCP involved later.

How participants are identified

4.1 By the end of June 2019, each sub-regional programme had received almost all or more than the number of referrals it was expecting to have received by that point in time (Figure 4-1). Referral volumes against profile ranged from meeting profile (100% of profile achieved in LL) to significantly above (113% in CLF).

4.2 However, it is worth noting the distinction between number of total referrals[25] and the number of unique referrals[26]. In each sub-region, between 15-21% of referrals made to date have been re-referrals of customers already referred to their sub-region's programme at least once previously. This has implications for the rate at which gross referrals subsequently become programme starts and is explored further in Chapter 5.

Figure 4-1: Total referrals against profile referrals, March 2018 – August 2019

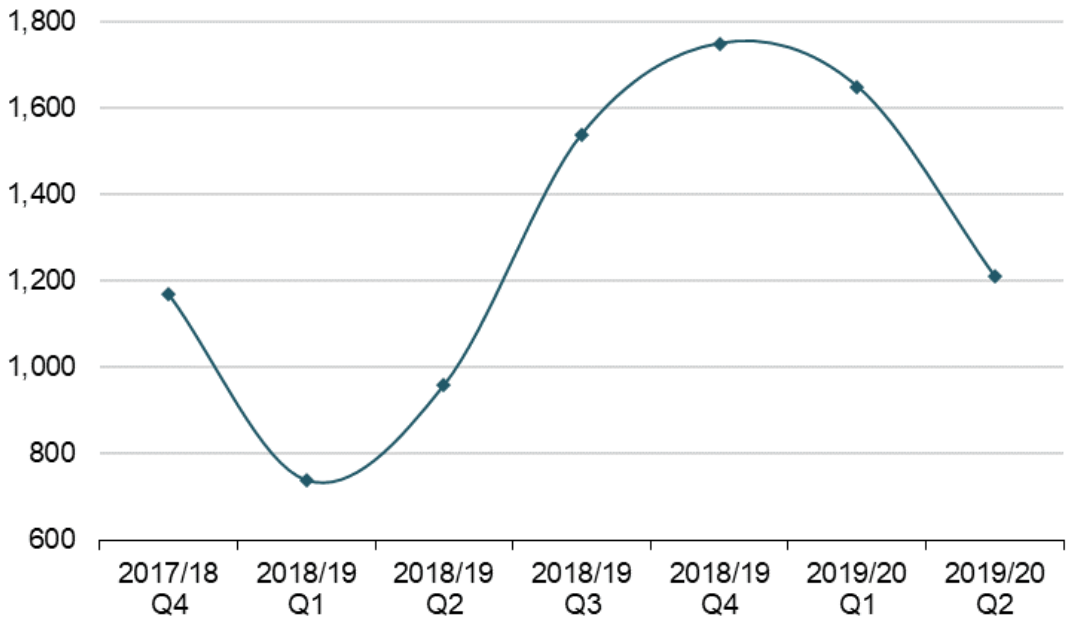


Source: DWP WHP Statistics, November 2019 release (total and unique referrals); provider MI from each sub-region (referral profiles)

4.3 Referral volumes were reported to have varied significantly over time in each sub-region, spiking late in the 2018 calendar year. Although data demonstrating this for the London sub-regions were not available[27], this fits with trends observed in the national programme. For example during the first financial quarters of the national programme, referrals across the Devolved Deal Areas (DDAs)[28] were generally below 1,000 per quarter, before rising sharply towards the end of 2018/19 and sitting consistently above 1,500 per quarter (Figure 4-2). Referrals then subsequently started to decline again later in the most recent quarter of 2019/20.

[25] An instance of an individual being referred to the programme. If an individual has been referred to the programme more than once (e.g. due to failing to attend an initial appointment) each time they have been referred would be recorded as one referral.
[26] Unique individuals referred to the programme (one or more times).
[27] Published data do not enable referral volumes in London to be examined prior to Aug-Oct 2018.
[28] In six areas of England & Wales DWP designed local programmes in consultation with Local Enterprise Partnerships and city regions. These six areas (known as 'Devolved Deal Areas') are: West Midlands Combined Authority; Sheffield City Region; Liverpool City Region; West of England; Cambridgeshire and Peterborough; and Cardiff Capital Region.

Figure 4-2: Total referrals over time, by sub-region



Source: DWP WHP Statistics, November 2019 release

4.4 Throughout the lifetime of the London programmes, providers in each sub-region have undertaken direct engagement with JCP staff to build their understanding of their sub-region's programme and its objectives, and to promote their sub-regional programme as a support option for work coaches to refer their customers to. Findings from qualitative interviews with team managers within providers and JCP suggest that following a run-in period, consistent engagement of Jobcentre staff by sub-regional providers has broadly addressed initial barriers relating to JCP awareness of the programmes and understanding of their content/objectives. An example of the impact of this engagement work can be seen in Camden (CLF): since key workers in Camden started regularly visiting Jobcentres (in March 2019) to promote the programme to work coaches (as well as participants), Camden has subsequently seen a sharp increase in its referral numbers.

4.5 Provider and JCP team leaders also reported a combination of factors as being behind the recent dip in referral rates. These included:

- a reduction in the rate at which unsuitable referrals were being included alongside eligible customers
- a declining base of existing JCP customers to refer to the programmes
- some work coaches becoming less willing to make referrals due to negative feedback they had received about the programme from customers.

4.6 **Reduced unsuitable referrals.** Clients were reported as unsuitable because they did not match the characteristics described in the design of the programme, in particular they were not seeking work. Work coaches felt that they had a good understanding of the criteria that make participants Health & Disability (H&D), Early Access (EA) or Long-Term Unemployed (LTU). H&D and EA referrals are generally being identified by work coaches during appointments, based on whether or not they feel a customer would benefit from the

programme. LTU referrals are being identified automatically (usually in advance of attending an appointment) by the length of time they have been out of work.

4.7 As with provider-JCP engagement to raise awareness of the programme, provider and JCP staff interviewed felt that ongoing engagement of JCP staff by providers was also improving work coach understanding of eligibility criteria for referrals. This included reinforcing the message that the WHP is intended for people who are committed to finding work within 12 months, and the criteria that can help work coaches determine this. This was felt to have helped improve both referral numbers and quality in each sub-region, with the proportion of unsuitable referrals[29] said to be dropping in each sub-region.

4.8 In all sub-regions there were, however, reported instances of work coaches continuing to refer people with barriers that mean they will be unable to find work via the programme (e.g. people preparing for significant surgery or chemotherapy, or with little/no English language skills). Feedback from key workers and work coaches suggested this is because some work coaches see the WHP primarily as somewhere to send individuals with multiple health and personal barriers, without considering that participants need to be able to ultimately become work ready within the programme's timeframes.

> *"One of the eligibility criteria is 'do you see yourself in work in 12 months?', [but] customers are coming and they are saying 'I can't work'. On the other hand, you feel, how can you say to a customer that he is not eligible when he has already had an interview with the Job Centre?"*
>
> *Provider key worker*

4.9 The rollout of Universal Credit appears to have contributed to these ongoing unsuitable referrals. This is primarily due to work coaches being assigned new customers they have not previously supported (and whose circumstances/barriers they consequently understood less). These work coaches are therefore only now starting to develop their understanding of the WHP and customers who are/aren't suitable referrals. This suggests engagement with work coaches (either by the provider and/or JCP managers) needs to continue.

4.10 **A shrinking base of eligible JCP customers.** Some work coaches reporting that their 'stock' of eligible customers was diminishing after 16 months of programme activity, feeling they had already referred everyone they already could from their existing caseloads. Some had therefore begun to only make referrals from among new customers. This apparently shrinking base may be partially due to work coaches focusing on, or having more reliable/consistent access to, the economically active customers whom they see more regularly (and can therefore discuss the programme with during routine appointments).

4.11 **Reduced willingness among some work coaches to make referrals.** Work coaches' willingness to make referrals into the programme varied. While some were positive about the programme, citing good and holistic provision and outcomes they had seen customers realise, others reported they had received negative feedback from customers they had previously referred and subsequently become reluctant to continue encouraging customers to attend as

[29] Referrals who are not able and/or willing to look for work.

voluntary referrals. In some cases this meant they were referring fewer customers, or had begun to focus primarily on referring LTU customers.

4.12 This feedback fits with trends evident in providers' monitoring data. **Providers in all four sub-regions have received a higher-than-profiled proportion of LTU referrals**, although the extent to which referral numbers exceed profiles varies between sub-regions, as indeed did the expectation (Table 4-1). The difference is most market in CLF which had the lowest expectation and an actual level over three times what was expected.

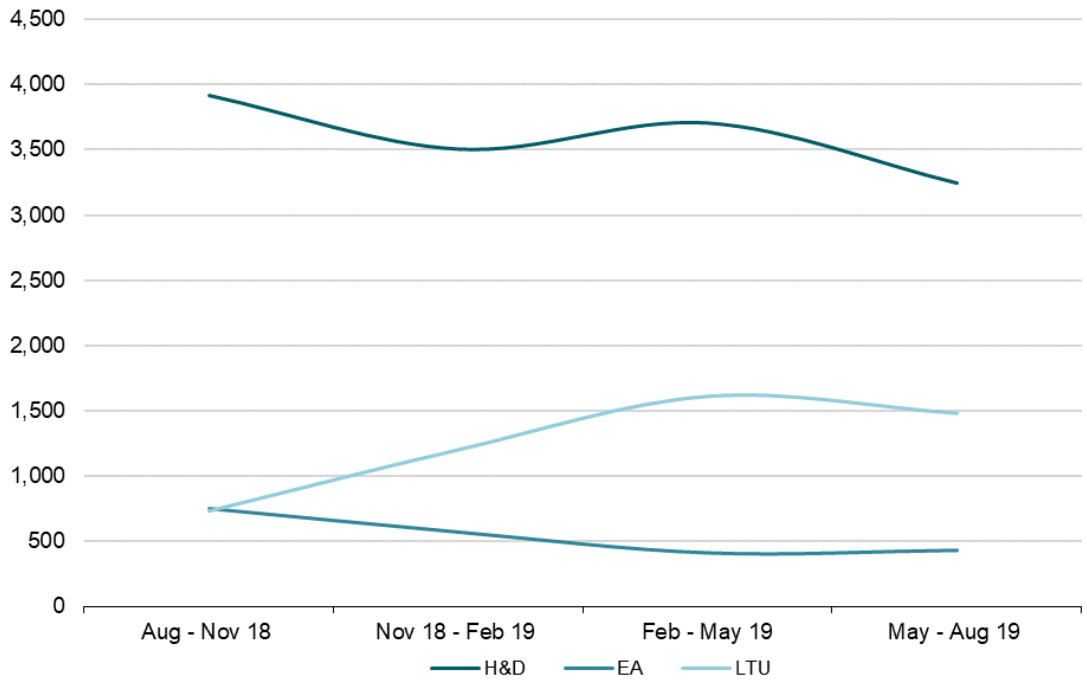
Table 4-1: Proportion of referrals from the LTU group, profile vs actual (up to August 2019, inclusive)

	Profile	Actual
Central London Forward	6%	22%
Local London	13%	16%
South London Partnership	8%	12%
West London Alliance	15%	24%

Source: DWP WHP programme statistics, November 2019 release ; provider data on profile referral groups

4.13 The significant increase in the proportion of LTU referrals over the previous two quarters has been driven primarily by a fall in the overall numbers of H&D and EA referrals being made in each sub-region and across London as a whole (London figures shown below in Figure 4-3). At the same time as H&D referral numbers have fallen, the volume of LTU referrals has remained relatively stable.

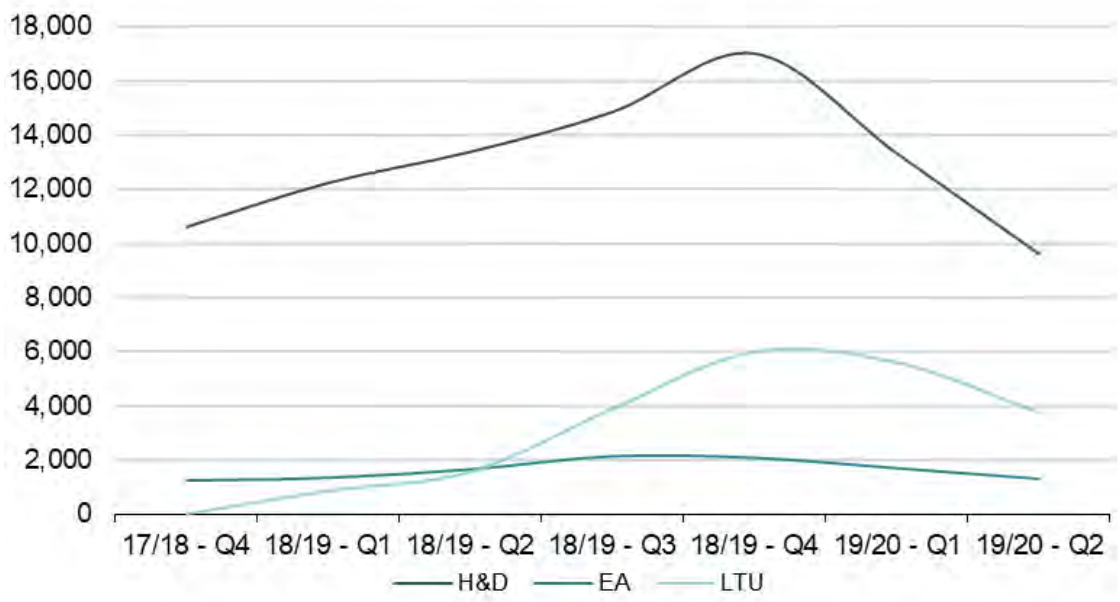
Figure 4-3: Number of referrals per quarter, by cohort (London)



Source: DWP WHP programme statistics, multiple releases

4.14 DWP data show that this is consistent with national trends, with the number of LTU referrals to the national programme rising faster than numbers of H&D or EA referrals during 2018/19, and subsequently dropping at a slower rate than H&D referrals (Figure 4-4).

Figure 4-4: Referrals by quarter, by participant group (national programme)



Source: DWP WHP programme statistics, November 2019 release

4.15 The extent to which negative participant feedback was a contributory issue appeared to vary between Jobcentres, even within the same sub-region. This suggests that the consistency of feedback being provided to Jobcentres (or, where feedback is provided, passed on to individual work coaches by Jobcentre team leaders) might be the issue, rather than a lack of positive outcomes experienced by participants.

Good practice point

More active sharing of 'good news stories' by providers – as is being done in WLA - could help balance the feedback that work coaches receive. This would ensure work coaches hear about the positive impacts the programme is having, thereby remaining engaged and willing to encourage their customers to attend.

4.16 Some work coaches also reported that the RCT process[30] put them off making referrals. Although the tool used to determine whether referrals are accepted onto the programme has been designed (by DWP) to be fully randomised, some work coaches reported feeling that the tool 'isn't really random'. These work coaches felt that the tool was more likely to accept people onto the Programme if they fitted a certain profile (e.g. being more work ready). One work coach spoke about feeling they had developed an understanding of which answers are the 'right answers' to enter into a referral form to ensure a participant is accepted onto the programme (and so avoid people being 'rejected' by the tool).

[30] Eligible referrals are randomized on or off the programme by DWP, to create a randomised controlled trial (RCT) for the national Work and Health Programme evaluation.

Good practice point

Work is underway in WLA to promote the purpose of having an RCT to work coaches. Ongoing work of this nature with work coaches might help combat some of these misconceptions and avoid a situation whereby work coaches consequently make fewer referrals, or refer fewer people who are further from the labour market.

Work coaches' conversations with participants

4.17 Work coaches in each sub-region reported that they were clear on the rationale and objectives of the Programme in their area and the support participants should be able to access. This is partly the result of extensive face-to-face engagement providers have undertaken with individual Jobcentres in response to initial low referral numbers and/or higher-than-expected proportions of unsuitable (not sufficiently close to work ready) referrals.

4.18 Participants and work coaches both reported that it was the programmes' wider offers – with health problems and other personal circumstances – that most appealed to participants and encouraged them to sign up to their local programme. This aspect of the support was noted by participants as being a key difference between the Work and Health Programme and other support they had previously received (such as the Work Programme), and something they saw as offering particular value to them.

"For me, [the barrier] is not work problems. It's family problems."

Programme participant

4.19 The level of information provided to participants does, however, vary. Participants are generally well-informed about the aims of the programme by their work coaches, although in some instances work coaches were emphasising either the 'back to work' elements of support or the health support, but not both. LTU referrals often reported that they were not told much more than that they were being referred to a programme that will help them find work.

4.20 Participants who receive less information from their work coaches were reported by key workers to be more likely to disengage, either because they do not see any benefit to them in taking part (especially in the case of LTU referrals), or because the programme does not match their expectations (e.g. if they are anticipating a programme that mostly or entirely focuses on helping them with health problems).

4.21 Work coaches in most sub-regions said that if a participant was rejected from the Work and Health Programme by the randomisation process then this was something they tended to find disheartening[31]. While it is important to promote the benefits of the programme to participants, to encourage engagement and willingness to sign up, during initial conversations it would also be worth work coaches highlighting to participants that they might not get a

[31] Although work coaches in each sub-region did also note that there was other provision customers could be referred to if they didn't get onto the WHP.

place, to avoid disappointment if they are rejected by the randomization process. Interview feedback suggests that this is not always done. This, plus the sometimes inconsistent way customers are informed about the support on offer and the programme's objectives, suggest a possible need for work coaches to receive training and/or an outline 'script' to guide the content of initial conversations they have with customers about the programme.

Good practice point

WLA and West London JCP District have started a trial to test consistent, behavioural insights-based approaches to talking to customers across the support offered by the programme, with the aim of reducing the proportion of referrals who fail to attend their first appointments or disengage from programme support. The results of this initial trial will be known later in the year.

4.22 One other challenge identified by work coaches during evaluation interviews was that standard Jobcentre appointments often do not give them time to talk to their customers about the programme in much detail (with some lasting 10-15 minutes). Providing more detail during an appointment, without that appointment over-running and causing a backlog later in the day, therefore proved challenging for some.

Good practice point

Provider staff in Harrow (WLA) and Camden (CLF) have been running regular sessions in their local Jobcentres that customers can attend to find out more about the programme (including the support on offer and its intended benefits). This has been done to help ensure that customers are given clearer and more detailed information about the programme prior to agreeing to be referred, without an additional burden being placed on work coaches to spend more time explaining the programme to individual customers. It also ensures that by the time customers are referred and booked for a first appointment, they are already familiar with the provider and the provider has already successfully established direct contact with them.

External referrals partners

4.23 During scoping, one area of programme delivery where stakeholders felt integration might be particularly beneficial is in increasing referral numbers. A significant proportion of eligible residents are likely to not be in regular contact with Jobcentre Plus, and therefore will not be engaged by the programmes unless referred by other organisations. Stakeholders were in the early stages of engaging other services (including local authority support services, and mental health teams) to raise awareness of the programmes and encourage these services to refer their service users.

4.24 Stakeholders are, however, concerned that third party organisations might be deterred from making referrals due to:

- The randomisation of referrals onto or off the programme, if these organisations are worried that service users they refer to their local programme might be rejected, despite being eligible (and are therefore deterred from making referrals in the first place).
- The length of and number of steps in the referral process, as referrals from third parties are still required to be processed via Jobcentres.

Good practice point

One approach that has been taken in LL to streamline the external referral process is for referrals to be sent straight to the provider, instead of first attending a Jobcentre appointment. The key worker then undertakes initial suitability checks with the participant before speaking to the Jobcentre over the phone to send that participant's referral to the RCT gatekeeper. If the referral is successful then the work coach will notify that participant's key workers, who invites them in to provider premises for their booking appointment.

This helps reduce the number of steps and time involved in the referral process for participants, with the referral only requiring one appointment involving both the provider and Jobcentre prior to the participant starting the programme (instead of two Jobcentre appointments followed by their first provider appointment). It also means that by the time of the participant's first appointment their key worker has already started to collect some background on the participant, such as their circumstances and their barriers (compared to the name and contact details they will have from a regular JCP referral).

4.25 Work coaches and key workers did, however, note that in their boroughs there were generally other programmes of support available. This point would be worth providers emphasising to external organisations, with clear, up-front messaging to both the external organisation and the individuals they support that a place on the programme itself is not guaranteed, but that whatever happens they will be supported.

4.26 Given the nature of the barriers most participants have, local authorities are reported to feel that health services will likely be a significant source of external referrals to each sub-region's programme. Providers, however, reported struggling to identify relevant stakeholders in their local health services or to secure much engagement or buy-in from them.

Good practice point

In Tower Hamlets and Lambeth this has been addressed by the borough councils identifying key contacts in local clinical commissioning groups (CCGs) and facilitating introductions between them and the provider. Lambeth has subsequently been seeing relatively higher rates of external referrals than other CLF boroughs, although no data is currently available on the number or proportion of referrals that originate from an external organisation.

4.28 Until now, sub-regional referral profiles have (on average) been met by Jobcentres referring their regular customers. Limited engagement from external organisations in making referrals has therefore not yet been a significant issue. However, if the trend of falling referral numbers in each sub-region continues, external referral organisations will become increasingly

important over time. The issues outlined above will therefore potentially be key for providers to address over the coming months.

5. Transfer from Jobcentre to provider

Throughout the lifetime of the London Work and Health Programmes the proportion of referrals that have resulted in a start has steadily risen, up from 49% in 2017/18 Q4 to 62%.

The number of participants starting on each sub-regional programme has consistently increased over time, with all sub-regions exceeding their profile start numbers by 2018/19 Q4. Since, then start have fallen in all sub-regions, with CLF and SLP falling below profile.

Did Not Attends (DNAs) have been an ongoing challenge generally sitting between 25% and 45% of all referrals. Peaks in DNAs have at times aligned to high numbers of referrals, when providers were not staffed to coped with these unpredicted peaks.

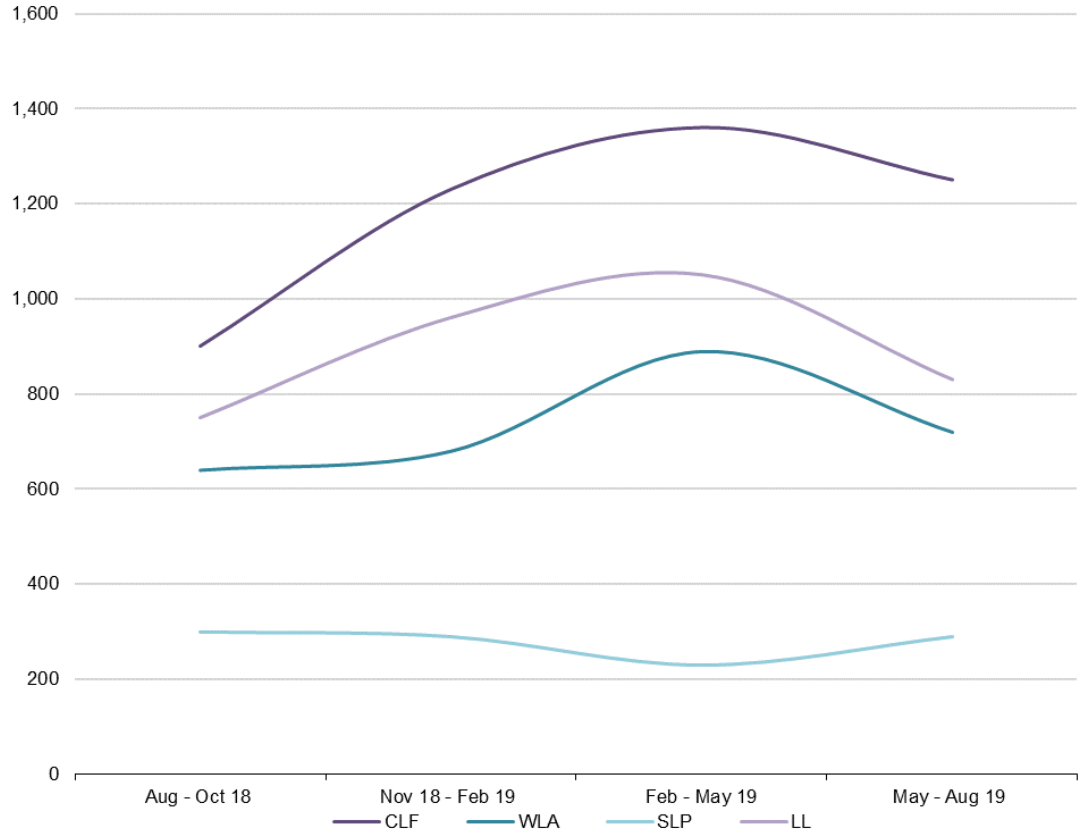
Initially, participants referred onto the programme were first referred by their work coaches and then contacted by their provider at a later date. To reduce DNAs, providers in each area have subsequently begun trialling different approaches to ensuring key workers and participants have contact prior to first appointments being booked.

Rate of engagement

5.1 Interviewees reported that throughout the lifetime of the London Work and Health Programmes the proportion of referrals that have resulted in a start has steadily risen. One sub-region reported that over the lifetime of their programme, the proportion of starts had risen from just over half to around two-thirds.

5.2 Alongside these improvements the overall number of participants starting on each sub-regional programme has consistently increased over time (Figure 5-1), with all sub-regions exceeding their profile start numbers by the end of the 2018/19 financial year.

Figure 5-1: Total number of referrals in each sub-region, by three-month period



Source: DWP WHP programme statistics, multiple releases

5.3 Start volumes were reported to have subsequently dropped during the first months of 2019/20, and in CLF and SLP had fallen below profile again. This drop in all four sub-regions' overall numbers of starts coincides with the drop in referral numbers each sub-region experienced in the same quarter (Figure 4-2, previous chapter), and is likely a direct consequence of that drop (as sub-regions' referral-to start conversion rates each remained the same between the two quarters).

5.4 Did Not Starts (DNSs)[32] are reported to have declined significantly since the programmes began. Did Not Attends (DNAs)[33] however, have been reported to be an ongoing challenge in each sub-region throughout the lifetime of the programme. In one sub-region, for example, the provider reported that around one-quarter of referrals have resulted in a DNA[34].

Contributing factors

5.5 Peaks in DNA rates were reported to have coincided with increases in referral numbers within sub-regions, particularly between October and December 2018. Feedback from managers within both CLF's and SLP's providers was that during earlier stages of delivery these providers had been hiring key workers 'reactively', increasing staff count in response to increases in demand. This meant they had been unable to cope with the sudden increase in

[32] A DNS is a participant who attends their first appointment but then declines to continue participating in the programme. This differs from a Did Not Attend (DNA), which is someone who is referred but does not attend their first appointment.
[33] Participants who are referred onto the Programme, but then do not attend their first appoint with the provider.
[34] MAXIMUS monitoring information.

referral numbers they experienced from October 2018 onwards. In CLF the provider has subsequently increased its permanent head count to anticipate potential increases in referral numbers, and DNA rates have reportedly since reduced.

5.6 The persisting level of DNAs might be partially explained by the volume of re-referrals. As noted in paragraph 4.2, a significant proportion of referrals in each sub-region appear to have been referrals of customers who have already been referred at least once previously but failed to start. Interviewees reported that this has been consistent throughout the lifetime of the programmes.

5.7 At present there is no data available to the evaluation on how likely a re-referred customer is to DNA/DNS on their second or third referral. However, if a customer has been re-referred then that means they have been recorded as a DNA or DNS at least once already, for reasons including the provider being unable to contact them or the customer refusing the start on the programme after attending their first appointment. It is therefore probable that a re-referred customer has an above-average likelihood of becoming a DNA or DNS on their second (and any subsequent) referral(s) to the provider than the average customer who is being referred to the programme for the first time.

5.8 However, re-referrals are unlikely to be the only reason for persisting DNA/DNS rates. Ongoing instances of DNAs and DNSs are likely also explained at least in part by the proportion of LTU referrals each sub-region continues to receive (Table 4-1). Interviews with key workers and participants found that LTU referrals are more likely than other referral groups to be told relatively little about the WHP at the point of referral, and therefore be less motivated to participate.

5.9 Where DNAs or refusals to start have persisted, feedback from key workers, work coaches and participants indicated that some participants are not interested in the programme but are reluctant to say this to their work coach. They therefore express willingness to be referred while in the Jobcentre, but then later either DNA, or attend their first appointment then disengage. Qualitative feedback suggests this has been a particular issue among LTU referrals, for whom the programme is mandatory.

"Some (customers) just say 'yes' because they're sat there in front of you."

Work coach

"Some of the clients we've got, they don't want to work full stop."

Provider key worker

How appointments are arranged

5.10 Initially, participants referred onto the programme were first referred by their work coaches and then contacted by their provider at a later date. In general, the provider would ring the participant to arrange a time for their first appointment. This was often resulting in participants not answering calls (and therefore no appointment being set up), or participants missing scheduled appointments.

5.11 Providers in each area have subsequently begun trialling different approaches to ensuring key workers and participants have contact prior to first appointments being booked. This was either participants speaking directly to providers to arrange appointments (by phone or face-to-face) while in the Jobcentre seeing their work coach, or being given the opportunity to meet someone from the provider in the Jobcentre prior to making a decision about whether to join.

Good practice point

Provider staff in Brent and Harrow (WLA) have been running regular sessions in their local Jobcentres that customers can attend to find out more about the programme (including the support on offer and its intended benefits) prior to being referred. Initially attending Jobcentres one day per week during the initial months of WLA's programme, key workers have begun to increase these visits to 2-3 days a week more recently.

One reason for doing so is to ensure that by the time customers are referred and booked for a first appointment, they are already familiar with the provider and the provider has already successfully established direct contact with them.

5.12 Interview feedback from work coaches and key workers suggested that since warm handovers and other direct provider-participant contact have begun to be rolled out in each sub-region, the scale of this problem has started to decrease. Monitoring data from providers appears to support the theory that this is due to the increased provider-participant engagement. In WLA, for example, referral-to start conversion rates have consistently been higher in two boroughs in which provider staff have been undertaking more regular engagement with Jobcentre customers prior to referral) than in the sub-region as a whole.

5.13 Key workers in CLF, LL and SLP reported that referral forms they receive only provide participants names and contact details, the latter sometimes being incomplete and/or out-of-date. This has made it difficult for them to contact some participants to book first appointments.

"There was one time that… 21 people were referred to the project from this particular Jobcentre, and only 6 had the correct information."

Provider key worker

5.14 To address this, some key workers are starting to go direct to a Work Coach team leader with details of customers that need chasing about appointments. In addition, the increased provider presence in JCP gives them more opportunities to speak to work coaches face-to-face about problem customers or missing information.

5.15 It would also be useful if referral forms were to give participants' preferred method of contact. Some participants (particularly with mental health issues such as anxiety) have been unwilling to answer calls from unknown numbers, and the referral form could advise key workers on this and suggest they try other forms of contact (such as a text or email).

Participants starting on the programme

5.16 With all participants it would be worth work coaches doing more 'groundwork' with participants in advance of making a referral (e.g. introducing the programme to them over several appointments, to give the work coach more time to discuss an individual's barriers and how the programme might help them). This is an approach some work coaches in LL have found to be successful in increasing customer engagement.

Table 5-1: Referral-to-start conversion rate by sub-region and participant group, programme start to August 2019 (inclusive)[35]

	H&D	EA	LTU	All
CLF	50%	46%	57%	**51%**
LL	63%	55%	66%	**63%**
SLP	59%	50%	61%	**60%**
WLA	59%	51%	65%	**60%**

Source: DWP WHP Statistics, November 2019 release

5.17 The other ongoing barrier contributing to DNA rates is the difficulty providers have getting hold of some participants to book first appointments, even when they have contact details. Key workers in all areas reported instances of calls going unanswered by participants.

Greater use of direct contact between providers and participants in the Jobcentre, in advance of their first appointment – ideally face-to-face – would help resolve this. Areas trialling warm handovers or direct provider engagement with participants prior to their first visit to provider premises (e.g. holding booking appointments within a Jobcentre) reported that doing so has helped reduced DNA rates.

Good practice point

Work coaches in one SLP Jobcentre reported that in response to high DNA rates they have begun entering the provider's phone number into customers' phones at the time of referral.

[35] Calculated by looking at total starts to date as a percentage of total referrals to date. Some referrals made in July or August may have been converted into a start after the end August and therefore not captured in the data, and so final conversion rates of all referrals made prior to the end of August 2019 may end up being slightly higher than the figures shown in this table.

This was so that when the provider calls customers to set up an initial appointment, customers recognise the phone number and are more likely to answer the call. Work coaches felt this had helped reduce DNA rates among referrals from that Jobcentre, although at the time of this impact could not be exploring quantitatively using the data provided to the evaluation[36].

5.18 Having a direct line of contact between key workers and work coaches was something interviewees felt would help to reduce DNA rates and improve referral-to-start conversion rates further. Having such a direct line would enable key workers to get in contact with a participant's work coach if they do not show up for their first appointment (or subsequent appointments) and ask the work coach to follow up with the participant directly.

5.19 One option might be for details of a participant's work coach to be included in referral forms, or (as some key workers in LL reported was the case for them) for key worker team managers to regularly collate feedback on participants' attendance and progress and share this with work coach team leaders at the relevant Jobcentre.

[36] The Jobcentre in question is one of two making referrals within the same borough, meaning borough-level data (the lowest geographic level of data we current have) on referral numbers and DNA rates combines data from these two Jobcentres.

6. Ability of provision to meet participant need

The majority of participants starting on each sub-region's programme have, as expected, been H&D referrals. Mental health issues have been common among referrals in each sub-region (particularly anxiety and depression). The other key barrier observed in all four sub-regions is housing (incl. securing stable housing and dealing with evictions).

Key workers in all sub-regions reported receiving a higher-than-expected proportion of referrals who are over 50 years old. Monitoring information from the four sub-regions shows that the proportion of older (50 years or more) participants has been higher than the national average in London – particularly in CLF and WLA.

Each provider uses their first 1-2 appointments to complete participants' paperwork, give them more information about the programme, ask them questions to identify their barriers, and draw up an action plan. Participants in each sub-region reported that their initial appointments were good and initial assessment conversations comprehensive.

Each sub-regional provider offers a range of in-house employability and health support. If unable to address one or more of a participant's barriers using this in-house support, they will signpost/refer that participant to external services. Providers in each sub-region all have slightly different in-house support offers

Key workers in all sub-regions were confident that they were aware of the range of in-house support they were able to offer, and that they knew where they could send participants to access support for the needs they had encountered, either in-house or from external organisations. However, the latter appears very informal and so may be face challenges if staff turnover is high or wider support agencies are facing issues.

Formalised engagement between providers and external organisations (to generate external referrals or to make onwards referrals to additional support) are still in their relatively early stages of developing. This means that providers rely on participants to provide feedback on wider services.

Key workers reported a range of intermediate outcomes being achieved by participants, including improvements in wellbeing and in personal living situations. Participants we spoke to had generally been engaged on their respective programmes for six months or less and had yet to find work. They did, however, report increased confidence and motivation, improved wellbeing and better management of physical health issues

The level of lower earnings outcomes achieved is about one third of profile, although performance is, broadly, in line with national performance. Key workers generally felt able to source vacancies for participants (either from their own searches or using vacancies lists created by an in-house team) and help them back to work, although key workers in SLP felt they were struggling with a 'saturated' jobs market.

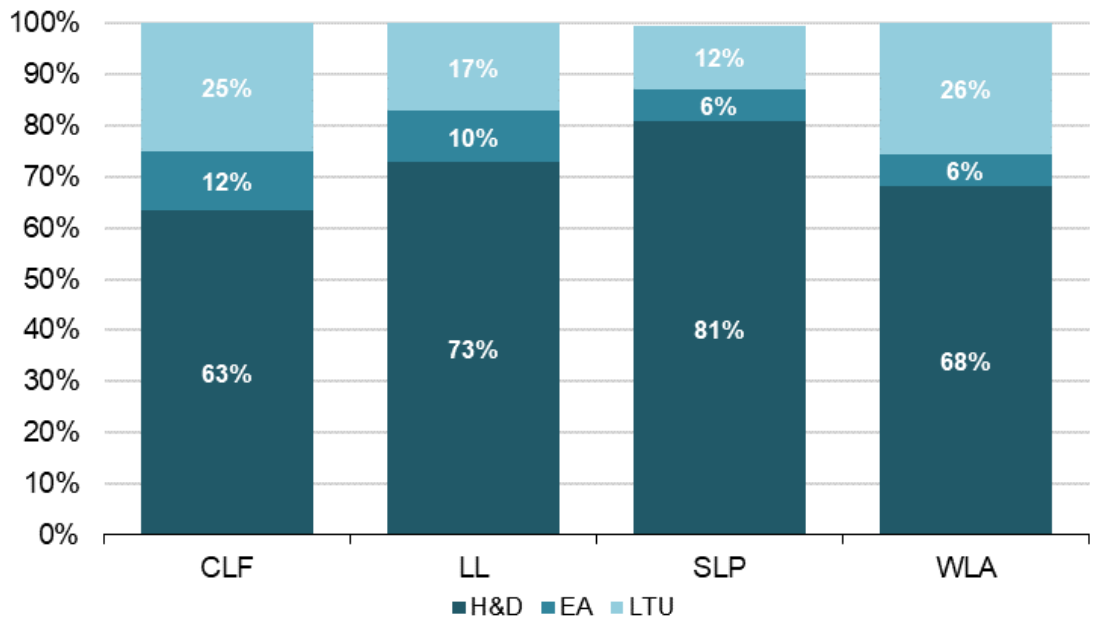
Some key workers felt that higher referral volumes from late 2018 onwards, and the consequential increase in their caseload size, might have a knock-on effect on their capacity to sustain job outcomes rates, although any potential impact has not yet had time to evidence itself within monitoring data

Participant profile

Barriers

6.1 The majority of participants starting on each sub-region's programme have, as expected, been H&D referrals, although there is substantial variation across the CPAs (Figure 6-1).

Figure 6-1: Proportion of starts by participant group, by sub-region



Source: DWP WHP Statistics, November 2019 release

6.2 Perhaps unsurprisingly, mental health issues are reported as being common among referrals in each sub-region (particularly anxiety and depression). The other key barrier observed in all four sub-regions is housing (incl. securing stable housing and dealing with evictions). Debt and personal finances were also mentioned frequently by key workers in CLF and LL.

6.3 Reflecting the higher than expected proportion of LTU referrals being made in each sub-region (see Chapter 4), the proportion of LTU starts in each sub-region has also been higher than originally profiled. A gap between profile and actual start group breakdowns exists in all four sub-regions, although the size of the gap varies. The largest gap is in CLF (Table 6-1), which had assumed the lowest proportion of LTU starts.

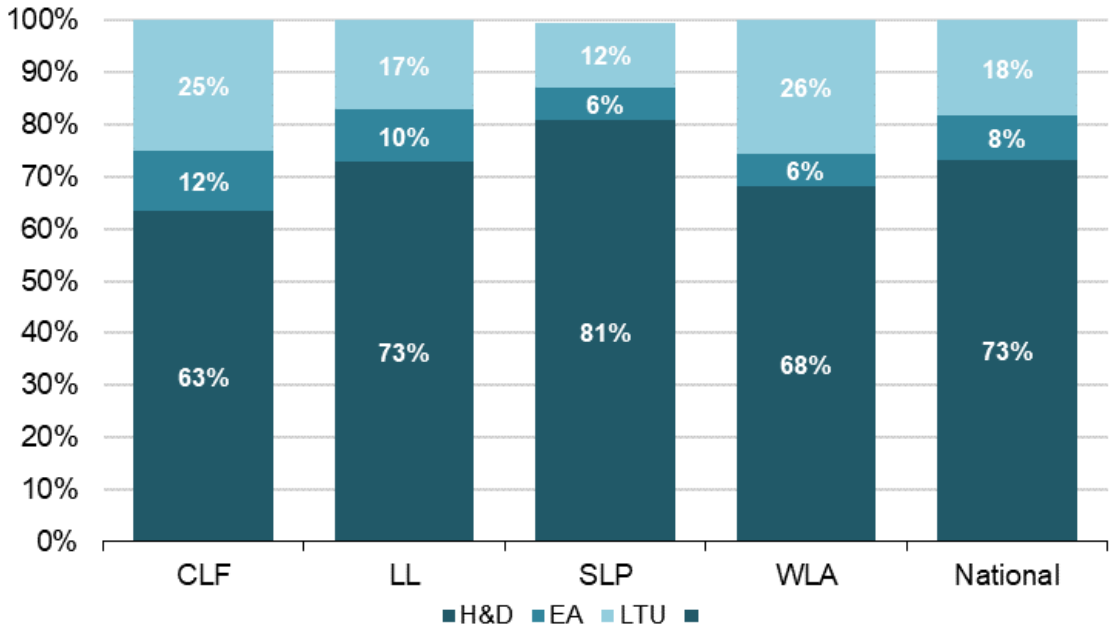
Table 6-1: Proportion of starts from each participant group, actual vs profile by sub-region

	H&D		EA		LTU	
	Actual	**Profile**	**Actual**	**Profile**	**Actual**	**Profile**
CLF	**63%**	83%	**12%**	10%	**25%**	7%
LL	**73%**	75%	**10%**	13%	**17%**	13%
SLP	**81%**	82%	**6%**	9%	**12%**	9%
WLA	**68%**	75%	**6%**	10%	**26%**	15%

Source: DWP WHP Statistics, November 2019 release (actual); provider MI (profiles)

6.4 Monitoring data show that the proportion of LTU referrals currently starting on the CLF and WLA programmes is significantly higher than the national average (Figure 6-2).

Figure 6-2: Proportion of starts from each participant group, November 2017 to August 2019 (inclusive)



Source: DWP WHP Statistics, November 2019 release

Demographics

6.5 Key workers in all sub-regions also reported receiving a higher-than-expected proportion of referrals who are over 50 years old. This cohort tend to have higher rates of physical issues such as arthritis and back pain, and can relatively more frequently experience age-related discrimination (which in turns reduces their self-belief and confidence). Monitoring information from the four sub-regions shows that the proportion of older (50 years or more) participants has been higher than the national average in London – particularly in CLF and LL (Figure 6-3).

Figure 6-3: Programme starts by age, programmes start to August 2019 inclusive

Source: DWP WHP Statistics, November 2019 release

6.6 London providers reported receiving referrals with a diverse mix of ethnicities. The mixture was perceived to be higher in London than in other regions of the country[37]. This might link to key worker reports of referrals with little/no English-language skills, although further data would be needed to explore this more fully[38].

First appointment(s)

Location and format

6.7 Each provider uses the first 1-2 appointments to complete participants' paperwork, give them more information about the programme, ask them questions to identify their barriers, and draw up an action plan. Participants showed a good understanding of the programmes' rationale and intended content following these conversations, and reported having the opportunity to flag anything they felt was a barrier stopping them returning to work (including health issues).

6.8 Appointments have generally taken place at providers' premises, although some key workers in CLF have recently begun holding first appointments in Jobcentres. Holding first appointments in Jobcentres has two advantages: it increases the likelihood of participants attending, and it gives key workers an opportunity to speak to work coaches about participants' barriers and background.

[37] There is no published data available on the ethnic mix of London or national programme participants.
[38] As all ethnic groups will contain a mixture of British/non-British nationals, and a mixture English native/non-native speakers with different levels of spoken English.

Success engaging participants

6.9 Participants in each sub-region reported that their initial appointments were good and initial assessment conversations comprehensive. They were given the opportunity to identify any barriers they faced returning to work, and in the minority of cases where they did not identify all barriers (due to being unfamiliar with their key worker or realising later that something was a barrier) they did then flag these issues at later appointments.

6.10 Providers reported getting some resistance from participants who had been mandated onto the Programme, primarily in the form of refusing to disclose information during initial appointments or missing appointments. This likely links back to issues explored above about some referrals attending because they feel they have to, rather than because they are attracted by the support on offer.

> *"Sometimes if they've been pushed to come, their attendance might be a bit more erratic, but once we capture them and they come in, they tend to engage."*
>
> *Provider key worker*

Support available

Ability to meet participant need

6.11 Each sub-regional provider offers a range of in-house employability and health support. If unable to address one or more of a participant's barriers using this in-house support, they will signpost/refer that participant to external services.

6.12 Providers in each sub-region all have slightly different in-house support offers (detailed more fully in Annex B), but all provide a range of support in each of the following areas:

- **Employability support**, such as help with CV writing, interview skills, motivational coaching and job searches
- **Basic skills,** including numeracy, literally, communication skills and English language
- **Physical health support**, such as advice on condition management, or yoga/Pilates classes for pain management
- **Mental health support**, including groups sessions and counselling to support participants with anxiety, mindfulness and their general wellbeing.

6.13 In CLF a participant's physical and mental health assessment and signposting is managed by an in-house health practitioner, who is a separate individual to that participant's key worker[39]. In the other sub-regions identification of need and referrals to support are managed by one key worker.

[39] Although health practitioners and key workers case conference and will sometimes also attend appointments with participants together.

6.14 Key workers determine whether or not a participant needs to be referred to external support based on their assessment of participant need and knowledge of whether or not that need could be met by the provider in-house. Key workers in all sub-regions were confident that they were aware of the range of in-house support they were able to offer, and that they knew where they could send participants to access support for the needs they had encountered, either in-house or from external organisations.

6.15 In the case of external organisations, they generally identified these using their own knowledge or by asking colleagues/delivery partners, although found this to be sufficient. These key workers generally reported that this awareness came either from their own or colleagues' experience providing support to participants on other employability support programmes in the borough(s) they worked on, or in some cases by contacting local partner organisations (who had the connections to help signpost participants).

6.16 Where centralised lists or databases of external services existed, these were generally felt to be too 'high level' and/or contact details and key points of contact for external organisations tended to become out of date rapidly.

6.17 This means key workers are fairly reliant on informal networks and knowledge. Although this was reported by the key workers as being generally sufficient so far, building and maintaining links with local partners would ensure key workers have consistent access to local knowledge and connections (helping mitigate against key worker turnover). For example, provider staff have been attending support 'hubs' in boroughs such as Brent and Camden, giving them regular contact with other services in their borough.

6.18 No issues with the accessibility of provider support were raised. Feedback from key workers and participants in each sub-region indicated that the part-time and flexible nature of provision on offer enabled participants to attend alongside other commitments (such as childcare). Participants generally felt that provider locations were reasonably accessible, and that they were getting support for any barriers they faced to returning to work.

6.19 However, in some instances participants referred to external services were contacting these services and then finding that they were over-subscribed and/or had a long waiting list. Although not always the case, this was flagged as a particular challenge with NHS and local authority services especially housing support.

Integration with external services

Co-ordination between provider and external organisations

6.20 Formalised engagement between providers and external organisations (to generate external referrals or to make onwards referrals to additional support) are still in their relatively early stages of developing. Those formed so far have generally been relationships with individual borough councils, which have helped providers identify key contacts with local authority and/or health services to establish external referral pathways.

6.21 Common barriers participants present with in each sub-region include mental health issues (particularly anxiety and depression), plus housing (incl. securing stable housing and dealing with evictions). The external services that key workers most commonly reported referring to

therefore included local mental health support (such as IAPT[40]) and housing support teams within local authorities.

6.22 Referrals to debt and personal finance management advice services were also reported (by key workers) to be common in CLF, while key workers in LL reported referring a lot of participants to a charity that unemployed people with interview clothes[41].

6.23 Key workers were reliant on feedback from participants to find out whether they have been able to access external support and whether this has helped them. In LL and SLP, key workers reported accompanying participants to support in some instances. No sub-region had a system that was used by partners to routinely share information between providers and partners.

6.24 Key workers generally reported being able to get sufficient feedback from participants on whether they had managed to contact and receive support from other services, and the progress they made once support commenced. This means the lack of a formal feedback mechanisms has not created any significant issues that the key workers reported. However, this reliance does create a risk of key workers not being kept fully informed, which could pose particular issues if they receive imbalanced feedback about service quality (similar to the inconsistent feedback some work coaches appear to receive). It could also lead to any problems, such as participants being referred to an over-subscribed service, taking longer to resolve, as key workers need to wait until they receive feedback from the participant before they can identify any problems.

Outcomes

Moving participants towards work

6.25 Key workers reported a range of intermediate outcomes being achieved by participants, including improvements in wellbeing and in personal living situations. For many, seeing these outcomes was just as rewarding as helping participants back into work, and seeing participants realising these outcomes helped to motivate key workers.

> *"I find this more rewarding, to be honest. I've changed someone's life for the better."*
>
> *Provider key worker*

[40] Improving Access to Psychological Therapies (IAPT) teams provided psychological therapies to help with conditions such as anxiety and depression.
[41] Suited & Booted.

"I have genuinely made changes in people's lives."

Provider key worker

6.26 Participants we spoke to had generally been engaged on their respective programmes for six months or less and had yet to find work. They did, however, report increased confidence and motivation, improved wellbeing and better management of physical health issues (such as a reduction in physical pain, or sleeping better).

6.27 Work coaches also reported customers realising positive outcomes from the Work and Health Programmes, including accessing counselling and developing greater confidence and motivation. However, awareness of these benefits was inconsistent between different Jobcentres (and sometimes between work coaches within the same Jobcentre).

6.28 In general, work coaches tended to more often hear about participants' negative experiences, as these experiences are the ones participants are most likely to feed back during Jobcentre appointments. Additionally, if a participant finds a job this will often result in them being removed from the work coach's caseload and they therefore lose the ability to keep track of participants' progress.

"I very rarely hear about somebody who's happy with the Work and Health Programme. I hear more about complaints and failings."

Work coach

6.29 As mentioned earlier, more active sharing of 'good news stories' by providers could help balance the feedback that work coaches receive and ensure work coaches remain engaged in making referrals. Work coaches in Jobcentres that did consistently receive positive feedback (either from participants themselves or from information shared by the provider) reported feeling more motivated and more willing to promote the programme to customers/make referrals.

"Some people on the team, on my team especially, are very proactive at referring because they know they've had people that have had good news stories."

Work coach

Job outcomes and in-work support

6.30 The proportion of participants realising employment outcomes was reported to be lower than expected in each sub-region. Key challenges raised by key workers (discussed earlier in this report) were the high level of barriers some participants arrive on the programme with, and the unwillingness of some people to look for work. In some cases, key workers would either

put participants who were not looking for work on a programme break or the participant would disengage from the programme; in other cases, key workers would continue to offer support but found it difficult to progress participants towards work at a sufficient pace.

"We are not able to get them into work in that 15-month period. We are struggling."

Key worker

6.31 Key workers generally felt able to source vacancies for participants (either from their own searches or using vacancies lists created by an in-house team) and help them back to work, although key workers in SLP felt they were struggling with a 'saturated' jobs market. The range of type jobs participants found varied. For example, in LL the most common types of jobs reported were in retail and warehouses. In CLF, key workers reported participants finding jobs in sectors such as retail and security, but also professional roles within the NHS and civil service.

"They don't let you downgrade yourself. Whatever potential you have, they want you to realise that."

Programme participant

6.32 In general, participants were said to be sustaining work once placed into a role. Some interviewees noted that while participants generally tended to stay in work, the likelihood of drop out was slightly higher among participants whose key point of contact at the provider changed during their in-work support – highlighting the importance of participants' ongoing relationships with a key contact they are familiar with and trust.

6.33 In LL, SLP and WLA participants' key workers remain their main point of contact once they are in work, whereas in CLF a different in-work team take over primary responsibility. CLF key workers reported that an advantage of this system was that it enables the provider to be flexible in delivering support to participants outside of office hours, without placing an increased burden on key workers.

6.34 One disadvantage was that some participants are uncomfortable dealing with a new point of contact, and key workers therefore sometimes maintain contact with participants during their in-work support anyway (if participants are reluctant to engage with or seek support from their new point of contact in the in-work support team).

6.35 The system used in CLF does not appear to have caused any specific issues with participants dropping out of employment. CLF's start-to-LEO conversion rate to date is lower than LL's or SLP's, but the same as in WLA (where participants' key workers remain their primary point of contact throughout their in-work support).

6.36 Key workers noted that during earlier stages of the programme, lower than profile referrals meant their caseloads had been smaller than their contractual maximum. This meant they had been able to spend a relatively high amount of time providing support to participants who started on the programme earlier. Some felt that higher referral volumes from late 2018 onwards, and the consequential increase in their caseload size, might have a knock-on effect on their capacity to sustain job outcomes rates, although any potential impact has not yet had time to evidence itself within monitoring data[42].

> *"Having the lower case load definitely helps, because you can support your clients more and have more time to actually invest in things like in-work support, going out to employers, putting the time in to help with applications. And I think it helps to build the relationship as well and kind of get the customer trusting you."*
>
> *Provider key worker*

[42] Participants generally appear to be taking at least 5-6 months to start entering employment, meaning most participants who joined the programme since the increase in referral numbers may well not be expected to enter employment until after June 2019 (the latest month covered by monitoring data).

7. Conclusions and recommendations

Conclusions

7.1 This report has assessed the delivery of the Work and Health Programmes in London. They are being delivered across four sub-regions, with different providers and slightly different models in each. This report has focussed primarily on Theme A of the research brief, focusing on the match between participant characteristics and programme design.

7.2 **The programmes have taken some time to reach a steady state**, with similar issues around referral numbers and starts to those seen in many other parts of the country. This has been a key focus of activity and is reflected in the focus of the evaluation to this point. The improved number of referrals reflects the efforts of providers to build awareness of the programme amongst work coaches. This should also mean that more appropriate people are referred (i.e. those at whom the programme is targeted) and so reduce the numbers who do not start/attend following referral.

7.3 **More recently new issues have manifested with referrals, with numbers falling again** due to a declining base of existing Jobcentre Plus customers to refer to the programmes and some work coaches becoming less willing to make referrals due to negative feedback they had received about the programme from customers. There are also issues with third party organisations referring people, which appears to be due the complexity of the referral process (including the RCT element) and probably issues of general awareness.

7.4 While many participants have health and wider barriers (especially housing) to work, **the mix of people coming on the programme has differed from expectation in two key ways:**

- The proportion who are long-term unemployed has been higher. This is the only group who are mandated to attend the programme
- The number of people aged over 50 is higher than expected, who may be more likely to face health issues and so be harder to support in to work.

7.5 **The feedback on the process of referral from Jobcentre Plus to providers was mixed**. Key shortcomings included: limited or missing information about participants; participants not fully understanding the programme, being aware of only a particular aspect and not interested in the others; and time and distance between when people agreed to take part in the programme and first appointments. The increased presence by providers in Jobcentres and arranging appointments while the participant is in the Jobcentre should help to improve this.

7.6 **Participants' feedback on their first meetings with providers was positive**. These sessions are used to gather information about the person and the barriers that they face and agree how these can be addressed. It is encouraging that the participants we interviewed thought that this was being achieved.

7.7 Participants are then referred to support, either with the provider or elsewhere. **Provider staff were confident that they knew what support was available and could signpost effectively**. They did not highlight particular gaps or blockages, although given the nature of

the process it is not clear how well informed they would be about this. For example, after the signpost they might not find out for some time if a participant has sought the wider support, if there is a waiting list, etc. There has been some progress with individual borough councils, which have helped providers identify key contacts with local authority and/or health services to establish external referral pathways. There are some risks around this which will need to be explored further as the programme matures:

- Referral to external organisations appears informal, based on the knowledge of individual key workers. How far this lead to a consistent service is unclear and this could change if there is staff turnover or if providers change or face issues
- Providers rely on participants for feedback on services. There are no formal mechanisms for the service to update providers about the participant, or for the provider to explain the participant/their barriers to the service. This likely means that provision is less integrated than it might be, with participants having to 'tell their story' multiple times and the risk that things do not always get picked up
- Blockages with wider services may not be identified and participants may not receive the full range of support that they require.

7.8 **There was good feedback from participants and key workers about increased confidence and motivation, improved wellbeing and better management of physical health issues** (such as a reduction in physical pain, or sleeping better). Key workers were motivated by this, as were work coaches (although their awareness was more mixed). This general improvement in well-being should help improve job and earning outcomes in time.

7.9 **The picture on job and earning outcomes to date is less positive**. The level of people entering work and reaching the earning thresholds is considerably less than expected. Key challenges raised by key workers in each sub-region were the high level of barriers some participants arrive on the programme with, and the unwillingness of some people to look for work. These factors meant that it was difficult to progress participants towards work at a sufficient pace. This is an important issue to revisit in future reports.

Recommendations

7.10 The evidence gathered points to a number of recommendations to improve program performance. These are set out below.

Programme design

1. **Review of the anticipated profile of referrals and work with providers to ensure staff resources are in place before any significant increase occurs**. This will also need to take account of existing caseloads and so true, additional key worker capacity.
2. **Continue to focus on developing links with external organisations that can refer people into the programme**. Feedback from work coaches suggests some are seeing a decreasing number of customers they can refer (especially from JSA), and the mismatch between the benefits profile of participants and the sub-regions as a whole suggests a lot of individuals the programme is aimed at will need to be engaged outside of JCP. The challenge for JCP appears to be how to reach out to the wider client

group, including those who received ESA and who would have health related issues to be addressed.

3. **Review the impact of the alternative external referral entry route being trialled, whereby people don't go from third party organisations to JCP but instead go directly to the provider**. If successful, then this could be expanded to increase starts.

Engagement at Jobcentre

4. **Training and/or script for work coaches to guide their first conversations.** To ensure the health and back-to-work elements of the programme are both being highlighted equally to customers during initial conversations. In addition, it should help work coaches to introduce the RCT element. Results of the trial currently in progress in WLA should be shared with the other sub-regions to inform any approaches they develop/adopt.

5. **Develop good news stories which can be used to promote the programme to JCP staff and potential participants**. Work coaches are receiving inconsistent feedback about participants' experiences of the programme, and in some cases are becoming disengaged from referrals if feedback is primarily negative. Consistent feeding back of good news stories by providers in all four sub-regions would help address this.

6. **Providers to maintain and where required raise their profile in Jobcentres**. This will help to build awareness further and provides an opportunity to address any issues in flows of information and reduce DNAs.

Transfer from Jobcentre to provider

7. **First contact between provider and participants to take place while the participant is in the Jobcentre.** This could be through the provider being 'on site' or through a telephone call from the work coach, who then hands over to the participant.

8. **Ensure claimants are given (and record) the phone number the provider will contact them from** and suggest that they enter this number in their phone so that the call is not ignored.

9. **Stress to work coaches the importance of providing accurate participant information.** This should include contact details and flag up any particular issues, including how the person might like to be contacted or where they would want to meet.

Ongoing support

10. **Develop close links with councils in their boroughs.** To help ensure a consistent point of contact exists that has an up-to-date knowledge of the local support landscape and has the right contacts (including in the health sector) to help providers engage external organisations in both delivering additional support and supplying referrals to the programme.

11. **Develop simple protocols for sharing participant information** between support organisations, and for support organisations to update providers about participants' progress or barriers.

Jobs and employment outcomes

12. **Review through a short term, focused deep-dive exercise the types of participant coming on to the programme and how they compare to expectation**. It is unclear if the lower performance is due to the nature of participants and/or delivery. A short exercise reviewing how the allocation tool is working or asking providers to use their internal data (for example) would help clarify the focus for any remedial actions.

13. **Conduct a review with each provider of the scale and range of vacancies that they offer to participants, and participants' success rate in applying for jobs**. This review would consider how many people are deemed job ready and their outcomes, and the extent to which outcomes are constrained by job opportunities (which could be a growing issue due to Brexit uncertainty).

14. **Ask each provider to re-profile their expected job entry and earnings outcomes over the next six months**. This should set out how far they expect to move back towards their original profile or, if not, provide a basis to discuss why not and the longer-term implications of this. It will also provide a new profile against which to track short term performance and so to see if the position is improving.

Learning for the design of future programmes

15. **Revise referral targets, to ensure targets incentivise both volume and quality of referrals.** For example, set one target for the number of unique referrals, one for a minimum number of times someone is re-referred[43], and a target relating to the quality of referrals. Improving referral quality would help ensure referrals made are sufficient to produce the desired numbers of starts and outcomes.

16. **Consider revising or lifting the cap on referral numbers**. Given the likelihood that some referrals will be re-referrals (relatively hard to engage) and/or unsuitable referrals (people not seeking work and so not who the programme was designed for), ensure that any cap on referrals still enables sufficient unique/appropriate referrals for starts and outcomes targets to be realised. Applying the cap to unique referrals instead of total referrals might help.

17. **Consider whether a 50% job outcomes target is realistic for the participant groups targeted.** Given the achievements of other, similar programmes and the ongoing potential for unsuitable referrals to be sent to providers, a lower outcomes target might be reasonable.

18. **Incorporate external referral organisations into initial programme design and engage them from the outset.** Many of the individuals targeted by the programme

[43] To ensure a target for unique referrals does not result in individuals who DNA/DNS but may be willing/able to participate in the programme (e.g. if the provider was unable to contact the individual following first referral), subsequently missing out on support because they are never re-referred.

are not in regular contact with JCP and are therefore more likely to be successfully engaged by other services that they are in more regular contact with.

19. **Explore options for shortening the time between first referral and starting on the programme**. For individuals referred by external referral organisations, this might include developing referral pathways that don't necessitate attending JCP prior to seeing the provider. Shortening the referral process would likely help avoid DNAs.

Annex A: Documents received from sub-regions

A.1 The table below details all background documentation received and reviewed from each sub-region by the time of writing this report.

Table A-1: Documentation from sub-regions

London sub-region	Documents received
Central London Forward	CLW Work and Health Programme Contract – Schedules
	Ingeus Method Statement A - Design Overview
	Ingeus Method Statement B.1: Processes to support participants starting and staying on the programme
	London Work and Health Programme Health Assessment Process
	Central London fixed premises and co-location/outreach sites
	Ingeus – Central London Works: Service Delivery Model Presentation
	Central London Works: Work and Health Programme: Schedule 1 Appendix 1 Specification
Local London	LL WHP Programme Presentation
	MAXIMUS HealthWorks Local London Work & Health Programme – Example Participant Journey - Overview
	Local London Work and Health Programme Presentation – Delivery Model
	Employer Email for Verification of Employment Template
	Participant Email for Verification of Employment Template
	Self-Employment Job Outcome
	LL WHP specification
	Local London WHP: Borough profiles
South London Partnership	BWF SL – Management Summary Spreadsheet, September 2018
	SLP WHP Referrals and Starts, September 2018
	Specification for the WHP – South London Region
	South London WHP – Instructions and Guidance
	Work and Health Schedules and T and Cs
	South London Memorandum of Understanding
	London Borough of Croydon Integration Plan
	South London WHP presentation
West London Alliance	WHP WLA Briefing Feb 2018 – Shaw Trust
	Shaw Trust Group Presentation, September 2018
	WLA Participant Service Standards – July 2018 Update
	Shaw Trust Limited Invitation to Tender MS Response Document

London sub-region	Documents received
	WLA Forecast Starts + Targets BI Model
	Referral and Starts 12th Oct
	Participant data schema
	Referral and Caseload Report
	WHP WLA – Performance Against Earning Notification Profiles
	West London Alliance WHP MI to 24th October 2018
	WLA Participant Service Standards – July 2018

A.2 In May 2019 and July 2019, the four sub-regions submitted monitoring data to SQW. The table below highlights the key data points within these submissions. Data was asked to be broken down by participant group, BME status and borough where possible. Data requested was received from all four sub-regions.

- Number of people referred
- Profile referral numbers
- % and number of referrals starting on the programme
- % and number of referrals marked as 'Did Not Attend'
- % and number of referrals marked as 'Did Not Start'
- % and number of programme starts achieving employment outcomes
- % and number of programme starts achieving lower earnings outcomes (and, where applicable, higher employment outcomes)

Annex B: Provider delivery models

Central London Forward

B.1 The Central London Forward programme is supporting residents living in and/or accessing Jobcentre Plus (JCP) services in the following local authority districts: City of London, Camden, Hackney, Haringey, Islington, Lambeth, Lewisham, Royal Borough of Kensington and Chelsea, Southwark, Tower Hamlets, Wandsworth and City of Westminster.

Table B-1: Delivery partners

Delivery partners	
Main provider	Ingeus is the main Provider for the Central London Forward programme.
Sub-contractors	Ingeus are working with supply chain partners to co-deliver a single delivery model. For health and disability participants, their end-to-end delivery partners are Pluss and Leonard Cheshire. For long-term unemployed and early access participants, their end-to-end delivery partners are Get Set UK, Hyde Housing, Metropolitan Housing and Renaisi. Leonard Cheshire have been subcontracted to integrate their Able, Capable, Employable pathway across the Ingeus partnership and Get Set UK have been subcontracted to use the existing relationships they have with hospitality, security and cleaning sector employers to secure work trials for Central London Forward residents.
Partners delivering support/training	The provider has undertaken borough-level service mapping, engaging with over 125 providers delivering specialist support against 38 areas of participant need, including health conditions/disabilities, Armed Forces, BAME, refugees and women-specific. They have in-principle agreements with 73 agencies, including The Hub, Camden (colocation/case-conferencing to access free mental health support); Westminster Adult Education Service (referral pathways to free Level-2 courses); and St Hilda's East Community Centre, Tower Hamlets (health/fitness classes). In terms of skills training, the provider has referral agreements with CONEL, Free2Learn and Westminster Adult Education Service. Ingeus has a Community Investment Fund which is being used to procure specialist provision to cover unmet needs throughout the programme. The provider has in-principle Community Investment Fund subcontractor agreements with specialist providers including St Giles Trust (ex-offenders), RBLI (ex-armed forces), Shelter (housing/homelessness), Turing Point (addiction) and Gingerbread (parents/childcare).

Source: SQW analysis of Central London Forward documentation

Table B-2: Recruitment

Recruitment		
Expected referrals	2017/18	727
	2018/19	7,560
	2019/20	7,992
	2020/21	8,280
	2021/22	4,893

	2022/23	2,304
Referral process	Following referral, participants are telephoned by a Participant Liaison Officer within 48 hours to arrange their appointment and are offered a warm handover meeting with their caseworker, work coach and any external referral organisations, if applicable. Within 7-10 working days of referral, each participant meets their caseworker at one of 54 accessible locations. Initially these were all the premises of Ingeus or one of their sub-contracts, although in some boroughs Ingeus caseworkers have begun (as of mid-2019) to hold initial appointments within Jobcentres instead.	
Assessment process	Following the initial engagement period and face-to-face start meeting, an assessment and Action Plan must be in place within 20 working days of the referral. The assessment is conducted by the participant's caseworker and takes between 90 and 120 minutes over two face-to-face sessions. The provider has an end-to-end distance-travelled measurement Progression Framework tool which reviews four interrelated areas: MyLife, MyHealth, MySkills, MyWork. The assessment produces a visual indicator of strengths/needs on a 1-6 rating for each area and the Progression Framework is then be used to track the impact of interventions in each of these areas. If a participant has a health condition or disability, they have a face-to-face EQ5D-L conducted by their caseworker which can then lead to a GAD-7 or PHQ assessment taking place with an Ingeus Health Practitioner.	
Expected starts		**Health + Disability** / **Early Access** / **Long Term Unemployed** / **All**
	2017/18	410 / 41 / 0 / **450**
	2018/19	4,158 / 495 / 297 / **4,950**
	2019/20	4,095 / 473 / 630 / **5,250**
	2020/21	3,942 / 486 / 972 / **5,400**
	2021/22	2,272 / 320 / 608 / **3,200**
	2022/23	1,065 / 150 / 285 / **1,500**
Conversion rates of referrals to starts (%)	2017/18	**62**
	2018/19	**65**
	2019/20	**66**
	2020/21	**65**
	2021/22	**65**
	2022/23	**65**
Any recruitment payment	There are no payments linked to recruitment.	

Source: SQW analysis of Central London Forward documentation

Table B-3: Delivery

Delivery	
Payment triggers	A service fee is being paid for the purpose of supporting the delivery of support to all participants, and especially to secure the delivery of the service standards and the provision of non-employment outcomes. A proportion of the service fee can be deducted if the Management Service Standards or Non-Employment Outcomes have not been met. The service fee represents approximately 30% of the total contract value.
Expected key worker/staff ratios	On average, the key worker: claimant ratio is 1:65, with a maximum of 1:85. However, participants also receive additional support from a Personal Support Team, made up of health professionals, employer relationship consultants, hub guides, engagement advisors and specialist caseworkers. This allows participants to have more varied and frequent activity and reduces the participant-to-frontline staff ratio to 46:1.
Performance standards set	The Management Service Standards for the programme include targets related to the provision and content of: • the timings of initial meetings; • the assessment; • action and exit plans; • the average and maximum caseload size; and • the amount of contact time with participants. A full list of the Management Service Standards can be found below this table. Ingeus has a set of additional service standards, which do not appear to be attached to the service fee. These include, but are not limited to: • a personalised 'on-boarding call' prior to the first appointment, participants being able to have appointments at convenient locations • a personalised follow-up for participants who miss appointments • in-work participants continue to receive tailored vacancy information for progression activities • all participants area offered a follow-up call with their JCP Work Coach to share achievements, strengths, opportunities and next steps A full list of the additional service standards can be found below this table.
Ongoing support	Participants receive a minimum engagement of one hour per week with their caseworker/the Personal Support Team (face-to-face, telephone-based where appropriate; at least 50% with the caseworker). This implies that face-to-face casework includes fortnightly 1-to-1s to jointly review progress and refresh activities; and quarterly 1:1 'deep-dive reassessments' to review progress across the Progression Framework. Participants also receive four hours per week in group activities and 24/7 access to e-learning support through IngeusHub[44]. This gives a minimum caseworker/Personal Support Team contact offer over 15 months of 65 hours (at least 32.5 hours with a caseworker) and total interpersonal contact of 325 hours. Ingeus provide support for different participant groups at different stages of their time on the programme. As a standard offer, each participant is offered support for their health condition (where relevant), motivational support, employability support and access to vocational training opportunities. Where appropriate, support is also available to participants to deliver measurable progress in literacy, numeracy, communication and language skills, ESOL and ICT skills. In addition, Ingeus are providing service packages for participants that ensure the personal

[44] IngeusHub provides participants with 24/7 access to additional digital content, learning and links to support.

	challenges they face to secure employment are tackled comprehensively and in a coherent and sequenced way, using available local services where appropriate (e.g. mental health services, skills provision, housing support) and maximising their own in-house expertise in addressing health and employment barriers.
In-work support	Participants have a pre-work assessment to determine a bespoke package based on sustainability risks presented by themselves and their job/sector. As a minimum, participants receive the same contact time in-work as pre-work. These minimum levels can increase to ensure sufficient time to address needs. There is also a three-phase progression pathway, starting with stabilising participants in-work, then thinking about in-role progression and finally focusing on new job progression.

Source: SQW analysis of Central London Forward documentation

B.2 The Management Service Standards for Central London Forward are included in the table below.

Table B-4: Central London Forward Management Service Standards

Management service standards
MSS 1: 85% of all initial meetings with referrals must occur within 10 working days.
MSS 2: 80% of Participant Starts must be assessed and a detailed action plan in place within 20 working days of the Participant Start.
MSS 3: 80% of Participant Starts remain engaged in the programme during the 15 month employability support window.
MSS 4a: The average caseload size per caseload carrying advisor shall not exceed 65:1
MSS 4b: The maximum caseload size per caseload carrying advisor shall not exceed 85:1
MSS 5a: Minimum of 4 direct casework hours per month, guaranteed per Participant, and across all Participants 85% of the total guaranteed direct casework hours must be planned and booked for specific times with Participants.
MSS 5b: Minimum of 12 direct casework hours per 3 months, guaranteed per Participant, and across all Participants 85% of the total guaranteed direct casework hours must be planned and booked for specific times with Participants.
MSS 6: 95% of "9-month reviews" will be completed within two weeks.
MSS 7.1: 90% exit plans complete within 10 working days
MSS 7.2: 100% exit plans complete within 15 working days

Source: SQW analysis of Central London Forward documentation

B.3 The Non-Employment Outcomes for Central London Forward are included in the table below.

Table B-5: Central London Forward Non-Employment Outcomes

Non-employment outcomes
Non-Employment Outcome (NEO) 1: 65% of each Cohort who have not successfully accessed paid work on the programme
Over the lifetime of the Contract the Provider shall deliver the following
a) 3,113 of participants completing work placement, work experience or a work trial
b) 6,743 of participants completing accredited training / skills provision,
provided that there are a sufficient number of Participant Starts who do not successfully access paid work on the programme.
NEO 2: The Provider will ensure that the majority of Participants with an identified health condition will have, by the end of their participation, accessed the relevant health support requirements as set out in their action plan.
This will be measured on a once-per-Cohort basis when the last Participant in the Cohort ends their participation on the programme (up to a maximum of 21 months following such Participant's start).
NEO 3: The Provider will ensure that a majority of Participants report an improved health and wellbeing outcome from their participation on the programme (to be measured at a minimum on start of programme and completing the programme).
This will be measured on a once-per-Cohort basis when the last Participant in the Cohort ends their participation on the programme (up to a maximum of 21 months following such Participant's start).

Source: SQW analysis of Central London Forward documentation

B.4 The additional Service Standards for Central London Forward, which do not seem to be linked to payment, are included in the table below.

Table B-6: Central London Forward Additional Service Standards

Additional service standards
All Participants will receive a personalised 'on-boarding call' prior to first appointment.
All Participants given opportunities at initial and subsequent appointments to request service access in locations convenient to them.
All voluntary Participants who miss an appointment to receive personalised follow-up text, call or letter to re-engage them within 5 working days, continuing until they re-engage/exit the programme.
At 9-month point, all Participants have 3-way appointment with their Caseworker and Employer Relationship Consultant to identify/access personalised job-carving opportunities with individual employers.
Every participant entering work offered a personalised pre-work assessment* identifying individual support needs such as 'bridging costs' (e.g. work uniforms).
*(subject to 1 working days' notice)
Every participant receives an agreed in-work support offer tailored to their working patterns and/or personal circumstances.
All in-work Participants continue to receive tailored CLW vacancy information for progression opportunities (e.g. higher wages, more/preferable hours, increased responsibilities/status).
All participants exiting CLW offered personalised statement, co-produced with their Caseworker, for their Exit Report.

All participants offered follow-up call to their JCP Work Coach to share achievements, strengths, opportunities and next steps.

All participants have access to IngeusHub for 12 months after exit.

Source: SQW analysis of Central London Forward documentation

Table B-7: Outcomes

Outcomes	
Payment triggers	70% of the contract value is paid on condition of the provider moving participants into employment. The provider receives outcome payments when participants reach a lower earnings threshold and when participants reach a high earnings threshold. The lower earnings outcome payment is triggered when a participant earns the equivalent of someone working for 16 hours per week for six calendar months, earning the adult rate (aged 25 and over) of the NLW during their time on the programme, or within six months after provision completion. A second outcome fee is paid once a participant has earned an amount equivalent to being paid London Living Wage for 21 hours per week for six calendar months. For those entering self-employment, an entitlement to a fee equivalent to the 'lower earnings threshold' outcome is triggered when a participant achieves a cumulative period of not less than six calendar months. There will be no eligibility for the 'higher earnings threshold' for the self-employed. The outcome payments are paid on a unit price basis. The provider receives an outcome payment of £2,696.96 excluding VAT when a claimant reaches the lower earning income threshold or the self-employment outcome. The provider receives an outcome payment of £948 excluding VAT when a claimant reaches the higher earnings threshold.
Expected numbers (and %) into work	*There was no mention of this in the documentation reviewed.*
Expected numbers (and %) generating payments	Central London Forward have a target of 10,376 participants reaching the lower earnings threshold (50%), and a target of 8,052 participants reaching the higher earnings threshold (39%).
Other outcomes linked to payment	A proportion of the service fee can be deducted if the Management Service Standards or Non-Employment Outcomes have not been met. However, the documentation does not give further detail on this. The non-employment outcomes relate to participants who do not access paid work: • 60% of participants will access relevant health support as set out in their Action Plan (10,376) • 75% of participants will report improved health and wellbeing outcome (15,562) • 32% of participants will complete accredited training/skills provision (6,743) • 15% of participants will complete a work placement, work experience or a work trial (3,113).
Other outcomes – no payment attached	There are no other outcomes not attached to payment.

Source: SQW analysis of Central London Forward documentation

Local London

B.5 The Local London programme covers the following local authority districts: Barking & Dagenham, Bexley, Bromley, Enfield, Greenwich, Havering, Newham, Redbridge and Waltham Forest.

Table B-8: Local London programme

Delivery partners	
Main provider	MAXIMUS is the main provider for the Local London programme.
Sub-contractors	MAXIMUS is delivering 55% of the programme, and its supply chain partners are delivering 45%. Two supply chain partners are working across all London boroughs: • Health Management, who are conducting clinical assessments with all participants and are responsible for Clinical Governance unpinning health delivery • Remploy, who are providing disability support and training expertise and seconding disability expert advisors to MAXIMUS frontline. In certain boroughs, MAXIMUS are also working with end-to-end supply chain partners who seem to have been subcontracted. These are: • Ellingham (Redbridge and Waltham Forest) • Barking & Dagenham Job Shop (Barking & Dagenham) • Learning & Enterprise College Bexley (Bexley) • GLLaB (Greenwich) • Workplace Newham (Newham) • L&Q Housing (Newham) • One Housing (Newham) • Hyde Housing (Newham).
Partners delivering support/training	Partners include, but are not limited to: • Havering Volunteer Centre • Barking and Dagenham College • MIND • Aspire Education Academy • Talking Therapies • Richmond Fellowship • Family Mosaic • National Careers Service • The Sycamore Trust • Hero Projects • Christians Against Poverty • The Pier Road Project • Bexley Voluntary Service Council

Source: SQW analysis of Local London documentation

Table B-9: Recruitment

Recruitment	
Expected referrals	*No information on expected referrals has been received from Local London.*
Referral process	MAXIMUS Health Works are running marketing and awareness sessions in JCP offices, ESOs, and community service providers. Within 24 hours of the participant's referral session with their JCP work coach, the participant is contacted by MAXIMUS' support centre to book the initial meeting. Within seven working days of the referral, the participant has a face-to-face welcome meeting. At the claimant's welcome meeting with the provider, there is a warm handover with the JCP work coach to help maintain confidence and trust.
Assessment process	Within 48 hours of the welcome meeting, the participant has a BioPsychoSoical Assessment (BPSA) which is telephone-based and delivered by a clinician. The BPSA assesses mental, physical and social challenges affecting the participant's ability to work and recommends appropriate keyworker allocation. Within five working days, the participant has an enhanced work readiness assessment which is conducted face-to-face with an allocated keyworker. The enhanced work readiness assessment involves a review of the BPSA outcome report, uses optional tools assessing skills and disabilities and includes a Better Off-in-Work calculation. It also involves establishing a co-designed Action Plan corresponding to health, wellbeing and job goals. This will be appropriately sequenced to address the barriers the participant faces.
Expected starts	*No information on expected starts has been received from Local London.*
Conversion rates of referrals to starts	*No information on conversion rates has been received from Local London.*
Any recruitment payment	

Source: SQW analysis of Local London documentation

Table B-10: Delivery

Delivery	
Payment triggers	*No information on payment triggers has been received from Local London.*
Expected key worker/staff ratios	No specific key worker: claimant ratio is mentioned, except that caseloads are low. In Havering, Maximus key workers had caseloads of up to 45, as per the limit. In Bexley, LECB key workers had caseloads of 63.
Performance standards set	The documents received from Local London do not set out the contracted service standards. However, a document related to the self-employment job outcome sets out a number of Customer Service Standards but it is unclear how the standards are linked to payments. The standards that are set out are: • Participants will receive intensive Support Manager support of at least two hours per month for the first six months, provided either face to face or by telephone. This may just apply to in-work support rather than general support. • In Work Support Action Plans will be reviewed monthly and signed by the Support Manager and Participant and uploaded to ADAPT. • Participants will attend a 3-month progress review to update their CV experience.

	• All contact with a participant or employer should be recorded as a summary note within Adapt via the 'In Work Support' workflow on the 'Job Details' record. • Distance Travelled Tool updated Quarterly on ADAPT. • Support Manager to review Motivation and Well Being Assessments completed by Participant. • For those in self-employment – a requirement for monthly evidence of trading (e.g. bank statements, invoices) for 182 days from the start date.
Ongoing support	Participants receive a minimum of four hours face-to-face per month with the keyworker. This is both one-to-one and group-based and involves monthly Action Plan reviews and gives participants access to in-house Health Interventions either one-to-one or in a group. In addition, participants have regular and consistent activity including accredited and non-accredited skills training, community volunteering and peer-support activities. Participants also receive support from a job broker, including bespoke vacancy-sourcing shaped to job goal/needs, and work experience and work placements that build confidence and skills. The job broker may come from MAXIMUS' national Employer Services Team which is a nationally-focused Accounts team holding relationships with over 3,500 employers. There is 24/7 online support via MAXIMUS HealthWorks online portal. This gives access to employability tools and guidance and wellbeing support and health tools.
In-work support	At job start, participants have a 'Transition to Work Review' which involves confirming in-work adjustments and an in-work support plan (e.g. travel to work support) and a workplace introductory meeting with the employer, job broker, keyworker and participant. Once in-work, two hours of keyworker support is available per month for participants which might include job coaching and reassessments. Participants continue to have access to in-house health interventions either one-to-one or in a group. This complements the job broker support to employers. For most participants, the focus on in-work progression begins after 3 months in work and involves a progress review to update CV/experience, sector-specific careers development support, supporting participants with in-work calculations, and putting in place appropriate plans for continued skills training.

Source: SQW analysis of Local London documentation

Table B-11: Outcomes

Outcomes	
Payment triggers	The only information on payment triggers received from Local London is for self-employment outcomes. A self-employment job outcome is achieved once a participant has traded over a cumulative period of 182 days or 26 weeks.
Expected numbers (and %) into work	*No information on expected numbers into work has been received from Local London.*
Expected numbers (and %) generating payments	*No information on expected numbers generating payments has been received from Local London.*
Other outcomes linked to payment	*No information on other outcomes linked to payment has been received from Local London.*

Other outcomes – no payment attached	*No information on other outcomes – no payment attached has been received from Local London.*

Source: SQW analysis of Local London documentation

South London Partnership

B.6 The South London Partnership programme covers the following local authority districts: Croydon, Kingston on Thames, Richmond, Sutton and Merton.

Table B-12: Delivery partners

Delivery partners	
Main provider	Reed is the main provider for the South London Partnership programme.
Sub-contractors	Specialist counselling support has been contracted to address the levels of need amongst participants.
Partners delivering support/training	Local partners may include, but are not limited to: • DWP/Jobcentre Plus • Local Enterprise Partnerships • Local Authorities • Regional ESF Partners • Employers • National Offender Management Service (NOMS) • Skills Funding Agency (SFA) • Local Health Services • Voluntary and Community Sector and Specialist Organisations; • Big Lottery

Source: SQW analysis of South London Partnership documentation

Table B-13: Recruitment

Recruitment			
Expected referrals		**Provider**	**DWP**
	2017/18	145	116
	2018/19	1,819	1,608
Referral process	The provider makes initial contact with the participant by appropriate means to make arrangements for the face-to-face start meeting and sends the participant confirmation of the time and place. Once the provider acknowledges a participant referral from JCP on DWP's PRaP system, DWP transfers appropriate participant information and data held on DWP systems to the provider to enable it to offer a bespoke and personalised service to participants. Referrals should result in a participant starting on the programme within 10 working days of the referral being made and, if this fails to happen, the reason why must be recorded on the provider's relevant database. At the face-to-face start meeting between the provider and the participant, the discussion centres around the provision, the needs of the individual, informing the participant that the provision is funded by the ESF, checking eligibility for ESF provision, gathering relevant ESF data and issuing agreed ESF literature.		
Assessment process	Following the initial engagement period and face-to-face start meeting, the provider ensures that an agreed assessment and detailed		

	employability action plan is in place within 20 working days of the participant's start on the programme. The assessment includes: • finding out personal and background information about the participant • a commitment from the participant to continue to engage with the caseworker and a plan, agreed with the participant, on how that engagement will take place • a Better Off in Work calculation • practical steps to be taken by the caseworker to support the participant and key milestone dates • evidence that the caseworker has mapped out the relevant services that will be seeking to engage in the participant journey going forward • a clear direction of travel provided by the assessment towards the development of a 'detailed employability; action plan' • a completed initial data sharing consent form. In addition, as the majority of participants in the scheme will have health issues or a disability, the provider ensures that a full health and condition management assessment is undertaken for these participants, in conjunction with trained and relevant health professionals.		
Expected starts		**Provider**	**DWP**
	2017/18	96	87
	2018/19	1,197	1,224
Conversion rates of referrals to starts		Provider	DWP
	2017/18	66%	75%
	2018/19	66%	76%
Any recruitment payment	No information on recruitment payment has been received from South London Partnership.		

Source: SQW analysis of South London Partnership documentation

Table B-14: Delivery

Delivery	
Payment triggers	The Service Fee will be an amount payable by the Lead Authority to the Provider on a monthly basis for the express purpose of supporting the delivery of the Services in accordance with this Contract. The Service Fee will be calculated as: • 30% of the estimated total contract value (ETCV), as estimated by the Lead Authority in its absolute discretion, divided by the total number of months of Referrals, as estimated by the Lead Authority in its absolute discretion; • in the last 6 months of Referrals, the Service Fee will fall from 30% of the ETCV to 15% of the ETCV. Performance against a series of customer service standards will influence future service fee payments.
Expected key worker/staff ratios	The maximum caseload size of participants per caseworker is 45.
Performance standards set	The customer service standards include targets based on: • the timings of 'client starts' on the programme, the assessment and action plan, the health and well-being evaluation for participants in the health and disability group and follow-up with participants who miss an appointment

	• the maximum caseload and minimum caseworker hours with participants • MI reporting • non-employment outcomes • in-work plans and progression. A full list of the customer service standards can be found below this table.
Ongoing support	Participants have fortnightly face-to-face appointments with their caseworker. They are also contacted each week in between their appointments, either by phone or email. The minimum caseworker hours provided for each participant by nature and frequency of contact is: • core support for each participant: 16hrs 31mins total (12hrs 3mins face-to-face, 4hrs 28mins phone/email) • Additional support for each participant: case conferencing 3hrs 6mins. The provider review participant progress at specified intervals and adjust plans accordingly. Case management varies between participants according to their needs, but the provider makes sure that each participant receives a minimum number of casework hours and that there is regular case reviews and case conferences when required. Wherever a client has a need identified the caseworker will work to find appropriate support to address that need. Additional support is provided both in-house and externally. Much of the in-house support is around health, wellbeing and employability, although some limited courses for skills have been run internally. Support is generally in a workshop or group format, but this depends on the need and intensive one-to-one support is usually available. Caseworkers use the Pathfinder tool to navigate the available support, where they can find instructions on how to make referrals.
In-work support	In-work support is delivered by the caseworker, predominantly via regular catch-ups over the phone. In total, each participant is expected 4hrs 40mins in total (2hrs face-to-face and 2hrs 40mins phone/email). Once a participant secures a job, in-work support is provided by the provider as needed to help them sustain and progress in employment and to achieve the higher earnings threshold. Generally, the support is more frequent and intensive initially and becomes less frequent as the six months progress; although this depends on the participant's need and indicated preference. Participants are offered a career progression review after two or three months to explore progress to date and establish their next steps. For participants who have made little progress during their time on the programme (i.e. have spent less than16 hours in voluntary or paid work by nine months) the provider shall ensure that there will be a formal review by the caseworker.

Source: SQW analysis of South London Partnership documentation

B.7 The customer service standards for South London Partnership are included in the table below.

Table B-15: South London Partnership customer service standards

Customer Service Standards
The Provider must ensure that: a. 100% of 'Referrals' will result in a 'Client Start' or a Participant Failure to Start) within 10 working days of the Participant Referral. b. This activity (i.e. Start or Failure to Start) will be recorded in DWP's Provider Referrals and Payment System (PRaP) within 15 working days of Referral.

The Provider must ensure that for all 'Client Starts'

a. assessment and detailed action plan is in place within 20 Working Days of the Client Start. This will be monitored monthly.

b. where the Participant is part of the disability or health condition group an agreed health and well-being evaluation is completed within 20 Working Days of the Client Start and at the completion of the Programme (i.e. at the exit interview)

The maximum caseload size of participants per caseworkers is 45

The minimum caseworker hours that are to be met for each participant (more detail below in delivery process)

65% of all Participants with a health condition or disability will report an improvement in health & wellbeing from point A (Programme Start) to point B (Programme Completion).

The provider must provide the lead authority with timely, full, accurate and complete monthly management information, using MI reporting template

Evidence of outcomes must be kept

Percentage of Participants who fail to attend provision will be followed up within 1 working day by their Caseworker: 95%

Percentage of Participants who have not accessed paid work on SLWHP who achieve a non-employment outcome (e.g. non-accredited/accredited training) by the end of their participation: 85%

Percentage of Participants starting work who will have an Into Work Meeting to create an in-work plan outlining in-work support: 95%

Percentage of Participants reaching the LEOP who will be offered an in-work Progression Review with their Caseworker: 95%

Source: SQW analysis of South London Partnership documentation

Table B-16: Outcomes

Outcomes	
Payment triggers	Outcome payments are the core payments by results element of the programme and represent at least 70% of the total contract value, divided between a lower earnings threshold and a higher earnings threshold. A lower earnings outcome threshold is achieved when an employed participants' earnings reach an earnings threshold equivalent to the participant working at the National Living Wage (NLW), for 16 hours per week, for 26 weeks. The higher earnings income threshold is achieved when an employed participant's earnings reach a second threshold equivalent to London Living Wage, for 21 hours per week for 26 weeks within the same 21-month period. For the self-employed, an entitlement to a Lower Earnings Outcome Payment will be triggered when a participant achieves a cumulative period of not less than 182 calendar days' self-employment. Any period of self-employment can only be counted once regardless of whether the participant has one or multiple self-employed occupations during that period. There will be no eligibility for the Higher Earnings Outcome Payment for the self-employed.
Expected numbers (and %) into work	2,953 participants to the programme will start employment.
Expected numbers (and %) generating payments	2,510 (50.1%) programme participants will achieve the lower earnings outcome payment.

	1,902 (51.4%) Disability and Health Condition Group Participants will achieve the lower earnings outcome payment. 263 (51.3%) Early Access Disadvantaged Group Participants will achieve the lower earnings outcome payment. 345 (43.2%) Long Term Unemployed Group Participants attending on a mandatory basis will achieve the lower earnings outcome payment. 2,114 (42.2%) participants will achieve the higher earnings outcome payment. 1,602 (84.2%) Disability and Health Condition Group Participants will achieve the lower earnings outcome payment. 222 (84.4%) Early Access Disadvantaged Group Participants will achieve the lower earnings outcome payment. 290 (84.1%) Long Term Unemployed Group Participants attending on a mandatory basis will achieve the lower earnings outcome payment.
Other outcomes linked to payment	Health Improvement: 65% of all Participants with a health condition or disability will report an improvement in health & wellbeing from point A (Programme Start) to point B (Programme Completion). The specification states that, where appropriate, the provider shall ensure that support will also be available to participants to deliver measurable progress in literacy, numeracy, communication and language skills, ESOL and ICT skills.
Other outcomes – no payment attached	No information on other outcomes not linked to payment has been received from South London Partnership.

Source: SQW analysis of South London Partnership documentation

West London Alliance

B.8 The West London Alliance programme covers the following local authority districts: Barnet, Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon and Hounslow.

Table B-17: West London Alliance programme

Delivery partners	
Main provider	Shaw Trust is the main provider for the West London Alliance programme.
Sub-contractors	There are two subcontractors working on the West London Alliance programme. The first is Groundwork London who are covering the borough of Barnet (18% of volume). The second is Prospects who are covering the boroughs of Harrow and Hillingdon (14% of volume).
Partners delivering support/training	**Employability** • There are plans to work with London Green Skills Partnership, which is a partnership between employers, LAs, training providers and VCS creates opportunities for unemployed Londoners to move into green jobs. • Faith Regen provide tailored employability training to people from BAME and faith groups in Brent. • Enterprise Exchange specialise in helping people with additional barriers become self-employed or start a business • Working Chance provide tailored support to women ex-offenders and care leavers. **Skills** • Provide access to training, qualifications and apprenticeships through FE/SFA, including through providers such as West Thames College, Uxbridge College, Barnet & Southgate College, London Work Based Learning Alliance members

- Use local skills providers to access local, short training in specific skills to meet local labour market needs, such as forklift licences
- There are plans to deliver skills training in-house, such as courses of digital skills for work

Health

- Plans to work with various local CCGs, GPs, NHS Trusts and IAPTs teams
- The Health & Wellness Team is planning to facilitate access to pain management clinics at CCLH, CNWL and Imperial
- Various mental health charities are mentioned as sources of support
- Support from specialist groups for specific conditions e.g. Genius Within (targeted support for neurodiversity conditions e.g. autism spectrum, ADHD), RNIB (vision impaired) and Clarion (hearing impaired)

Other support

- Housing support will be sourced through organisations such as Crisis as well as local authority housing teams
- There will be access to support with finance and debt such as learning to budget
- Various local authority teams and programmes will be used to support participants, including one-stop shop and hub initiatives
- Support targeted at specific issues or types of participants are mentioned at times, such as domestic violence, refugees, single/lone parents and ESOL
- Engaging with local police and probation services as part of integration with local support and services, including meaning multi-agency case reviews, sentence planning, and risk management to effectively co-produce action plans that sequence activity that enables compliance with all statutory requirements and promotes achievement of targets
- Activities aimed at reducing social isolation.

Support from volunteers

The volunteer model builds on an approach the Shaw Trust used for the Work Programme, for which 1,600 local people volunteered as 'expert volunteers' including those participating in the programme. There are also corporate volunteers, for example Lloyds Banking Group encourage their staff to volunteer. A Volunteer Coordinator will manage their activities and seek to expand the number of volunteers. The volunteers provide the following support:

- Employment support covering CV building, career coaching, confidence building, interview preparation, job searching and 'IT Buddy'
- Wellbeing support covering meditation, mindfulness, book groups, confidence building, walking groups, yoga
- High-quality volunteer programme provided in addition to (not replacing) core support; harnessing the expertise of local/remote volunteers offering a range of support from mentoring to interview coaching to self-employment advice and counselling. For example, volunteers might be qualified counsellors, disability-specific mentors, IT experts, or corporate volunteers sharing professional knowledge/skills.

Time Credits

Participants receive Time Credits when they have volunteered with the programme (e.g. leading a walking group, supporting peers with IT skills,

	befriending) which can be exchanged for training, leisure activities and other benefits from local partners, although it is unclear what activities and with which local partners.	

Source: SQW analysis of West London Alliance documentation

Table B-18: Recruitment

Recruitment		
Expected referrals	2017/18	358
	2018/19	3,120
	2019/20	3,336
	2020/21	3,336
	2021/22	2,004
	2022/23	952
Referral process	The provider is holding marketing and awareness sessions at the job centres several days a week for interested participants to find out more about the programme. Once participants have been accepted onto the programme, they have a warm handover and will receive a call from the customer support team at the provider to arrange their start meeting, which Is booked within 15 days of the referral. This is followed by a welcome call from their support manager within 48 hours of the participant appearing on their system and the participant will also get a letter confirming their start meeting. At the start meeting, the discussion centres around what the programme involves, the needs and background of the individual and the paperwork that needs to be completed. All referrals are via JCP Work Coaches although local authorities can signpost or recommend a referral. Once they've been referred, all claimants are assigned to a single Support Manager.	
Assessment process	Within 20 working days of the referral, an initial assessment is conducted by the Support Manager, potentially with support from the Health and Wellbeing Team in validating health assessments. The provider is using two tools with some additional discretionary screening tools available: Key Life Assessment (KLA) – a collaborative tool covering nine work readiness themes: Life-skills and Experience, Work, Physical Health, Mental Health, Housing, Finance, Social Networks, Lifestyle, and Personal Responsibilities. The KLA offers a person-centric initial assessment/distance-travelled tool enabling consistent measurement of participant progress throughout the programme. Occupational Support Questionnaire (OSQ) – utilises a psychosocial assessment approach measuring self-efficacy, motivation and perception in relation to illness, injury or disability and return to work. The OSQ recognises the importance of these factors as predictors of successful engagement, improved health condition self-management, and behavioural change learning to job outcomes. Screening tools: discretionary tools based on individual needs include GAD7 (anxiety), PHQ9 (depression), British Dyslexia Screening and BKSB (functional skills). The assessment outcomes inform an Employability Action Plan, which is co-produced with participants and reflects priorities, aims and ambitions; identifies needs/challenges, including health/wellbeing; and considers services already accessed. This is supported by the Tools for Success toolkit.	
Expected starts	2017/18	358

	2018/19	3,120
	2019/20	3,336
	2020/21	3,336
	2021/22	2,004
	2022/23	952
Conversion rates of referrals to starts	Based on the above figures, the Provider is expecting a 100% conversion rate of referrals to starts.	
Any recruitment payment	No information on recruitment payment has been received from West London Alliance.	

Source: SQW analysis of West London Alliance documentation

Table B-19: Delivery

Delivery	
Payment triggers	The service fee requested by Shaw Trust in their tender response is 30%.
Expected key worker/staff ratios	The average keyworker: claimant ratio is around 1:40-50.
Performance standards set	Several service standards have been set relate to: • Caseload sizes • Average contact hours • Timing of the initial meeting, referral, start and action planning • Engagement, pre-work support and exits. A full list of the service standards can be found below this table.
Ongoing support	The Tools for Success toolkit provides a flexible structure for pre-work/in-work support. All Tools interventions (themed around work/self-employment, health/condition management, functional, vocational and life skills, holistic wellbeing, social activities) comprise activities mapped to KLA themes. Support Managers and participants work collaboratively to select and sequence activities to build personalised pathways to overcome challenges and develop assets to achieve sustainable employment. Participants can also access self-guided interventions via the Shaw Online digital platform containing learning resources, podcasts and access to their sector-leading job matching system. Other teams and organisations will be drawn on to determine interventions and ensure they are appropriately sequenced. For health interventions, the Health and Wellbeing Team – which includes psychotherapists, counsellors and occupational therapists – play a key role in determining health support referrals through providing advice and guidance to Support Managers to help them address the health and wellbeing needs of participants. This may include reviewing treatment plans for pre-existing health conditions to ensure they are appropriate. Others include JCP Work Coaches, housing organisations, probation services, Talking Therapies Service, and health and social care teams.
In-work support	There are several ways in which participants are supported once in-work: • Participants receive multi-agency in-work support with their Support Manager, mental health worker, employer supervisor, skills providers and other stakeholders providing coordinated tapered support to them and their employer. Support managers continue to

	be in contact with the participant and can liaise with the employer if necessary. • In-work support may include a focus on career progression, including through the Skills Escalator • Use of extended introductory periods to reduce the perceived 'risk' in employing a disabled/Long Term Unemployed (LTU) person.

Source: SQW analysis of West London Alliance documentation

B.9 The service standards for the West London Alliance are included in the table below.

Table B-20: West London Alliance service standards

Service Standards
Caseloads per frontline advisor not exceeding an average of 40 and a maximum of 48. Average contact hours of 8.5 hours every 4 weeks, including: • Face-to-face initial/on-going assessment and formal review meetings: 1 hour per participant, every 4 weeks. • Face-to-face or video/conference call for 1:1 support/development: 30 mins per participant, every 4 weeks. • 7 hours of activity per participant every 4 weeks - comprising of group support sessions with participants, work placements, interventions, SM directed activities. Initial meeting: • 98% of Referrals will result in a Participant Start or Failure to Attend within 15 Working Days of the Referral being made. This activity will be recorded in PRaP within 15 Working Days of Referral. • No more than 4% of Referrals will be in Backlog (defined as an accumulation of uncompleted work or matters that need to be dealt with. In line with the above standard, this would be more than 15 working days). Referral - Referral will be acknowledged within two Working Days of the referral on PRaP. Start - Shaw Trust will send a copy of the ESF form to an agreed WLA address by electronic means or otherwise within 20 Working Days of date of Participant signature. Action Planning - for all participant starts, an agreed action plan is in place within 20 working days of the start date. Engagement - 91% of voluntary attachments who do not find work will be attached at the 9 months review point. Pre-Work Support - All participants will agree a 'target date into employment' at the start of WLA WHP, which will be reviewed and updated at least every 13 weeks to maintain a work focus to all activity. Exits - 95% of records of achievements (Exit Reports) will be completed and sent to JCP and the participant within 20 Working Days of the participant leaving WLA WHP

Source: SQW analysis of West London Alliance documentation

Table B-21: Outcomes

Outcomes	
Payment triggers	*No information on payment triggers has been received from West London Alliance.*
Expected numbers (and %) into work	The provider is expecting 6,148 participants to move into employment. 49% of starts are expected to lead to job outcomes, while those who do not secure a job will nonetheless move towards sustainable employment through tailored support that overcomes their barriers.
Expected numbers (and %) generating payments	West London Alliance are expecting 49% of participants to achieve the lower earnings outcome.
Other outcomes linked to payment	No information on other outcomes linked to payment has been received from West London Alliance.
Other outcomes – no payment attached	The provider is expecting to increase awareness of the benefits of employing disabled people and to help employers adapt with the

	intended outcome being the creation of employment positions and employment-related opportunities for disabled people that otherwise would not exist. The programme is expecting to affect change in the areas of recruitment processes (e.g. accessible online recruitment), roles (e.g. re-designing to support specific conditions) and environments (e.g. workplace adaptations). Whilst specific outcomes are not detailed in the documentation, the areas within skills that outcomes for clients are expected include: Uptake of apprenticeships Improved functional skills, including improved English for those with ESOL. Improved vocational skills, including a focus on ensuring the outcomes meet local labour market needs Improved employability skills, such as job-searching, interview, team working and presentation skills Soft skills, such as confidence, resilience and motivation Life skills, such as budgeting

Source: SQW analysis of West London Alliance documentation

Annex C: Methodology

C.1 The evaluation will explore a range of research questions, which are grouped together as three broad strands of investigation:

- **Theme A:** examining the match between participant characteristics and programme design/support available.
- **Theme B:** participants' experiences, including level of access to relevant support and how well integrated and coordinated different services are.
- **Theme C:** the quantitative performance of the Programmes, and factors influencing any variance.

C.2 The core questions explored under any one theme[45] touch on numerous topics and issues that are relevant to other themes. Consequently, several research methods employed during this evaluation will generate data and insights relevant to more than one theme. For example, one round of interviews with participants may be used to provide insights relevant to research questions under both Theme A and Theme B.

C.3 Over the course of the evaluation, the depth to which each theme is explored and reported on will vary. This variation will reflect the maturity of each sub-regional programme at each stage (and consequently the learning that will be most useful to commissioners and providers[46]). Broadly speaking, however, the first phase of fieldwork and data collection primarily focused on exploring Theme A, with the second phase due to focus primarily on Theme B, and the final (third) phase on Theme C.

C.4 The rest of this annex sets out our methods and work plan for the remaining phases of the evaluation.

Theme B

Research questions

C.5 Research undertaken for Theme B will answer the following core research questions:

- How many users required input from more than one public service in order to address their barriers to work?
- What services were required to work together to address the users' barriers to employment?
- What was the experience of users who needed input from more than one type of service?

[45] The core questions examined under each theme are detailed in theme-specific sub-sections later in this annex.
[46] For example, in the earlier stages of the evaluation it will be important to examine the participants being brought onto the programme, the extent to which target cohorts are being successfully recruited and engaged, and how well aligned provision is to those cohorts' needs. As programme referral and engagement processes mature, issues with participant recruitment will likely decrease and therefore will not need to be covered in as much detail during alter stages of our research.

- Which aspects of the service provision were integrated/joined up e.g. referral routes, action plans, data sharing, personnel, premises joint action plans?
- What impact has programme provision had on the health and wellbeing outcomes of participants, and what factors / provision is most important in supporting improved health and wellbeing?
- What are the critical success factors to integration & coordination, what areas of the programmes have the providers and commissioners found challenging to join up, and what are the remaining barriers to a coherent approach to service provision that will need to be addressed in future?

C.6 A summary of the methods we will use to address each question, and our reasoning for selecting each method, is included in the table below. The 'fieldwork' sub-section then sets out our full methods and the evidence each will generate in greater detail.

Table C-1: Theme B methods

Question	Methods	Reasoning
How many users required input from more than one public service?	Review and development of MI data Analysis of MI data to produce key ratios and descriptive statistics Interviews with provider delivery staff	The scale of the Programmes and the nature of participants lend themselves to a largely quantitative approach
What services were required to work together to address the users' barriers to employment?	Informed by the MI to identify sequences of support or overlaps. Then, qualitative research with services identified to understand if/how they have worked together and how they work with the provider.	The proposed qualitative research is likely to elicit more in-depth findings about how integration is working than a quantitative survey of providers.
What was the experience of users who needed input from more than one type of service?	We anticipate that something on the effectiveness of support should be included within the MI. In addition, the qualitative interviews proposed in Theme A with participants would also probe on this issue.	As immediately above, qualitative, semi-structured interviews are more likely to elicit a rich understanding of how the process is experienced by participants.
Which aspects of the service provision were integrated/joined up	This can be informed by: • The pathway mapping proposed in Theme A • The qualitative interviews with providers, external services and participants.	We have not included surveys of providers/partners because: • We hope to collect data (add questions) on participants' pathways/onward referrals/progress through the MI process • A qualitative survey exploring the factors influencing integration will likely generate high-level impractical responses, without opportunity for researchers to explore these further (as they could in an interview).

Question	Methods	Reasoning
What impact has programme provision had on the health and wellbeing outcomes of participants	This aspect should primarily come through the MI, with individual cases identified through the interview programme. The interviews also provide an opportunity to develop **case studies** to demonstrate how the process has worked and to what effect.	The use of MI data is described above. Case studies provide a means to illustrate key points and can be useful in communicating lessons to wider audiences.
What are the critical success factors to integration & coordination?	A number of the research methods will be addressed sequentially, ensuring that each feeds in to the other to build the evidence base.	Focusing the whole team on each question ensures we draw in the full range of evidence gathered in advance of writing the draft report. It provides the writer a clear overview of key sources and findings at a time when thinking is at its most flexible.

Mid-term review fieldwork

C.7 We will hold semi-structured qualitative interviews with a range of individuals engaged in the Programme, including: JCP District Managers and work coaches; provider managers/staff; providers; partner organisation staff (e.g. VCS, local authorities); participants; and strategic leads. Interviews will explore views on the key research questions for Theme B (e.g. user experience when accessing more than one service, and how well joined up the pathway is), and revisit challenges/barriers identified during earlier fieldwork to explore progress made since the Theme A report.

C.8 As with the Theme A fieldwork, we will undertake a mixture of telephone and face-to-face interviews, except for participants where we anticipate conducting all interviews face-to-face. Sampling/selection of interviewees will be undertaken in the same way as during the Theme A fieldwork: analysis of Programme MI to identify variation between referral partners regarding factors such as number and profile of participants received and attrition/completion rates (assuming this can be identified from the MI or other provider-held data), with JCP managers helping identify and recruit work coaches, sub-region management teams identifying provider/partner staff, and provider staff facilitating access to participants.

C.9 This fieldwork will consist of interviews with up to:

- **16 strategic staff** involved in the commissioning and/or management of the Programme at the sub-region or pan-London level, exploring perceptions of how effectively JCP-provider-partner supply chains are functioning and the role of Programme-level strategic leads in facilitating this. We anticipate interviewing 3-4 strategic staff with a pan-London remit, and 3-4 from each sub-region.
- **16 JCP staff**, exploring manager and work coach: understanding of the Programme's objectives; views on the effectiveness of processes for tracking onwards referrals by providers/coordinating with external partners; and initial impressions of the provision's impact on participants. We anticipate interviewing each sub-region's JCP

District Manager, plus a day of fieldwork in each sub-region to visit and interview JCP staff (including write-up time).

- **16 provider staff** exploring: whether appropriate participant groups are being referred; perceptions of how well Programme provision aligns with their needs; how well the referral and transfer process is working for providers, including onwards referrals to other partners and tracking participants; effectiveness of networks with other local partner organisations; and the wellbeing, health and/or employment outcomes they anticipate participants realising.

- **16 external partners**[47] exploring: effectiveness of links with the Programme, changes in referrals to/use of their services (and attribution to the Programme), and capacity/ability to provide support to different participant groups referred to them. We anticipate interviewing four external partners in each sub-region.

- **32 participants**, exploring: participant understanding of the Programme; experience of the referral process; effectiveness/appropriateness of support provided via the Programme (including how this differs from 'business as usual'); ongoing barriers to work; and their views on the likely benefits of the Programme for them. We anticipate interviewing approximately eight participants per sub-region, sampling to include a balance of H&D, LTU and EA groups, barriers to work, demographics (incl. age, gender and ethnicity) and number of services accessed.

MI collation and analysis

C.10 We will undertake analysis of the quarterly returns providers have submitted by Summer 2020, exploring the profile/characteristics of participants entering the Programme and the support different participant groups access, including any variation between sub-regions and individual boroughs. This analysis will:

- explore any shift in alignment between participant need and provision on offer since the Theme A report

- highlight any persisting gaps (and successes) important for us to explore as part of our qualitative fieldwork

- assess the extent to which participants needing more than one service are receiving more than one, including any variation between areas and participant profile, for triangulation with interview data on how well joined up provider/partner networks are

- explore the quantitative evidence to date on participant outcomes.

Mid-term report

C.11 This will provide an update on how well provision continues to align to different participant group needs, including progress made addressing challenges identified in the Theme A report. It will also include early findings on the volume and profile of participants requiring more

[47] Including organisations making external referrals and/or providing additional support to participants.

than one service from the Programme, the effectiveness/connectedness of the pathway for these participants, and emerging evidence of the outcomes the Programme is delivering for participants. Ongoing challenges and best practice will be highlighted (including learning on effective partnership working between services) and recommendations made for improvements/areas of focus going forward.

C.12 The final structure of the report will be agreed with the client group prior to drafting, but we anticipate a possible report structure would be:

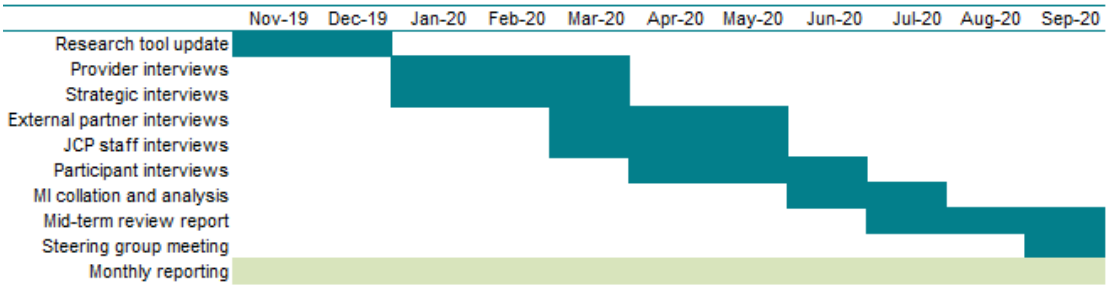
- **Purpose**: Programme structure, aims and intended outcomes/impacts (sub-regional)
- **Alignment to need**: participant profile recruited to date, support provided to different participant groups (including participants requiring more than one service), and any persistent gaps
- **Implementation learning**: on reasons for any misalignment/under-performance, and success factors where implementation has been effective. This will also present initial learning emerging around what works in delivering health, wellbeing and employment outcomes for participants (including factors to explore further in the final Theme B report)
- **Outcomes**: early evidence on outcomes the Programme is delivering for participants, and the key elements of provision that enable achievement of these outcomes.
- **Next steps**: recommendations for ongoing improvements to Programme delivery, implications of findings for the follow-up Theme B fieldwork (including key issues to explore further), and work plan for the remainder of the Theme B work.

C.13 This report can be in Word (with standalone executive summary) or PowerPoint, including a data annex, written in either SQW's template or a template nominated by the client group.

Timeframes

C.14 Timeframes for undertaking the mid-term review research (including reporting) are set out in Table C-2 below.

Table C-2: Mid-term review workplan



Theme B final fieldwork

C.15 Further qualitative interviews will be undertaken in early 2021 with each of the interviewee cohorts included in the mid-term review fieldwork, revisiting the key research questions from

the previous round of fieldwork and exploring the user experience, effectiveness of provider-partner networks and impacts of the Programme in greater depth one year on.

C.16 We will interview greater numbers of participants and delivery staff (from JCP, providers and partners) and likely a different range of integration partners, enabling us to undertake more granular sampling, exploring variance in Programme performance and experience in relation to a wider range of participant and organisation profiles (with key issues and cohorts/organisations of interest identified during the 2020 fieldwork and data analysis).

C.17 We intend to speak to a mixture of new interviewees and individuals spoken to during the mid-term review fieldwork, with whom we can explore change over time and (in participant interviews) develop a deeper longitudinal understanding of the user experience. We anticipate interviewing up to:

- **32 JCP staff**
- **32 provider staff**
- **24 external partners**
- **48 participants**
- **16 strategic staff**

C.18 As with the mid-term review, the qualitative data collected via these interviews will then be triangulated with updated analysis of Programme MI (in Spring 2021) to examine developments including any change in the extent to which participants needing more than one service are receiving more than one, alignment between provision and participant need, and participant journeys and outcomes, including the reasons behind any changes since the mid-term review.

Theme B final report

C.19 The Theme B report will include findings on the volume/profile of participants requiring more than one service from the Programme, the effectiveness/connectedness of the pathway for these participants, and emerging evidence of the outcomes the Programme is delivering for participants.

C.20 It will also provide an update on how well provision continues to align to different participant group needs. Ongoing challenges and best practice will be highlighted (including learning on effective partnership working between services) and recommendations made for improvements and areas of focus for sub-regions going forward, that can be shared with providers.

C.21 The final structure of the report would be finalised with the client group prior to drafting, but at present we anticipate a possible report structure would be:

- **Purpose:** Programme structure, aims and intended outcomes/impacts (sub-regional).

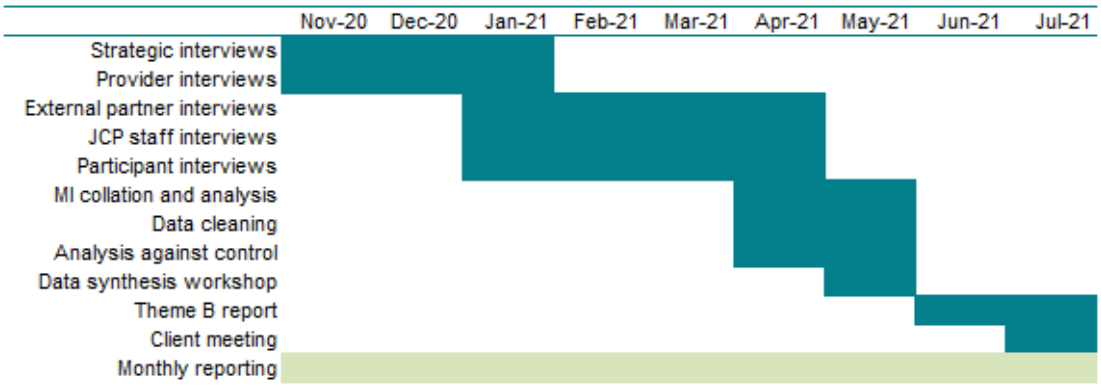
- **Support delivered:** participant profile recruited to date, support provided to different participant groups (including participants requiring more than one service), and any gaps evident.
- **Outcomes**: emerging evidence on outcomes the Programme is delivering for participants, and the key elements of provision that enable achievement of these outcomes. We will also undertake an initial round of outcome analysis for Programme participants (linking to the wider DWP evaluation of the national programme as a whole).
- **Implementation learning:** on reasons for any misalignment/under-performance, and success factors where implementation has been effective. This will also present initial learning emerging around what works in delivering health, wellbeing and employment outcomes for participants (including factors to explore further during Theme C)
- **Next steps:** recommendations for ongoing improvements to Programme delivery, implications of findings to date for the Theme C fieldwork (including key issues to explore further), and work plan for the final phase of the evaluation.
- **Case studies:** concise pull-out documents presenting the user journeys and outcomes of 3-4 participants, that can be disseminated to showcase Programme delivery and impact.

C.22 We will agree the timing and format of the final Theme B report with the client group prior to drafting but it can be Word (with standalone executive summary) or PowerPoint, including a data annex, written in either SQW's or in a template nominated by the client group.

Timeframes

C.23 Timeframes for undertaking the Theme B final research (including reporting) are set out in **Error! Reference source not found.** below.

Table C-3: Theme B final research workplan



Theme C

Research questions

C.24 Research undertaken for Theme C will answer the following core research questions:

- What impact have programmes had on the chances of a participant finding and retaining employment?
- Do the London programmes perform differently in terms of job outcomes, sustainment, and average earnings relative to each other and to the national programme, and what factors explain any differences?
- The four London programmes operate different payment models to incentivise different priorities. To what extent have these designs delivered on these objectives, and what can we learn from the new incentives and contract structures?
- What are the continued barriers to higher performance on the four programmes, and what lessons should be drawn from the data analysis of the four schemes?
- Cost benefit analysis of the four programmes taking account of different participant groups and their needs.

Analytical approach

C.25 Our modelling approach involves comparing the performance across the four sub-regions. It does not provide any counterfactual. A national counterfactual group is being developed, including from within London. At present it appears likely this data will only be made available to the London evaluation in aggregate form (with some sub-group analysis).

C.26 **The aggregate data will enable the evaluation to develop a number of simple comparisons**. The extent of these comparisons would depend on the size of the comparison group and how far it truly replicates the characteristics of the treatment group. The latter should not be an issue given the planned recruitment approach, assuming that it is effective in practice.

C.27 For reporting in late 2022 we would anticipate that the comparison group would need to have been recruited around 18 months in advance, to allow the treatment group their full time on the Programme and earning outcomes to be tracked through the system. This implies a cut-off point of around mid-2021.

C.28 Looking at the estimated number, by this point there should be 2,000–3,000 cases in three of the four sub-regions. This would be more than adequate for comparison. The situation in South London is more complex, with under 1,000 cases expected by that point. However, even that number would enable us to be confident in overall differences of 3 or more percentage points and so would **enable a difference in difference comparison of net performance in each of the four sub-regions**.

C.29 The extent to which sub-groups can be analysed will be similarly influenced by scale. For variables with a small number of sub-groups an analysis should be possible in each sub-

region. This type of analysis would likely hold for a number of key variables. For example: gender; age[48]; time out of work[49]; and qualifications[50].

C.30 In such cases we would be looking for differences of 5-10 percentage points to signal a statistically significant difference[51].

Statistical methods

C.31 It is possible to evaluate two aspects using quantitative methods: the characteristics of those that benefit the most from the Programme, and – should national programme data be available – analysis of the impact of the Programme on employment outcomes (finding and retaining employment).

C.32 In terms of the characteristics of those that benefit most, three analytical approaches could be considered. Simple crosstabulations of outcomes by different client characteristics provides the most basic level of analysis. **Logistic regression may be applied to provide an assessment on the strength and statistical significance of the association between a range of factors/characteristics and employment outcomes**. The factors that we expect can be covered are listed in the table below and include elements at the level of the individual, Programme areas, and local area. Interaction terms may be used to explore differences in the services offered.

C.33 An alternative and/or complementary approach would be to exploit the hierarchical nature of the data (individuals – local areas – sub-regions) and **adopt a multi-level modelling approach**, which has the ability to explore more detailed interaction-terms more effectively and efficiently than with a logistic regression approach. It will also enable an assessment of the relative importance of each level in the hierarchy (e.g. the proportion of the variance in the data explained by individual, local, or Programme-level factors).

C.34 Variables that we expect would be relevant at each level are set out in Table C-4 below.

Table C-4: Variables for use in multi-level modelling analysis

Individual-level	London Programme-level	Borough/job centre-level
Gender	Delivery model/services offered	Level of deprivation (IMD)
Age		Unemployment rate
Ethnic group		Skills composition
Participant group		Other relevant local characteristics
Barriers to work		
Area of residence		
Level of education		
Duration of unemployment		
Programme support (e.g. service(s) accessed)		

[48] Which could be banded into three groups: under 25, 25-50, and over 50.
[49] Two groups: less than two years out of work, or 2+ years out of work (these are the two categories captured in providers' monitoring returns).
[50] ISCED level.
[51] Exact numbers of participants brought onto each sub-regional programme, and the size of different participant subgroups in each, will be explored nearer the time of conducting this analysis to

C.35 Based on our review of the forms used by providers to collect data on each participant, all the above variables will be available at individual-level for our impact analysis. Borough and individual job-centre level variables are not specifically recorded by providers but we can add them into-individual-level data using the post code stubs[52] of participants' home addresses (which are recorded).

C.36 Providers are all collecting data on participants' health and wellbeing at the time of initial engagement, and at later stages in their engagement. The exact measures used by each provider vary, as does the frequency with which they are collected. It will, however, be possible for us to use participants' health and wellbeing scores to create a generic measure of improved health and wellbeing, to examine health/wellbeing impacts in each sub-region.

C.37 Providers' collection of precise data on the support and services given to each participant is likely to be patchy or inconsistent. Our assessment of the extent to which different services offered by providers affect participant outcomes may therefore need to be primarily based on qualitative feedback from sub-regional stakeholders and the information contained in their documentation.

Cost-benefit analysis

C.38 The assessment of impact is one part of the cost-benefit analysis. As set out above we think that it should be possible to calculate the gross and net impact (even with limited national data) and would use this to feed in to the cost benefit analysis.

C.39 Against this should be put the costs of delivering the programme. We anticipate that these will come from the programme budget and actual expenditure, and include both DWP and ESF funding.

C.40 **We would then create a series of ratios to compare the cost per job and earning outcome** (including enhanced earnings and jobs sustained outcomes) in London and the four sub-regions; to the equivalent national performance. This would enable an assessment of the return in London for the higher planned level of spend per participant.

C.41 We also have experience in using New Economy's cost benefit tool and can look at wider savings through reduced benefit payments. We could also estimate savings arising from health and wellbeing outcomes, although this analysis could only be based upon forecasts of potential impacts based on qualitative feedback collected during interviews (as providers are not collecting data on the specific health and wellbeing outcomes included in the New Economy tool).

Fieldwork and analysis

Qualitative fieldwork

C.42 Further qualitative interviews will be undertaken with the different groups of staff involved in overseeing and/or delivering the Programme in each sub-region. These will take place in late 2021/early 2022, exploring the impact of different payment/incentive models on

[52] A post code 'stub' is the first half of that post code. For example, the Palace of Westminster's post code is SW1A 0AA. The stub of this postcode is SW1A.

provider behaviour and performance, as well as revisiting key research questions from previous Themes to assess any challenges/barriers that continue to need addressing.

C.43 As with the Theme B fieldwork we will speak to a mixture of new interviewees and individuals spoken to during previous rounds of fieldwork, with whom we can explore change over time. We anticipate these interviews covering:

- 16 strategic staff
- 16 provider staff
- 16 external partners.

C.44 As with the mid-term review, the qualitative data collected via these interviews will then be triangulated with updated analysis of Programme MI. It will also be examined in combination with our analysis of programme performance against DWP's control group and our CBA analysis.

Analysis against control

C.45 Individual-level data from the London sub-regions will be reviewed and cleaned to ensure variables in each dataset are formatted, coded and banded consistently. The quantitative analysis detailed above will then be undertaken, producing an assessment of:

- The key personal and programme characteristics which influence outcomes in each of the sub-region.
- The net difference between outcomes in the London sub-region against the outcomes reported for the control group.

Cost-benefit analysis

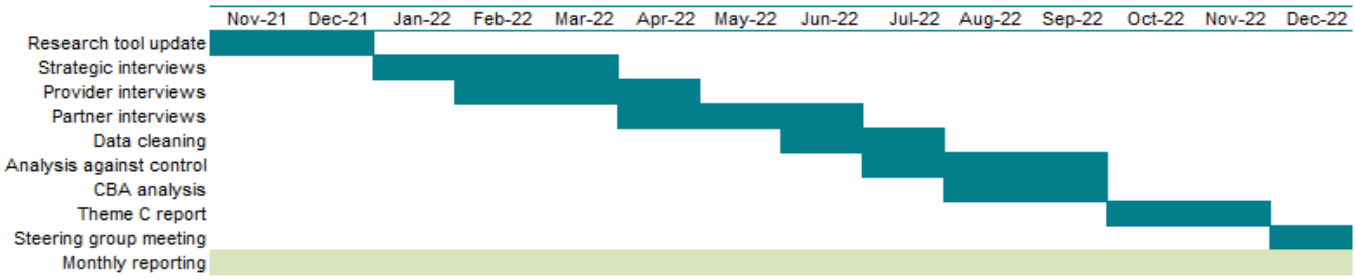
C.46 We will collect and collate data on the overall cost to each sub-region of delivering their Programme, primarily the programme costs. Wider service costs could be estimated using standard national tariffs (where available).

C.47 We would then create a series of ratios to compare the cost per job and earning outcome (including enhanced earnings and jobs sustained outcomes) in London and each of the four sub-regions to the equivalent national performance, as detailed above.

Timeframes

C.48 Timeframes for undertaking the Theme C research (including reporting) are set out in Table C-5 below.

Table C-5: Theme C research workplan



Reporting

C.49 The Theme C report will include findings on the Programme's impact on participant outcomes, and any variation between sub-regions resulting from variation in either delivery models and/or commissioning and payment mechanisms. It will also examine any ongoing barriers remaining in relation to meeting participant need, providing a joined up service and/or delivering outcomes for participants. Ongoing challenges and best practice will be highlighted (including learning on effective partnership working between different services) and recommendations made for improvements and areas of focus for sub-regions going forward, that can be shared with sub-region providers.

C.50 The final structure of the report would be discussed and finalised with you prior to writing, but at this stage we anticipate a possible report structure would be:

- **Purpose**: Programme structure, aims and intended outcomes/impacts (sub-regional)
- **Programme impact**: an assessment of the outcomes the Programme is delivering for participants, including variation in employment (and wellbeing/health) outcomes between sub-regions and participant groups, and the key elements1
- of provision that have contributed to these outcomes and any variation between areas/groups.
- **Cost-benefit analysis**: presenting our findings on the overall value for money of the Programme in each sub-region, considering the funding allocated to Programme delivery and the outcomes achieved over and above outcomes realised by the control group.
- **Conclusions**: synthesis of key findings on the impact and cost-benefits of the Programme, including variation between participant groups/sub-regions and underlying reasons for these, and recommendations for any ongoing improvements to Programme delivery or for future programmes (including delivery models and priority areas/groups to target further support at).

C.51 We will agree the precise format of the final report with the client group prior to drafting but it can be Word (with standalone executive summary) or PowerPoint, including a data annex, written in either SQW's template or another template nominated by the client group.