



**THE WORK
FOUNDATION**
PART OF LANCASTER UNIVERSITY

Is welfare to work, working well?

- **Improving employment rates for people with disabilities and long-term conditions**

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About us

Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends; The Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

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About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at The Work Foundation, it draws on The Work Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence-based voice capable of articulating the views of all stakeholders.

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Introduction

People with long-term health conditions and disabilities experience disproportionately lower employment rates relative to their peers without such conditions. Data from 2015 shows a significant gap in the employment rates of disabled and non-disabled people – while the non-disabled population was 80.3%, for those with disabilities¹ it was 46.7% (Work and Pensions Select Committee, 2016).

This is a continuation of a long term pattern - examining LFS statistics since 2008, the Trades Union Congress (TUC) reported that the employment rate for people who are considered disabled under the Equality Act has been consistently lower than for those without, by an average of 31.1 percentage points. Rates of unemployment² have also been consistently higher - by an average of 4.1 percentage points over the same period (TUC, 2015). 'Long-term conditions', which we discuss in this paper, covers a wider range of conditions than the LFS definition of 'disability' (see box A). The employment rate for those with long-term conditions and disabilities is also substantially lower – at 59.6% at the end of 2014 (DWP 2015a).

Box A: Definitions

In this paper we primarily discuss the return-to-work support that is available from people with **long-term health conditions (LTC)**. LTCs are those that:

- Persist for a long period of time (the World Health Organisation suggests three months)
- Have an impact on a person's life and/or that of their family and other carers
- May require on-going treatment or management
- We use this term inclusive of the term disabled, which is a legally defined term in the Equality Act.

'Active' labour market policies and programmes that aim to support people back into work are a central feature of Britain's welfare system. Recent years have seen a significant extension of these programmes to people with long-term health conditions. Alongside this, there has been a proliferation of resources, guidance and legislation that intends to encourage and support employers to employ people with long-term health conditions. This both draws on and, hopefully, helps to further an increasing recognition amongst policy-makers, politicians and other key stakeholders that many people with long-term health conditions want to work, and with the right support can contribute significantly to employment and the economy (Barnes, 2000). Given that over a third of the working-age population (34 per cent) (Steadman, Sheldon and Donnalaja, forthcoming) report having at least one long-term health condition, developing interventions and providing support to improve the employment prospects of people with such conditions, is a vital task.

Mainstream return-to-work provision in the UK has not performed as well for participants who have long-term health conditions as for those who do not. The current flagship Work Programme, introduced by the Conservative- Liberal Democrat Coalition in 2011, is a case in point. Though employment outcomes have improved significantly since its introduction, the actual proportion of people with long-term health conditions moving into work and staying in for a defined period of time (three or six months) has remained low. Indeed, the Work Programme has fallen short of expectations around employment outcomes

(1) Equality Act disabled

(2) Unemployment measures people without a job who have been actively seeking work within the last 4 weeks and are available to start work within the next 2 weeks. Unemployment rate is the proportion of the economically active population (those in work plus those seeking and available to work) who are unemployed.

achieved for those claiming ESA - just 1 in 7 participants who are new claimants of Employment and Support Allowance (ESA) (see Box B) achieve a job outcome via the Work Programme, compared in 1 in 4 who are claiming Jobseeker's Allowance (JSA). For those individuals who have been migrated onto ESA from Incapacity Benefit, outcomes are worse: only 1 in 20 obtained a job (DWP, 2016a).

Box B: Benefits

Jobseeker's Allowance (JSA) is for people aged 18-64 who are expected to be looking for work.

Employment and Support Allowance (ESA) is for people aged 18-64 who are expected to experience some difficulty in finding work due to a health condition. ESA replaced **Incapacity Benefit** from 2011. It is split into two groups:

- **Work-Related Activity Group (WRAG):** for people who are expected to be able to move into work within 12 months
- **Support Group:** For people whose conditions are expected to prevent them from moving into work within 12 months

Universal Credit, when fully rolled out, will replace JSA, ESA and a number of other benefits, combining them into one single payment with additional 'elements' paid, for example for disability or unemployment.

Moreover, many people with long-term health conditions are receiving JSA rather than ESA. Analysis by Inclusion (2015) estimated that 58 per cent of people with long-term health conditions in the Work Programme are claiming JSA. These individuals are often left out of the conversation around improving return-to-work support for people with long-term health conditions, which is primarily focused on those claiming ESA. Indeed, previous research has suggested that people with long-term health conditions claiming JSA may be particularly at risk of receiving inadequate support (Rees, Whitworth and Carter, 2014).

The reasons that someone with a long-term health condition might not be in work are often wide ranging and complex. In previous Health at Work Policy Unit (HWPU) papers we have looked at various challenges – identifying key themes and exploring through their lens how we might improve support both in work and out of work to enable more people with long-term health conditions to enter, remain and progress in work. In this paper, we focus specifically on the support that is available to those individuals with long-term health conditions who are not currently in work, to help them enter employment. Our focus is on how we might optimise current welfare-to-work policy and practice to the end of achieving better employment outcome for individuals with long-term health conditions.

This is particularly pertinent in relation to forthcoming changes to policy in this area - including the re-commissioning of the Work Programme and Work Choice, due to take place in 2017; the creation of the Department for Work and Pensions and Department of Health's Work and Health Joint Unit, whose remit includes return-to-work support; the planned devolution of welfare, both regionally and nationally to Scotland, the Government's 'Disability Confident Campaign' and the Work and Health green paper, to be published later this year. Measures aimed at supporting people with long-term health conditions who are unemployed or economically inactive into work are central to Conservative manifesto pledges to halve the disability employment gap and produce full employment (Conservative Party, 2015).

The paper begins by exploring the current position in the labour market of people with long-term health conditions, as well as examining the case for improving the support that they are offered via return-to-work programmes and systems, and what we know about 'what works' in this respect. In the third chapter, we move on to discuss current national and local initiatives - government funded and otherwise. The fourth chapter identifies challenges within the current system and suggests ways of overcoming these based on the findings of an evidence review, and our conversations with a number of experts. Finally, the report concludes with a series of recommendations for improving the government's provision of back to work support for people with long-term health conditions.

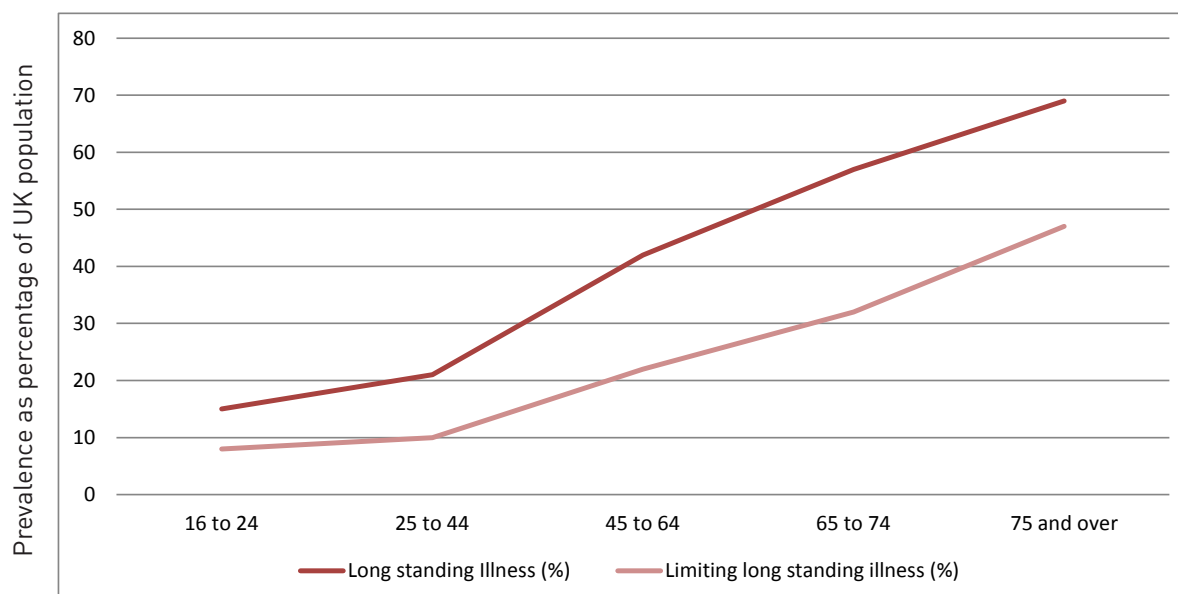
2. Background: health, employment and back-to-work support

People with long-term health conditions experience significant disadvantage in the UK labour market. In this chapter we provide an overview of situation, identifying indicators of disadvantage and highlighting some of the barriers that can stand between people with long-term health conditions and employment. We then discuss why return-to-work support matters for people with long-term health conditions, in both social and economic terms: what are the benefits associated with supporting and enabling people with long-term health conditions to work and what, conversely, are the risks of not providing adequate and appropriate support? Finally, we outline what we know about 'what works' which will provide a basis for comparison with current UK return-to-work support in the subsequent chapters.

The employment position of people with long-term conditions

A survey of UK employees suggested that almost **one in three** (32 per cent) had experienced a long-term health condition during the previous year (Steadman, Wood and Silvester, 2015). The prevalence of a long-term health condition increases with age – analysis of the Health Survey for England data found that while 15 per cent of those aged 16-24 report having such a condition, with 8 per cent reported that it limits their activities or ability to work; for 65 – 74 year olds, the comparable figures are 57 and 32 per cent respectively (Steadman, Sheldon and Donnalaja, forthcoming).

Figure 1: Prevalence of long-term conditions and limiting conditions by age group (UK)



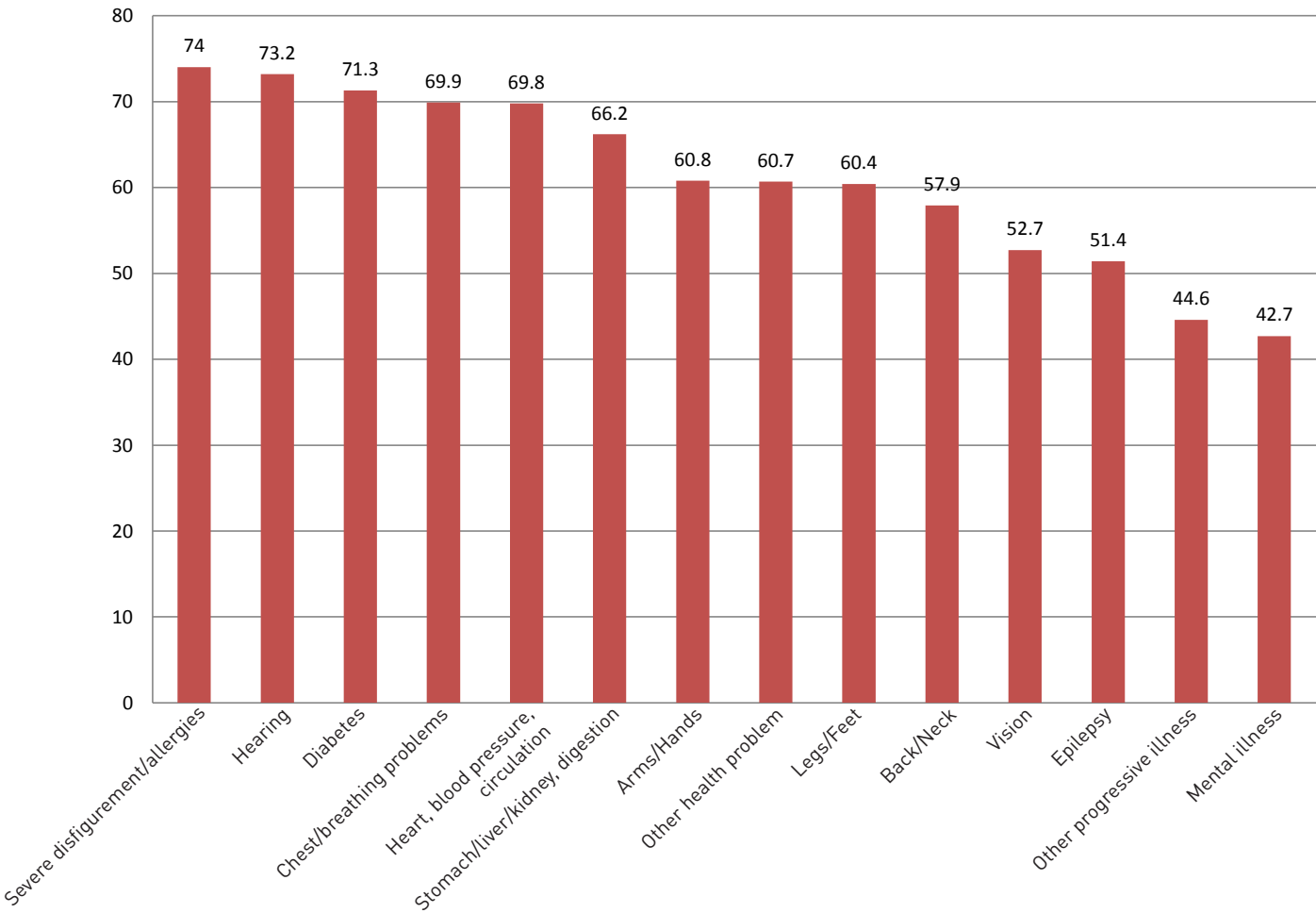
Source: Steadman, Sheldon and Donnalaja, forthcoming

This variation is important because the average age of the workforce is expected to increase due to population demographic change and the planned raising of the state pension age. It is estimated that by 2030, some 40 per cent of working age people will have at least one long-term health condition (Vaughan-Jones and Barham, 2009). Moreover, older workers are more likely to have multiple conditions (co-morbidities) - a study of Australian primary care discovered that while 20.6 per cent of under 25s had more than one health condition, this rose to 75.5 per cent of 45 to 64 year olds and 87.5 per cent of 65 to 74 year olds (Brett, Arnold-Reid et al., 2013). While many people with long-term health conditions find and remain in work, many others experience considerable difficulty, and for those with more than one condition the challenges may be greater.

At the end of 2014, the UK Labour Force Survey (LFS) data indicated that 46.1 per cent of people with disabilities (according to the Equality Act definition) and 59.6 per cent of people with long-term conditions were employed. This compares to 73.5 per cent of the working-age population as a whole (DWP, 2015a). Further analyses of LFS data showed significant differences between different demographic groups of people with disabilities, for example, men fare worse than women - the gap was 29.3 percentage points for men and 23.5 percentage points for women³ (Labour Force Survey, 2015).

There is also considerable variation in employment outcomes for people with different conditions (Figure 2). For example, while the employment rate for people with hearing difficulties (73.2 per cent) is close to the usual employment rate, for those who list mental illness as their main condition we see a very different picture - with only around four in ten (42.7 per cent) employed in the same period (DWP, 2015a).

Figure 2 Employment rate by condition, Q4 2014



Source: DWP, 2015a

[3] Full data tables can be accessed here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/444500/Chapter_5.csv/preview

The figures relating to **mental health conditions** are particularly concerning because these affect a relatively large proportion of the workforce. The Adult Psychiatric Morbidity Survey (McManus et al., 2007) suggested that around one in six working age people in England (15.1 per cent) are at any one time experiencing a common mental health problem such as anxiety or depression, while the Health and Wellbeing at Work Employee Survey (Steadman, Wood and Silvester, 2015), suggested that around one in eight (12 per cent) current employees had experienced a mental health condition within the preceding twelve months. Evidence suggests that the picture may be even worse for those who have a severe mental health condition, with the various studies indicating that employment rates are staggeringly low - for example, people with schizophrenia in the UK have an estimated employment rate of just 8 per cent (Schizophrenia Commission, 2012).

People with **physical health conditions** also experience lower employment rates than those without (see Figure 2). Musculoskeletal (MSK) conditions are particularly common among the working age population, with around 1 in 10 employees reporting such a condition in the past twelve months (Steadman, Wood and Silvester, 2015), and expectation that the proportion of working age people with MSK conditions will grow in the next few years (Vaughan-Jones & Barham, 2009). According to LFS data the employment rate is 59.7% (DWP, 2015a). Though the LFS data suggests that employment rates may be slightly better for those with a physical condition as their main health problem than for those with a mental health problem, we must bear in mind the substantial proportion of working age people who have more than one condition. Data from the Health Survey for England suggests that almost 1 in 7 (14 per cent) of working age (16-64) people have two or more long-term health conditions, and that the employment rate decreases with the number of health conditions experienced (Steadman, Sheldon and Donnalaja, forthcoming). Further, research has indicated that where there is a combination of mental and physical health conditions, the barriers to employment are even greater (Steadman, Wood and Silvester, 2015; Steadman, Sheldon and Donnalaja, forthcoming).

Despite these disappointing figures, many people with long-term health conditions – including those that are seen as presenting major barriers - want to work. For example, Waddell and Burton (2006) suggested that although as low as 10-20 per cent of people with severe mental illness are employed, the proportion who want to work may be as high as 50 per cent. Many people with such conditions identify a return to work as important for financial and social reasons, as well as seeing it as an indicator and goal of their recovery (Bevan, Gulliford et al., 2013; Adams and Oldfield, 2011). We return to this topic in the following section.

In reality, despite aspirations, there are numerous barriers to work for many people with complex health conditions - due to the nature of the conditions, as well as attitudes towards it (Bevan, Gulliford et al., 2013). People with long-term health conditions who were not in work (including those who had experienced a period of unemployment previously) have expressed fears and cited experiences of falling into a downward spiral, losing a hold on the labour market, and thus experiencing greater barriers to re-entry (Adams and Oldfield, 2011). This concurs with evidence that suggests that longer durations of unemployment create barriers to work in themselves, affecting the unemployed individual's skills and morale, and employer perceptions of their capacity to work (Layard, Nickell and Jackman, 2005; Seymour and Grove, 2005; Merz, Bricout and Koch, 2001). These risks are likely to be magnified for people with long-term health conditions, who may already perceive limitations on the types and levels of work that are available to them (Bevan, Zheltoukhova et al., 2013), and who may face additional barriers to employment. These include negative attitudes of employers (Brohan and Thornicroft, 2011) and employer concerns about the additional costs and risks of hiring a person with a health condition (Kaye, Jans and Jones, 2011).

Why is work important for people with long-term conditions? Health, social and economic benefits

Many people with long-term health conditions want to work, yet their position in the labour market does not fully reflect this. This, in itself, is a compelling case for improving the quality of employment support that is available. Employment potentially also has wider benefits. In Waddell and Burton's (2006) review, they identify the financial, social, psychosocial and broader health benefits of employment. The benefits of employment for health and wellbeing are particularly pertinent to this discussion, and have been discussed in much subsequent research (e.g. Parker and Bevan, 2011).

This builds on the recognition that being unemployed is associated with poorer health. Large meta-analyses have suggested that unemployed individuals have lower psychological and physical wellbeing than their employed counterparts (Mathers and Schofield, 1998; McKee-Ryan et al., 2005; Paul and Moser, 2009). Further analysis has suggested there is not only evidence that unemployment is correlated with mental distress, but also that it can cause it (Paul and Moser, 2009), or can aggravate health conditions (Waddell and Burton, 2006).

Further, evidence indicates that while wellbeing declines as individuals move from employment into unemployment, it improves as individuals move from unemployment into reemployment (McKee-Ryan et al., 2005). In this context however, it is further suggested that the positive effects of becoming reemployed may be limited to those who regain *satisfactory* new jobs (McKee-Ryan et al., 2005).

A growing body of evidence indicates that the benefits of work are only fully realised where job quality is taken into account. Arguing that work is generally good for health presupposes that the work on offer is 'good work', defined by the presence of certain key characteristics (see Figure 3). The absence of these characteristics, and the presence of features such as insufficient pay, job insecurity, and hazards associated with the nature of work itself, is associated with a negative impact on health (Waddell and Burton, 2006; Parker and Bevan, 2011). Butterworth et al. (2013) suggest that poor quality work can be worse than having no job at all for people with common mental health conditions - thus illuminating a risk when job seeking.

Figure 3: what do we mean by 'good work'?



Moving into work from unemployment or inactivity therefore entails risks and benefits to the individual. The balance of these risks and benefits may be somewhat different for many people with long-term health conditions than for those without, and will vary according to contextual factors including the individual, the job, the employer, and their condition. For people with health conditions it is perhaps even more important that there is a good fit between the individual, the job, and the support provided by the employer, to improve the likelihood for retention and progression.

A summary of the wider positive effects of 'good work' is shown in Box C, below.

Box C: Possible benefits of 'good work'

'Good work'...

- is therapeutic;
- helps to promote recovery and rehabilitation;
- leads to better health outcomes;
- minimises the deleterious physical, mental and social effects of long-term sickness absence and worklessness;
- reduces the chances of chronic disability, long-term incapacity for work and social exclusion;
- promotes full participation in society, independence and human rights;
- reduces poverty;
- improves quality of life and wellbeing.

Source: Waddell and Burton, 2006

Moving from social security benefits into work is, in Waddell and Burton's words, a 'special context' of the relationship between unemployment and employment. Individuals who are claiming benefits may be able to access support in moving to employment, and may also have to fulfil certain conditions to remain eligible for benefits. These factors potentially impact on the nature of the relationship between health and work, both positively and negatively. Looking at health and work within this context, the picture becomes more complex. It has been suggested for example that given that the benefits of work are often seen as financial and psychosocial, any positive impacts of returning to work are more likely associated with moving *into work* – not simply moving off benefits (Waddell and Burton, 2006).

Further we must consider whether the association between entering or re-entering employment and improved health and quality of life (Mowlam and Lewis, 2005; Schuring et al., 2010), might be seen as the 'health selection effect' (i.e. those who are more healthy are more likely to move into work), but it may also reflect cause and effect. Also of importance to this social security context, is the evidence that people whose benefits are disallowed (for example due to sanctioning or a failure to meet eligibility criteria) *'often report a deterioration in mental health, quality of life and wellbeing'* (Waddell and Burton, 2006). If there is a health selection effect at play in determining which claimants move into work and which do not, we might infer that this would be deleterious to work prospects.

Further to the many potential benefits of working for an individual, and for their health, there are also broader economic and societal benefits of supporting people with health conditions to participate in the labour market. As suggested by Dame Carol Black's 2008 report on working age health, the total costs to the economy of long-term conditions – including welfare costs, health costs and foregone taxes - have been estimated at over £60 billion annually (Black, 2008).

The view that there are savings to the welfare budget by boosting employment rates for people with long-term health conditions is an issue that has received growing attention in recent years. In 2013/14 existing Employment and Support Allowance (ESA) claims totalled £416 million (DWP, 2015b), while new claims made during 2013/14 added an additional £209 million (DWP, 2015c). The most recent statistics (to December 2015) indicate that there are 2.51 million ESA recipients in the UK (DWP, 2016a), 53 per cent of whom were men. The biggest single age cohort are the 35-44 year olds, who made up 19 per cent of all ESA recipients, and the smallest is the under 24s who made up just under 7 per cent. Total numbers of people receiving ESA or its predecessors (including Incapacity Benefit (IB) and contribution only benefit Severe Disablement Allowance) have remained relatively stable since 2000, hovering around the 2.5 million mark, with some increase seen in the numbers of claimants aged over 35 (DWP, 2016a).

Not all benefits claimants who have long-term health conditions will be eligible for ESA . 30 per cent of new ESA applicants from April to June 2015 were designated as 'fit for work' and therefore ineligible for the benefit (DWP, 2016b). Data on how many subsequently claim JSA is not readily available, but research by Inclusion (2015) indicated that the majority (58 per cent) of all people with disabilities on the Work Programme are actually claiming JSA. Looking at spending on ESA alone therefore under-estimates the amount paid in employment-related benefits to people whose health is a barrier to work. This also does not include the cost of additional benefits that may be paid, such as housing benefit or tax credits.

What works for supporting people with long-term conditions into work?

As illustrated above, there is currently a significant gap between people with and without health conditions when it comes to employment. This gap is mirrored in the performance of much of the return-to-work support that is available to them, which we discuss in detail in the following chapter. However, having established the extent of the gap and the general desirability of moving people from unemployment or inactivity into employment, we first offer a brief overview of a range of approaches to this challenge that have been shown to work in either the UK or other contexts.

Localised services, such as those run by Local Authorities in the UK working with local community and health partners, have often shown promise in improving employment outcomes (Turok & Webster, 1998; Finn, 2000). They are able to **draw on local knowledge and resources, to build support relevant to local needs**. Research on such services have highlighted their 'impressive job entry and progression rates' and their popularity with providers (Turok & Webster, 1998: 324; Finn, 2000). A European 'best practice' review also concluded that 'local actions' often led to better employment outcomes because local co-ordination of return-to-work support enabled programmes to be devised that better reflected the specific problems faced by the unemployed in the particular area (ERGO, 1992). Not only is local knowledge important in designing schemes that fit local needs: it also allows for improved control over funding streams, better inter-linkage and coordination between services, and ability to mobilise new actors to become part of the employment-focused networks that local co-ordinating actors construct (Finn, 2000).

Creating and sustaining multi-agency working partnerships is an important part of devolving responsibility for employment to the local level, allowing for **integrated and holistic ways of working** (Finn, 2000; Campbell, Foy and Hutchinson, 1998). Integrated schemes are especially important when working with people who have long-term health conditions as well as other barriers to employment - as this approach allows for greater co-ordination between the multiple different services that people may find themselves using. The value of integrated approaches was emphasised by expert contributors, who highlighted the value of being able to refer service users immediately to appropriate support relating to additional needs, and being able to share information and knowledge with those services. **Co-ordinated design and delivery of health and employment support** can be an effective means of producing employment outcomes: often more so than delivering such interventions separately (Office for Public Management, 2011). London's 'Working for Wellness' programme (see case study A) provides a good example of this approach.

Much of the activity related to devolving and integrating services at a local level in the UK is still at an early stage; consequently there is little strong evidence available on implementation and delivery. However, there is good evidence being built in other countries (for example Germany and the Netherlands), where

reforms to promote integrated services have been 'associated with reductions in benefit caseloads, public expenditure reductions and increased employment' (Finn, 2015). This is encouraging, though we note there is little specific evidence on the effects in these countries of such reforms on people with long-term health conditions.

Case study A: 'Working for Wellness'

'Working for Wellness' led the development of integrated psychological therapy (IAPT) and employment support pathways. In recognition of poor employment outcomes for those who have spent significant periods of time out of the labour market due to mental health problems, 'Working for Wellness' provided individually tailored, practical and motivational support and advice to people affected by mild to moderate mental health issues, with the aim of either getting them into employment or retaining their current employment.

Working for Wellness operated across 5 IAPT Sites in London (City & Hackney, Camden, Ealing, Southwark, Haringey). In Southwark, the employment support service is co-located with the IAPT service with the staff having the same employer (South London and Maudsley NHS Foundation Trust). Every individual entering the employment service is assessed for their employment needs, and a plan of action developed jointly by the individual and their advisor. These solutions are varied, but include measures such as 'post placement in work support', 'access to expert advice regarding benefits and debt counselling', and 'access to occupational health support'.

In 2010, across the 5 boroughs, 865 people entered the 'Working for Wellness' scheme. Of these, 260 were supported to retain employment, 95 were supported to move into work, and 41 previously unemployed were supported into education and training. Evaluation suggests that after 12 months, for every £1 spent by the state on the IAPT employment services, £2.87 of benefits is generated for both the individuals and the state.

The programme started in April 2008, and was sponsored by NHS London and delivered by the London Development Centre for people with common mental health problems. It operated as a pan-London partnership with Primary Care Trusts, Local Authorities, Job Centre Plus, Independent Sector (Third Sector/Private) and employers

Sources: Office for Public Management, 2011; Southwark Council; London Development Centre,

Targeted schemes, i.e. schemes wherein the components of employment support might vary for different cohorts depending on their needs (be they health or otherwise) can lead to improved results when used to help people with long-term health conditions back to work (Foster, Henman et al., 2012). For example, a Norwegian study on the use of financial incentives and employment outcomes for people receiving disability related welfare support (an ESA equivalent) found significant heterogeneity in the responsiveness of individuals to financial incentives, leading them to conclude that greater targeting of policies may be the more effective for helping those on disability benefits back into paid employment (Kostøl & Mogstad, 2012).

There is also evidence to suggest that **personalised support** can be very helpful in supporting return to work. A systematic review of 42 papers assessing various welfare-to-work schemes in the UK from 2002-2008 found that the use and quality (i.e. competent and well-informed) of **personal advisors and individual case managers** made a significant difference to the likelihood of securing an employment outcome (Clayton, et al., 2011). This review also emphasised the value of having a range of services in one place (i.e. a one-stop-shop approach) (Clayton, et al., 2011).

A model of employment support which includes a number of these features is **Individual Placement and**

Support (IPS).⁴ This voluntary support is primarily used with people experiencing severe mental illness (for which there is a strong and growing evidence base), but increasingly with those with common mental health problems (Rinaldi et al., 2007; Steadman and Thomas, 2015) (see case study B). In contrast to traditional vocational rehabilitation and welfare-to-work approaches, which emphasise skills training and support as a precursor to obtaining employment, IPS focuses on getting individuals into competitive employment first and providing them with ongoing training and support while they are working. The IPS approach requires the integration of health and employment support (preferably with health and employment providers co-located) and there is emphasis on providing a personalised approach which reflects the needs and ambitions of the individual participating in the scheme (Bond, Drake and Becker, 2008).

Case Study B- Psychological Wellbeing at Work Pilots

The DWP and the Department of Health (DH) commissioned a report into psychological wellbeing at work to investigate how people with common mental health difficulties can be helped to gain or maintain employment, in response to continued poor employment outcomes for this group. The report recommended that four different models of service delivery for improving mental health be piloted, one of which was “Vocational support based on Individual Placement and Support (IPS) model in primary care”.

IPS services were placed within primary care IAPT (Improving Access to Psychological Treatment) services, designed for people with mild to moderate mental health problems. ESA claimants who identified as having mental health difficulties in the four pilot sites were offered access IAPT and IPS employment support as well. These were to be provided concurrently. By placing vocational specialists into local NHS services this programme accessed a cohort that previously may not have had access to specialist employment support, despite employment difficulties.

Within the pilot, this scheme produced good results and garnered considerable positive reactions across participation groups, with 15 service users finding employment and numerous other users achieving employment-related outcomes. These schemes are now being trialled on a larger, longer term basis by the new Work and Health Joint Unit.

Source: Steadman and Thomas, 2015

Peer support is another model, drawing on the health system, which has shown promise in enabling people with long-term health conditions to achieve various employment outcomes (see case study C). Peer support, traditionally used in treatment and recovery programmes, is increasingly being used to achieve employment outcomes –as a standalone service, or as part of a wider support programme (Disability Rights UK et al., 2016; McEnhill, Steadman et al., 2016). The evidence for effectiveness in achieving employment outcomes is at an early stage, with a focus on health outcomes more common. However the trials that do exist indicate the approach has benefits in terms of return to work (MacEachen et al., 2007; Kowlakowsky-Hayner et al., 2012), and job retention (Ochocka et al., 2006; Nelson et al., 2006; Nelson et al., 2007).

[4] <http://www.centreformentalhealth.org.uk/individual-placement-and-support>

Case Study C – Peer Support

There is a burgeoning evidence base looking at the role of peer support in achieving employment outcomes for people with long-term conditions and disabilities.

Peer support is the process of people who have lived experience of a long-term health condition or other impairment supporting others with a similar condition/s. The unique experience that someone with a condition can provide, the encouragement of a 'role model', and the ability to build trusted networks of peers are all suggested benefits of utilising peer support in regards to a health condition. Peer support may be used to support job seeking, as well as job retention, and progression.

There are different models and forms of peer support delivery, utilised in different settings for different purposes, for example – including group work, one to one support, mentoring sessions, online support, and workplace networks. It is provided as standalone service, or as part of a broader initiative.

Building on its use by many specialist and community employment support services, a model of peer support has been integrated into Jobcentre Plus provision on a trial basis, through The Journey to Employment (J2E) pilot programme. Here people living with long-term conditions or disabilities are given access to a Job Club, which offers peer support in job seeking and skills. The scheme is holistic and as such also tackles other barriers to employment, such as confidence. The specialists on the scheme who work alongside the Jobcentre Plus staff provide lived experience, advice on disability issues and deliver a programme of employer engagement.

As of April 2016 31 per cent of participants within one centre [Spectrum in Hampshire] had secured employment; and 50 per cent of participants were either in work, on placements or volunteering. The DWP calculated that a 4 per cent employment outcome rate would mean that the J2E programme cost £10,375 per participant (cheaper than both Work Choice and the Work Programme), meaning that the significantly higher employment outcome rate indicates an even greater value for money.

Sources: Disability Rights UK et al. (2016); McEnhill, Steadman et al. (2016)

While many people with long-term health conditions will find and maintain work without additional support, we know that for many others the transition into work is more challenging. Further there is a growing body of evidence and a lot of good practice showing what effective employment support for people with long-term health conditions looks like. Back to work support provided through the welfare system has a potentially important role in enabling transitions into work for those with long-term health condition. However, despite widespread recognition of the potential value of this, and a continued push towards a greater focus on work in the UK's welfare system, this has not translated into the wider inclusion in the workforce. In the following chapter we review current UK provision of welfare-to-work support, as used by people with long-term health conditions.

3. Current programmes and support services

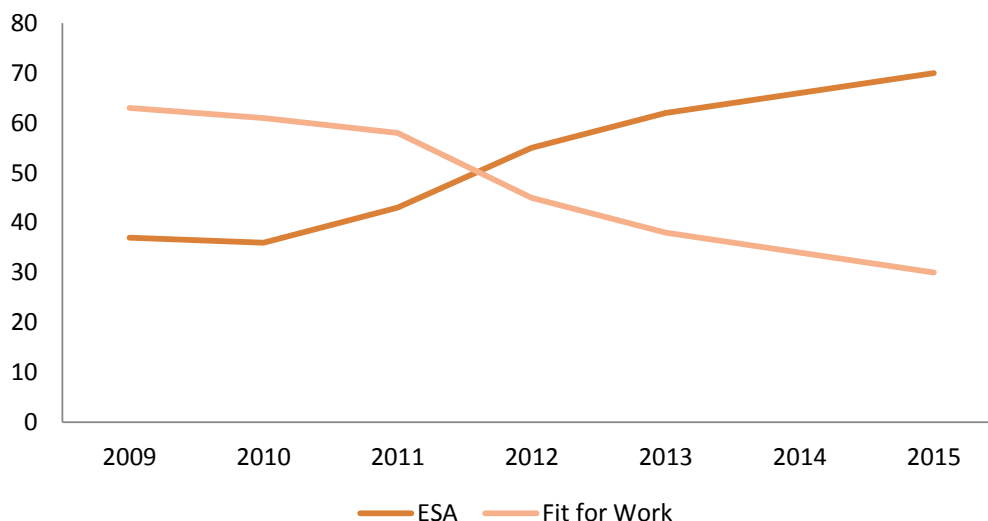
In this chapter we review the national government led services available in the UK that are intended or used to support people with long-term health conditions who are currently unemployed/inactive to return to or enter work – including what they are, and how they are performing. We also look at where devolution and decentralisation has offered opportunities for local flexibility and innovation in welfare-to-work provision, as well as some examples of other local return to work support – both independent and government funded. This forms the foundation of Chapter 4, wherein we discuss the problems and the challenges in current provision, and explore areas for potential change, to end of improving support and employment outcomes for people with long-term health conditions.

National initiatives

Work Capability Assessment

The Work Capability Assessment (WCA) is used to determine eligibility for ESA by examining the applicant's capacity to work. The WCA comprises a first assessment to determine whether the applicant is eligible at all and, if so, a second assessment to determine which of the two ESA groups they will be put into. Eligible applicants are either put into the Work Related Activity Group (WRAG) (if they are expected to be able to work within the next twelve months) or the Support Group (if there is no expectation of work). People who are found ineligible for ESA because their health needs are not assessed as presenting a significant enough barrier to work, are transferred to JSA. As noted above, being on JSA does not mean that the individual does not have a health condition: only that their health condition is not judged to have a sufficiently significant impact on activities for them to qualify for ESA. The WCA is used for both new ESA applicants, and for those who are transferred to it from the former Incapacity Benefit (migration from Incapacity Benefit to ESA began in 2011 and is close to being complete at the time of writing). The group that the individual is placed in has implications for the sorts of return-to-work support that they are offered (or compelled to take), via Jobcentre Plus - including the Work Programme and Work Choice - and the expectations of work related activities.

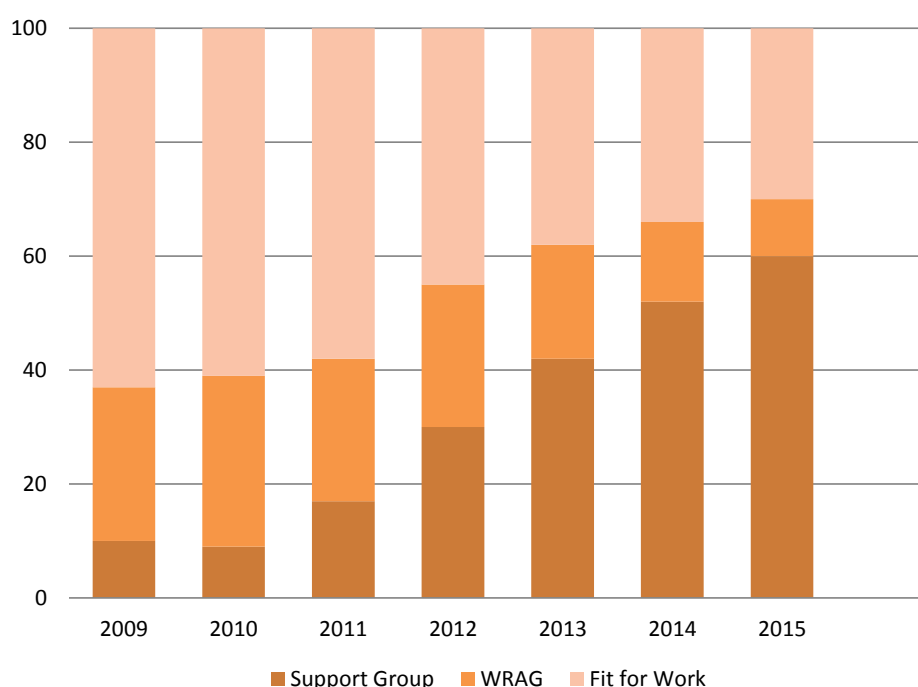
Figure 4: Initial outcomes of Work Capability Assessments, proportion found eligible for ESA, 2009-2015



Source: DWP, 2016b

The latest DWP figures, based on claims from April to June 2015, show that the initial outcomes of WCA assessments for new applicants placed 70 per cent on ESA. 10 per cent were placed in the WRAG group, and 60 per cent were placed in the Support Group. The remaining 30 per cent were assessed as 'fit for work' and therefore not entitled to ESA (DWP, 2016b). Since ESA was introduced there has been a downward trend in applicants assessed as 'fit for work', and an upward trend in those entitled to the benefit (see figure 4). Further there has been an upward trend in numbers of those placed in the Support Group (see figure 5). In contrast with the most recent figures, in 2009, 63 per cent of people undertaking the WCA were found 'fit for work' (i.e. not eligible for ESA), and just 10 per cent were placed in the Support Group (Litchfield, 2014).

Figure 5: Outcomes of initial ESA assessments, fit for work/WRAG/Support group, 2009-2015



Source: DWP, 2016b

There are a number of factors that may explain these trends, including changes in eligibility criteria and changes to the WCA itself as a result of the DWP's own reviews, and others (DWP, 2016b; Litchfield, 2014). These reviews were borne out of major concerns over the decision-making process for ESA, including evidence suggesting that **the WCA often resulted in incorrect decisions, and decisions that were perceived to be incorrect**. Up to March 2015, 36 per cent of all 'fit for work' decisions had been appealed against. Of those appeals relating to claims made from July to September 2014, 46 per cent of decisions were upheld, and 54 per cent were overturned (DWP, 2016b). Partly as a result of this, the last government review concluded that while significant changes had been made to the WCA, there is still **substantial negativity and mistrust** towards it - highlighting that it is crucial that the test for ESA is not only fair in practice, but is perceived as being fair by those who have to undergo it (Litchfield, 2014).

Jobcentre Plus

Jobcentre Plus (JCP) is responsible for administering and delivering out-of-work benefit claims, including for ESA and JSA, and for providing employment services (including advice, job matching and referral to welfare-to-work programmes) to people using its services.

One function of JCP is applying sanctions and conditionality to claimants. Different levels of conditionality are applied to people claiming different benefits. The ESA WRAG group has some conditionality attached: claimants can be mandated to take part in aspects of the Work Programme, and may be sanctioned if they do not fulfil conditions that are set out in their initial meeting with a Jobcentre advisor, such as participating in 'work focused interviews'. The Support Group has no conditionality attached but claimants in it can choose to take part in programmes and support on a voluntary basis. People claiming JSA are subject to full conditionality⁵. Since 2014 both JSA and ESA recipients have had to agree to a 'Claimant Commitment' (which will later form part of Universal Credit) which outlines 'specific and measurable' job seeking activities that they must fulfil weekly (Work and Pensions Select Committee, 2014a).

Non-compliance with the Claimant Commitment results in a sanction, which is open-ended until such time as the individual re-engages with the terms of their Commitment. It is therefore important that claimants' feel able to comply with the terms of their Commitment, and that where they are experiencing health conditions, the Commitment takes account of these and does not impose actions that are unrealistic or likely to exacerbate an existing problem (Mind, 2014). Applying conditionality appropriately requires Jobcentre staff to have an **adequate understanding of how health conditions may affect ability to work or look for work**, or to be able to access good quality information on this. Understanding the conditions imposed on them and the consequences of breaking these is crucial in ensuring that conditionality can be correctly and fairly applied (Oakley, 2014), and as the Litchfield review highlights, 'people are unlikely to trust an organisation if decision making is not clearly justified and honestly explained to them' (Litchfield, 2013).

A second role of JCP is to provide employment advice and support to claimants. Specialist provision in Jobcentre Plus for ESA claimants is available through Disability Employment Advisors (DEAs). However, there are a **very small number of DEAs available to deal with the ESA caseload**: in 2014, there were just 900 across 719 Jobcentres (Work and Pensions Select Committee, 2014a). The number of full-time DEAs has been declining since 2011 (Stone, 2015). DWP states that this is consistent with the introduction of Universal Credit, where support in Jobcentre Plus is provided to all service users by Work Coaches (who provide more generic support). The total ESA caseload is around 1.2 million people, with 546,000 in the WRAG group and therefore likely to be subject to some level of conditionality and job-seeking requirements. The Work and Pensions Select Committee therefore calculated that 'the ratio of DEAs to ESA claimants requiring some level of employment support is over 600 to one', compared to around 140 claimants per (non-specialist) JSA advisor (Work and Pensions Select Committee, 2014a). **This limits the extent to which specialist support is available to people with a health condition on either ESA or JSA**, with the latter group perhaps even more vulnerable to missing out on this.

The Work Programme

Jobcentre advisors and Work Coaches are also responsible for referring their clients to the Work Programme - the flagship welfare-to-work programme set up in 2011 by the Conservative and Liberal Democrat Coalition Government. It replaced a number of welfare-to-work initiatives set up by the previous Labour Government, and has operated as a single, nationwide initiative from the outset. It is open to those claiming JSA, ESA, and the former Incapacity Benefit, with different conditionality applied depending on the benefit being claimed.

[5] Subject to 'all work related requirements' and are required to be available for and actively seeking work

Figure 6: Work Programme participant groups

Benefit	Participant group	Participation in Work Programme
Jobseeker's Allowance	Aged 18-24	Mandatory
	Aged 25+	
	'Seriously disadvantaged', including some who have recently received incapacity benefits	Some mandatory, some voluntary
Employment and Support Allowance	Some of WRAG (i.e. those expected to be fit for work within 3 months)	Mandatory
	All others	Voluntary
Incapacity benefits	All	Voluntary

Source: DWP, 2012

The Work Programme contracts employment support to a variety of public, private and third sector organisations, arranged in a prime and subcontractor structure. **Large private companies dominate at the prime contractor level**, while **small, voluntary sector organisations tend to be represented at the subcontractor level** – in particular, as 'Tier 2' subcontractors whose purpose is to provide support to those participants with specialist needs. 'Tier 1' subcontractors, in contrast, deal with larger numbers of clients and provide more generalist, 'end to end' support throughout the participant's time on the Work Programme (McGuinness and Dar, 2014).

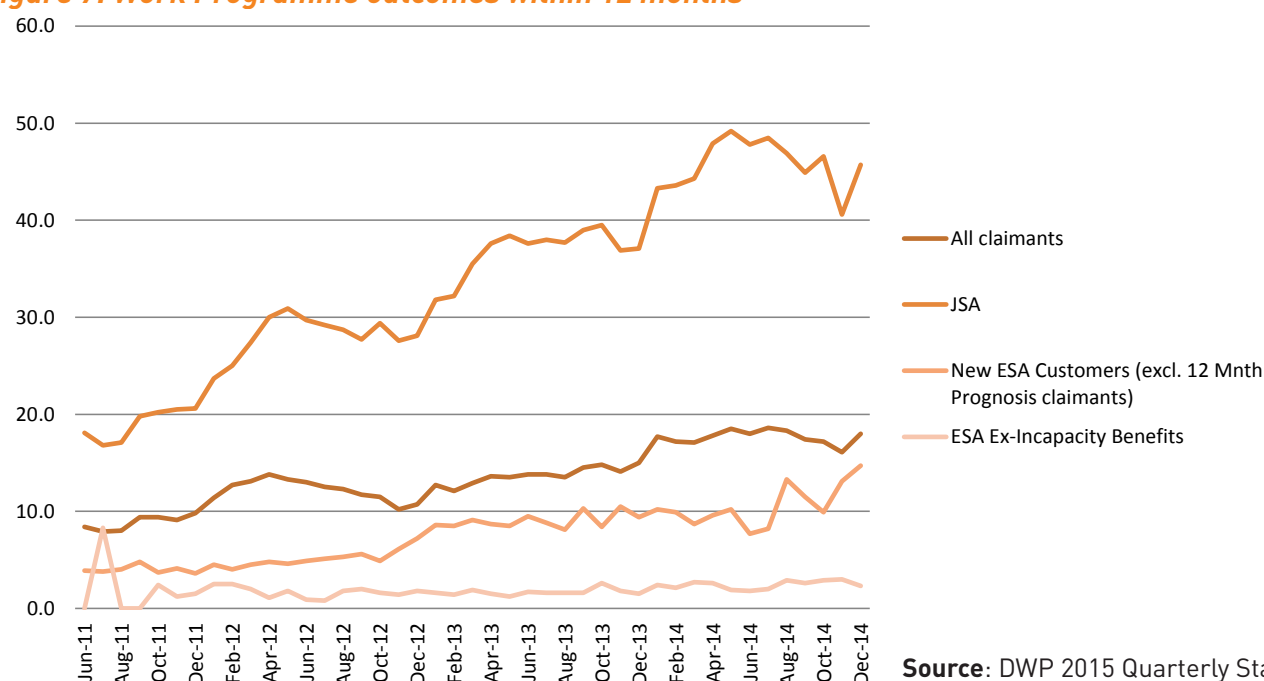
Prime providers are paid using a 'payment by results' structure whereby a small initial 'signing on' payment is followed by more significant payments if and when the participant gains employment, and retains it for a specified amount of time (e.g. 12 months). Primes then pass parts of these payments on to their subcontractors, as and when they engage their services. The Work Programme offers differential payments based on the participant's benefit group and circumstances, which aims to incentivise providers to support harder-to-help participants. The presence or absence of health conditions plays a central role in defining who the 'harder-to-help' are: finding work for an individual who is claiming ESA generally attracts a higher payment than for someone who is claiming JSA, and finding work for someone who has transferred onto ESA or JSA from Incapacity Benefit (i.e. one who has been out of work for longer) attracts a higher payment again (DWP, 2012).

The Work Programme is commissioned using a 'black box' approach. Providers have the freedom and flexibility to arrange their services and supply chains as they see fit. This has the potential to enable providers to set up innovative packages of support to meet their participants' specific needs – including funnelling participants with health needs towards organisations that have greater experience in addressing these. However, at commissioning stage, only five of the eighteen Primes made explicit reference to helping Work Programme participants with long-term health conditions (Ceolta-Smith, Salway, & Tod, 2015). This may indicate a lack of awareness of the kind of support required by those with health conditions, or a lack of prioritisation of these individuals within their strategies.

Nearly 70 per cent of the participants on the Work Programme completed the two year programme without gaining sustained employment. The picture for those with complex or multiple barriers is even worse (Work and Pensions Select Committee, 2015). The DWP initially set performance expectations at 22 per cent for new claimants of ESA, later revising this down in light of substantially lower outcomes (NAO, 2014). In fact just 11 per cent of this group had achieved a job outcome within two years on the

Work Programme (by 2015) (Inclusion, 2015). The DWP has forecast that this will rise to 14 per cent by the end of the Work Programme in 2017 (NAO, 2014), but has now recognised that initial performance expectations were set too high. The 11 per cent of participants that achieve a job outcome through the Work Programme is broadly in line with that of previous, comparable welfare-to-work programmes (which were around 12%) (NAO, 2014), indicating that the Work Programme has not achieved its goals regarding improving disability employment rates.

Figure 7: Work Programme outcomes within 12 months



Source: DWP 2015 Quarterly Statistics

Despite this comparable performance, the fact that nine out of ten new ESA claimants leave the programme without obtaining a sustainable job is concerning, especially since these should be the easier ESA group to help. Indeed, amongst ex-Incapacity Benefit claimants, outcomes are even worse, despite the higher payments attached to their job outcomes: just 4.5 per cent gain employment and meet parameters (Inclusion, 2015). Moreover it is essential to re-state that many claimants with long-term health conditions are not in the ESA group, but receive JSA: as many as 58 per cent of Work Programme participants with long-term conditions claim JSA. This leaves them vulnerable to being ‘parked’ in favour of other participants who may face fewer barriers to work, and be more likely to obtain a job outcome payment (Inclusion, 2015; Rees, Whitworth and Carter, 2014).

Work Choice

Alongside the Work Programme, the DWP also established a smaller, specialist programme in 2010: ‘Work Choice’. Work Choice replaced three previous programmes: Work Preparation, WORKSTEP, and the Job Introduction Scheme (Thompson et al., 2011). Eligibility is determined by having a long-term health condition that impacts on work capacity; **being able to work at least sixteen hours per week** (after receiving skills development support and advice); needing support in work; and, needing support that cannot be met by other government programmes and schemes, including JCP, Access to Work and the Work Programme⁶. Work Choice provides pre-employment advice and support, short to medium-term in-work support for both the employee and their employer to support job retention (for up to two years), and open-ended help and assistance to help the employee progress in work and move away from the support system.

Work Choice operates partly on a payment by results model. However, this is a much smaller part of the commissioning model than it is for the Work Programme; a much greater proportion of the payment is

[6] <https://www.gov.uk/work-choice/eligibility>

allocated at the outset of an attachment, reflecting the greater costs and more intensive support that is likely to be required to get its participants into work. 70 per cent is paid at the outset, with a further fifteen percent being allocated when a client moves into supported employment, and the final 15 per cent when they move into unsupported employment (sustained for at least six months). It therefore also differs from the Work Programme in **recognising progress towards unsupported employment** as an outcome.

As of 2015, 90,000 people had enrolled in Work Choice, while 1.8 million had enrolled in the Work Programme in the same period (House of Commons Library, 2016). Of those who entered Work Choice between July 2014 and December 2014, 57.3 per cent had entered a job by the end of June 2015 (Work and Pensions Select Committee, 2015). This compares very favourably to the outcomes for ESA claimants on the Work Programme. This can be partly attributed to some of the key differences between the two programmes, including the **greater involvement of smaller providers** in Work Choice thanks to the smaller contracts and **its voluntary nature**, which means that participants may be more personally motivated to achieve success – especially if, for example, they have actively sought to join the programme without having had prior involvement with Jobcentre Plus (Work and Pensions Select Committee, 2015).

Ahead of recommissioning in 2017, it has been suggested (including by Employment Minister, Priti Patel) that Work Choice could be integrated with the proposed new, more specialised, 'Work and Health Programme' provision. This could reduce costs by reducing the number of contracts, simplifying procurement processes and producing further efficiencies in contract management. However, a Work and Pensions Select Committee report on welfare-to-work indicated that such an approach was not favoured by a majority of witnesses, including major providers such as the Shaw Trust and Remploy, as Work Programme demonstrates poor outcomes for claimants with complex, health-related needs (Work and Pensions Select Committee, 2015).

A new 'Work and Health Programme' was announced in the Spending Review and Autumn Statement of November 2015. It was proposed as the new source of specialised support for claimants with health conditions or disabilities after current Work Choice and Work Programme contracts end. The DWP is still yet to formally set out exactly how the new programme will operate, and what services will be included.

Access to Work

Access to Work is a government service aimed at employees with a long-term health conditions who are either already in work or about to start a new job. Grants can be provided to the employee to cover the cost of adaptations to the workplace that enable the employee to carry out their job, beyond standard requirements. Access to Work funding can also be used for travelling to a job interview if a job seeker cannot use public transport, and for a support worker or communicator to attend job interviews alongside them.

Prospective employees must self-refer to Access to Work; ideally in good time before starting their job as it may take some time for their claim to be processed and for the necessary adjustments to be provided. As such, awareness of the service and **an understanding of the application process is essential – both on the part of jobseekers, and on the part of JCP or Work Programme advisors in directing them towards it**. There are concerns around awareness of the programme, with the Sayce review referring to it as the Government's 'best kept secret' (Sayce, 2011). In light of concerns about awareness of and access to support through Access to Work for people with mental health conditions, a dedicated Mental Health Support Service (run by Remploy) was set up at the end of 2011. Though uptake has increased somewhat over the years, concerns have remained about the under-utilisation of this service (Mind, 2014), with those with mental health problems accounting for just 5% of new Access to Work starts in 2014/15, and under 3% since 2011 (DWP, 2015e).

Decentralised, devolved and local initiatives

The Coalition oversaw a number of initiatives intended to devolve responsibility for areas of policy 'away from Westminster and Whitehall to councils, communities and homes across the nation' (HM Government, 2010). The various processes of decentralisation and devolution has led to variations in return to work

support. In this section, we discuss the drivers and outcomes of these processes, highlighting examples of good practice in welfare-to-work that have resulted from them. We also look briefly at local, independent return to work initiatives, often operating in the voluntary and community settings, and often (but not always) supported to some extent by public sector funding or grants.

Decentralisation within national frameworks and initiatives

Some government departments have embraced decentralisation more fully than others. Extensive examples can be found in the Department of Health's policy areas - through the creation of Clinical Commissioning Groups [CCGs] and Health and Wellbeing Boards, while the Department of Business, Innovation and Skills has overseen the development of Local Enterprise Partnerships (LEPs) which are responsible for boosting local economic growth. **DWP's approach to decentralisation has been more limited.** The main example of decentralisation within welfare-to-work is the Work Programme's 'black box', which allows providers to decide what sort of support they will deliver to their participants and in what format. The evaluation of the Work Programme suggested that the potential for innovation enabled via the black box has generally been perceived by DWP and providers themselves as beneficial for their service delivery (Foster et al., 2014). Finn (2015) suggests, however, that more extensive decentralisation has been constrained by the overall framework of the Work Programme, in part because the DWP is concerned that national "work first" priorities should not be undermined by divergent local interests and/or capabilities'. He suggests that this has 'constrained local integration and partnership working' (Finn, 2015).

Nonetheless, where we have seen inside the '**black box**', we can still identify some interesting examples of innovative service provision, albeit in a small-scale, pilot form. An example of this is the Shaw Trust's 'Community Hubs' pilot, discussed in case study D.

Case study D: Shaw Trust Community Hubs

Shaw Trust is a contractor on the Work Programme and Work Choice (operating at both prime, and subcontractor levels), providing specialist support to people with disabilities and long-term health conditions. In 2014, Shaw Trust transformed two of its Work Programme provider offices in Hackney and Lewisham into 'Community Hubs' to trial a new approach to return-to-work support for their client groups.

Community Hubs are notable not just for the additional advisors and lower caseloads assigned to them, but for the range of services that are co-located within them. Each Hub contained a version of the following elements:

- The Wellness Hub; where wellbeing is focussed on, and support with health-related barriers is available
- The Job Essentials Hub; where support is available to remove employment barriers
- The Interview Hub; where interview training and short notice support is available

The Hubs also took a 'journey' based approach to moving clients into work, focusing not on employment outcomes as such but on 'distance travelled' towards employment. The removal of hard targets on employment outcomes allowed advisors to be more innovative in the support that they offered to clients. Additionally, the design of the Hubs – as a community centre – was intended to encourage a productive and respectful relationship between clients and advisors, and to make them into somewhere where clients wanted to attend. This helped to overcome barriers to accessing support, which Shaw Trust found was especially useful for engaging those clients who had greater barriers to work, self-imposed or otherwise.

Source: Shaw Trust Community Hubs pilot Evaluation summary (2016)

There is also some flexibility in the way that Jobcentre Plus works with local community organisations and local authorities to provide return-to-work support that meets local needs, and individual client needs, via the **Flexible Support Fund**. In 2014/15, the budget for the Fund was £136 million. Jobcentre advisors have discretion to use the Flexible Support Fund to provide extra support to their clients to meet return-to-work related costs, such as childcare or travel to interviews. This could be of significant use to individuals with long-term health conditions, who may incur extra costs in going through the process of looking for work. The Flexible Support Fund cannot be used if an individual is enrolled on Work Programme or Work Choice. It also includes a grant mechanism that allows Jobcentre Plus District Managers to develop partnerships with local actors to address challenges (McGuinness and Kennedy, 2016). **DWP does not collect data on how the Flexible Support Fund is spent.** The current Minister for Employment, Priti Patel, has explained in response to a parliamentary question that it has no intention to do so because it is a discretionary fund (McGuinness and Kennedy, 2016).

In principle, Jobcentre Plus could develop partnerships with a number of local actors via the Flexible Support Fund, including LEPs, CCGs, local councils, and voluntary organisations. We can identify some promising examples of where this is already taking place: for example, the Tomorrow's People initiative (case study E) is a joint council and Jobcentre Plus scheme. However, at present the extent of integration and partnership working led by Jobcentre Plus at the local level with some of these organisations is quite limited and entirely discretionary. Integrated working with LEPs has been particularly limited: for example, Finn (2015) notes that LEPs *'have no direct role in the design or commissioning of [Jobcentre Plus] support and only limited influence on how resources are deployed to meet local needs'*. This **limits the possibility of a more extensive, embedded approach to joint working between decentralised elements of different departments** at the local level; it appears the relationship between LEPs and Jobcentre Plus is not as symbiotic as it might be.

Case Study E: Tomorrow's People – 'Pathways to Employment'

The employment charity Tomorrow's People is a Work Programme contractor in Bath, Bristol and Plymouth. In London, they were chosen by the Lambeth, Southwark and Lewisham councils to run their joint specialised scheme: 'Pathways to Employment'. The scheme is joint-funded by the councils, Jobcentre Plus via the Flexible Support Fund, and national government grants. The focus is on preventative intervention with a series of groups at high risk of long-term unemployment, including those with mental health difficulties. Participants have one-to-one and group guidance, where their ongoing barriers to work are discussed and personalised action plans are devised. These plans vary according to individual need, but can include CV writing, job search training, interview coaching, employer visits, sector presentations and work experience. The service also trains individuals and puts them in contact with partner employers.

Though no evaluation data is available, Tomorrow's People reports success stories. For example, 'H' was a 34 year old long-term ESA claimant with mental health problems. Her keyworker on Pathways to Employment identified that H's lack of financial management skills were posing a major barrier to her gaining and retaining employment. H's keyworker discussed the importance of opening a bank account and facilitated access for H to a money advice service. After this, the keyworker helped H gain some work experience in a customer facing role to build her confidence and gain skills. After her three month placement, H secured a permanent role as a kitchen porter and works 16 hours a week.

Source: Tomorrow's People and Lambeth, Lewisham and Southwark council, via Transforming Public Services.

There are also examples of programmes that draw on a wide range of local and national funding sources and use national delivery partners. The Tomorrow's People initiative for example (see case study E), is jointly funded by three councils facing similar employment challenges, national government funding, and the Flexible Support Fund, and is delivered via the boroughs' Jobcentres. This approach emphasises **sharing and pooling resources** that address a range of barriers to work, as well as a means of getting

better value for money by ensuring a co-ordinated approach, spending 'the right amount of money at the right point' (Work and Pensions Select Committee, 2015).

At national departmental level there are some examples of co-operation between Departments in supporting the employment of people with long-term conditions, although reflecting the situation at local level, BIS has not generally been extensively involved in this. A good example is the *Psychological Wellbeing at Work pilot*, discussed in case study B (see previous chapter), which was developed jointly between the Department for Work and Pensions and Department of Health. The extent of BIS' role in the Work and Health Joint Unit is also unclear. In principle, at national as at local level, **there is room for much more effective integration and strategic working**, especially given the evidence outlined in the previous chapter regarding how valuable this can be to support people with multiple barriers associated with long-term health conditions into work.

Local initiatives

A range of other initiatives provide health and employment support on a local basis, outside of the frameworks of large national programmes. These include CCGs, LEPs, local councils, the voluntary sector and private companies. By operating outside of the funding constraints of initiatives such as the Work Programme, and Jobcentre Plus's concern with linking support with benefit entitlement, these providers are often freer to take an innovative approach to employment support. The focus of such programmes is usually on those who are less likely to be well served by mainstream welfare-to-work programmes, due to a complex range of barriers to working – often including people with long-term health conditions. Here we highlight some illustrative examples of good practice.

Frequently, local initiatives demonstrate integration between services (for example, employment, health and housing) which can address the range of barriers to work that unemployed people with health conditions often face. An example of this is the Bromley-by-Bow Centre, discussed in case study F. Experts that we spoke to also highlighted that the **voluntary nature** of such provision is important in ensuring its success: because individuals often self-refer to the programmes and are under no continuing obligation to take part, they may be more motivated, more open to the possibility of moving into work, and more receptive to the range of services that are on offer. The **local dimension and ability to build small-scale working partnerships** is important in developing such provision.

Case study F: Bromley by Bow Centre

The Bromley by Bow Centre is a community organisation based in East London, working with some of the Capital's most deprived communities. It focuses on providing support to people who are difficult to reach through conventional channels, including young people, long-term unemployed adults, and older people. Many of the people that Bromley by Bow support have health conditions.

Whilst the Bromley by Bow Centre is not part of the Work Programme, it did strongly consider this. It nonetheless supports many who are on the Work Programme and works closely with Jobcentre Plus. Users self-refer to the Centre on an entirely voluntary basis. The Centre prides itself on its ability to maintain a good relationship with services users, particularly in integrating the care provided through the GP/ health services and the Employment Advisors.

The Centre delivers "Active Futures" a programme which specialises in supporting young people aged 14-35 years with learning difficulties and mental health needs to overcome barriers to employment and wellbeing. Building on the local Motivate East Paralympic legacy programme, inclusive sport is used to engage young people in the services - with the joint aim of tackling both the low level of disability employment and engagement in sport. The programme is delivered by the Centre and funded by Barclays, who also provide volunteers and offer opportunities for work experience for participants.

Active Futures seeks to improve wellbeing and increase employability skills, while supporting progression into work and training via three key features:

- Inspiring – building on the 2012 Legacy "Inspire a Generation", opening up a range of opportunities within the sports and fitness sector
- Engaging – utilising the attraction of participating in inclusive sport to support young people with learning disabilities and mental health needs into further training and employment
- Accessible – providing accessible and supportive learning programmes designed specifically around the needs and capabilities of individuals, with the aim of improving employability skills alongside wellbeing.

Active Futures works with a wide range of strategic partners, including the Disability Employment Advisors in local Jobcentres, local authorities, youth, and disability and mental health organisations/ charities, to support referral into the programme and to enable participants to access further support and skills and employment progression pathways. Of 95 young adults engaged in the programme through 2015, 41 entered further education or training, including Sports Leadership Level 2 training and 18 secured employment or long term apprenticeships.

Source: Bromley by Bow Centre

Though there are some examples of local initiatives – like Bromley by Bow – which have managed to generate funding to allow them to provide innovative, specialist support (often via the private sector) it remains that the main mechanism for obtaining long-term funding is via the Work Programme. Hence for organisations that chose not (or were unable) to participate, funding can be difficult to obtain. Often funding is achieved through relatively short-term grants. This poses a particular problem when it comes to **evaluating the effectiveness of these schemes**, especially as they may be helping people who are a long way from the labour market and hence may not get into work over the course of the funding cycle. Additionally, many such services offer a holistic approach - seeking to support people with a range of issues rather than being focused on singly on employment outcomes. Consequently, even where evaluation is carried out, it can be difficult to isolate the effect on employment. McEnhill, Steadman & Bajorek (2016) highlight these challenges amongst others in evaluating schemes which are anecdotally very effective.

The increased remit of bodies such as CCGs and LEPs, mean there is a (currently underused) capacity to develop and commission local services – including, potentially, working together (PHE, 2016). The extent to which LEPs have engaged with supporting employment is quite limited. There is somewhat greater involvement amongst CCGs, although this varies considerably, with many CCGs not seeing employment as part of their remit, or recognising employment as a health outcome. Some, however, do offer employment support: for example, Nottingham CCG runs the ‘mental health pathway’ that brings together a number of clinical and social services, including those focused on employment (Shreeve, Steadman and Bevan, 2015), and there are several examples of CCGs commissioning IPS services.⁷

Devolution

The shift towards devolving power from central government to major cities in England, via City Deals, could have significant implications for the provision of return-to-work support. This has enabled cities to begin developing and implementing their own return-to-work support separately from the national framework. Typically this has been focused on those with complex needs, who have been or are likely to be poorly served by the Work Programme.

An advanced example of a devolved initiative offering support to people with long-term conditions to move into work, is Greater Manchester’s ‘Working Well’ programme (see case study G). The high employment rate resulting from the pilot- exceeding expectations- is striking, and may strengthen the case for further devolution (Finn, 2015). As above, it is important to note that **data collection and evaluation of these schemes is limited**: it is often based on small numbers of participants over a short amount of time, and many initiatives are still in the development stage or the early stages of implementation. This makes it difficult to draw any firm conclusions about their wider effectiveness.

[7] See “Centre for Mental Health: IPS Centres of Excellence” for locations: <http://www.centreformentalhealth.org.uk/ips-centres-of-excellence>.

Case study G: Manchester 'Working Well'

'Working Well' is a Manchester based scheme aiming to improve employment rates. The city-region of Greater Manchester has seen stubbornly high unemployment or under-employment for the past three decades, with over 260,000 people still out of work in 2014. Half of these were ESA/former IB claimants (Ainsworth, 2014). 48 per cent of the ESA claimant group had diagnosed mental health or behavioural conditions, which as a cohort saw particularly poor outcomes from the Work Programme (Work and Pensions Select Committee, 2015). The assessment of ESA claimants that led to the Working Well pilot being introduced suggested that most had a series of complex issues that needed to be addressed, such as housing, health, or financial problems, before an employment outcome could realistically be gained (Ainsworth, 2014). Progress resolving these issues is taken alongside employment support in the Working Well programme, with 'Big Life' (the prime contractor) subcontracting to two multidisciplinary teams to ensure these needs were met by a specialist and tailored package of support.

In contrast to the Work Programme, required services in Working Well are integrated into one bespoke package of support, providing a greater opportunity to overcome linked barriers. The number of caseworkers employed on the scheme is also significantly higher than the equivalent on the Work Programme, allowing for them to take extra time over each participant and provide a holistic approach to support. Intervention is also offered on a whole family basis where appropriate, to tackle psycho-social issues around low motivation and low self-confidence.

'Working Well' was first piloted in 2014 and rolled out across Greater Manchester in early 2016. Early assessment suggested that 25 per cent of clients on the pilot were able to access physical health support services during their time on the programme, with 47 per cent accessing mental health services (a figure almost exactly tallying with the number of participants who had initially reported mental health problems). 82 per cent of participants reported an overall improvement in their general health and their belief in their ability to find work. The pilot had forecast 124 job starts - but 131 people gained and retained employment during it (Ainsworth, 2015). Greater Manchester City Area's assessment of the programme reports that 'all the indications are that the intensive support, motivational interviewing techniques and integration of services are already making a difference'

Source: Manchester City Council, 2015.

Further devolution will take place as a result of the Scotland Act (2016) which transfers powers over large parts of the welfare system to the Scottish government; however, it remains to be seen what changes will be made and what programmes will be developed. Developments in this area require further study as and when changes are made.

4. Challenges in the current system – and how to address them

In the previous chapter we outlined current provision for supporting people with long-term health conditions into work – reviewing both the large-scale, mainstream national programmes and smaller-scale local initiatives. Though we identified pockets of good practice and innovation, overall we saw a system of support that was not as effective or comprehensive as it might be. In this chapter we take a critical look at current welfare-to-work provision for people with long-term health conditions, identifying key challenges, and exploring the barriers they face in using current provision. This are discussed under four themes:

- The assessment process and Jobcentre Plus
- Welfare-to-work commissioning and payments
- Providing specialist support
- Driving devolution, decentralisation and the development of local, integrated services.

Considering both national provision and local opportunities, acknowledging the limitations of this report's scope, we then make recommendations for changes to current welfare-to-work provision.

The assessment process and Jobcentre Plus

There are a number of challenges in the current system for determining eligibility for benefits, and the conditionality attached to this. The Work Capability Assessment (WCA) has generated significant controversy since it was introduced. There have been a number of high-profile mis-categorisations, and claimant dissatisfaction with the former contractor delivering the assessments, Atos, has been extensive and widely reported (Work and Pensions Select Committee, 2014b). Criticism of both the WCA and the conditionality process that it leads to have been particularly scathing from some disabled people organisations (see We Are Spartacus, 2012) and research has found that many applicants find the assessment process a significant source of stress (Garthwaite, 2013). Many new applicants view it as a threat, with the negativity around it demotivating people even before they attempt to access support (Griffiths & Patterson, 2014). Health care professionals have also raised concerns, for example in 2012 the British Medical Association voted to back resolutions calling for the computer-based assessment to be scrapped (BMA, 2012). Concerns about damaging perceptions of the WCA have also been highlighted in independent reviews (Litchfield, 2013).

Combined with other aspects of the welfare system – including sanctions, for which evidence on effectiveness is limited (Meager, Newton et al, 2014) and the all-to-common perception that many benefit claimants are 'scroungers' (Baumberg, Bell and Gaffney, 2012) – **a culture of mistrust in the welfare system** has developed, which is particularly felt by those with long-term health conditions. Indeed, the stigma associated with being a welfare claimant prevents some people from claiming benefits to which they are entitled, and consequently also from accessing support (Garthwaite, 2013).

Even the highest quality of support would be limited in its effectiveness by these contextual factors. As noted above, the Litchfield review of the WCA (2013) highlighted that a credible assessment needs to be both fair, and perceived as fair. Trust is not something that can be quickly and easily rebuilt, but to make progress on this the Department for Work and Pensions must clearly show that it acknowledges the valid concerns about the WCA, and show it is taking constructive and comprehensive steps to address them.

An early criticism of the WCA was that organisations representing disabled people were not adequately represented in the design process – only being consulted at a secondary stage (Work and Pensions Select Committee, 2014b), something which would likely have contributed to the negative reception, and an omission which has not been adequately addressed subsequently. An important step in righting this, and in improving perceptions (and hopefully practice) of the WCA would be to work much more closely with people with long-term health conditions, disabled people's organisations, charities and others to openly **co-produce a fundamentally reformed assessment of work capability**⁸. Building on the evidence-based review of the WCA (Litchfield, 2013) which engaged a number of key partners in its comparison of different assessment criteria, a new co-produced approach should reform not only the assessment criteria, but the processes surrounding it (including in terms of evidence collection and submission). Importantly, it must be transparent in doing so. By placing users at the centre of the process, and ensuring the views and experiences of people with complex requirements are represented and understood, it will not only improve the way the WCA works but also go some way towards re-building trust between the Department and the people that will have to undergo assessments. This should not be seen as a one-off exercise – the co-production group should be engaged on an ongoing basis in the monitoring of the reformed assessment and process to ensure that unintended negative effects are minimised, managed and addressed. This should be as part of a process evaluation, to be conducted alongside an outcome evaluation.

Lack of trust in a system rarely arises in isolation from the substance of the system itself. A number of reviews and research has highlighted concerns with the WCA, and this existing evidence and commentary highlighting concerns and options for changes should be fed into the co-production process. One such key issue, as highlighted by previous reports, is in **linking assessment of entitlement to ESA, with the assessment of barriers that a claimant faces to work** (Baumberg, Warren, Garthwaite and Bamba, 2015). This link can cause problems as claimants can feel they have to continually 'prove' that they are not capable of working, and as such may feel that engaging in any back-to-work activity could prevent them from receiving the benefits they believe they are entitled to. For individuals in the ESA Support Group in particular, who are making up increasing numbers of new participants (see figure 5), this could provide a disincentive to becoming voluntarily involved in any work-related activities or employment support. Changes to the ESA-WRAG payment may worsen this, as financially the WRAG will no longer act as a mid-point between Support Group and JSA. Given the considerable disadvantages that individuals with long-term health conditions perceive, and often do face, when seeking work in the open labour market (OECD, 2010), the linking of assessments makes engaging in work related activities a risk. Moreover, it has been suggested that the current system fails to capture information on barriers in a useful way for JCP staff or Work Programme providers (Harrington, 2012), meaning that even if individuals are put in the correct group for their needs, the information may not be available for the correct assistance to be provided.

This furthers the case for DWP to consider substantive changes to the assessment process, and to the use of that information by JCP in case management. In other countries, the assessment of an individual's barriers to work, and the assessment of their entitlement to claim a particular benefit are separated; for example in Australia, which was the model advocated by the Work and Pensions Select Committee (2015). Charities including Scope and Mind, as well as the OECD (2010) have advocated a similar approach in the UK (see also Baumberg, Warren, Garthwaite and Bamba, 2015). We agree that the DWP should consider **separating the assessment for determining benefit eligibility from the assessment that identifies an individual's likely barriers to work**. As well as looking at the impact of an individual's health conditions – the number, the severity, and the extent they fluctuate – assessments should look at other factors that affect their likelihood of obtaining work, including age, employment history, confidence, access to transport, housing issues, caring responsibilities and the nature of opportunities within the local labour market. If a higher quality, more holistic assessment of barriers is to be introduced, it is also important that the information obtained from this is able to be used appropriately. In particular, it should be collected in a format that Jobcentre Plus advisors are able to use effectively.

Having been assessed for support, it is then important – particularly for individuals with long-term

(8) Co-production is based on the sharing of information and on shared decision making between the service users and providers. It builds on the assumption that both parties have a central role to play in the process as they each contribute different and essential knowledge (see Realpe and Wallace, 2010)

health conditions – that they can be **confident in the ability of the Jobcentre Plus to meet their needs**, and understand their condition and how it affects their ability to work. This is true irrespective of which benefit is being claimed; it must be emphasised that a substantial proportion of individuals with health conditions are claiming JSA, not ESA. Such knowledge is important in enabling Work Coaches to apply conditionality fairly, and to ensure that their clients are directed towards the support that they need. For example, Mind (2015) raised concerns about the number of people with mental health problems who are sanctioned, stating that *'many people with mental health problems find it difficult to participate in [mandated] activities due to the nature of their health problem and the types of activities they're asked to do, which are often inappropriate'*. This might apply particularly to those on JSA, who are subject to full conditionality even though in some cases they may have significant health-related barriers to work. The picture becomes even more complex when we take into account non-health related barriers, such as age, housing difficulties or caring responsibilities.

Evaluations of the Work Programme have emphasised that service users value continuity in their advisor relationship (Meager et al., 2014), and a consistent on-going relationship with a Work Coach, as is planned under Universal Credit (Newton et al., 2012). However, this is unlikely to allow the specialist support that many people with long-term health conditions will benefit from. **Maintaining access to experts** within mainstream employment offices – both specialist employment support and external medical specialists – has been prioritised in some OECD countries, such as Denmark (OECD, 2010). However, in the UK, the number of specialist Disability Employment Advisors in Jobcentres is declining, and this trend is expected to continue – with DWP indicating that Work Coaches will become the main point of contact (quoted in Stone, 2015). Though it has been proposed that Work Coaches will be upskilled to improve their ability and confidence to provide appropriate support for those with health conditions, this will have limitations, and is unlikely to be a substitute for the support provided by DEAs. Consequently it is becoming less likely that individuals with long-term health conditions using Jobcentre Plus will come into contact with specialists – who will have an understanding of the barriers to work presented by their health, as well as by other linked barriers. Though there is value in a consistent relationship with a Work Coach, this is not a substitute for specialist advice. **DWP needs to ensure that in the future access to Disability Employment Advisor in all Jobcentres** (proportional to need) to provide specialist advice. The Department should also consider ways of meeting additional need in areas where long-term conditions are particularly prevalent, including enabling access to external sources of support such as Occupational Health and vocational rehabilitation advice – from health and community partners, as well as utilising the support available through Access to Work. This is crucial to implementing conditionality effectively, and ensuring that individuals with health conditions receive fair and appropriate treatment. Such specialist support should be available for anyone in the welfare system who has a long-term condition – irrespective if they are in the Work Programme's replacement, or receiving support from the JCP.

Welfare-to-work commissioning and payments

One of the Work Programme's aims was to increase the flexibility of service provision by being open to **small, local providers and allowing for the provision of innovative, targeted schemes** (DWP, 2012). It was hoped that this would allow for organisations to deliver more specialised, person-centred services, which would achieve better outcomes for 'hard to help' groups. The Work Programme payment structure identifies the presence or absence of a health condition as the primary determinant of whether an individual is 'hard to help' into work. Though there was a priority to enable organisations dealing with specific health problems and underlying issues to deliver aspects of the programme (Lane et al., 2013), unfortunately this ambition has not wholly been realised.

Although there are some specialists operating at Prime and Tier 1 (for example, Shaw Trust), specialist provision is mainly concentrated at 'Tier 2'. Tier 2 subcontractors are dependent on referrals. There was no guarantee that they will receive sufficient numbers of referrals, and in practice numbers were often insufficient to guarantee a viable income stream (AVECO/Shaw Trust, 2013; NCVO, 2011). Referrals were also often highly complex cases, with less likelihood of payment. The risk for these providers is significant and can act as a barrier to involvement, even though they may be highly effective in helping those with complex health-related barriers. **Many smaller and specialist providers had to leave the programme in**

its earlier years (Lane, Foster, Gardiner, Lanceley, & Purvis, 2013), impacting on the diversity of providers and the quality of support available for people with health conditions.

The DWP's **supply chain management tool, the Merlin Standard**⁹, was intended to promote good supply chain management and provide some protection to subcontractors. All providers have now achieved Merlin accreditation. However, a review of Merlin found that many did not feel the introduction of Merlin had helped to improve supply chain management with over half reporting that it had made no difference, and had not improved supply chain management. Voluntary organisations were least likely to report satisfaction with Merlin (DWP, 2015d).

We suggest more needs to be done to improve the **relationship between Primes and subcontractors** – especially the smaller organisations at Tier 2. Though the Merlin Standard provided a welcome step towards ensuring that smaller providers were protected from mistreatment, smaller subcontractors are less likely to report an improved experience. The DWP's review set out a number of options for taking Merlin forward in the next iteration of the Work Programme (DWP, 2015d), though recognising that there are a number of unknowns that make it impossible to make concrete recommendations on the future of Merlin. However, we can assume that the innovation associated with smaller providers will continue to be an important part of Work Programme's successor. It has been widely suggested that these organisations will be key to improving outcomes for people with long-term health conditions. It is crucially important that the Department is very **clear from the outset how Merlin will apply to subcontractors**: what risks it will protect them from, what their recourse is, and what risks are not covered. This will enable subcontractors to tender and plan on an informed, secure basis, which is essential to providing consistent, on-going support to welfare-to-work participants.

Despite the intention of the Work Programme to improve specialist support for people with long-term health conditions, in reality there has been a tendency towards **over-reliance on more 'generalist' employability support such as skills training** (for example, CV writing, interview techniques or application forms) (Davies and Raikes, 2014). As discussed, many participants with health conditions have not received specialist support aimed at helping them address their specific barriers (Davies & Raikes, 2014), and this is even less likely for those claiming JSA than for those claiming ESA. This is exacerbated by the lower outcomes payment attached to JSA claimants, which is less likely to reflect the true cost of support and leaves them vulnerable to 'parking'.

This tendency towards 'creaming' of easier to place individuals within each client group, and the parking of those who face greater barriers to work, is often seen as **the result of the Work Programme's Payment by Results structure**. People with mental health problems have been identified as being particularly vulnerable to not having their needs properly identified and managed (Work and Pensions Select Committee, 2015). Those with fluctuating conditions face similar problems; does their assessment measure them on a good day, or a bad one? It is difficult for the assessment system to give a full picture of how and why conditions fluctuate over time and the effects this has on an individual's ability to work on an ongoing basis (Meager, et al., 2013). These problems arise in part because the current client group structure takes inadequate account of the diversity of individuals within each group, and of their barriers to work. While one individual within each group may be relatively work-ready, another may be significantly further from the labour market; yet both attract the same outcome payment, creating an incentive to help the individual that represents an 'easy (and cheap) win'. While those with conditions that fluctuate can may be misjudged and not receive the appropriate support.

To enable support and resources to be more effectively focused on those participants with more severe barriers to work, the new work programme needs to have a **refined payments structure which better reflects the costs associated with providing support** to people with long-term health conditions and other complex circumstances. An improved assessment process, as discussed above, is crucial to this. In particular, the distinctions between client groups need to be more nuanced than they are at present. The current method – using benefit claimed as a proxy for support required – has resulted in many claimants

[9] <http://www.merlinstandard.co.uk/>

with health conditions that present more serious barriers to work not receiving the support they need. This may be especially applicable to those on JSA.

Assessments should take into account a broader range of issues and barriers to work, so should the payment structures reflect specific individual characteristics – such as health condition, age, and employment history – alongside the likelihood of a claimant actually getting a job in the ‘real’ labour market (Baumberg, Warren, Garthwaite and Bambra, 2015). This would improve the ability for support to be developed that reflects need. This should help to reduce the risk of parking by recognising the diversity, number of barriers faced and support needed within each client group, reducing the incentive for providers to focus on those closer to the labour market.

Providing specialist support

Work Choice, the main specialist health welfare-to-work scheme, has (as one might expect) delivered substantially better outcomes for people with health conditions than the Work Programme. Work Choice is relatively small, and it has been suggested that a scaled-up form of Work Choice would be an effective means of helping many more people with long-term conditions into work (Work and Pensions Select Committee, 2015). The extent to which this suggestion has influenced the development of the forthcoming Work and Health programme is not yet clear.

Though Work Choice has shown promise, there are issues to consider in deciding whether it is an appropriate model to scale up. Importantly, Work Choice is voluntary, and consequently those who self-refer to it are likely to be more motivated to work and perhaps more ready to do so. This in itself could have a significant effect on the outcomes associated with it. The restrictions on eligibility criteria further refine the characteristics of people who are able to join the scheme. **Work Choice requires that participants are able to work for a minimum of 16 hours per week**, meaning that many would-be participants, who might benefit greatly from it, are currently not eligible. The 16 hour rule excludes many individuals with more substantial or fluctuating health conditions from participating at all. For those who might be capable of working for 16 hours or more, but need some time to build up to this, the rule may prevent Work Choice from acting as a bridge into more substantial employment.

We also believe that there is scope for improvement in Work Choice. Its first ‘stage’, which is provided for up to six months, is composed of ‘advice and personal skills’ training to help participants find and obtain a job. For some participants – particularly those with limited work history, and little experience of job seeking – this may be helpful, although it will usually need to be combined with other more targeted interventions (Greve, 2009). Indeed, evidence from other contexts suggests that there may be **limited utility in an on-going strong emphasis on employability skills training in producing job outcomes**. For example, such an approach (‘train then place’) is associated with weaker employment outcomes for those with severe mental illness, when compared with the ‘place then train’ or ‘work first’ approach of the well-evidenced Individual Placement and Support (IPS) model. This is seen as particularly relevant to those whose entry into work is blocked by a number of other factors including stigma from employers, doubts about their capacity to work, and self-stigma (Bevan, Gulliford et al; 2013). Depending on the proximity to work of users, the focus on ‘training first’ may not be the most appropriate or beneficial model.

Therefore, although we would like to see a new approach building on the successes of Work Choice, we also support some changes. We need to be sure that the sort of specialist support currently offered is reaching the people with long-term health conditions who could really benefit from it. For example, those whose conditions are more difficult to manage within the structures of employment (such as individuals with fluctuating conditions), those who presently have little experience of work and may need to slowly build up their hours, and those who would benefit most from the ‘distance travelled’ payment structure that it supports.

To enable this we recommend that the DWP **trails the removal of the 16 hour rule**. This is not only in the interest of participants, but also employers; if there are flexible employers who can employ and want to employ with those with a fluctuating ability to work, they should not be stopped by the 16 hour rule.

We propose conducting small-scale pilots with groups of claimants who are not eligible under the 16 hour rule, to determine the costs and benefits of extending eligibility, and to identify where a specialist programme could be most effectively focused.

We also call for the DWP to **consider the possibility of incorporating different models of support into specialist welfare-to-work provision** – with special consideration given to piloting IPS-style approaches, that prioritise getting a participant into competitive employment as soon as possible; linking health and employment support and providing ongoing support to the individuals and the employer to help with job retention and progression. Strong evidence of the approach for people with severe mental illness – who experience considerable disadvantage in the labour market – and burgeoning evidence of effectiveness with people with common mental health conditions, might be built on by piloting an IPS-type approach with people with other health conditions and barriers.

It is important that in scaling up specialist welfare-to-work support, such as that provided by Work Choice, provision does not become ‘one size fits all’, but **maintains its distinctive flexibility** to the needs of the client. Incorporating different strategies within it would provide a means of maintaining this, enabling providers to tailor their approach to then needs of participants.

Driving devolution, decentralisation and the development of local, integrated services

There are a number of benefits of running welfare-to-work schemes on a local basis; indeed, the ability to commission smaller providers (which local organisations usually are) is an important aspect of the Work Programme. Integrating employment support with providers’ knowledge and understanding of the local labour markets has been shown to bring benefits for unemployed people in general, irrespective of whether they also have a health condition (Meadows, 2008; Hasluck and Green, 2007). For people with multiple, complex barriers to work often including those with health conditions, such support can be particularly helpful. Local providers are also uniquely placed to develop integrated services, working with health providers and others.

The DWP has begun to pilot integrated service models. For example, delivery of psychological therapy in Jobcentres (Bruce, 2015) and the placement of Remploy job coaches in GP surgeries (reflecting a 2007 research report by Sainsbury et al.). Both schemes have proven controversial, and have been met with opposition from disabled people’s organisations (Gayle, 2015; 2016), with such approaches felt to cross the line between accessing treatment which might improve someone’s employment prospects, to coercion to undertake treatment. Within this context, experts that we spoke to suggested that it is unlikely at this stage that such provision will receive a positive reception from many of those with health conditions who use the Jobcentre’s services. Indeed, our own evaluation of the ‘IPS in IAPT’ feasibility pilot, indicated a preference for health and employment co-location sitting outside of the mainstream welfare-to-work programmes (Steadman & Thomas 2015), i.e. distant and distinct from conditionally or mandatory activities. Services operating outside of mainstream JCP provision may therefore provide a better chance of integrating services.

Decentralisation of return-to-work support has been rather limited, with DWP still prioritising meeting nationally defined targets (Finn, 2015). Beyond the Work Programme ‘black box’, we have seen little by way of local variation. There has not been much interaction between DWP and other devolved bodies, such as Local Enterprise Partnerships (LEPs), which were developed to drive local economic growth. It has been suggested that working in collaboration with such organisations could lend a less adversarial ‘face’ to welfare-to-work provision, and build on the perspective of improving employment support and outcomes for people with health conditions, as being an important part of local economic growth (Shreeve, Steadman & Bevan, 2015).

Integrated, local solutions can be (as we have seen in practice) entirely complementary to national programmes. Often they are aimed at *‘those workless people who are not covered or are poorly served by mainstream programmes’* (Finn, 2015), including people that have been through the Work Programme and come out the other side. People with health conditions are well represented in this demographic.

In practice, these services tend to be small scale, focussed on a specific location and client group, with wider provision limited by funding. Their presence tends to depend on sufficiently strong recognition among local actors (including CCGs and local government) that employment is a health issue. In practice, the commissioning of relevant services is hugely variable nationally. As we have discussed in other Health at Work Policy Unit papers, there is much to be done in influencing health partners to recognise employment as a health outcome (Shreeve, Steadman & Bevan, 2015).

There needs to be a greater drive towards decentralisation and service integration in the health and work area. The DWP must show greater **willingness to cede centralised control of welfare-to-work** to local providers on a larger scale, particularly in the case of jobseekers who could benefit from this provision at an earlier stage in their journey into work. However, the importance of integrating services means that this is not just a matter of DWP handing over control: **local organisations, including LEPs and CCGs need to recognise the employment of people with long-term conditions as their responsibility**, and understand that improving employment outcomes is to their benefit, and fulfils their remits – to the end of partners working together locally to develop more comprehensive local provision.

As discussed in chapter four, Jobcentre Plus districts do have some space to design their own provision and develop integrated working partnerships with devolved and decentralised bodies and non-government organisations, via the Flexible Support Fund. However, the reported underspend of £64 million in 2014/15 implies that awareness of the fund is low. **The DWP does not collect data on usage of the Flexible Support Fund**, so it is not possible to see how it is being used for Jobcentre clients. As regards developing local partnerships, this was barely mentioned in consultations on DWP's localisation agenda (McGuinness & Kennedy 2016), with lack of awareness suggested to have hindered the partnership building purpose of the fund.

The Flexible Support Fund appears highly relevant to improving support for people with long-term health conditions – in both of its guises, i.e. in driving local partnership and in supporting individual claimants. We recommend that concerted activity be undertaken to **raise awareness of the fund** to relevant parties – including internally within the Jobcentre Plus. We also recommend that DWP **evaluate use of the Flexible Support Fund** with a limited number of Jobcentres. This would improve understanding of whether and how it is used to support people with long-term conditions, and if the introduction of further guidance could make it more effective in this respect.

The previous chapter also highlighted examples of local provision – funded by both local government and on a private basis – that appear to be working well for people with health conditions (see case study F). Public sector and grant funding for **local initiatives is often allocated on a short term basis - hindering service provider's ability to plan ahead, or to undertake effective evaluation**. Indeed, many of the case studies we have included in this report did not have good quality evaluation data on which to draw, offering little information on employment outcomes or cost benefits. Where government is funding local provision, it needs to ensure that it is getting the best possible value for money - particularly important within the current economic context. The lack of good quality evaluation evidence also limits our ability to learn 'what works' from this provision, which both other local schemes, and national provision could learn from. This knowledge gap wastes potentially valuable experience and may prevent the expansion of innovative and effective interventions. Effective evaluation requires longer funding cycles (as the government has recognised the value of in the Work Programme and Work Choice) and greater emphasis on lesson-learning. It is particularly important in the case of people with long-term conditions that evaluations examine outcomes over a longer period of time, reflecting the fact that some people are likely to be much further from the labour market than others and therefore it may take longer to demonstrate effectiveness and value for money. The Joint Unit should prioritise **learning through evaluation of the many pockets of good practice that exist in the voluntary and community sectors**.

Conclusion

It is clear from the evidence presented in this paper that there are considerable challenges in providing effective welfare-to-work support for people with health conditions. In the shorter term, the DWP needs to focus on re-building trust amongst people with health conditions that use its services, and ensuring that the structures put in place specifically to help them – such as Payment by Results and the diversity of providers in the Work Programme. In the medium to longer-term, the Department needs to think more boldly, building on, extending and evaluating the substantial pockets of good practice that are already in evidence, often at a local level.

In the final chapter of this paper, we summarise our recommendations for how the current welfare-to-work model might be improved, to improve employment outcomes for those with long-term health conditions.

A more radical approach?

In this paper, we focussed explicitly on improving employment outcomes for people with long-term health conditions, *within* the current welfare-to-work system – in which the new Work and Health Programme will be a major feature.

We believe the recommendations proposed in this paper, if implemented in the new Work and Health Programme and in Jobcentre Plus, will improve employment outcomes for people with long-term conditions. However, our reading of the literature and conversations with a range of experts indicates that if we are to make real progress towards halving the disability employment gap we need to take more radical action. Unfortunately, it is still the case today that for many people, their disability or health condition makes them less likely to be selected for work by potential employers. Radical change to address this would move beyond welfare-to-work reforms and into approaches which seek to increase employer demand for hiring people with long-term conditions, as well as influencing the availability of disability friendly jobs and employers. An exploration of this is beyond the scope of this paper, but we suggest that there would be value for the Joint Unit and other departments, working with disability groups and other key stakeholders, in exploring how we might use incentives to encourage the employment of people with long-term conditions, for example through developing social enterprise opportunities, or the apprenticeship levy.

Halving the disability employment gap is an ambitious and laudable aim, but a country looking for a truly inclusive and productive economy should do more. A more radical approach of attempting to change the labour market itself with innovative solutions is required to ensure that in the future, having a physical or mental health condition, does not dictate their chance of rewarding and fulfilling employment.

5. Recommendations

Work is, in many cases, beneficial for health and wellbeing – this is true for people with and without long-term health conditions. Much lower employment rates for people with long-term health conditions belies the fact that many people want to work – and with the right support and opportunity – can and do work. If we are to sustainably reduce the disability employment gap, then we need to ensure that everyone people with long-term health conditions have opportunities to access, be retained and progress in employment.

Many of the answers to these challenges lie with employers themselves, and with improving access to high quality in-work support for all their employees. In this paper however we have focused on the first stage of the journey: getting into work. In developing this paper, which focusses on the currently available provision of welfare-to-work support, we found indications that the support intended to enable people with long-term health conditions to enter work is not functioning as effectively as it should and could be. We conclude therefore with a series of recommendations to make changes to the current model of provision, which we believe, if enacted by policy makers, would substantially improve provision and employment outcomes for this group.

The assessment process and Jobcentre Plus

Recommendation 1: Co-produce a new assessment for work capability to ensure the reality of living with long-term conditions is at the heart of the process

There is a widespread distrust, and even fear, around the Work Capability Assessment process. This colours the relationship between DWP and those who use its services from the outset. We propose the assessment be fundamentally reviewed and reformed, taking a co-production approach inclusive of people with lived experience. They should be fully engaged, from start to finish. This will not only improve the process and the experience of the assessment - by grounding it in the reality of those who experience it - but will also increase trust and accountability within the system.

Recommendation 2: Separate testing for benefit eligibility from assessments of barriers to work

The implementation of the single benefit payment under Universal Credit offers an opportunity to reconsider the *purpose* of a Work Capability Assessment. We recommend that the assessment of eligibility for the disability component of Universal Credit should be separated from the assessment of barriers to work. This would allow for a more open assessment process and could facilitate greater engagement with clients, especially those with complex and multiple barriers. Any assessment of people's capability to find and maintain work needs to be broad – including the number, the severity and the fluctuations of health conditions, but also factors such as age, previous employment history, caring responsibilities, confidence, access to transport, housing issues, as well as the available opportunities in the local labour market.

Recommendation 3: Maintain and enhance specialist health-related support in Jobcentre Plus

Maintaining a consistent, yet flexible relationship between Jobcentre Plus Work Coaches and individuals is important, as is ensuring the Work Coaches are appropriately trained and confident in doing their job. This should not however be at the expense of specialised support for people with health conditions, such as that provided by Disability Employment Advisors. DWP needs to ensure that access to such specialist support is maintained in every Jobcentre Plus. Further, given the variation in demand for such support across Jobcentre areas, DWP should take a more flexible approach, and investigate ways of linking in further support in localities where need is higher. This may involve working more closely with the voluntary sector, local businesses, or health partners (see local innovation recommendations below).

Welfare-to-work commissioning and payments

Recommendation 4: Protect and support subcontractors/smaller providers by improving their understanding of their rights

The Merlin Standard was introduced by DWP as a response to concerns raised by providers operating as subcontractors regarding their treatment by prime providers. Though the Merlin Standard seems to have improved contractors' perceptions of supply chains, it has done little to improve the experiences of subcontractors, with these smaller, often more specialised organisations still facing uncertain referrals and risks. In commissioning the Work Programme's replacement, the DWP needs to make very clear to subcontractors how Merlin will apply to them, and what protections and reassurances they are entitled to. This will assist them in tendering and planning on an informed, sustainable basis, and should reduce additional risks faced by subcontractors which may inhibit their ability to function properly.

Recommendation 5: Reform the payment structure to better reflect the costs of helping claimants with more significant barriers

As discussed in recommendation 2, a reformed assessment of barriers to work should take into account a broader range of factors which are known to influence someone with a long-term condition's ability to find and maintain employment. Payment structures should be reviewed and reformed in turn to better reflect the costs of supporting an individual into work, and to provide a more readily understandable and fair justification for eligibility for benefit.

Specialist support

Recommendation 6: Remove the 16 hour rule from specialist employment support (currently Work Choice)

By restricting eligibility for Work Choice to claimants who are likely to be able to work at least 16 hours per week, access to this largely successful initiative has been denied to some of the claimants who experience the greatest barriers to work. We should seek to build upon what we have seen to work – any new programme should consider the removal of any such rules, potentially trialling this aspect to ascertain value for money and the impact on job outcomes.

Recommendation 7: Pilot and test models of Individual Placement and Support (IPS) within specialist employment support provision.

The Individual Placement and Support model has been shown to be effective in supporting people with severe mental illness into work, and is currently being trialled for people with common mental health problems. We should continue to build upon this work, reflecting on the IPS model and testing approaches for people with other long-term health conditions within (or alongside) mainstream welfare-to-work support.

Local innovation

Recommendation 8: Improve integration between return-to-work support, health and the economy at the local level

Integration between the decentralised, devolved and other local bodies on return-to-work for those with health conditions is currently limited; yet we know that such ways of working can be very helpful. To enable this to succeed on a wider scale, DWP must consider how to decentralise its practices, and forge stronger links with local health and business stakeholders (such as CCGs and LEPs) to enable greater decentralisation of effective and locally appropriate welfare-to-work provision. Bodies such as NHS England, Public Health England and the Department for Business, Innovation and Skills will all have major roles to play.

Recommendation 9: Evaluate and learn from existing provision

The Government needs to ensure that it is getting the best possible value for money on local and devolved initiatives, and that it learns lessons from these regarding 'what works' for people with long-term

health conditions. In order to build a solid evidence base, which includes return on investment, funding for initiatives needs to be allocated on a longer-term basis, with in-built allowances for evaluation. Additionally, the Joint Unit should prioritise evaluating the many examples of good practice that exist in the voluntary and community sectors at a local level.

Recommendation 10: Improve awareness of and quality of information on usage of the Flexible Support Fund

The Flexible Support Fund is potentially a useful resource for individuals with long-term conditions and can be used to facilitate beneficial local partnership working. However, to gauge whether it is working effectively in this respect - or whether improvements could be made - it needs to be more widely used, and we need a better understanding of *how* it is used. DWP should both publicise it internally within Jobcentre Plus, and commission an evaluation within a few target areas to better understand how it is used and to what end.

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