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Employment & Support Allowance: Evaluation of pilots to support Work-Related Activity Group customers with an 18 to 24 month re-referral period

A synthesis of evidence

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January 2019

Employment & Support Allowance - Evaluation of pilots to support Work-Related Activity Group customers with an 18 to 24 month re-referral period: A synthesis of evidence

A report of research carried out by the Department of Work and Pensions.

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Value of this research

This report is a summary of key findings from a research report and process and impact evaluation to produce new evidence to inform policy about what works to help Employment and Support Allowance (ESA) and Universal Credit claimants with complex health conditions to improve their prognoses, enabling them to move closer to work and to fulfil their potential.

Trustworthiness

These reports form part of the DWP research report series and as such adhere to the Government Social Research publication protocol and the Government Social Research Code for Products. All these reports have been assured by professionally badged Government Social Researchers in DWP and their production has been supported by other professionally badged analysts from the relevant government analytical services including the Government Statistical Service.

Quality

Collection, analysis and reporting of findings in the research report have been carried out by approved independent research contractors, the Learning & Work Institute and NatCen Social Research, commissioned by DWP through a competitive tender process. DWP analysts have worked closely with the contractor throughout the project to assure the quality and ethics of all research methods, tools and analysis used in the production of this report. This includes adherence to relevant published guidance such as The Magenta Book on evaluation and GSR professional guidance on ethics.

The impact evaluation was conducted internally by DWP professionally badged analysts using management information and DWP administrative data. The methods and analysis described in the report have been internally peer reviewed and assured by other analysts in the department.

Executive summary

The purpose of this report is to bring together or ‘synthesise’ the findings from externally commissioned research and an internal process and impact evaluation of pilots to support ESA (Employment and Support Allowance) WRAG (Work-Related Activity Group) customers with an 18 to 24 month re-referral or ‘prognosis’ period.

These pilots provided 2 years of enhanced support to ESA claimants with a prognosis of 18 to 24 months who had been placed in the Work-Related Activity Group. The pilot had three variants, each with a different provider: a Healthcare Provider (HCP) model; a Work Programme Provider (WP) model and a Jobcentre Plus Work Coaches (JCP) model.

The pilots aimed to establish whether enhanced support for this client group has a beneficial effect, and to identify who is best placed to provide that support. Each of the pilots took place in one of three different JCP districts with a randomised control trial approach used to allocate participants.

Analysis of the pilot implementation found that deficiencies in administrative data may have led to some people who should have been recruited to the pilot, not participating.

Analysis of outcomes found minimal employment impacts shown across all three pilots but there was evidence of impact on reduction in days on benefit, in particular the JCP and Work Programme pilots.

However, a majority of participants were positive about the pilot support overall, with over 80 per cent reporting a ‘good’ or ‘very good’ experience and substantial minorities reporting that the support had helped them to overcome barriers or helped with their health condition, with those in the JCP and HCP showing positive effects on soft outcomes.

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Acknowledgements

The Department is grateful to Peter Dawson and Samuel Smithers of the Department for Work & Pensions for producing this summary report.

Glossary of Terms

Employment and Support Allowance (ESA) – a type of unemployment benefit offering financial support to people who are out of work due to long-term illness or disability.

ESA Work-Related Activity Group (WRAG) – people claiming ESA are placed into two groups depending on to extent to which their illness or disability affects their ability to work. The work-related activity group are required to have regular interviews with an adviser and undertake work-related activities.

ESA WRAG 18-24 month Prognosis Group – once a claimant has been found to be eligible for ESA they will be allocated a re-referral or 'prognosis' date when their entitlement to benefit will be reconsidered. The prognosis group was used to determine whether claimants were eligible for the Work Programme. This pilot extended mandatory referrals to the Work Programme for participants in the 18-24 month Prognosis Group.

Jobcentre Plus Work Coach – front-line DWP staff based in job centres who support claimants into work by challenging, motivating, providing personalised advice and using knowledge of local labour markets.

Work Capability Assessment (WCA) – a requirement of every ESA claim, this assessment measures the extent to which illness or disability affects one's ability to work.

Work Programme (WP) – an employment support programme delivered by a range of providers with the aim of helping long-term unemployed JSA and ESA claimants find employment.

Abbreviations

DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
HCP	Health Care Professional
HMRC	Her Majesty's Revenue and Customs
JCP	Jobcentre Plus
JSA	Jobseeker's Allowance
RCT	Randomised Controlled Trial
WP	Work Programme
WRAG	Work-Related Activity Group

1 Summary

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The pilots provided 2 years of enhanced support to ESA claimants with a prognosis of 18 to 24 months who had been placed in the Work Related Activity Group. The pilot had three variants, each with a different provider: a Healthcare Provider (HCP) model; a Work Programme Provider (WP) model; and a Jobcentre Plus Work Coaches (JCP) model.

The pilots aimed to establish whether enhanced support for this client group has a beneficial effect, and to identify who is best placed to provide that support. Each of the pilots took place in one of three different JCP districts with a randomised control trial approach used to allocate participants.

The internal impact evaluation provides details on the pilot implementation observed from admin data, detailing information about the random allocation and participants’ characteristics, alongside the impact each trial had on benefit durations and employment outcomes.

The externally commissioned research, conducted by the Learning and Work Institute and NatCen, included a quantitative survey of participants via a two-wave telephone survey and qualitative interviews with pilot participants and staff. It provides a wealth of information into the implementation, delivery and effect of the pilots, allowing us to see beyond what can be observed via admin data.

Analysis shows that there were issues with the pilot implementation with a small number of misallocations and higher than expected exemption rates. We believe that some of this may be due to deficiencies in the admin data. However, staff reported that it was inappropriate for some of them to be on the programme due to the severity of their conditions, which may explain the higher exemption rates.

Overall, the three pilots showed a reduction in benefit receipts, with statistically significant reductions showing in the WP model after 12 months and within 3 months in the JCP model with much larger affect and over a longer period.

The three trials all had small but positive effects on employment outcomes, with the difference only being around 1 percentage point at most, and only statistically significant in the JCP model, but not for a sustained period of time. The survey found that very few participants had made job applications with the majority of respondents across all three pilots reporting that their health condition or disability currently prevented them from working.

The majority were, however, positive about the pilot support overall, with over 80 per cent reporting a ‘good’ or ‘very good’ experience and substantial minorities reporting that the support had helped them to overcome barriers or helped with their health condition, with those in the JCP and HCP showing positive effects on soft outcomes.

2 Introduction

The ESA WRAG 18 to 24 Month Prognosis pilots provided enhanced support for a period of two-years to claimants receiving income based Employment Support Allowance (ESA) that had placed them in the Work-Related Activity Group (WRAG) with an 18-24 month prognosis following their Work Capability Assessment (WCA).

The pilots were launched in 2013, following the Government's 2013 Disability and Health Employment Strategy, to test innovative approaches to providing increased support to the ESA Work-Related Activity Group (WRAG) claimants who had an 18-24 month prognosis. These are claimants who may have limited capability for work and complex health conditions who currently receive the standard Jobcentre Plus intervention which includes receiving 88 minutes of work coach time per year.

The pilots tested three different approaches to enhanced support which ran separately in three Jobcentre Plus Groups.

- Jobcentre Plus (JCP) model
- Work Programme (WP) model
- Healthcare Provider (HCP) model

For each pilot a randomised control trial (RCT) design was implemented comparing the enhanced support offered as part of the pilot with a control group receiving the standard JCP support offer.

All three pilot variants began on 25th November 2013 and nominally continued with enrolment until 29th August 2014. Each participant actively engaged with the pilot for up to 104 weeks which meant that the pilot support extended to the end of August 2016.

It is important to emphasise that comparisons cannot be drawn between the three pilots but only between the treatment and control groups within a pilot. As we are randomly allocating *within* each pilot variant we can in principle attribute differences (between the treatment and control group) *within* that variant to the pilot impact. However, because we are not randomly allocating *between* the different pilot variants, factors other than the relative efficacy of the different pilot models (such as the local labour marker) will potentially contribute to the difference in the pilot impacts from one model to another.

In the next section, the three models will be summarised before we move on to discuss the evaluation methods, the findings from the implementation of the pilots before concluding with the outcomes of the pilots. For more detailed information refer to the two original reports that are published alongside this summary.

3 The Pilot Models

There were 3 pilot models each with a different provider. Within each, outcomes of pilot participants were compared with non-participants receiving the standard JCP support.

3.1 Healthcare Provider (HCP model)

The HCP pilot comprised of a series of appointments delivered by healthcare professionals contracted through a private provider. The aim was to help support participants in the management of their health condition or disability and assisting them towards (a return to) work. The support offered would comprise: an initial meetings lasting at least 60 minutes; two more mandatory meetings being at least 45 minutes in length within the first 26 weeks; and a further two mandatory meetings at 12 and 18 months. Additional support was voluntary and at the claimants and providers discretion. The payment comprised only an attachment fee and not an outcome related component.

The HCP model ran in the Central England Group which, at the time, was compromised of the JCP districts of: Black Country; Derbyshire; Leicestershire and Northamptonshire; Staffordshire and Shropshire; and Lincolnshire, Nottinghamshire and Rutland.

3.2 Work Programme (WP) model

Participants in the WP model were referred to their local Work Programme provider for the standard two years of support. The nature of this support was not defined by DWP as WP providers operate under a 'black box' model. The WP provider was incentivised by the standard payment model (applicable to the Payment Group 7 group[1]). Attendance at appointments and completion of agreed work-related activity was mandatory for all participants on the pilot.

The WP model ran in the North East Group which, at the time, comprised the JCP districts of: Durham and Tees Valley; North East Yorkshire and the Humber; and Northumberland, Tyne and Wear.

3.3 Jobcentre Plus (JCP) model

The JCP model comprised of 530 minutes of work coach support a year, coupled with improved support for work coaches, such as additional case conferencing and access to Work Psychologists where appropriate. The extra time with participants was intended to provide more intensive support to

[1] There are nine payment groups reflecting the different levels of support that particular populations of DWP claimant will, on average, need in order to enter employment.

encourage them towards work. Attendance of appointments and completion of agreed work-related activity was mandatory for pilot participants.

The JCP model ran in the Southern England Group which, at the time, comprised of the JCP districts of: Greater Wessex; Thames Valley; Devon, Cornwall and Somerset; Surrey and Sussex; and Gloucestershire and West of England.

4 Evaluation methodology

The evaluation is comprised of two strands: an externally commissioned research report which focused on the pilot implementation, and the staff and customer experience through quantitative surveys and telephone interviews, and the formal impact assessment drawing on administrative data, carried out internally by Department of Work and Pensions (DWP) analysts. This two pronged approach is standard as administrative data, whilst useful for determining impact on key outcomes, does not allow us to understand the effects of pilot implementation, staff and participant experience, and measures of softer outcomes, for example confidence building.

4.1 Externally contracted research report

DWP commissioned the Learning and Work Institute and NatCen to conduct research into the delivery of support, exploring participants' experiences of this, softer outcomes from the pilots and participants' perceptions of pilot impacts.

The evaluation of the pilots was carried out using a two-wave survey of participants, supplemented by two waves of in-depth interviews, to explore the views and experiences of pilot participants and staff involved in pilot delivery.

A two-wave quantitative telephone survey was undertaken of both pilot participants and their control groups across the three pilots. The first wave was undertaken between October and November 2015, when most respondents were 15 to 24 months into the 24-month package of support. In total, 2,575 individuals took part in the Wave 1 survey. The second wave was undertaken between August and October 2016, when most respondents had completed the 24-month package of support. In total, 1,540 individuals completed the Wave 2 survey.

Qualitative interviews were also carried out with participants across the three pilots in two waves. Control group respondents were not included in the qualitative research. Across both waves, pilot participants took part in in-depth interviews (face-to-face or by telephone) which lasted up to an hour. At Wave 1 (September - November 2015), 24 interviews were undertaken with participants in each pilot (72 in total). At Wave 2 (July – December 2016), 62 interviews were undertaken with pilot participants – a mixture of longitudinal and new interviews.

Staff involved in the management and delivery of the three pilots were also interviewed for the evaluation, again in two waves of qualitative fieldwork. Both individual and small group interviews were carried out by telephone, lasting between 30 and 90 minutes. Wave 1 interviews took place between September and December 2015 and Wave 2 interviews took place between June and October 2016.

4.2 Internal DWP evaluation

The internal quantitative analysis takes two strands, a process evaluation and an impact evaluation.

The process evaluation assesses the implementation of the pilots in terms of claimant participation. This involves using DWP administrative data to analyse if elements such as randomisation and exemption criteria were implemented correctly, and if participants received the intended interventions.

The impact assessment further uses HMRC P45 data to examine the differences in the benefit dependency rate (benefit receipt) and the employment rate between the treatment and control group for each pilot. The analysis was conducted using a standard intention-to-treat approach based on the nominal (intended) allocation to counter any potential biases due to the discrepancy between the realised allocation and nominal allocations.

It is worth noting here that some sources of administrative data had quality issues, particularly when using Work Capability Assessment (WCA) data to identify when participants had their WCA in relation to starting on the pilots. There are also known issues with HMRC P45 data concerning data quality, and not containing information on the self-employed which will limit the impact assessment. Please see the Impact Assessment for more details.

5 Implementation and participation analysis summary

This section summarises the findings looking into the randomisation, volumes and the characteristics of participants before moving on to the findings of the pilots. The impact assessment published alongside this report goes into great depth using admin data to identify those accounting for any admin errors where possible, exemption criteria and meaningful participation; however some important observations are noted below.

5.1 Recruitment and randomisation

In all three pilot models, eligible participants were randomly allocated to either the treatment or control group based on the last three digits of their national insurance number.

The random allocation aimed to achieve a 50/50 spilt between treatment and control groups, save random fluctuations around this figure. An exception was the Central England Group where from the 6th May 2014 onwards the split was altered to 60/40 in favour of the treatment group. This change was made because of low referral numbers to the HCP Provider and a request by DWP Commercials to increase those referrals. Table 4.1 shows the resulting volumes and intended allocation for which the rest of the discussion in this report will be based upon.

Table 5.1 Pilot Volumes

	HCP	WP	JCP
Treatment	2,654	1,922	2,554
Control	2,324	2,038	2,657

Source: From participant characteristics table in Annex A

Analysis shows that allocation errors, ranging between 1.4% and 5.8% across pilots, were greater for the treatment group than the control group, meaning that JCP staff were more likely to 'move' someone from the treatment group to the control group than they were the opposite. This is a common phenomenon in randomised control trials (RCTs) and is often assumed to happen because the people doing the random allocation do not think that the trial is appropriate for some individuals so they do not put them in the correct group.

This might be explained by the research finding that many staff saw participants who had complex needs and that it was inappropriate for some of them to be on the programme due to the severity of their conditions.

5.2 Participant characteristics

Before considering outcomes and the impact that the pilot intervention has upon those outcomes it is important to be assured that the treatment group and the control group are similar in their personal and labour market characteristics.

Annex A contains tables that show breakdowns such as gender, age, ethnicity, partner and parental responsibilities, International Classification of Disease codes and geographical distribution of the treatment and control participants for each of the three pilot models. Importantly to note, the differences between the treatment and control groups are usually less than 1 percentage point and statistical tests suggest that the nominal (intended) random allocation process has produced groups that are reasonably well balanced.

Generally it can be observed that treatment (and control) participants are moderately more likely to be male, mostly white and the majority are over 40. This is fairly similar to the sample results from the research report, leading credence to the sample achieved underlying its findings.

Participants' health conditions and disabilities, and the extent to which their lives were affected, varied widely. Research showed that some participants could manage daily life independently and work a small number of hours, while others had more limited mobility, were on strong medication or had regular hospital stays, and some had unstable conditions with fluctuating effects. Participants' health issues were cited as a key barrier to work, along with a lack of confidence, and anxiety and pessimism about returning to work. Staff felt that participants' mind-sets about work, linked to their perceived limitations, was also a key barrier, particularly for longer-term claimants.

Using admin data, we can check to see how well aligned each pilot's control and treatment groups are when comparing their benefit and employment histories. For the HCP model the control group were marginally more dependent upon benefits one to two years prior to the pilot and less likely to be in employment, but were closely aligned on the year up to the pilot's start. For the WP and JCP pilots, the groups benefit histories were very well aligned although the employment histories between their respective control and treatment groups showed a marginal but persistent difference.

Given the good balance of characteristics and relatively well-aligned benefit and employment histories, it appears that the randomisation has worked well and as such this does not raise any major concerns regarding confidence in measuring any impacts.

6 Pilot delivery, outcomes and impacts

This section details the findings from the research report alongside the impact assessment for the three pilots in turn. As a reminder, comparisons can only be robustly made *within* each pilot rather than *between* each pilot as the random allocation happens within each pilot. Meaning that differences between pilots could be due to different local provision, population or geographical difference.

For each pilot below, analysis leads with the internal impact assessment on benefit dependency and employment outcomes, and follows up with findings from the research report. It is worth noting here that there are known data quality issues with HMRC P45 data. Please refer to the full impact assessment and research report published alongside this summary for more details and findings.

6.1 Healthcare Provider (HCP) model

The HCP model did lead to 1.7 additional days off benefit on average per person over 1 year leading to 3.3 additional days after 2 years and 5.3 after 3 years. However, these positive effects of the pilot were not significantly different from the control group.[2] Similarly, the pilot led to a consistent 0.5 percentage points higher chance of being employed over the same time frame, however it was not significant.

Analysis of outcomes measured in the survey suggests that the HCP pilot appears to have made no difference to employment outcomes or job search activity among participants, but did appear to have an impact on some of the soft outcome measures. Around a third (34 per cent) of pilot participants said that the pilot had increased their motivation to leave ESA, compared to 26 per cent in the control group, and a smaller proportion than in the control group said that the support had decreased their motivation to enter work (5 per cent compared to 15 per cent).

As with the WP pilot, a large majority of participants on the pilot (80 per cent) felt that their health condition or disability left them unable to work currently. However over half (54 per cent) felt that the pilot had helped with their health condition and two fifths (41 per cent) said that it had helped with overcoming some of their barriers to work. Only around a fifth (21 per cent) though, felt that the pilot had helped them move closer to work. This is unsurprising given the pilot's focus on health rather than employment support.

Face-to-face meetings were the preferred and predominant mode of support delivery, with 71 per cent of participants receiving only face-to-face support, and 21 per cent experiencing both face-to-face and telephone appointments. Just eight per cent had telephone support only with no face-to-face meetings.

[2] All statistical significance tests referred to, unless otherwise stated, were conducted using a 95% degree of confidence.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Three quarters (77 per cent) of pilot respondents reported that they had not missed any of their appointments.

The HCP model was delivered by a single provider who recruited healthcare professionals (primarily occupational therapists) to deliver the pilot. A key challenge for this pilot was securing and maintaining adequate levels of appropriately trained and experienced staff to deliver the support. Managers reported that the full complement of staff was not in place until 6-7 months into pilot delivery. This was managed by the provider using healthcare professionals already in the organisation (who were supporting Work Programme delivery) to undertake pilot delivery in the early months and so did not unduly affect pilot delivery.

HCP pilot staff reported receiving a comprehensive programme of training for the pilot and a good level of support in pilot delivery, through processes such as case conferencing, peer observation and group supervision.

The content of support delivered on the pilot was not specified in guidance and staff reported that they had the flexibility to offer support that met individuals' needs and priorities. Pilot staff used a tool developed for the pilot, which enabled an open-ended discussion about the participant's health conditions, treatment history, support networks and employment history. Health professionals also relied on their clinical experience in making client assessments. Action plans were used to set goals and monitor progress.

6.2 Work Programme (WP) model

The WP model led to 1.6 additional days off benefit on average over the first year rising to 8.7 additional days after 2 years and 14.6 after 3 years. The WP model shows an unambiguous impact from roughly twelve months, sustained to the two year point after which the impact lessens for the final year with the difference after three years not being statistically significant. This reduction in impact may be due to support for claimants on the Work Programme ceasing after two years.

The pilot led to a consistent 1 percentage point higher chance of being in employment roughly over the same period between 1 and 2 years after starting on the pilot, however it was not statistically significant.

Analysis of outcomes measured in the survey suggests that the WP pilot did not have an impact either on employment and job search activity or on soft outcomes (e.g. motivation to leave ESA and to find work or readiness to work). The vast majority of participants on the WP pilot (82 per cent) reported that they were currently unable to work as a result of their health condition or disability. Around a third (31 per cent) felt that the pilot had helped them overcome some of their barriers to work, while a smaller number (25 per cent) felt that the pilot had helped them with their health condition and just 18 per cent felt that the pilot had helped them move closer to work.

The WP pilot operated under a 'black box' model, which meant that pilot delivery was not prescribed. However, interviews across different WP providers suggested that pilot delivery largely mirrored the support provided to all ESA customers on the Work Programme.

Pilot support was delivered through a combination of face-to-face and telephone meetings, although face-to-face meetings were preferred by staff, as they believed these built better rapport and encouraged programme engagement. Around half of participants (48 per cent) had only face-to-face appointments, while another two fifths (40 per cent) had a mix of face-to-face and telephone appointments. Just 11 per cent had telephone meetings only with no face-to-face contact.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Around three fifths of participants (62 per cent) said they had never missed an appointment.

The extent to which delivery staff received pilot-specific training varied across the provider organisations. One prime provider sourced specialist training for staff delivering the pilot, but other providers generally did not. Support from specialists, such as occupational health staff, was also variable across the providers, but where this was available it was regarded by staff as helpful.

WP providers were not contract managed against any specific job outcome targets for this pilot group but were instead incentivised by the standard WP payment model. While providers reported that this model did not affect delivery of support on the pilot, they expressed concern that the Payment by Results (PbR) funding model, based on payments for job outcomes, was not sustainable for supporting this participant group in the longer term, because of the limited job outcomes that could be achieved within two years. Some also suggested an outcome payment model linked to the achievement of intermediate or soft outcomes, rather than purely job outcomes, might be appropriate.

6.3 Jobcentre Plus (JCP) model

The JCP model led to 3.8 additional days off benefit on average over the first year rising to 11.8 additional days after 2 years and 19.3 after 3 years. The JCP model shows an unambiguous significant impact almost straight away (around the first 100 days) and continues to sustain this difference up to around the 3 year mark. This positive effect is also reflected in the employment outcomes with the treatment group, showing a significant difference of around 1 percentage point from roughly 12 months to 24 months.

Analysis of outcomes measured in the survey suggests that the JCP pilot appeared to have a positive impact on participant motivation to leave ESA and to find work. Just over a third (37 per cent) of pilot participants reported increased motivation to come off ESA as a result of the support received, compared with 28 per cent in the control group (nine point difference), and a similar proportion (38 per cent) said they

were more motivated to find work as a result of support received, compared with 27 per cent in the control group (11 point difference). It should be noted, however, that over half of participants reported that the support received had no effect on their motivation to leave ESA or to find work (58 per cent and 54 per cent, respectively).

The JCP pilot also appeared to have positively influenced participants' feelings about how ready they were for work. Almost two thirds (63 per cent) of the pilot group reported that they felt unable to work due to their health condition at the time of the survey, compared to 71 per cent in the control group, and 16 per cent felt they could return to work 'right now', compared to 11 per cent in the control group.

While a majority of participants reported that they felt unable to work due to their health condition at the time of the survey, around two fifths (42 per cent) felt that the pilot support had helped a lot or a little with overcoming some of their barriers to work, and a similar proportion (39 per cent) said that the pilot had helped them to manage their health condition or disability. Around a third (34 per cent) said that the pilot support had helped them to move towards work.

Attending appointments was mandatory and staff reported low fail-to-attend rates. Just over three fifths of respondents (62 per cent) reported that they had never missed an appointment. Where participants failed to attend, staff reported that this was usually because of their health condition or disability.

JCP staff delivering the pilot had flexibility to offer support that met individual needs and priorities and in a sequence that worked for the individual. Staff used action plans to document participants' goals and planned activities and to monitor progress over time. It was seen as important for goals and activities to be achievable for participants, to prevent disengagement from the pilot.

Participants were also referred or signposted to health-related support, either to their GP or to self-help groups, pain management groups or mental health services. Almost a third of participants (31 per cent) reported that they had received support to help them manage their health condition in relation to work, significantly more than in the control group (23 per cent). Soft skills support, such as confidence building, was received less frequently (by 13 per cent of participants), but still more commonly among the pilot group than the controls.

7 Conclusions

Recruitment to the ESA 18 to 24 month re-referral or 'prognosis' pilots has been subject to some errors, with random allocation error rates varying from 1.4 per cent to 5.8 per cent across the different pilot and treatment groups, however the impact assessment took an Intention-To-Treat approach and not one where the treatment group was restricted to correctly allocated pilot participants. As a result, any impacts measured are likely to have been diluted by the presence of misallocations in the treatment group and control groups.

The net impact upon benefits suggests that the HCP model has led to an average additional 5.3 days off benefit per participant after 3 years, with the WP variant leading to 14.6 additional days off benefits. The JCP model however showed a significant and sustained impact very quickly leading to an on average an additional 19.3 days off benefit per treatment group participant.

The assessment shows that here were minimal employment impacts shown across all three pilots. However, given the P45 data quality issues, it is likely that employment impacts are underestimated as they will not show any self-employment outcomes. However the research suggested that the JCP pilot had an impact on softer outcomes such as feelings about leaving ESA and starting work. The HCP pilot also appeared to have an effect on some of these soft outcomes.

Across all of the pilots, staff reported that the participant group had complex support needs, and that it was inappropriate for some of them to be on the programme due to the severity of their conditions. Staff also suggested that the severity of their conditions and/or their perceived distance from the labour market meant that work and work-related outcomes were difficult to achieve within the two year duration of the pilot.

The participant survey found that only a minority of pilot participants had made job applications and very few had entered paid employment during the lifetime of the pilot. The majority of survey respondents across all three pilots reported that their health condition or disability currently prevented them from working and fewer than one in five on the JCP pilot and one in ten on the WP and HCP pilots felt that their health was such that they could return to work 'right now'. The majority were, however, positive about the pilot support overall, with over 80 per cent reporting a 'good' or 'very good' experience and substantial minorities reported that the support had helped them to overcome barriers or helped with their health condition.

Annexes

Annex A: Tables of pilot participants characteristics

Table A.1 Characteristics of the HCP model participants. Differences which are statistically significant are marked with a double asterisk.

Characteristic	Treatment	Control
Active Participants	**2,654**	**2,324**
Gender		
Male	53.7%	54.7%
Female	46.3%	45.3%
Ethnicity		
White	85.3%	85.7%
Black	1.6%	2.1%
Asian	5.2%	4.7%
Mixed	0.8%	0.9%
Chinese/Other	0.9%	0.6%
Prefer not to say	5.3%	5.5%
Unknown	0.9%	0.6%
Age at Start of Pilot		
16 to 24	9.0%	9.2%
25 to 29	4.9%	5.1%
30 to 39	17.7%	16.6%
40 to 49	28.6%	27.9%
50 to 59	33.5%	33.6%
60 or Over	6.4%	7.5%
Primary Condition		
Certain Infectious and Parasitic Diseases	0.9%	0.9%
Neoplasms	0.6%	0.8%
Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism	0.2%	0.0%
Endocrine, Nutritional and Metabolic Diseases	1.8%	1.3%
Mental and Behavioural Disorders	50.6%	52.2%
Diseases of the Nervous System	6.1%	6.5%
Diseases of the Eye and Adnexa	0.7%	0.6%
Diseases of the Ear and Mastoid Process	0.6%	0.5%
Diseases of the Circulatory System	2.6%	3.1%
Diseases of the Respiratory System	1.8%	1.4%
Diseases of the Digestive System	1.2%	1.6%
Diseases of the Skin and Subcutaneous System	0.8%	0.4%

Diseases of the Musculoskeletal system and Connective Tissue	18.7%	18.1%
Diseases of the Genitourinary System	0.5%	0.4%
Pregnancy, Childbirth and the Puerperium	0.0%	0.1%
Certain Conditions Originating in the Perinatal Period	0.0%	0.0%
Congenital Malformations, Deformations and Chromosomal Abnormalities**	0.2%	0.5%
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified	8.0%	8.1%
Injury, Poisoning and certain other consequences of external causes**	3.9%	2.8%
Factors influencing Health Status and Contact with Health Services	0.8%	0.7%
Skills Needs		
Basic Skills Need	8.5%	8.6%
English as a second language**	1.3%	0.6%
Number of Children		
1 Child	9.6%	9.3%
2 Children	6.4%	6.8%
3 Children	3.1%	2.6%
4 or More Children	2.2%	1.7%
Age of Youngest Child		
0 to 2	3.1%	2.4%
3 or 4	2.0%	1.5%
5 to 10	6.7%	5.9%
11 to 15	5.2%	6.5%
16 or Over	4.9%	4.8%
Unknown	0.9%	0.5%
In Receipt of Partner Allowance	21.0%	20.7%

Source: DWP benefits administrative data: April 2017 and Labour Market System: July 2017

Table A.2 Characteristics of the WP model participants. Differences which are statistically significant are marked with a double asterisk.

Characteristic	Treatment	Control
Active Participants	**1,922**	**2,038**
Gender		
Male	51.5%	52.6%
Female	48.5%	47.4%
	0.0%	0.0%
Ethnicity		
White	94.8%	94.3%
Black	0.1%	0.1%
Asian	0.7%	1.0%
Mixed	0.4%	0.3%
Chinese/Other	0.3%	0.4%
Prefer not to say	3.3%	3.4%
Unknown	0.4%	0.4%
Age at Start of Pilot		
16 to 24	7.0%	6.9%
25 to 29	4.6%	4.6%
30 to 39	15.0%	16.4%
40 to 49	28.5%	29.6%
50 to 59	37.7%	36.9%
60 or Over**	7.1%	5.6%
Primary Condition		
Certain Infectious and Parasitic Diseases	0.5%	0.4%
Neoplasms	0.4%	0.8%
Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism	0.1%	0.1%
Endocrine, Nutritional and Metabolic Diseases	1.0%	1.1%
Mental and Behavioural Disorders	51.4%	49.7%
Diseases of the Nervous System**	5.7%	7.6%
Diseases of the Eye and Adnexa	0.9%	0.6%
Diseases of the Ear and Mastoid Process	0.4%	0.6%
Diseases of the Circulatory System	2.8%	2.7%
Diseases of the Respiratory System	1.8%	1.8%
Diseases of the Digestive System**	1.7%	0.9%
Diseases of the Skin and Subcutaneous System	0.5%	0.6%
Diseases of the Musculoskeletal system and Connective Tissue	17.8%	16.1%
Diseases of the Genitourinary System	0.5%	0.7%

Pregnancy, Childbirth and the Puerperium	0.1%	0.0%
Certain Conditions Originating in the Perinatal Period	0.0%	0.0%
Congenital Malformations, Deformations and Chromosomal Abnormalities	0.3%	0.2%
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified	9.6%	10.6%
Injury, Poisoning and certain other consequences of external causes	3.9%	3.9%
Factors influencing Health Status and Contact with Health Services	0.9%	1.4%
Skills Needs		
Basic Skills Need	7.5%	8.8%
English as a second language	0.1%	0.1%
Number of Children		
1 Child**	8.0%	10.4%
2 Children**	5.0%	6.7%
3 Children	2.3%	2.8%
4 or More Children	1.9%	1.9%
Age of Youngest Child		
0 to 2	1.9%	2.5%
3 or 4	1.1%	1.5%
5 to 10	5.9%	7.0%
11 to 15**	4.1%	6.0%
16 or Over	4.7%	5.9%
Unknown	0.8%	0.7%
In Receipt of Partner Allowance	19.9%	20.6%

Source: DWP benefits administrative data: April 2017 and Labour Market System: July 2017

Table A.3 Characteristics of the JCP model participants. Differences which are statistically significant are marked with a double asterisk.

Characteristic	Treatment	Control
Active Participants	**2,554**	**2,657**
Gender		
Male	53.5%	53.2%
Female	46.5%	46.8%
Ethnicity		
White	85.6%	87.4%
Black	1.3%	1.8%
Asian	2.0%	2.5%
Mixed	0.8%	0.9%
Chinese/Other	1.1%	0.8%
Prefer not to say**	9.2%	6.1%
Unknown**	0.1%	0.5%
Age at Start of Pilot		
16 to 24	8.6%	7.6%
25 to 29	4.4%	4.2%
30 to 39	17.3%	16.4%
40 to 49	28.6%	30.3%
50 to 59	34.6%	34.0%
60 or Over	6.5%	7.6%
Primary Condition		
Certain Infectious and Parasitic Diseases	1.1%	1.2%
Neoplasms	0.6%	0.4%
Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism	0.1%	0.2%
Endocrine, Nutritional and Metabolic Diseases	2.0%	1.5%
Mental and Behavioural Disorders	51.0%	49.3%
Diseases of the Nervous System	6.0%	6.8%
Diseases of the Eye and Adnexa**	1.7%	0.9%
Diseases of the Ear and Mastoid Process	0.4%	0.5%
Diseases of the Circulatory System	3.0%	3.2%
Diseases of the Respiratory System	2.0%	1.5%
Diseases of the Digestive System	1.5%	1.6%
Diseases of the Skin and Subcutaneous System	0.4%	0.5%
Diseases of the Musculoskeletal system and Connective Tissue	17.0%	17.8%
Diseases of the Genitourinary System	0.6%	0.7%

Pregnancy, Childbirth and the Puerperium	0.0%	0.0%
Certain Conditions Originating in the Perinatal Period	0.0%	0.0%
Congenital Malformations, Deformations and Chromosomal Abnormalities	0.0%	0.2%
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified	8.8%	8.4%
Injury, Poisoning and certain other consequences of external causes**	3.2%	4.4%
Factors influencing Health Status and Contact with Health Services	0.6%	0.8%
Skills Needs		
Basic Skills Need	6.3%	6.3%
English as a second language	0.5%	0.6%
Number of Children		
1 Child	9.3%	10.6%
2 Children	5.3%	5.7%
3 Children**	3.0%	1.7%
4 or More Children	1.5%	1.3%
Age of Youngest Child		
0 to 2	1.8%	2.2%
3 or 4	1.4%	1.2%
5 to 10	6.8%	5.7%
11 to 15	4.7%	4.9%
16 or Over	5.2%	5.6%
Unknown	0.5%	0.8%
In Receipt of Partner Allowance	16.9%	16.7%

Source: DWP benefits administrative data: April 2017 and Labour Market System: July 2017