

SMOKESCREEN

a Spartacus Network report
in response to
Improving Lives: Health, Work and Disability Green Paper

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Spartacus Response to the Ministerial Foreword

This Government is not determined to build a country that works for everyone. It is determined to build a country where virtually everybody works as units of productivity for the benefit of the State, regardless of the damage and danger to the individual's health.

A disability or health condition very much dictates the path a person is able to take in life. Often a person's talents can't be unlocked or fully utilised due to the nature of their disability or health condition. No amount of determination or aspiration will change this, and it is distasteful that within the opening paragraph of the Ministerial Forward the Secretary of State for Work and Pensions considers it appropriate to comment on the determination or aspiration of sick and disabled people.

The Minister concedes that periods of ill health or experiencing a condition that gets worse can cause huge difficulties. However the Minister himself then openly admits that people are then, as a consequence of ill health, unable to support themselves. Clearly the Minister fails to recognise the agreement between state and citizen, and that it is the failure not of the claimant who is too ill to work, but of the poverty levels of benefit that this report is trying to hide. It is this poverty that causes health conditions to become worse, placing the individual further from recovery and the return to work and it is this poverty that creates additional burdens on the NHS.

Charities, organisations and disabled people have all repeatedly explained that work programmes, unless highly specialized and with large financial commitments centred on the individual, will fail. However this report suggests that the solution is to reduce the finances of the individual and replace them with much generalised overseeing, not the highly specialized support that people need.

The Minister acknowledges that the right type of work can be beneficial; however there is no evidence that the right type of work is available. Instead for many they will enter the revolving door of the low-pay/no-pay cycle, where the benefits system often responds slowly and inadequately, leading to financial insecurity, stress and often eviction.

The Minister's speech talks of protecting those with the most needs in society, yet the report speaks of increased assessments, claimant commitments, and work as a cure. The work capability assessment is to be further reviewed, increasing fears that the intention is not support, but instead to deny increasing numbers of sick people the financial support they need.

The Minister claims the UK has a strong track record on disability rights and that the NHS provides unparalleled support to people with poor health, and yet the UN reports major failings of this Government, and the NHS is in crisis. The Minister claims to have put mental and physical health on the same footing, and yet people whose minds have broken are regularly kept at police stations due to the lack of beds in secure units. The Minister's claim of hundreds of thousands of more disabled people in work in recent years is due in part to the method of data collection changing, including people whose health affects their ability to work.

Throughout the report there is a constant conflation of minor health conditions, disability and chronic disabling illness. It serves the Government to constantly act as if these three states are one and the same. Halving the disability employment gap would indeed be cause for celebration; however the employment gap is firstly a measure of the difference of two variables, (the employment rates) and secondly the 'disability' unemployment rate includes those who have chronic illness, and are not disabled in the literal sense.

The Minister speaks of highlighting, confronting, and challenging the attitudes, prejudices and misunderstandings and yet creates a Green Paper that is suggestive, prejudicial and misleading. Indeed there are prejudices in the minds of employers and the welfare state. An employer is quite rightly prejudiced against a person who is too sick to work, and will generate no

profits. The welfare state assumes our NHS and GPs are incapable of judging if a person is too ill to work.

The Minister talks of innovative action, asking what will it take to transform employment prospects for disabled people and people with long term health conditions. And yet had the Minister listened he would have heard the very simple message: healthy disabled people need social care packages, access to work packages, training and specialized job brokers. Those with long-term health conditions, whose condition is incompatible with work, should not be forced into further assessments and financial deprivation. These are the people who can't work and won't be employed.

Finally to give you a flavour of this report about the UK sickness benefit 'Employment and Support Allowance': the report mentions disability 245 times, but never once does it mention chronic illness, nor does it mention that the UK's current legislation places people judged too sick to work on a subsistence-level income, designed to force people in material deprivation and thus restrict their participation in society.

Introduction

Definition of smoke screen

- 1: a screen of smoke to hinder enemy observation of a military force, area, or activity
- 2: something designed to obscure, confuse, or mislead

In 2016 the Conservative Party stated that they would reduce the financial support for people too sick to work from £102.15 per week to £73.10 per week, equivalent to Job Seekers Allowance (JSA), by removing the WRAC – the work related activity component of the Work Related Activity group (WRAG).

JSA, and previous unemployment benefits, were designed to be short term subsistence financial help, originally expected to average six weeks. It is not designed to cover long term costs – such as extra heating, hospital appointment parking expenses, replacement of white goods, clothes, vehicle costs etc. or for bridging the financial gap between the Local Housing Allowance and private rent. It is designed to be an uncomfortably low income to prevent people being financially and emotionally secure, and thus increase their motivation to find paid work.

The average amount of time a person with a mental health condition stays on ESA in the WRA group is 51 months (excluding contributory (c)ESA); whilst on JSA over 50% of people move off within six months. The cut to ESA means that sick people are expected in future to bridge the gap in their finances for a significantly longer time, whilst being also unable to change their circumstances due to the severity of their illness or disability.

To enter the WRA group people have to demonstrate that they have health or functional barriers to work, which are significant enough to prevent them from entering sustainable work in the longer term. This comes after people have reached possibly the end of their occupational sick pay, the end of an additional period of statutory sick pay, and have been certified as too sick to work for a period of at least 13 weeks.

The changes were introduced to ‘remove the financial incentives that could otherwise discourage claimants from taking steps back to work’.¹

It is clear that the Government, when stating this as the reason for the cut; failed to recognise previous financial restrictions, failed to appreciate that numerous assessments including their own have already identified people as too sick to work, and failed to recognise that previous limitations to income have not discouraged claimants from claiming.

£640 million a year of savings were initially forecast by 2020-21; this was later revised to £450 million a year.

The changes were widely criticised by disabled charities. The idea that the WRAC incentivises claimants to not look for work has been particularly disputed.

The proposals were opposed by opposition parties. Amendments to retain the component (and equivalent in Universal Credit) were tabled and agreed at the Lords Report Stage of the Welfare Reform and Work Bill 2015-16...

These were then overturned by the Commons. A further amendment requiring the Government to provide analysis of the impact of the changes before introducing them was also proposed by the Lords, and subsequently overturned by the Commons.

Alongside the changes to the WRAC was an announcement to provide ‘new funding for additional support to help claimants return to work’. The Government has since announced a series of measures and funding to deliver this... in the October 2016 Green Paper, Improving Lives.

¹ House of Commons Library Briefing: Abolition of the ESA Work-Related Activity Component. January 2017.

This report examines the proposals in the Green Paper to investigate if this additional support in any way mitigates the financial effects of the cuts.

The Green Paper itself refuses to address the cut – referring to it as ‘current legislation’. Instead the paper offers new forms of Work Programmes, using Prime contractors who have already failed to perform in previous work programmes. Under the Government proposals the Primes will have 80% less funding than previous work program initiatives.

The Government is seeking to address the concerns about the volume of claimants who claim ESA due to Mental Health, and further for musculoskeletal conditions. To achieve this the report; fails to recognise the spectrum and severity of the targeted ‘mental health and behavioural’ group, attempts to downgrade the severity of the conditions by using terms such as ‘common’, and by suggesting that non-medical employment assistants could be trained to be capable of diagnosing not just the condition, but the severity and the impact of work, via a one-off Health and Work conversation.

It denigrates the experience of GPs claiming they are not trained in Mental Health illness, and demands for GPs to make work a health outcome, suggesting mandating them if necessary. The proposals involve using the Voluntary sector – such as Mind – to provide the mental health support, without identifying if the voluntary and charitable sectors have the capacity or the capability to assist. Previously the use of voluntary and charitable sectors as sub-primes has failed, as they have frequently not been adequately or reliably compensated for their input, or the Primes failed to utilise them properly or even engage with them at all.

Additionally there is no proposed future legislation for employers to retain or employ sick and disabled people; however there is the suggestion that employers instead purchase income protection insurance, which raises more questions regarding the role of National Insurance and the future of the NHS.

The overwhelming strategy in the Green Paper is the commodification of sickness, and making treatment an intrinsic part of eligibility for financial support by embedding it into a work program.

Significant Themes

This chapter is about the significant themes that occur within the Green Paper. It provides an analysis and commentary on how the government's stated beliefs and plans compare to its actions since 2010 and to the available research and data. We show that much of what the government writes is a fatuous, disingenuous and a smokescreen for its real intentions. The government uses buzz words to give an appearance of good intent and genuine care, but the reality is a report designed to give the appearance of helping sick and disabled people whilst actually cutting and restricting access to their income, increasing conditionality, removing choice and imposing an ideological goal of being in paid work on every chronically sick or disabled person, regardless of the appropriateness of this goal for the individual.

The government repeatedly, through either callous intent or gross ignorance, trivialises the severity of illness and disability experienced by ESA recipients by constantly referring to 'health conditions' and giving its examples of such conditions as obesity, smoking, drinking, mild-moderate depression and mild-moderate back pain. This allows it to make suggestions for support that are far too low level for the needs of chronically ill and disabled people in general, and of ESA recipients in particular. The government appears to believe that computerised counselling will cure people with schizophrenia, and one-off physiotherapy appointments will heal people with brittle bones or epidermolysis bullosa.

It is not only the sick and disabled citizens of this country which the government denigrates. It also insists in the face of evidence that the doctors of this country are wholly ignorant of the generalised benefits of work, and of being unaware that a person does not need 100% health to be able to work. The government then accuses the friends and family of sick and disabled people of holding them back from work through their negative attitudes and expectations, in direct conflict with the evidence the government cites in support of its position.

Finally, the government appears to be seeking inappropriate transfers of responsibilities. The government wants to impose upon doctors a requirement that they always provide healthcare in the context of getting a person to work, over-riding the doctor's medical expertise and discretion in favour of a blanket ideology. The government then proposes and plans for a transfer of the health-related assessment of an individual's capacity for work from the patient's GP and, in the WCA, privately contracted medical professionals to the non-medical, generalist Work Coaches of the DWP's JobCentre. The government also wishes to transfer its responsibility for healthcare, in particular public health, and the income protection role of Social Security from itself to employers.

Committed to helping everyone

The Green Paper is peppered with statements of the government's care for and commitment to its sick and disabled citizens. But these are words, and the government's previous and planned actions belie them.

It is disingenuous to suggest that people with chronic illness and disability can all be "*all they want to be*". Life does not work like that. We all have responsibilities to one another and at times have to sacrifice our desires to their needs. Sick and disabled people experience additional limitations which can unavoidably prevent them from being and doing all they want. The statement "*giving them the chance to be all they want to be*" is both trite and untrue. Phrases such as these have no place in a Green Paper.

The government says it is committed - but its actions don't match up. For everyone to have the independence, security and (as far as possible) good health that being in work can bring, the government will need to provide these through non-work means for those people who are unable to work because of ill-health or disability (the government should provide for people who have other reasons for not working, such as insufficient jobs, child-raising, caring or pensions age, but that is not the subject of this Green Paper). But the government does not provide the necessary income and access:

16. This government is committed to helping everyone, whoever they are, enjoy the independence, security and good health that being in work can bring, giving them the chance to be all they want to be.

22. This government is committed to building a country and an economy that work for everyone.

154. We want to create a country and an economy that works for everyone, in which disabled people and people with health conditions are given the chance to be all they want to be and employers can benefit from a large, valuable and under-used section of the labour market.

- living-costs benefits (ESA) are only 56% of what is needed for an adequate standard of living;
- the extra-costs benefits (PIP) fall very far short of what is needed;
- housing benefits rarely cover the cost of rent;
- council tax support does not cover the full tax;
- hardship payments and discretionary housing payments are temporary and limited;
- Social care and the NHS are both drastically underfunded, meaning people get neither the treatment nor the support at home that they need;
- The public environment remains largely inaccessible; and
- Access to Work is so slow to act that it is all-but unusable.

If the government wants everyone to have independence, it must act quickly to make all public spaces accessible, and to increase the funding through PIP and social care for the assistance needed with daily life and the extra costs incurred by sick and disabled people.

If the government wants everyone to be financially secure, it must provide all sick and disabled people who are out of work because of their health or disability with an adequate income to cover their needs and social participation, as is their human right.

If the government wants people to live and act independently and responsibly, it must give them the physical and financial capability to make their own choices and live their own lives.

But this Green Paper does not provide for these things.

The government says it will “not seek any further welfare savings beyond those in current legislation”, but this is inadequate in the face of the swinging cuts since 2010, and the legislation to reduce many people's sickness benefit to 39% of what they need (less after using some of it to top-up rent and council tax).²

The government promised its MPs that the legislation change lowering some sick and disabled people's incomes to that of jobseekers would not cause objectionable harm because there would be a substantial increase in employment support³ - essentially, that sick and disabled people deemed incapable of work but capable of work-related activity would get such good employment support that the large majority would enter work very quickly. Therefore, people on ESA WRAG could survive on a level of income set to ensure that jobseekers do not feel 'comfortable' on it, and in the expectation that the majority of jobseekers will enter work within a short period of time.

But this is not the position of sick and disabled people on ESA WRAG. They will have already been on this level of income for 13 weeks whilst waiting for their Work Capability Assessment. They are defined in law as incapable of work, having been assessed as such by one of the harshest such tests in the developed world.⁴ These people are not going to get work within six weeks - they are already seven weeks past that date! Conservative estimates using the DWP tabulation tool suggest that most ESA WRAG recipients have such long-lasting illnesses or disabilities that they remain on ESA WRAG for over four years.⁵ No amount of employment support can make up for the poverty endured, and there is substantial risk that the individual's health will deteriorate even further as a consequence of the harmful effects of poverty.⁶

The government's perception of the workplace

The government is being disingenuous in its account of the workplace. They want everyone to enjoy the “good health that being in work can bring” (para 16). But they do not discuss how it is that work brings health, and therefore also do not discuss how work can harm health and how worklessness can benefit health. They write that the presence of certain features can promote health (“autonomy, an appropriate workload and supportive management”, para 20), but not that it is their absence that harms health.⁷ They say that the need for good working conditions “can be very personal”, when no research has suggested that the important factors are anything other than universal.⁸ They recommend employers to supply public health programmes, without checking that the employer isn't making his employees sick in the first place. They talk about the ‘business case’ for protecting employees’ health (via public health measures, not good working practices) but not about employees’ rights to non-exploitative, non-harmful work.

² Davis, A., Hill, K., Hirsch, D. & Padley, M., 2016. A Minimum Income Standard for the UK in 2016, York: Joseph Rowntree Foundation.

³ Mortimer, C., 18/03/2016. Iain Duncan Smith: John McDonnell and Nadine Dorries lead social media in shock and amusement at resignation. The Independent.

⁴ Grover, C. & Piggott, L., 2012. Employment and Support Allowance: capability, personalization and disabled people in the UK. *Scandinavian Journal of Disability Research*. 15(2):170-184 doi:10.1080/15017419.2012.686890

⁵ Based on averaging the number of ‘people months’ on ESA by the number of people, using the upper boundary of each timeframe. ESA data has a bias towards short claims because it has not been in existence long enough to accumulate long-term illnesses and disabilities.

⁶ Baer, J. C., Kim, M. & Wilkenfield, B., 2012. Is it Generalised Anxiety Disorder or poverty? An examination of poor mothers and their children. *Child and Adolescent Social Work*

Raphael, D., 2002. Poverty, income inequality, and health in Canada. Centre for Social Justice Foundation for Research and Education, Toronto.

⁷ Baumberg, B., 2014. Fit for work – or work fit for disabled people? The role of changing job demands and control in incapacity claims. *Journal of Social Policy*. 43(2):289-310 doi:10.1017/S0047279413000810

⁸ Ibid.

This disingenuousness is dangerous. It allows the government to write what should be a seminal paper on sickness benefits and supporting sick and disabled people without actually discussing how work makes healthy people ill and makes sick people even worse. This smokescreen allows the government to talk about getting sick people into work as though work will cure not harm them; and the measures it recommends for employers and for employment support workers are inadequate and inappropriate. This is not the revolution in employment support that Conservative MPs were promised in return for voting to cut the incomes of sick and disabled people who cannot work.

The benefits of employment

17. The evidence is clear that work and health are linked. Appropriate work is good for an individual's physical and mental health. Being out of work is associated with a range of poor health outcomes.

279. Evidence shows that being in appropriate work is good for health and that being out of work can have a detrimental effect on health.

Work does not cause good health directly. Rather, it is associated with (mental) good health via six mediating factors. These six factors are what support good health, and their absence can lead to bad health. Five of the factors are 'latent' benefits: social interaction; social identity or status; a schedule or time structure; fulfilling activity; and collective purpose.⁹ These factors promote good mental health, and their absence can lead to depression, anxiety and stress. Poor mental health can in turn result in poor physical health through the influence of chronic stress on the body.¹⁰ The sixth factor, income (the relief of financial strain), is a 'manifest' benefit.¹¹ It is more obviously linked to health: inadequate income is stressful, time consuming, and brain sapping;¹² long-term, it leads to chronic stress-related illness

such as heart disease;¹³ at the extreme end it means malnourishment, malnutrition and unhealthy living accommodation.¹⁴

These illnesses are public health matters. They are the consequence of poverty, and can be alleviated by lifting someone out of poverty. This is one of the purposes of proving income protection via social security. The government misleadingly uses 'worklessness' as a rough, and unnecessary, proxy for the effects of poverty. In so doing, it implies that the chronic illness or disability of people on ESA is due to their worklessness. This misleads the reader.

People on ESA are there because of a huge range of illnesses and disabilities, which are often neither preventable nor controlled. The existence of infections, cancers, auto-immune disorders, neurological damage, personality disorders, learning disability, sensory impairment, autism spectrum disorders, genetic disorders and more - these are not due to worklessness, and nor are they cured by taking up work. It is trivial, demeaning and dishonest to write a paper on health and work as though the illness that prevents work is the depression, anxiety and stress associated with

⁹ Jahoda, M., 1981. Work, employment and unemployment: values, theories and approaches in social research. *American Psychologist*, 36(2), pp. 184-191.

¹⁰ Cooper, C.L. & Marshall, J., 2013. Occupational sources of stress: a review of the literature relating to Coronary Heart Disease and mental ill health. In *From Stress to Wellbeing, Volume 1. The Theory and Research on Occupational Stress and Wellbeing*. Ed. Cooper, C.L.

¹¹ Fryer, D., 1986. Employment deprivation and personal agency during unemployment: A critical discussion of Jahoda's explanation of the psychological effects of unemployment. *Social Behaviour*, 1(1), pp. 3-23.

¹² Mullainathan, S. & Shafir, E., 2013. *Scarcity: why having too little means so much*. Times Books.

¹³ Cooper & Marshall, 2013.

¹⁴ Shelter, 2015. *Cuts and changes to Housing Benefit for private renters (LHA)*.

want (poverty) and idleness (lack of opportunity), rather than the disabling, chronic illnesses and impairments that are largely a matter of chance.

The government's persistent focus on work as both the goal and the solution marginalises sick and disabled people who cannot work, and diverts public attention away from the government's deliberate choice not to support those people who need it. Because work does not directly cause good health, but only indirectly via mediating factors, it is not work that is important but the presence of these mediating factors. It is possible, therefore, for work to harm health by not providing these factors; it is possible also for worklessness to improve health by providing these factors and more. A person can have an income through inheritance, a partner's wealth, savings, or social security - work is not the only source. A person can achieve all of the latent (social) benefits of employment through other means such as family duties, religious observances and voluntary work. Outside of paid work, a person can also improve their physical and mental health through beneficial physical activity; retired people report an improvement in health after leaving work because they are freed up to engage in activity that is beneficial for their health.¹⁵

There are jobs in the UK that are so low-waged as to fail to provide an adequate income; that have such variable hours that they fail to provide a time structure; that are so mundane as to be unable to provide any fulfilment; so exploitative as to actively counter any sense of collective purpose; and where the working conditions are set to prevent social interaction. The only thing a bad job does is provide a status, and even then it is only the passive one of not being a recipient of charity. It is entirely possible therefore that work causes harm, not benefit, as we will discuss further in the next section, and that leaving work will result in an improvement in health.

This conflation of activity - including therapeutic activity - with paid or unpaid employment is disingenuous and dangerous. Appropriate activity may be good for an individual's physical and mental health, but work can be damaging. The workplace can be more than "unsupportive" of health and wellbeing; it can be actively detrimental. This was a key finding of both Waddell and Burton's 2006 paper¹⁶ and Sir Marmot's 2011 report.¹⁷ It is well established that high-strain workplaces are detrimental to health.¹⁸ High strain jobs tend to be those with high pressure and low autonomy. By definition, these tend to be

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17. The workplace can either support health and wellbeing and the health system can actively support people into work in a virtuous circle or the workplace can be unsupportive and health and work systems can work against each other.

jobs at the bottom end of the market - ones where the employee's main selling point is his ability to work fast under pressure, and where the role is simple enough or so highly managed as to leave little to no discretion over job tasks.¹⁹ They are therefore often also low wage and insecure, and employers are known to evade their statutory duties regarding paid leave and rest breaks during work.²⁰

¹⁵ Ding, D. et al., 2016. Retirement - a transition to a healthier lifestyle?. *American Journal of Preventive Medicine*, 51(2), pp. 170-178.

¹⁶ Waddell, G. & Burton, K. A., 2006. Is work good for your health and well-being? DWP.

¹⁷ Marmot, M., 2010. Fair society, healthy lives. Department for Health.

¹⁸ Baumberg, 2014.

¹⁹ Selenko, E., Batinic, B. & Paul, K., 2011. Does latent deprivation lead to psychological distress? Investigating Jahoda's model in a four-wave study. *Journal of Occupational and Organizational Psychology*, 84(4), p. 723-740.

²⁰ Business, Innovation and Skills Committee, 2016. Employment practices at Sports Direct. House of Commons Third Report of Session 2016-17

Wasley A. 22/12/2015. UK chicken farming puts workers and food safety at risk: a climate of fear and often appalling conditions grip workers in the UK's chicken abattoirs and processing plants. *The Guardian*.

These jobs are not uncommon in the UK. They are a key part of the 'low skill equilibrium' and job polarisation which marks the UK out from the other western European countries.²¹ They are likely to be a significant contributor to the rise of work-limiting mental illness.²² In what should be a seminal paper on work and chronic illness, produced by a government that has held power for approaching seven years, it is appalling that the government gives no consideration to the impact of bad work on health.

It is not work per se that should be the goal of a government for its citizens, but the latent and manifest benefits of work. For most people - provided the government regulates employers to prevent exploitative and harmful working places - this is best provided by a paid job, both because people tend to prefer to earn their income and because it is an opportunity to provide all six benefits through one means. But not everyone can work, and a focus on work as the goal - rather than the six benefits of employment - means that sick and disabled people who are unable to work are marginalised, and allows the government to neglect its duty to provide for its sick and disabled citizens.

Smokescreen

Focusing on work as the goal allows the government to neglect its duty to provide for its sick and disabled citizens.

Low-skill jobs

The government trivialises the issue of health at work by assuming that all work is at least not actively harmful in and of itself. It ignores the existence of "toxic" workplaces that actively make people ill. These workplaces are normally at the bottom of the job market, where the main 'selling point' of an employee is their ability to work fast for long hours. Unskilled and low-skilled workers have little to nothing else on which to sell themselves to employers. The unskilled nature of the work means there is little discretion or autonomy within the job; such prioritising and decision-making skills tends to be by definition higher-skilled jobs.

Unskilled and low-skilled jobs are typically competed for on the basis of productivity - who can work fastest for longest. In these sectors, 'work to targets, 'work under pressure' and 'highly motivated' are euphemisms for competitive, pressured environments with mundane and often repetitive tasks. In a country with many workers unemployed or underemployed, employers of low-skill jobs have access to a substantial labour pool of people competing for any work they can get. Employers hold the power, and use it to keep wages and working conditions down. They have no incentive to invest in the health of their workforce, because they can easily dismiss a sick employee and hire a healthy one, on the grounds that the sick employee can no longer perform the job role. Sick and disabled people often have no 'edge' to offer to make the employer desire them specifically over a different, healthy person. No amount of research on the business case for employers recruiting and retaining skilled or higher professional staff will cause employers at the bottom of the market to take on less productive workers.

²¹ Finegold, D. & Soskice, D., 1988. The failure of training in Britain: analysis and prescription. Oxford Review of Economic Policy, 4(3), pp. 21-53.

Casebourne, J. & Coleman, N., 2012. Making it work: tackling worklessness through innovation. Nesta.

²² Baumberg, 2014.

Changing world of work

27. Older people will make up a greater proportion of the workforce in the future.

28. There is a known correlation between an ageing population and an increasing prevalence of long-term chronic conditions and multiple health issues.

29. New information and communication technologies have changed the nature of work tasks.

This change may bring... more flexible working... but can also have less positive effects like work intensification that may affect people's ability to cope or adapt in work with a health condition.

30. Lifelong learning can also offer the opportunity for people to gain new skills to change roles.

The government refers to the ageing workforce as a challenge to respond to, as employers may need to adapt their workplaces and working practices to accommodate more people with health conditions. Yet it gives no indication, either in this Green Paper or in direct reference, that it will increase funding to the NHS to meet the demands of an ageing population, and to ensure people are not unnecessarily kept from work due to 'public health' illnesses. The government expects individuals to improve their health and employers to provide healthcare, but makes no mention of its own role and responsibility to provide equitable, free-at-the-point-of-use healthcare to all its citizens.

The Government talks of old people, increased poor health, and work intensification and yet can see no contradiction at all with these scenarios and its planned cuts to sickness benefits. It blithely points to its assurance that it won't legislate for further social security cuts, as though this absolves it of responsibility to provide for people pushed out of work by the combination of increasing illness and increasing work intensity. It tells employers to provide public health for their employees (presumably out of their business profits), but does not consider its duty as a public body to provide public health.

The contents of this paper show that the Government also does not intend to support people who can do some work to access paid work or social participation. The government mentions lifelong learning, but not that it does not provide access measures or funding

for sick and disabled people to train for a job suitable for their abilities. Nor does it consider whether or not people on a less-than-subsistence income can actually try to invest in themselves. If the Government is to make lifelong learning a reality then it must commit itself to the provision of such learning and the costs involved, rather than blind the public to the true situation: that chronically sick people can't, and the government deliberately won't, invest in them.

Government perception of work-limiting illness

The government appears to believe that the majority of people on ESA have mild-moderate illnesses or disabilities which are not in themselves barriers to work. It seems to think that major impacts on the ESA caseload could be made by changing "how we live our lives". One way it wishes to see this happen is by introducing public health support schemes into workplaces. Another is to provide online Cognitive Behavioural Therapy. It thinks that our perceptions of ourselves as too sick to work stem predominantly from the outcome of our WCA and the low opinion of people around us - not from our daily realities. It points to the fact that some sick and disabled people are in work as if to say that every sick and disabled person can - and should - work.

All of this mounts up to an apparent belief that people with severe chronic disabling illness are not too sick to work. It combines with the government's emphasis on conditionality to imply that the government's belief is that sick people are not out of work because they can't or shouldn't work, but because they prefer ESA to paid work. Yet there is no evidence to support such a belief.

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The government isn't trying to help sick people. It's trying to abandon them and then convince the public it's not a deliberate policy choice.

Words matter. What would happen if every instance of 'health condition' or 'long-term health condition' were replaced with a more accurate 'chronic incapacitating illness'? Suddenly, the government's smokescreen would clear, and its disingenuousness would be revealed.

'Health conditions'

32. Almost 12 million working age people in the UK have a long-term health condition, and of these 7 million are disabled. A health condition does not, in itself, necessarily prevent someone from working. Indeed people with a long-term health condition who are not reported as being disabled have a very similar employment rate to people without any type of health condition – around 80%.

The government seems to think that 'chronic incapacitating illness' is the same as 'health conditions', which it covertly defines as obesity, smoking, drinking, mild-moderate lower back pain and mild-moderate depression.

A long-term health condition is not the same as a chronic illness; in fact, many health conditions are neither disabling nor incapacitating. For example, managed diabetes, epilepsy and spina bifida may have no disabling impact at all - because they are under sufficient control. Eating, drinking or smoking too much are not illnesses until complications such as severe leg ulcers, diabetic neuropathy, severe COPD or extensive cirrhosis. The government misleads its reader by using the term 'health conditions' rather than words such as chronic or long-term coupled with disabling or incapacitating illness or sickness.

The government points out that people with 'health conditions' that don't cause disability or work-limitation are not disabled or limited in regards to work. This is a tautology. But the consistent use of the phrase 'health condition' allows the government to imply that there is little substantive difference between those who work and those who don't. Again this is a conflation of minor conditions. Discussing those who are not sick in a report about sickness benefit is just an intentional distraction. It serves no purpose beyond suggesting that mild health conditions are in some way relevant to this debate, when in fact they are not.

The case studies that the government included exemplify this. None had an illness or disability that caused substantial, long-lasting incapacity for work. Some had a minor illness or injury that slightly impaired work and required minor adjustments or slightly reduced hours.

Smokescreen

Discussing those who are not sick in a report about sickness benefit is just an intentional distraction.

Others had acute crises that resolved quickly with moderate levels of healthcare. The majority, possibly all, would have been assessed as fit for work by the WCA. These people are not relevant to a paper on sickness benefit and how to support people who are too sick to work or who are so disabled as to need more than basic level adjustments in order to be able to work.

To actually be eligible for ESA a person has to be either very disabled, or have a disabling long-term unmanageable illness that creates huge barriers to work. It's incredibly difficult for an employer to make adaptations for illness - basic desirable attributes of the employee, such as reliability or working to deadlines, do not exist with seriously or chronically ill people. It is therefore no surprise that people with severe and chronic conditions are not moving into work; they simply do not have the basic attributes an employer needs. An employer may disregard punctuality, reliability, attendance and performance if the sick person has an outstanding and rare talent, but these scenarios are extremely uncommon.

Nor are disabled people easily incorporated into the workplace; in fact, despite often self-reporting as capable of at least part-time work, people with visual impairments and learning disabilities have amongst the lowest employment rates.²³ The provision of Access to Work in a timely manner, coupled with experienced and specialised job brokers, could make a huge difference to the employment rates of these people - yet bar learning disabilities, the government makes no mention of any of the 'static' disabilities at all.

There is no evidence in this report that the Government recognises health conditions to be chronic incurable states of being, that chronic illness can be so incapacitating as to prevent work, and that employers - quite rightly - won't employ those too sick to work. The government presents chronic illness as minor health conditions (which wouldn't be eligible for ESA) which the report suggests will be cured by work, and it uses this presentation as a smokescreen for financial cuts, increased conditionality, further assessments and so-called work-related activity that has no benefit.

Smokescreen

The government presents chronic illness as minor health conditions which would be cured by work, and it uses this presentation as a smokescreen for financial cuts, increased conditionality, further assessments and so-called work-related activity that has no benefit.

Sickness prevention

The government's focus on sickness prevention simply confirms its obsession with the types of illnesses that typically do not lead to needing sickness benefit. Very few people report obesity or drug addiction as a prime reason for claiming ESA. Because the DWP data records only an assumed primary reason, we have no idea what the underlying causative conditions were or how many other illnesses the individual has. Yet obesity and drug addiction are the conditions that the DWP and media choose to report and focus on, with callous disregard for the individual's personal situation, and in an apparent deliberate attempt to demonise ESA claimants and mislead the public.

If the government wishes to talk about preventable and manageable health conditions such as alcohol and tobacco addiction, obesity and diabetes it should explicitly say so, in order to make clear the difference between these and non-preventable, partially-manageable illnesses. The two need very different policy approaches. Preventable and manageable conditions are a matter of public health and fall under the purview of the NHS (not the employer). They typically are not incompatible with work. Unpreventable and partially-manageable illnesses are often severe and chronic, causing a severe restriction on capacity for activity and therefore also for work. These come under the NHS (not employers) in terms of healthcare, and under Social Security in terms of income protection, access to society and adequate living standards.

²³ People with disabilities in the labour market, 2011. Office for National Statistics.

Dench, S., Meager, N. & Morris, S., 1996. The retention and recruitment of people with disabilities. Institute for Employment Support.

30. And while many conditions are not preventable, the evidence is clear that the way we live our lives can influence health outcomes.

190. The benefits of physical activity are most pronounced for those who are currently inactive. Disabled people and those with serious health conditions are much less likely to be physically active than others.

Again, language is crucial. The government would have done better to mention serious lifelong illnesses here, such as Crohn's Disease, Huntington's Disease, lupus and muscular dystrophy, or 'severe and enduring' mental illness such as schizophrenia that can result in significant disability. Language is important, particularly in a document that purports to help people with severe chronic disabling illness. By choosing to mention common, controllable conditions, the government deliberately downgrades the severity of chronic illness in the reader's mind.

The chronic illnesses of people on ESA are typically not preventable and only mildly manageable. Fatigue and pain are two of the most common symptoms and tend to be the most difficult to control, not least because the majority

of painkillers are sedative. People with limited capacity for activity are extremely vulnerable to the whims of government policy, particularly in regard to social security, social care and healthcare systems. The deliberate choice of the government to underfund social security and place increasing responsibility on people who lack the capacity and support to use it should be widely condemned as immoral.

The government's suggestions on how to prevent and manage ill-health continues its (deliberate?) habit of discussing chronic illness as though it is the same as non-work-disabling health conditions. The measures it suggests employers take to combat illness are all centred on public health, such as diet, exercise and quitting smoking. It does not suggest that employers reform their working practices to protect their workers' rights and health, or that it would regulate to make such protection compulsory. Thus it ignores one of the primary causes of mental ill-health and physical stress-related illness.

Smokescreen

The deliberate choice of the government to underfund social security and place increasing responsibility on people who lack the capacity and support to use it should be widely condemned as immoral.

The government also tries to imply that chronic disabling illness is the fault of the individual. This is apparent in its choice to use obesity, drinking and smoking as examples of the chronic illness that keep people on ESA from work. These are typically perceived as under the individual's control (albeit a challenging one for people who are addicted). But as these are rarely, if ever, the (sole) illnesses that cause people to claim ESA, incorporating personal responsibility into a report on helping people with chronic illness or disability is pejorative and misleading.

Commenting on disabled and chronically ill people's activity levels in a context that implies the illness or disability is a result of or significantly exacerbated by low physical activity is wholly inappropriate. Many people are, as a fundamental part of their illness, in such pain and/or fatigue as necessarily negates significant physical activity, or rendered physically incapable by the illness or injury. The government should not be implying that these people simply need to be 'helped and encouraged' to be physically active when it has no awareness of the specific capabilities of the people concerned.

The government also seems to want employers to police the behaviours of their workforce in their daily lives. It is not employers' responsibility to comment on their employee's lifestyles. As far as it is the responsibility of any person or organisation (other than the individual concerned), it is

the responsibility of the government to support people in healthy lifestyles through measures such as providing access to affordable gyms, affordable healthy food, and affordable decent housing. The government should also be seeking to protect the health of its citizens in the workplace by regulating against 'toxic' workplaces and damaging working conditions, and by enforcing such regulations.

Sudden illness?

185. A person who falls ill in work or who has an existing condition or disability that worsens may face a critical point where the right support from their employer can make all the difference between them remaining and flourishing in work or struggling to cope and falling out of work.

People rarely face a 'critical point' at which they leave work (apart from cancer or major injury); rather, they experience declining health and increasing difficulty with work over a period that may last several years.²⁴ This may present initially as sickness presenteeism, undetected by the employer, followed by isolated short periods of sick leave or holiday used as sick leave. Some people will move to lower paid, shorter hour positions as they try to keep working. Many in the low end of the job market will experience multiple repeats of the low pay/no pay cycle before finally needing to be on sickness benefits long-

term.²⁵ At this point, they have a serious long-term illness.

When people do 'fall out of work' (and why use such a loaded term?), it is not the loss of work per se that is the cause of stress. It can cause some distress to lose one's identity and purpose as gained from work, but it can also be a relief for people to finally stop trying to push their body or mind to cope beyond its capabilities. The stress is the financial strain of poverty as caused by the benefits system, and the emotional strain of recounting one's difficulties to a stranger who has the power to remove one's only feasible long-term source of income.

Illness groups

37. People who have more than one condition are also more likely to be out of work – disabled people with one long-term health condition have an employment rate of 61%, but the 1.2 million disabled people who have 5 or more long-term health conditions have an employment rate of just 23%.

Multiple conditions

Most people on ESA have more than one chronic illness or impairment. Having more than one chronic illness is a proxy measure for severity as it necessarily increases the likelihood of having one fully incapacitating illness. There will also be an accumulation of disability, and different illnesses and impairments may have a multiplier effect on severity and incapacity.

²⁴ Bratsberg, B., Fevang, E. & Røed, K., 2010. Disability in the welfare state: an unemployment problem in disguise? IZA.

²⁵ Ibid.

Shildrick, T., MacDonald, R., Webster, C. & Garthwaite, K., 2012. Poverty and insecurity: life in low-pay, no-pay Britain. Bristol: The Policy Press.

Fluctuating Conditions

38. Of course not all health conditions are static. Many, such as some mental health conditions, fluctuate over time, and affect people differently at different times.

128. People might have fluctuating health conditions so they are able to engage with help one week but not the next. And survey data shows that 52% of people in the Support Group do want to work, although their health condition may be a barrier to this.

This approach would be truly responsive, allowing the work coach to adjust requirements and goals dependent on changes in a person's condition or circumstances. This is particularly important for people with fluctuating health conditions, as the support available would always be reflective of their needs.

226. There are primarily two types of health conditions:...

a long-term condition which may be fluctuating but once developed may last throughout an individual's life; and

a sudden health event... where the event happens and then there is a recovery phase to either full health or a new normal for the individual.

There is a clear misunderstanding about 'fluctuating conditions', almost suggesting that people fluctuate between being well and being ill. The government's implication is that these people should work when not ill, and not work when ill. But a person who needs repeated periods of sick leave is not desirable to an employer; this is why performance management focusses on sick leave as a reason for disciplinary action. In truth people fluctuate between being ill, and being very ill.

Hence a claimant in the Support group with a condition that fluctuates means the person is much further away from being well enough to work, with illness as a definite barrier to work, not a maybe. And there is no use in being able to engage in employment support one week and not the next - what employer wants someone who can at best only do a few hours a week every other week? What is the point of the government mandating people to take part in activity that does nothing for them bar remove the opportunity to do something productive, fulfilling, beneficial or enjoyable?

A fluctuating condition is usually random. A person cannot control when a health crisis will happen, or know how long it will last. The idea that a work coach can plan anything for the claimant is pure fantasy. Fluctuating conditions are conditions that cannot be managed. People cannot decide to have a multiple sclerosis relapse on a day of their choosing; a person with cystic fibrosis cannot foretell when they will get a respiratory infection; a person with fibromyalgia cannot time when they have a flare-up; a person with osteogenesis imperfecta does not pick a time to break a bone. The work coach would, as claimants do, have to wait and see what each day brings, or each hour.

Long-term

The government repeatedly implies that people on ESA are there not because of unavoidable chronic illness such as osteogenesis imperfecta, cystic fibrosis and leukaemia, but because of 'public health' conditions (obesity, smoking, drinking, mild-moderate lower back pain or mild-moderate depression) and the effect of long-term worklessness. The government writes that once on ESA, a person's "chance of finding work is slim", as though the onhly reason a person's chance of finding work at this point is because they haven't worked for some time, rather than because they haven't

18. We know that the longer a person is out of work the more their health and wellbeing is likely to deteriorate.

23. So, every day matters. For every week, every month, every year someone remains outside the world of work, it is increasingly more difficult for them to return and their health and wellbeing may worsen as a result. We must address this downward spiral.

38. What is clear, though, is that once someone is out of work due to a health condition and claims Employment and Support Allowance their chance of finding work is slim.

199. We know that the longer someone remains out of work the less likely they are to return.

been physically or mentally able to work for some time. That is, it assumes a 'duration' rather than a 'selection' effect.

Many of the non-preventable, non-public health illnesses are long-term. They are illnesses that are genetic, degenerative or otherwise incurable. People with these illnesses will necessarily, once at a severity that precludes work, remain unable to work in the long term. The fact that people who have long-term conditions that are incompatible with work may not be able to return to work should not be construed as a problem, other than in that it indicates a need for healthcare.

It should not come as a surprise to anyone, let alone the government, that the most sick and disabled people in the country remain on sickness benefit for more than 2 years. The support group contains people who are terminally ill, incurably and unmanageably ill, have a degenerative illness or have multiple disabilities. Compared to Incapacity Benefit, which used a less harsh (but still one of the harshest ever²⁶) test, the people on ESA are further away from the job market, and on average more sick or disabled than the IB group - because they have all been tested to a higher criteria, and found too ill or disabled to work. If this thinking was taken to its ultimate extreme and ESA was given only to those with a terminal diagnosis, then none of them would be returning to work.

Public Health

What is clear so far is that the government appears to have little to no awareness of the existence of chronic illness outside of what are typically considered 'public health' conditions; and little to no awareness of disability outside of learning disabilities; that it intends to abrogate its responsibilities as far as possible by claiming that the responsibility lies with charities and businesses; and that it intends to downgrade healthcare for chronically sick people to the provision of basic physiotherapy and CBT as delivered by Work Coaches in the JobCentre.

The government, by ignoring the existence of bad work places and chronic illness, has failed to make a good case for the benefits of good work for people in fair-good health. It has laid itself open to accusations of ignorance which undermine all of the policies it wants to bring in. We can have no faith in the government's ability to support sick and disabled people appropriately when it cannot even see the existence of anything other than mild-moderate cases of public health conditions, let alone distinguish between them and their different needs.

Smokescreen

A major problem with the government's thinking and its proposals as laid out here is its apparent inability to recognise the existence and extent of incurable illness.

²⁶ OECD, 2003. Transforming disability into ability: policies to promote work and income security for disabled people.

Much of what the government has proposed here may be appropriate for people with mild-moderate public health conditions: those who are overweight, not obese; who drink, but not excessively; who smoke, but don't have COPD or emphysema; who have back pain, but haven't taken time off work for it (bar any medical appointments); who are depressed, but only mildly so. We can't say for sure, though, because the government hasn't acknowledged that these people aren't the people on ESA, so has also failed to explain how it will identify these people for support. Furthermore, its focus on transferring healthcare away from the NHS towards JobCentres is fundamentally wrong and irresponsible, and it leaves us unable to trust any of the government's plans, however well-intended.

Government perception regarding other barriers

127. As a result of these trends, over 1.5 million people have been given the perception they do not have any capability for work and are unlikely to think about when and how they might start to prepare for an eventual return to work as a result of the Work Capability Assessment.

This label may then apply for years and results in them not receiving any systematic contact with a Jobcentre Plus work coach. 69% of those in the Support Group have been on the benefit for 2 years or more... a high proportion not being engaged for a long period of time.

Attitudes and perceptions

The government says that chronically sick people have been "given the perception" that they are too ill to work "as a result of" their Work Capability Assessment. By inference, this means that chronically sick people must have been agnostic regarding their capacity for work; were waiting for their WCA to tell them (as presumably was their doctor, even as he signed sick notes); and would have perceived themselves as capable of work if only the assessment had returned that result. The problem, according to the government, is not that the chronically sick person is too sick to work, but that the WCA mistakenly reports them to be too sick to work, and they mistakenly believe the WCA result.

This argument does not make sense. The WCA is a usually harsh test by the standards of the developed world²⁷ and has been heavily criticised for over six years for overstating the capacities for work of the people it assesses. Work Programme providers report that people on ESA WRAG are not fit to be there;²⁸ 'expert' panels identify multiple work-place adjustments needed before those

considered 'fit for work' can actually work;²⁹ and the people themselves find that their health deteriorates as they attempt to comply with the work-related activity required of them.³⁰

People who claim ESA have had to have been considered too ill to work by their GP for at least 13 weeks. The people concerned will have lived with their chronic illness or disability during all that time, observing and experiencing its daily effects on what they can and can't do. These are not people who need an external assessor to tell them whether or not they can work; these are people

²⁷ Grover and Piggott, 2013.

²⁸ Work and Pensions Committee, 2014. Employment and Support Allowance and Work Capability Assessments. House of Commons.

²⁹ DWP, 2013. Evidence based review of the Work Capability Assessment: a study of assessments for Employment and Support Allowance.

³⁰ Hale, C., 2014. Fulfilling potential? ESA and the fate of the Work-Related Activity Group. Mind

who know their limitations. What they want to know is not what they can do, but what the government will do to support them to live as independently and as fulfilled lives as they can.

This government's belief that chronically ill people misperceive their capacity is, quite frankly, bigoted. Self-rated health is a complex area. A minority of researchers choose to take the position that a mismatch between self-reported health and medical tests is due to a flawed perception on the part of the sufferer.³¹ The majority, however, consider that self-perception of health is more, not less, accurate than medical observation because it includes factors not measurable by an outside observer.³² This 'benefit-of-the-doubt' position is further supported by recognising that not every illness or injury is known to medical science; not every illness or injury is detectable through external tests; and not every illness or injury has an explained aetiology and pathology.

Smokescreen

What sick and disabled people want to know is not what they can do, but what the government will do to support them to live as independently and as fulfilled lives as they can.

293. Real and lasting change will only come about if we can also address negative cultural and social attitudes about disabled people and people with long-term health conditions.

294. Parents, carers and service providers can have misconceptions about working with a disability or long-term health condition, which can result in them advising against a disabled person or someone with a long-term health condition trying work for fear of it damaging their health.

295. We want these perceptions to change, so that the actions taken forward by the government and others are met by the right behaviours and attitudes.

In trying to cast the blame on sick and disabled people for their perceptions of themselves, the government abrogates its responsibility in the lives of sick and disabled people. It draws a veil over the true position of people with chronic incapacitating illness - that they are too sick for work. It leads to a conclusion that the best welfare for chronically incapacitated people is work. It disregards the probability that many people are too sick to work.

But the government goes further. Not content with covertly blaming chronically ill people for being and remaining ill, it extends the blame to the "parents, caregivers and service providers" of people with chronic incapacitating illness or disability. It cites three papers by McCluskey et al.,³³ which read together simply say that a close relative's perception of the sufferer's pain and disability is related to the actual level, and that despite debilitating and uncontrolled pain, the sufferers are still keen to work.

In reality, it seems unlikely that the majority of 'significant others' around a disabled person have exaggeratedly low expectations of them. The only evidence we could find that might support this statement asked disabled respondents to indicate if other people had a low

³¹ Waddell, G. & Aylward, M., 2010. Models of sickness and disability applied to common health problems.

³² Bombak, A.E. 2013. Self-rated health and public health: a critical perspective. *Frontiers in Public Health*. 1(15). doi: 10.3389/fpubh.2013.00015

³³ McCluskey, S., et al. 2011. The influence of 'significant others' on persistent back pain and work participation: A qualitative exploration of illness perceptions. *BMC Musculoskeletal Disorders* 12:236

McCluskey, S. et al.. 2014. Are the treatment expectations of 'significant others' psychosocial obstacles to work participation for those with persistent low back pain? *Work*. 48:391-398.

McCluskey, S. et al., 2015 'I think positivity breeds positivity': a qualitative exploration of the role of family members in supporting those with chronic musculoskeletal pain to stay at work. *BMC Family Practice* 16:85.

expectation of them³⁴ - which necessarily requires the disabled person to disagree with that expectation, which in turn necessarily requires that the disabled person has not imbued that expectation.

This denigrates the 'significant others' as unable to understand the people to whom they are close, and unable to extrapolate from their own short-term illness or injury to a reasonable understanding of the impact of severe long-term illness or injury.

Smokescreen

The government is being misleading to link these problems to worklessness rather than poverty; but then, worklessness is more easily blamed on the individual, whereas poverty is an issue of endemic and structural injustice for which the government is responsible.

31. To reduce the disability employment gap, we need to understand the reasons why disabled people might be unable to enter or stay in work, and to recognise the wide variety of conditions and circumstances they face. The disability employment gap is affected by a number of factors, for example people frequently move in or out of disability and employment over time.

36. We also need to recognise that some disabled people or people with long-term health conditions may face other disadvantages associated with worklessness...

These might include drug or alcohol addiction, a criminal record, homelessness or caring responsibilities for young children.

37. Factors unrelated to an individual's health condition or disability have a significant impact on their ability to work.

Non-health personal factors

The government rightly recognises that sick and disabled people may experience other difficulties in their life, just as healthy able-bodied people do. The phrasing it uses, however, in the context of this report, risks implying that such as difficulties as addiction, criminal behaviour, homelessness or young children are part of a package of deviant behaviour (entitled 'worklessness'), in contrast to the well-behaved people ('workers') who are not ill, not addicted, are fully law-abiding, are owner occupiers, aren't overweight and do not reproduce.

There is no association between sickness and criminality - when a main stream media outlet attempted to draw similar conclusions, a fact-checking site revealed that chronically sick and disabled people actually had a marginally lower rate of criminal behaviour than the general population.

Many chronically sick people do experience homelessness, but not because of any association with deviant behaviour. Rather it is the effect of too few houses and a government policy that sets housing benefit too low relative to market rent. Landlords have no need to rent to social security claimants because there is a large pool of working prospective tenants.³⁵ The properties that are available to those out of work are often 'beggar's choice' - damp, cold, mouldy, overcrowded and belonging to 'rogue' landlords.³⁶ But with increasing levels of in-work poverty as prices rise and incomes stagnate or fall, bad housing is not restricted to unemployed people; it is simply a consequence of poverty.

³⁴ Hall, J. 30/10/13. Attitudes meet actions: how does Britain feel about disability? Scope.

³⁵ Shelter, 2015.

³⁶ Ibid.

Drug and alcohol addiction at problematic levels are rare amongst ESA recipients. It is only when the effects of these become disabling, such as organ failure or a very strong addiction, that an award would be made. At this point these people are very sick and typically experienced enduring poverty and all the problems that poverty causes.

It's extremely distasteful that this report has stooped to framing the problems society faces as being more pertinent to chronically sick and disabled people, and in some way attributable to the nature of sick and disabled people. Many problems are related not to worklessness per se (many workless people are partners of relatively high earners), but to poverty (which includes people in work). The government is being misleading to link these problems to worklessness rather than poverty; but then, worklessness is more easily blamed on the individual, whereas poverty is an issue of endemic and structural injustice for which the government is responsible.

Deprivation and Inequality

The government writes of the Disability Employment Gap that it "leaves people, and in some places entire communities, disconnected from the benefits that work can bring." As with the majority of this report, the superficial interpretation is misleading. As discussed above, the benefits of work can be obtained through several other means, and for people who cannot work it is the responsibility of the government to ensure that they are not shut out from society as a consequence. It is not the disability employment gap but government policy that disconnects sick and disabled people from society.

23. [The DEG] leaves people, and in some places entire communities, disconnected from the benefits that work can bring.

33. We know that a person's health is affected by the conditions and environments in which they live...The conditions in which people are born, live, work and age, are the fundamental drivers of health and health inequalities.

Because of government policy, sick and disabled people who cannot work live not just in poverty but in deprivation. 'Deprivation' covers more than just poverty, and is more honest than the government's term 'worklessness'. The government quoted the Marmot report on this, saying that "*the conditions in which people are born, live, work and age, are the fundamental drivers of health and health inequalities*". A recent research report found that socio-economic factors can have as big, or bigger, an impact on mortality as lifestyle factors.³⁷ But the government then says nothing about how to improve the situation.

It is not enough for a report that came into creation with the alleged intention of relieving the deeper deprivation the government has caused for ESA WRAG recipients should see fit to state that a damaging situation exists, then move on without suggesting a solution or recognising its own responsibility. The government is pivotal to the inequalities people experience, and with every cut to social security they push people further from the employment market and deeper into poverty and deprivation. It is not worklessness that is the inequality for sick and disability. It is the deliberate refusal of the government to care for their basic rights.

It is inaccurate of the government to say that the disability employment gap is one of the greatest inequalities of the UK. It is not. Of all the inequalities in the UK, the fact that people who are too sick to work are not in work is not one of them. There are many forms of inequality, including justice, income and wealth, opportunity, treatment, and membership of society. The governments

³⁷ Stringhini, S. et al., 2017. Socioeconomic status and the 25 × 25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1.7 million men and women. *The Lancet*. 10.1016/S0140-6736(16)32380-7

since 2010 have knowingly gone backwards on many of these, and it is these that are causing significant inequality in the UK:

- Access to justice has been decimated for poor people, through legal aid cuts and the introduction of fees to tribunals;
- Top earners - who receive not just a wage but also bonuses and more - receive vastly more than care workers and cleaners;
- Access to education and life opportunities differs dramatically depending on where you were born;
- Sick and disabled people are trapped in their homes by cuts to public transport, libraries, day centres, the Independent Living Fund, social care, DLA/PIP and housing benefits;
- People in poorer areas receive poorer healthcare, despite typically having more health needs;

These are the most significant inequalities in the UK - the lack of State provision that means that random luck propels some people into health and success, and traps others in illness and poverty.

Disability barriers

Physical barriers are a sign of a badly built non-inclusive environment, and there is both legislation and assistance via Access to Work and Personal Independence Payment to overcome these barriers. However Access to Work is notoriously slow and poor on delivery, and PIP was deliberately designed to remove considerable numbers of working-age sick and disabled people from the extra-cost benefit they need. The government should be providing legislation and funding to remove these barriers, but there is no evidence in this paper that the government intends either to make the general environment accessible itself, to introduce appropriate legislation, or to enforce existing legislation such as that requiring all buses to be wheelchair accessible.

This is yet another example of a situation in which the government should have used this Green Paper as an opportunity to commit to fulfilling its side of the social contract that keeps a country together - but it hasn't. Everything in this paper is for employers, the NHS (without any additional funding, when it already has too little) or individuals to do; yet the only body the government can guarantee to influence is itself.

Sick/disabled in work

35. There may also be physical barriers to employment for some disabled people and people with long-term health conditions, such as difficulties accessing transport and buildings.

The government makes much of the fact that work and health are linked. However, as it is the healthy people who are able to work, it's fairly self-evident. There are some healthy people out of work, either of their own choice or because of a lack of jobs, and some sick people in work out of financial necessity. But in general, because healthy people can work and people who are disabled through chronic illness can't, there is a simple selection effect.

Disabled people are only in work if their level of disability is sufficiently low relative to their value as an employee. The fact that some people, even some severely disabled people, are in work does not mean that every chronically ill or disabled person can or should work. The more severely disabled a person is, the more valuable they must be as an employee if they are to be worth retaining. For example:

- Stephen Hawking is severely disabled and irreplaceable. He receives significant at-home and in-work support. There is no indication in this report that the government intends to devote anything like the level of support that Professor Hawking gets to every sick or disabled person in the country.
- Isabel Hardman, a successful journalist, is considered good enough to be worth allowing a few months' leave (as her own testimony shows³⁸) and a phased return to work following an episode of mental illness; ultimately, however, she is not irreplaceable, and whilst her employer might keep a job open for her, this would not itself exempt her from conditionality requirements if she were to claim ESA.
- A data analyst needing recurrent sick leave is replaceable, although it may cost the government's estimate of £25-40k to recruit a new employee, and therefore the company may seek to retain the analyst for some time before deciding that the cost of continued retention exceeds the cost of recruitment.
- A call centre has many alternative job candidates and can easily recruit more; there is nothing gained from attempting to keep a person who cannot maintain the expected pace of work.

We cannot compare high-functioning individuals such as Stephen Hawking with more typical sick or disabled individuals who do not have exceptional resources to overcome their condition or to 'trade' with the employer. There is a clear hierarchy of what an employer is prepared to 'trade' - the more valuable an employee, for whatever reason, the more accepting the employer is of temporary sickness, or disability.

Smokescreen

We cannot compare high-functioning individuals such as Stephen Hawking with more typical sick or disabled individuals who do not have exceptional resources to overcome their condition or to 'trade' with the employer.

The government's perception of the disability employment gap

The DWP has covered this ground before, and in more detail. Richard Berthoud discussed the disability employment gap over ten years ago in a research report written for the DWP.³⁹ Amongst many other factors, he noted the difference between people with short-term illness who naturally move off sickness benefits, and people with long-term illness or disability who naturally don't (and likely can't). In his words, this raises an important policy question: "is the objective a) to reduce and eliminate people's impairments, so that they cease to be disabled; or b) to help people live and work with their (continuing) impairments, so that they cease to be disadvantaged?" But there is a third objective, c), of providing people with chronic illness with their human rights, even when they cannot work and cannot be cured.

³⁸ Hardman, I. 28/10/2016. How we do (and don't but should) treat depression. The Spectator.

³⁹ Berthoud, R., 2006. The employment rates of disabled people, DWP.

22. While there has been an increase of almost half a million disabled people in employment over the last 3 years, there are still fewer than 5 in 10 disabled people in employment compared with 8 in 10 non-disabled people.

This disability employment rate gap, the difference between the employment rates of disabled and non-disabled people, has not changed significantly in recent years and now stands at 32 percentage points.

34. We also know that disabled people from more disadvantaged backgrounds are more likely to be out of work. For example, while employment rates can be as low as 16% for people with mental health conditions who live in social housing, for disabled people who live in a mortgaged house and who have 1 or 2 health conditions, the employment rate is as high as 80%. This is similar to the overall employment rate for non-disabled people.

37. There do appear to be some patterns in employment rates for people with certain conditions, or for those who have multiple conditions. For example, disabled people with mental health conditions have an employment rate of just 32%, which is significantly below the overall employment rate for disabled people at 48%.

The types of illness or disability, and the impact they have on people, vary hugely. It is not possible to usefully discuss 'disability' without considering the nature of disability itself. In Berthoud's paper for the DWP, he found that the three largest predictors of the impact of an illness or disability on the ability to work were the person's condition(s) (both number and type); the type of impairment(s) the conditions caused (again, both the total number and each different type); and the severity of impairment (cubed). It is not enough to simply note the main condition, as the DWP does in its records of ESA claimants. To do so grossly misrepresents the actual level of most sick and disabled people's capacity for work.

The definition of 'disability' matters. The Labour Force Survey, for example, is considered to have a particularly loose definition of disabled (until recently, when all surveys adopted the same definition, thus losing the additional information gained by using different phrasing), including in its count people with only mild disability. Consequently, both the prevalence of disability and the employment rate of disabled people are higher in the LFS than in other studies. When 'people with health conditions' is broken down into disabled vs non-disabled, or work-limited vs not work-limited, those who report no disability or work limitation have similar employment rates to people without a health condition. Clearly, it is not having a health condition that matters, but having an illness that causes disability.

The government misses a key reason why chronically ill people return to work: because they recover. One person who has an illness and moves into work is one person moving from disability unemployment to disability employment, but a person who recovers and moves into work is moving from disability unemployment into non-disabled employment. As many ill people need to have an improvement in health before they can work, and may then consider themselves non-disabled, measuring the disability employment gap is flawed. Success for sick people is adequate recovery, not working whilst too ill to work.

Tackling the systemic issues

There is a cause for chronically sick people being unemployed: they're too ill to work. And a cause for disabled people to be unemployed: the government does not provide the necessary support. There will always be sick people; there will always be disabled people. It's not a culture. The

40. The disability employment gap has persisted over many years and its causes are long-term, systemic and cultural. Efforts to help disabled people and those with long-term health conditions have been hindered by a lack of vision and by systems which fail to join up and take people's needs properly into account.

failure to support disabled people to be in work may be long term, systemic and cultural - but it is a culture in the government of not providing the extent of support necessary.

There has indeed been a lack of vision: primarily, the lack of ability on the part of the government to see and acknowledge the significantly differing needs and capabilities of a very ill person compared to someone who may have a learning disability or minor physical disability; and secondarily, a lack of understanding by the government of what an employer wants and needs from his workforce, and what he can provide.

It is this lack of vision from the government that results in this Green Paper repeating the same flawed systems that have not identified the actual needs of sick and disabled people. The government intends the same outsourced payment-by-results system as failed under the Work Programme and has been failing in Australia for nearly two decades. The employment support staff - Work Coaches - will still be generalist employment workers who have no idea what Parkinson's, Motor Neurone Disease or unmanageable diabetes is like. The government still gives no respite to sick people, and no active support to disabled people. It simply assumes that more of the same old stuff - attitudes, behaviours and unpaid placements - will magically remove the illness or disability that is keeping someone from work.

Smokescreen

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Misperceptions of NHS

218. The health service is facing significant challenges of preventable ill health and health inequalities and variable quality of services.

224. We have... encouraged health and care services to plan their Sustainability and Transformation Plans on 'footprints' which bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations.

As with so much else of this report, the government has the wrong perception of the NHS. The government appears to think that doctors are unable to distinguish between work that is helping patients, and work that is contributing to or exacerbating illness.

The government also gives no awareness that the delays in treatment are primarily due to its decisions not to give the NHS the funding that it needs. Thus it discusses a need for faster access to healthcare without any attempt to suggest how this can be achieved or any recognition of its own fault in this.

Delivering healthcare

A fundamental problem is the underfunding of the NHS. It is this, not the structure of the NHS, the working times of its doctors or their view on work that is keeping sick people from getting the early healthcare that could

224. We have:

- put in place ill-health prevention measures including the diabetes prevention programme, national immunisation and screening programmes, and public health campaigns such as the 'One You' campaign;

- funded local authorities to commission a range of public health services to improve the health of their populations, including health checks, stop smoking services and drug and alcohol treatment services.

219. We want to look at health in the broadest sense and do more to encourage employers, Jobcentre Plus staff, and those working in the voluntary and community sectors to support health through promoting health, preventing ill health, early intervention and ensuring access to joined-up services.

63. We want to support work coaches and employability professionals to provide positive work and health support.

who has gained excess weight because her MS means she struggles to exercise; or a person with gut dysfunction who cannot eat high-fibre foods and struggles to eat at all. These people cannot make changes to their current management approaches without medical support to provide or advise on different management techniques.

245. Alongside this we will consider how individuals at risk of job loss or recently unemployed can gain early access to talking therapies to prevent worsening health and drift away from the labour market.

prevent a development into, or ameliorate the disability of, chronic disabling illness. It is the underfunding of the NHS that means malnourished Crohn's sufferers have to wait too long for an operation to re-open their bowel; and it is lack of funding that means people with mental illness wait months for intensive talking therapy, are sent tens or hundreds of miles from home for hospital treatment, and get limited, if any, support from the Community Mental Health Team.

The government's focus, as with all of this report, is on public health. It is concerned almost exclusively with obesity, drug or alcohol addiction, mild-moderate back pain and mild-moderate depression. So the government cites some public health measures it has put in place, but says nothing about the crippling illnesses experienced by people on ESA. It writes of the 'Sustainability and Transformation Plans' and how it hopes these will improve health and care services, but does not address the widespread awareness that these are necessary not to improve care, but to reduce it in line with inadequate funding. It asks GPs to take on a greater role in the employment of their patients, without discussing the pressure that GPs are under and the unequal distribution of funding relative to need. This is disingenuous in the extreme. The government has a responsibility, and it passes the buck to over-worked doctors.

Whilst public health measures can be quite generic - smoking, drinking, diet, exercise - it is still necessary that any advice comes from a healthcare professional. People without medical training are not qualified to comment on the suitability of changes in lifestyle for an individual at that particular moment in time. For example, they cannot comment on a Crohn's sufferer who uses tobacco to alleviate her pain; an abuse survivor who uses drink to get through her life and override her suicidal impulses; a person

Prioritisation

The government seeks to prioritise people at risk of unemployment or who have recently become unemployed. But what about people who are long-term unemployed, struggling to maintain morale? What about people not at risk of job loss yet, but receiving Occupational and then Statutory Sick Pay, and struggling to manage on a

substantially lower-than-expected income? We cannot tell people who are long-term out of work that they are less worthy than those recently unemployed. Nor can we tell people who not at risk of immediate job loss that they do not need treatment for an illness until it has become so severe that they are at risk of immediate job loss.

Are we going to tell cancer patients that we will only treat them if and when it makes a substantial difference to their employment status? Or dialysis patients that they have to wait in a queue behind the recently unemployed, essentially putting them further and further away from treatment the longer they wait? Would we refuse to save the life of a homeless person because we think it isn't worth the cost, given the low likelihood of a quick entrance to employment following treatment?

Healthcare should be available to everyone, at the point they need it, regardless of their employment status and likelihood of moving swiftly into work.

Mental health services

242. Mental health conditions are the most commonly reported primary conditions among the total 2.4 million people who claim Employment and Support Allowance; around 1.2 million cite a mental health condition as their primary health condition them.

We have...

- invested in early intervention for psychosis, and improved access to talking therapies;

- set out plans to increase recurrent funding in primary care, including to support mental health in primary care, by an estimated £2.4 billion a year by 2020/21; and

- a 5-year 'turnaround' package of £500 million.

243. Service provision can be patchy and access difficult.

The government's approach to mental health conditions is the same as the rest of the paper: trivialising severe and enduring illness in an attempt to reduce the level of support the government is perceived to need to provide.

The government only discusses mental health as 'common', by which it means depression and anxiety. But there are many forms of mental illness covered in the 50%, and to say that half of ESA recipients have a mental illness or impairment as their primary illness is no more informative than to say that half have a physical illness or impairment.

It has been an ongoing theme of ESA that it is poor at assessing people with MH conditions, in that it over assesses their capacity for work. People on ESA because of a MH condition therefore have to be very severely affected to have qualified. These are not mild-moderate illnesses that are solved by CBT. CBT necessarily assumes that a person's condition is more affected by how one thinks than by the circumstances in which one lives, which is unlikely to be appropriate for people in ill health and poverty.⁴⁰ Computer-based CBT would be even more inappropriate when one considers that much of the success of talking therapies comes not from the method chosen by the skill of the counsellor and the relationship established with the counselee⁴¹ - how can one have a relationship with a computer?

⁴⁰ Hall, J. & Marzillier, J., 2009. Alternative ways of working. *The Psychologist*.

⁴¹ Thomas, C., 17/09/2013. Some perspectives on improving access to psychological therapies (IAPT). *Counselling Directory*.

101. The new support we will test to establish what works best for people with mental health conditions who are out of work includes: Group Work – to test whether the JOBS II model, a form of group work, improves employment prospects and wellbeing; and Supported computerised Cognitive Behavioural Therapy (cCBT) testing whether early access to supported cCBT can support employment outcomes alongside recovery.

244. The increasing access to psychological therapies programme has been successful in increasing access to NICE-approved treatments for common mental health conditions.

246. We are more than doubling the number of employment advisers in talking therapies to help people in that service retain, return to and secure employment... We also have a number of trials underway to identify new and innovative ways mental health and employment services could support people to return to work.

People with mental illness are vulnerable to pressure. Healthcare must remain a safe place for them, where they feel free to discuss whatever they are thinking and feeling without an imposed goal from a government agency of returning to work. There must be no element or impression of coercion, which putting access to healthcare in the same setting as employment services (JobCentre Work Coaches?) automatically implies, especially when those services have the power to sanction a person. People with mental illness do not need any discouragement to access the healthcare that is already very difficult to get.

A significant change to mental health services was the introduction of the Improving Access to Psychological Therapies programme, IAPT. But IAPT is not successful or adequate.⁴² IAPT is delivered by the lowest level of 'talking therapists' and was designed for people with mild-moderate depression or anxiety, not people with severe depression or anxiety, or any other mental illness - of which there are many. It is wholly inadequate and inappropriate for anyone with severe depression or anxiety, or with any other mental health condition at all. It suffers a high drop-out rate and its impact on mental health fades away by 18 months later.

IAPT assumes, much like the rest of this paper, that mental illness is due to a faulty behaviour or attitude of the individual; in fact, much depression, stress and anxiety in the UK is due to negative environments.⁴³ Attempting to change a person's thoughts rather than their situation is Orwellian and deeply inappropriate.

Research has shown that people with mental illness need the expertise of both a Community Mental Health Team nurse and a specialised mental health employment support worker. A generalised employment

support worker who has either retrained as, or works alongside, a low-level counsellor is neither appropriate nor adequate. Nor is it at all acceptable to suggest that employment advisers or Work Coaches can have any role in identifying, assessing the impact of or treating and form or severity of mental illness. This would be even more inappropriate than subjecting people with severe mental illness to the low-level IAPT service.

⁴² Hall and Marzillier, 2009.

Barrett, P., 2009. An uncertain prognosis: Mental Health Practice. March:12-15.

⁴³ Hall and Marzillier, 2009.

248. Around 2 million of the 3.8 million working age disabled people out of work suffer from some form of musculoskeletal condition... 309,000 of the total 2.4 million people on Employment and Support Allowance report a musculoskeletal or a connective tissue condition as their main disabling condition.

249. Some evidence suggests that waiting times for musculoskeletal services can vary from between 4 to 27 weeks¹³⁷ depending on where the person lives... This is unacceptable.

250. We are supportive of new ways of providing musculoskeletal care... These include physiotherapists working from general practice surgeries and self-referral to musculoskeletal services.

251. A preventive approach and encouraging early self-care and exercise is often appropriate to avoid over-medicalising some conditions for which the best treatment may be self-care and a return to normal activities, often including work, with workplace adaptations where needed.

Musculoskeletal services

Again the government has noted the inadequate provision of healthcare, and again it does not mention that this is due to underfunding of the NHS. It therefore misses the best and most appropriate solution, which would be to fund the NHS properly. Better access to physiotherapy is important, but the trend of the government's spending decisions does not suggest that it will invest the money required to fulfil the ideas it sets out. No re-structuring, changes in access or changes in what is offered will ultimately be effective if there is not enough money to fund the amount and quality of healthcare that is needed.

The government again trivialises chronic illness. Muscular pain or stiffness that can be treated without prescription-strength painkillers or without physiotherapy assistance is not at a severity that keeps people from work. As the McCluskey reports show, it is pain that is uncontrollable even with narcotics and which requires surgery to correct which results in people being out of work.⁴⁴ This is not the type of injury or impairment for which "self-care and a return to normal activities" is correct.

As preventative measures, we need not 'self-care', but pre-emptive provision of workstations set up specifically for the individual user, and access to personal advice on posture and movement to correct those misalignments that a typical lay person cannot identify or correct on their own. Other workplace provisions could include the right to move away from a desk frequently, or the right to do some work sat down several times a day.⁴⁵

Crucially, as with mental health, employment advisers cannot be allowed to comment or advise on medical matters. JobCentre staff are not doctors. They cannot make referrals. The most they can do is suggest that a person may benefit from seeing their GP and getting a referral to physiotherapy or, where the service exists, going directly to a physiotherapist.

Fit note

The government implies that GPs are unaware that there are measures that can be put in place to support people with illness or injury to return to work before a complete recovery has been made. Yet this would be odd; GPs must know from their own experience of illness or injury that they have attended work whilst ill or injured, or whilst not yet recovered. In addition, they have been using the fit note for over six years, and this clearly provides an option to say that someone might be able to

⁴⁴ McCluskey et al., 2011, 2014, 2015.

⁴⁵ NHS Choices: Back pain at work.

return to work if adjustments are made. When asked in surveys, no GP has reported that they were unaware that people could work with some illness or injury, or of the options provided on the fit note.⁴⁶ There is therefore no basis for the government's remark.

The government implies that, by not discussing possible adjustments at work with a patient on the first appointment when that patient presents with an illness or injury, the GP fails that patient. The government describes this as a lost opportunity to influence the patient's understanding of his or her ability to work. But the patient has a better knowledge of his or her job role than does the GP, and the patient also likely knows the impact of his or her illness on that job. The strong probability is that the patient attended work whilst ill for a number of days before visiting the GP, and therefore personally experienced the impact it had on work.

The only apparent difference between the government and GPs regarding views on individuals' capacity for work is that GPs are capable of recognising when a person needs to be signed off completely from work, whilst the government seems incapable of recognising that such situations exist at all. As regards fit notes, GPs are aware of their professional limitations. They know that they do not have the professional training to conduct what should be Occupational Therapy assessments. In turn, the government belief that an Occupational Health assessment is adequate is another example of what is either its ignorance of the people whom this policy affects, or a deliberate attempt to trivialise their illnesses.

GPs have a role as patient advocates, to help and not harm their patient. They do not know the varying roles of different jobs, nor the underlying culture and working practices at a patient's workplace. Nor do they know what forms of assistance exist, and what an employer can provide or the government will provide. They therefore are able only to indicate that they don't think work will necessarily be harmful, provided adjustments are made. It is the job of a trained Occupational Therapy professional to then assess what those adjustments need to be, acknowledging that a patient cannot return to work without them.

Smokescreen

The government appears to believe that its political, non-medical and population-wide assessment of individuals' capacity for work is more accurate than a GP's medical, professional and personalised assessment of the patient before him or her.

The government wants all medical professionals to "have the right skills and knowledge to provide early advice about functional ability to work." This is simply not possible in the manner the government envisions, let alone in a manner that is appropriate. Medical professionals are medical specialists. Occupational Therapists are occupational therapy specialists. A person is usually trained through a university degree and professional experience in one or the other profession; it would be unusual for a person to be trained in both and have ongoing professional experience and training in both. A medical professional cannot gain the knowledge and experience necessary to advise a sick or disabled patient on their capacity to work as regards their existing job, any job or jobseeker's allowance conditionality.

GPs need, and want, the opportunity to refer patients to a decent independent assessment of their ability to work and their support needs in order to work. This would help them where a patient might be able to do some work but the type of support needs to be identified and put in place; or where there is uncertainty regarding the patient's capacity, including where there is a disagreement between the patient and the GP (in either direction). What is needed is an

⁴⁶ Ibid.

independent Occupational Therapy assessment, developed in accordance with what sick and disabled people themselves say they need.

Work as a health outcome

A central theme of this Green Paper is the government's conviction that work should be used as a measure of successful healthcare, with the implication that work is a cure for illness. But the government's conviction is fundamentally flawed and wrong. This is a major reason why this entire Green Paper is so poor.

Work does not necessarily promote health. Bad work makes health worse. Work makes chronically ill people's health worse. The government can no more impose work as a treatment than it can insist that every cancer patient receive chemotherapy. The government can no more impose work as a health outcome than it can insist that being able to go running for half an hour five times a week is a health outcome for everyone. It simply isn't appropriate for everyone, and a paper on sickness benefits should be talking about those people for whom work is not appropriate.

Supporting an individual to be in work is not central to effective, let alone personalised, care. However good work is, it can still be detrimental for chronically ill people, for whom activity - however positive - can be harmful. Effective care means treating a person's physical and medical illnesses or injuries. Personalised care means supporting an individual to achieve the health they need for a good quality of life and, as far as possible, to engage in the activity(ies) that they personally find fulfilling or that helps with their independence in the areas most important to them.

Again, work is not a health outcome. This cannot be stressed enough. If work were a health outcome, what would we do with children, parents, volunteers, students and pensioners? Treatment should not be decided based on whether it enables a patient to return to work. It should be decided solely on the impact it has on the patient's health, well-being and quality of life. We are not robots to be patched up and sent back to work as soon as possible; we are people to be cared for.

63. We want to support: health and social care professionals so that the benefits that can come from work are an ingrained part of their training.

278. Underpinning all of the above actions is the conviction that work promotes health.

217. We still have a long way to go to ensure that people get the right health and employment support when they need it. Services do not always work well together.

The health system does not need to actively help people into work. Its role is to actively help people to stay healthy, recover from illness or injury, or manage a chronic condition. Where this is achieved, most people will retain or recover capacity for work; the health system has no need to expand into services beyond its remit or expertise. Being able to work is a natural consequence of being in good or good-enough health.

Working together

Another smokescreen concern of the government's is that of services 'not working well together'. This is predominantly in reference to healthcare and employment services, and to some extent to employers. Because the government believes that medical professionals do not recognise the generally beneficial effects of paid work, it is bothered by healthcare not having an overt orientation towards work. Because the government distrusts medics in this way and under-estimates the severity of the illnesses

and impairments that keep people from work, it believes that non-medical employment support staff (Work Coaches) can assess, supervise and treat the illnesses of people currently not in work.

The government is therefore concerned that the NHS and the JobCentre are not working together. It wants the NHS to more often assess someone as able to work and to centre healthcare around getting a person into work. It wants JobCentres to take over some of the healthcare of people on sickness benefits. But the NHS is already aware of when and how work can help people, and non-medics cannot ethically or appropriately apply any form of health or health-related care.

Health and work systems do not work against each other in the way the government claims. What we have is several systems none of which the government is fulfilling its role to manage. The NHS is underfunded, meaning people do not get timely diagnoses or adequate treatment. Business is deregulated and so is not required to maintain healthy working practices, whilst 'reasonable adjustments' and other related laws are not monitored and enforced. The government doesn't assist employers through subsidies, incentives or the direct provision of Occupational Therapy. Employment services are overly focused on people who can't or shouldn't work, leaving too little in the way of resources for those who could work.

Employment support is poor but the government does not appear to be aware of this. It is known, for example, that people with severe and enduring mental health conditions can benefit from the Individual Placement and Support model (although even then, the majority do not, and may not be able to, move into work). But this model depends upon a person receiving input from both the Community Mental Health Team and a vocational specialist. What the government proposes is to replace both of these highly trained and experienced professionals with a single non-specialised, non-medical employment support worker.

People who need input from more than one service (out of NHS, social care, benefits and an Occupational Therapy) may benefit from having a claimant advocate whose role is to oversee the provision of the different forms of support, to ensure that they are all brought in, and to discuss any conflicts. In practice, a conflict may be that a service won't provide what is needed, or that the government or an employer is pressing for a return to work before the person is ready or the necessary support has been put in place. This is much simpler than the government's desire to integrate health and work services, and allows professionals to retain their specialism and do what they are trained best to do, rather than attempt to generalise and deliver poorer services as a result.

There is no good reason to blur the boundaries between health and social care professionals, and employment professionals. For example, the Individual Placement and Support

139. People rightly expect public services to work together with each other, and to use the information they have provided to ensure the best possible service. This is even more important for services that provide essential financial support when someone is in need, such as when they have developed a health condition, or lost their job and their source of income.

model depends upon two specialised professionals: a vocational specialist, and a Community Mental Health Worker. This is not so much a 'single service that covers both' as a model that requires both to be in place at a high level to be effective. The two are not combined, just provided at the same time. These are two distinct areas of expertise and neither can validly or ethically comment on the other. Work is NOT part of healthcare, and this cannot be emphasised enough. Would the government exclude from citizenship every person who is unable to work, for whatever reason? That is a gross disregard of basic human worth and rights.

Data Sharing

146. Subject to establishing that any data to be shared is up to date and relevant, we can consider sharing of data between the two assessments for Employment Support Allowance/Universal Credit and Personal Independence Payment.

147. We will also explore how the assessment process could use data already gathered by the NHS or local authorities where appropriate.

The purpose of the Welfare system is not to be part of the health system. A welfare system offers financial support and advice to protect people who can't work and help those who can; the health system offers personalised healthcare to prevent, cure and manage illness or injury. Work may be a by-product, or for some it may promote some elements of health, but it is not itself a part of healthcare. 'Joining up around' an individual's needs is not person-centred support. There can be very few occasions when it would be appropriate for the welfare system to join up with the medical professionals - they have no common ground.

This is an attempt to justify the sharing of data from medical sources to untrained work coaches, dressed in the language of 'caring'. It is part of transferring mental and musculoskeletal services to JobCentre Work Coaches, which in turn makes it possible to include health treatments in sick

and disabled people's mandatory Claimant Commitments. Data sharing is not okay without the individual's explicit, clear consent. If it is necessary to know what other problems are occurring in a person's life, just ask.

Employers

Business case

The government wishes to convince employers that there is a good business case for caring about the health of its employees. But the government's business case is predominantly based upon an estimated replacement cost of £20-45 000 for a worker on a £25 000 salary. And the only health measures it suggests are basic public health measures.

The flaw in basing good working practice on the impact on profit is that where a business would not see an increase in profit, or would see a decrease, it is not going to implement good working practices. Unskilled and low-skilled jobs are typically competed for on the basis of productivity - who can work fastest for longest - and there is a relatively large pool of labourers competing for the jobs. In these sectors, 'willingness to work hard' is a frequent attribute cited on job adverts. Sick and disabled people often have no 'edge' to offer to make them more attractive to an employer than a healthy, able-bodied individual who can - for a time at least - work quickly under pressure. Employment regulations and Trade Unions are weak, with the result that employers have no incentive to invest in the health of their workforce, because they can easily dismiss a sick employee and hire a healthy one.

Small employers often report that they cannot compete with large employers if they are to provide such rights as the basic right to an adequate income off which to live, enough time away from work to provide for the right to rest and leisure, and statutory rights such as sick pay, holiday pay and maternity/paternity pay. It is unlikely that small employers will find the means to pay for

Smokescreen

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157. Businesses drive our economy and are rightly focused on growth, productivity and delivering a return on their investments.

Organisations that promote and value health and wellbeing benefit from improved engagement and retention of employees, with consequent gains for performance and productivity. Highly engaged employees are less likely to report workplace stress, take fewer days sick absence and make the most productive and happiest employees.

these simply because research indicates that, on average and in the long-term, it would benefit their business. Small employers need financial support from the government such as top-up wages for their staff and subsidies for statutory rights (perhaps via tax breaks for employers or tax credits for employees, for example), so that small businesses can afford to run without exploiting their employees. The government should support small businesses in recognition of the value of a diverse industry base for economic stability.

The government writes as though it is acceptable for them to allow employers to run unsupportive, unhealthy, discriminatory workplaces. They write of wanting to know how to “support, encourage and incentivise” employers to run what is in essence an ethical business. It should not be legal or culturally acceptable to do otherwise. It should not be a “vision” of the government to have employers realise the benefits of a healthy workforce. It should be a legal right that workplaces do not make people

ill or exacerbate illness. It should not be legally acceptable for employers to overwork their employees; it should not be legally acceptable for governments to not protect their citizens against exploitative working practices.

These companies are not going to introduce healthy lifestyle-support to their workplaces when they have no reason to care about direct working practices, never mind indirect ones. If the government wanted to protect its poorest citizens it would legislate for it - ‘good’ employers would not be affected, as they would already be carrying out the now-legislated good working practices; employers who are uninterested in behaving ethically would be forced to do so - as they should.

It should not be a ‘vision’ of the government to have employers realise the benefits of a healthy workforce. It is a basic right.

Smokescreen

It should not be a ‘vision’ of the government to have employers realise the benefits of a healthy workforce. It is a basic right.

Bad jobs

The government must recognise that many companies do not even comply with the law. Workers are coerced into working double shifts when tired or ill, and are physically and verbally abused. Working conditions are poor, with “intensive manual labour over long shifts”, and people have been sacked for sitting down or for taking time off due to sickness. Workers are refused toilet breaks and water breaks. At the same time, many are on temporary or zero hour contracts, and consequently have no job security, despite the high demands placed on them. And these are not isolated practices at rogue employers: they are widespread in the meat and poultry industry,⁴⁷ and have been found in diverse employers from factories producing sports equipment⁴⁸ to Amazon warehouses.⁴⁹

⁴⁷ Equality and Human Rights Commission, 2010. Inquiry into recruitment and employment in the meat and poultry processing sector.

⁴⁸ Business, Skills and Innovation Select Committee, 2016. Employment practices at Sports Direct. House of Commons. Jenkins, C., 13/12/2016. ‘I’ve sacked people for sitting down’: undercover inside JD Sports. Channel 4 News.

⁴⁹ Cadwalladr, C., 01/12/2013. My week as an Amazon insider. The Guardian.

Iain Wright MP, Chairman of the Business, Energy and Industrial Strategy Select Committee, told Channel 4 News,

“What really worries me if I’m honest, this is getting to be a longer and longer list. The number of company bosses that have to explain their actions and explain their working practices, and explain why they use agencies that exploit, that abuse, is really getting longer...

“I think there is a real problem. I think there is a cultural and structural issue in Britain. We treat our low paid workers in this country like scum. We don’t give them any dignity or respect. And I think it is an absolute disgrace that in this country you are on minimum wage and struggling to make ends meet, that you’re frightened you might lose your job and that you might not have an opportunity to go to another job. And yet you are shouted and barked at like a dog.”⁵⁰

Sickness absence

It is not sickness absence that causes lost productivity. It is sickness, period. People work less well or cannot work at all when they are ill. The remedy is to engage in public health for prevention and to promote quick recovery. People who attend work whilst ill prolong their recovery,⁵¹ which can result in more lost productivity than if they had waited until they were well enough to return to work.⁵² Sickness leaveism - using holiday leave to hide one's illness – also masks the extent of sickness in the workforce from the employer.⁵³

Smokescreen

The focus on leave rather than illness as a cause of costs implies that the government would like to remove or reduce non-illness leave as well.

It is not the leave itself that is the problem, but the fact that people are sick. Does the government oppose holiday leave and maternity leave as well?

It is not always easy for employers to offer the types of adjustments that sick and disabled people need, regardless of whether it is a temporary or permanent. flexible working that severely chronically ill people need - People who are recovering from an illness may benefit from a phased return to work or temporary re-focus on less onerous duties, but an employer may not have lighter

198. This is in the interests of employers who benefit from keeping employees in work and avoiding the costs associated with lower productivity, disruption and replacing employees.

Employers lose out when people go sick... One survey put the median cost at £622 for each absent employee.

duties to offer or be able to manage workflow to accommodate shorter, varied hours.⁵⁴ Many employers find it easier to ask the employee to remain off work until fully recovered. For chronically sick people, the challenge for an employer is how to manage workflow without knowing over the course of a day, week, month and year how much work a specific employee will do and when.

Conversations about returning to work do not need to be between employer and employee. Employers have an incentive to seek a fast return to work with as little effort and cost from themselves as possible. Employees feel pressure to relieve the burden on colleagues, get on with

⁵⁰ Jenkins, 13/12/2016.

⁵¹ Ashby, K. & Mahdon, M., 2010. Why do employees come to work when ill? The Work Foundation.

⁵² Garrow, V., 2016. Presenteeism: a review of current thinking. Institute for Employment Studies.

⁵³ Hesketh, I. & Cooper, C. 2014. Leaveism at work. Occupational Medicine. 64 (3): 146-147 doi:10.1093/occmed/kqu025

⁵⁴ Lalani, M., Meadows, P., Metcalf, H. & Rolfe, H., 2012. Evaluation of the Statement of Fitness for Work: qualitative research with employers and employees. DWP Research Report 797

their own work burden and return to a higher income. At the same time, for their health it may be better to wait longer, or to insist upon the adjustments that would make work more sustainable and less detrimental for them. This creates a conflict between employer and employee. These discussions should be mediated through an independent Occupational Therapist, who can make expert recommendations to the employer. It may be necessary for the government to consider requiring employers to either put recommendations in place or to pay full pay to employees who could return to (some) work if the employer were not holding them back.

24. The disability employment gap also represents a waste of talent and potential which we cannot afford as a country: poor health and unemployment results in substantial costs to the economy.

154. [We want employers to] benefit from a large, valuable and under-used section of the labour market.

157. Employers will have access to a wider pool of talent and skills if they have inclusive and disability-friendly recruitment, retention and progression policies.

Latent labourers?

The government speaks of chronically ill people as a 'pool of talent and skills' which it encourages employers to tap. But this is not the case for people who lack the health to access their own talents and skills. People who are too sick to work, or too sick for it to be reasonable for them to work, must not be treated as latent labour. The government harms us when it talks as though most people on ESA are latent labourers: it implies to the public that we do not need the support that in fact we do need; it marginalises us as unworthy unless we work; it allows the government to reduce and restrict our access to non-work income under the smokescreen of 'helping' us; and it hides from employers the true cost and extent of the support that those chronically ill people who could work would need in order.

We are not tools to be bought and sold. We are people with difficult lives.

Employer's Insurance

The government wants employers to take out insurance to cover the sick pay and associated business costs of people needing sick leave. But at the low end of the job market, little to no occupational sick pay is provided (many employees wrongly believe they are not entitled to Statutory Sick Pay either⁵⁵). At the higher end of the market, for a 16.6% reduction of long-term sick leave, employers may be offering private cover as much to attract talent as to cover its own costs. We cannot expect employers to voluntarily insure all staff.

There is a very simple solution to employer insurance: social insurance. When the goal is to cover everyone - as it must be - then a national or social insurance scheme is the most efficient, efficacious and effective method. We cannot ask business to take on the responsibility of the State. Private insurance will simply result in a patchy scheme that leaves out those who most need it - the people with employers who do not care about the health or wellbeing of their employees.

⁵⁵ Adam, L., Oldfield, K., Riley, C., Duncan, B. & Downing, C., 2014. Understanding the journeys from work to Employment and Support Allowance (ESA). DWP Research Report No. 902.

Others' role

The role of carers

Carers are struggling. They have seen care packages cut, placing more responsibility on them. They have seen respite services cut, leaving them without a break, year in, year out. This year their permitted work allowance wasn't upgraded when the minimum wage was upgraded - meaning that they can work fewer hours and receive less money. Informal carers often are in poverty themselves - unable to cope with a full time job plus provide the levels and hours of care needed.

The value of carers' work in the economy goes unrecognised, following Adam Smith's error in not accounting for the unpaid work of women in the home as part of the national economy.⁵⁶ Unfortunately, this error has continued, so that the government now expects carers to contribute twice to the economy - once through paid work outside the home, and once through unpaid caring work within the home. Yet the carers themselves have only 24 hours in a day, some of which they have the right to dedicate to personal care, rest and leisure. Unless the government pays a different

46. This government recognises that carers can play a fundamental role in enabling disabled people and people with long-term health conditions to be all they want to be.

47. The challenges of balancing paid work with a caring role can mean that carers have to reduce their working hours, pass up career opportunities, or leave employment altogether: an estimated 2 million people have given up paid work to care.

48. Many of the challenges faced by carers in balancing their work and caring roles stem from...a risk-averse attitude among employers to recruiting disabled people and caring responsibilities, and a lack of flexible working arrangements in many organisations.

person to do that care - yet why not pay the current carer? - the carer will not be free to undertake other work.

If the government wants carers to be in paid work outside of the home, it must pay for professional care workers to take over the caring role. To provide a level of care that compares to someone who remains available to the caree essentially 24/7 would be hugely expensive, and Social Care cannot afford it. Alternatively, the government could pay carers a decent wage/benefit for the work that they do. But to attempt to save on social care costs by making a family member provide the care, and then to additionally expect the carer to engage in paid work such that they do not get Carer's Allowance and do pay Income Tax is cavalier and shows a distinct lack of responsibility and care on the part of the government.

Furthermore, the idea that an informal carer can enable people to '*be all they want to be*' is extraordinary. For those who have good (physical) health but complex physical disabilities a carer can, in the role of professional personal assistant, ensure that the disabled person has all their care and assistance needs met whilst they pursue their goals - but this level of care is not the informal care delivered by family and friends. Nor is it the job of informal carers to micro-manage the workplace, negotiate with employers, act as a job broker, or to make medically-based decisions on whether the person is ready to return to work. The government must stop trying to evade its responsibilities.

⁵⁶ Marcal, K. 2015. Who cooked Adam Smith's dinner? A story about women and economics. Portobello Books.

The role of charities

The Government is clearly expecting that any deficits in the system they are creating will be absorbed by these broad 'voluntary and community sectors'. But charities are no replacement for government provision. The only body in a country that can provide full coverage, equitable access and adequate support is the government. Charities are dependent upon the good will of donors and grant givers; governments can raise taxes. Charities have a restricted remit; governments have the right, the ability and the responsibility to cover every need of its citizens. Charities are inefficient, patchy and risky; government provision is efficient, comprehensive and inherently low risk.

Smokescreen

Absolving responsibility from the Government to local authorities, and then onto the voluntary sector is simply a cost cutting exercise, designed to damage the local authorities and place the Government one step removed from blame, with the expectation that underfunding will cause the system to fail.

50. We recognise that the voluntary and community sectors play a crucial role in helping more people to lead healthy and fulfilling lives, and that there are many organisations from these sectors, with broad reach and diversity, working to support and involve disabled people and people with long-term health conditions. These voluntary and community organisations embody a spirit of citizenship upon which our country is built, and we want to better harness their expertise and capacity in order to achieve the best outcomes for disabled people and people with long-term health conditions.

It appears that having underfunded the NHS and social care and cut social security significantly, the government now wants to hand its responsibilities over to charities, employment agencies and employers, in the apparent hope that such fragmented and patchy support will somehow ensure that every person has access to all that they need. The government says one reason to use charities is their "unique perspective on their [clients] needs and how to improve services". But there are few charities for the chronically ill, and almost none for those with rare illnesses. Many charities have no finances and 'help' is a web page. Voluntary and community sectors do have links with the community they live and work in - but they are not job brokers, nor are they always experts in disability employment. Each one can cater only for the illness or disability for which it was set up, and many such local charities are not repeated across the country.

The government must accept its role as a social body with social responsibilities, and its unique position in being able to increase revenue, command full oversight of all of a country's needs, and its capacity for efficient and universal provision of support.

Government role

Throughout this report we have seen the government try to pass on its responsibilities to individuals, carers, charities and employers. We have seen it refuse to recognise the extent and severity of work-limiting illness and disability. And we have seen it insist that work is enough.

Now we will look at what the government does plan to do.

Government isn't ready

57. Change on this scale will take time to achieve and not everything we try will work.

167. There is already a wealth of information about how employers can support disabled people and people with health conditions, but the extent to which it is known about, used or found useful is unknown. So we want to consider how we can bring this information together, make it accessible and support employers to work together.

178. We want to know whether financial or other incentives would encourage employers to try new and creative things to support more disabled people and people with health conditions in work.

159. Disability Confident is a campaign that challenges negative attitudes to disability and disability employment and aims to help disabled people achieve their potential.

The government refers many times to innovation it wants to fund, or ideas it wants to trial. But the government has made cuts to what people unable to work can receive in the way of financial support, on the grounds that this is okay because the government will be significantly increasing and improving its delivery of employment support. So the government should be ready to put this high-quality, high-quantity employment support in place at the same time as – or ideally, before – any cuts to financial support.

But the government is not ready, and in the meantime people on ESA will be on a deprivation level of income without being offered the superior service that was used as the justification for the cuts.

Current Government schemes

Disability Confident

Disability Confident is essentially a scheme that praises companies for obeying the law. There is no requirement or even expectation for exceptional performance such as deliberately creating jobs to match a sick and disabled person, or making adjustments that are beyond what is legally termed reasonable (such as permitting a slower working pace or giving paid disability leave at full pay). In essence, there is no requirement that a 'Disability Confident' employer be an employer that provides for the main 'adjustments' of chronically ill people. As a result, sick and disabled people are unable to have any confidence in 'Disability Confident'.

The scheme brought itself into further mockery by offering the phrase to the first 'Disability Confident' city - Swansea.

The city had done nothing to make the public environment of Swansea fully accessible to all disability types, and nor did it have a wealth of employers who went beyond 'reasonable adjustments' to employ sick and disabled people. In fact, there is no feature of Swansea to mark it out as any better for sick or disabled people than any other town or city in the UK

Access to Work

159. Access to Work supports the disability-related needs of individuals in the workplace where they go beyond reasonable adjustments required under the Equality Act 2010.

Access to Work is considered one of the government's 'best kept secrets'. Instead of actively seeking ways that Access to Work funds could assist sick or disabled people to work, the government does not require JobCentre or Work Programme staff to offer its services. It cannot be used for training, volunteering or work experience, and consequently cannot be used for people to test their

capacity for work and prove to not only themselves but also a prospective employer that they can sustain that level and type of work. Apart from arranging taxis, which having proven the need is speedily put in place, Access to Work is painfully slow - so slow, that sick and disabled people have to leave work or are unable to take up job offers because the support is not there when they need it. Because it is so slow, it is not possible to get Access to Work support in time for a job interview.⁵⁷

Access to Work has been severely limited in scope. Instead of supporting employers to take on new sick or disabled staff, the government has made it more difficult by refusing to fund certain forms of support any more. It is well known that the more barriers there are in place for employers, the less likely they are to take on disabled staff. For example, countries which place stronger duties on employers to care for their current staff are also countries where employers are less likely to take on new sick or disabled staff. But loosening the duty of employers to employees means employers are less likely to support and thereby retain staff that become sick or disabled. An appropriate response might be to place stronger duties on employers for current staff - with grants or other such assistance for small employers - whilst the government funds support for new sick or disabled staff who have moved into that job from unemployment. If an employer recruits someone from a job, the employer should be responsible for the necessary support, in order to prevent employers circumventing the support measures by taking other businesses' staff.

The government's expectation that Access to Work will assist 60 000 sick or disabled people by the end of Parliament shows up just how badly the government has misunderstood the nature of disability and chronic disabling illness. Every deaf or blind person needs Access to Work in order to work; many with fatigue and pain need Access to Work to provide transport; people with learning disabilities or mental health conditions may need support workers; people with chronic illness may need access to paid disability leave, an area into which Access to Work should expand. There are far more than 60 000 people in this country who need the support of Access to Work in order to work, and the government cannot assume that the one million or more disabled people it wants to get into work are not in need of support.

Fit for Work

Fit for Work provides a free, expert, impartial work and health advice service for employers and a targeted occupational health assessment for employees who are off sick for 4 weeks or more

Fit for Work is a recent scheme to offer independent Occupational Health assessments to employers when an employee has been off work for four or more weeks. As explained elsewhere, an employee who takes four weeks off work is typically not at an early stage of sick leave (however if they had no sick pay for whatever reason, then they would be applying for ESA and being asked to a Health and Work Conversation, even though they have a job to return to). Support should be offered sooner, including for employees who are struggling in work but have not yet taken sick leave.⁵⁸ This is particularly important given the extent of a sick-work culture in the country, as the extent of sickness presenteeism and leaveism show.

Sadly, because the Fit for Work scheme offers only a telephone assessment, not actual provision of or requirement to provide assistance, the scheme in practice is expected to do very little. It is disappointing that, when provided with the opportunity to affect real change, the government so half-heartedly responded that it would have done better to have refrained and used the money for even a small amount of something that could work. It is even more disappointing

⁵⁷ Benstead, S. in press. Replacing Employment and Support Allowance: Part 3 – A new sickness benefit.

⁵⁸ Hillage, J. et al., 2015. Evaluation of the 2010-13 Fit for Work service pilots. DWP.

that, in this paper on supporting sick and disabled people - the paper that the government used to bargain with its MPs concerned by the extent of social security cuts - the government merely praises itself for the existence of this service, rather than committing to investing the funds and resources that would make it really be effective.

Social Security

Finance and employment system

The government has attempted to create a problem where there isn't one. The government alleges that the financial support a person gets determines what employment support they get. This is not true. It is the assessment of a person's capacity for work and for work-related activity that determines their financial support and the maximum conditions that can be applied. All claimants can voluntarily access JobCentre or Work Programme support, or indeed seek support from any provider of their choice.

Smokescreen

In claiming that financial entitlement determines employment support, the government has attempted to create a problem where there isn't one.

The government alleges that the WCA should determine financial entitlement only. Because the government has removed the WRA component of ESA, it means the WCA will determine only who gets the Support Group component. The majority of claimants will be required to attend a 'Health and Work conversation' at four weeks into their claim, nine weeks before the WCA. By placing this conversation before the WCA the government has prevented itself from determining who should not take part, and consequently people who will end up getting the Support Group component of ESA will have to take part. Presumably the government thinks this is okay because it has downgraded what the WCA means so that it no longer means anything other than capacity for work as it relates to finance entitlement. The government is effectively transferring the assessment of capacity for work as it relates to employment support to the Work Coaches in the JobCentre, without any legislative change.

The cut to WRAG "financial help" means people will be on in even deeper poverty – 36% of what they need – at a time of chronic illness that may last for years. Although for some there is no cut, the actual level of the "financial safety net" may not be cut for some, in real terms it has fallen behind living costs, supplementary benefits have been capped, and under Universal Credit people will see further reductions. It is therefore not a financial safety net, and promising merely to not drive sick people into deeper poverty is not acceptable.

This additional stress will exacerbate ill health and add to co-morbid mental health conditions. Effectively, at a time when person needs less stress, this Government is intending to add financial stress, poverty and 'engagement with employment support' to chronic illness.

Universal Credit

Evaluation has found that people receiving UC are only very slightly more likely to be in work nine months later than are similar people on JSA.⁵⁹ There is no significant difference in earnings. The initial difference in employment has been lost after nine months, suggesting that UC recipients are getting temporary or insecure work. The majority of UC claimants end up in rent arrears, compared

⁵⁹ Riley, R., 2015. Annex B: Independent NIESR Peer Review. In Estimating the early labour market impacts of Universal Credit – updated analysis. DWP ad hoc research report no. 28

75. Universal Credit is already making improvements which put people at the heart of the welfare system... It will also, for the first time, help those claimants with health conditions who are already in work to progress in the labour market supporting them to earn more.

to less than a third of JSA recipients.⁶⁰ Pushing people into debt and keeping them in the low pay/no pay cycle is not a success.

Universal credit brings the principle of conditionality to people who are currently in work for the first time. It pressurises people to continuously seek more hours and/or a higher rate of pay. It has not been explained whether people assessed as having limited capacity for work and who are undertaking a small amount of work will then be under conditionality to seek more work. Under ESA and tax credits, there would have been no conditionality or pressure

to increase work. People on Jobseeker's Allowance however will be subject to conditionality to seek more hours and/or higher pay, even though some people on JSA will have illnesses or disabilities that mean they do not have the capacity to work full-time.

The past six years show that the government has no interest in protecting people from excessive demands. People with mental health conditions or learning disabilities are more likely to be sanctioned,⁶¹ proving that JobCentre and Work Programme staff are not tailoring conditions to the person; if they did, these people would be less likely to be sanctioned in recognition of their reduced capability for work, work-related activity and mandated activity. People in ESA WRAG report that the conditionality applied to them makes their health worse, because it is beyond their physical, cognitive and/or emotional capabilities.⁶²

It is not clear if employers are able to provide the flexibility that Universal Credit assumes. Zero-hour contracts exist so that the employer can retain the flexibility over how many hours of work it pays for and whom to. It is not flexible for the employee, who typically wants more hours than are available and who is vulnerable to having their hours cut without any fault of their own. Universal Credit does not appear to recognise these vagaries and restrictions of the current labour market. Consequently, it risks putting significant pressure on poor people without giving them the independence to choose for themselves - the very things that make work bad.

Employment Support

The needs of sick and disabled people

This government attributes to itself the laudable goal of doing everything it can to help those who can and want to work to do so. Sadly, the government has a long way to go to be doing "everything we can" to support sick or disabled people into work. This has been made substantially more difficult

73. Where people want to work, and have the potential to do so immediately or in the future, we should do everything we can to support them towards their goal.

by the ground it has to recover just to get back to where it was before the Great Recession and the take-over of the government by the Conservative Party. It may well cost more now to put in place the means to fulfil a government's duty to its citizens than if these measures had been started six years ago. But this is no reason for a developed country

⁶⁰ Barnes, S., 07/06/2016. Three in four Universal Credit tenants in arrears. Inside Housing

⁶¹ Oakley, M., 2014. Independent review of the operation of Jobseeker's Allowance sanctions validated by the Jobseekers Act 2013. Her Majesty's Stationery Office.

⁶² Hale, 2014.

to shirk its duties, especially with the example of other countries such as Canada, Germany and the Scandinavian countries to follow.

The government is right to recognise that employment support should be for those who “have the potential” to work. But the rest of its paper does not suggest that it thinks there is anyone who does not realistically have the potential to work. Yet this is a crucial distinction to make, to ensure that sick and disabled people are neither harmed nor marginalised by government policies that insist everyone should work. People who cannot work and do not have the potential to work should also be given ‘everything [the government] can do to support them towards their goal[s]’. Fulfilment and independence are not rights earned by those who work; they are rights which everyone should be enabled to achieve.

Significant research has been undertaken over many years to explore what sick and disabled people need if they are to be able to work, and what are the best ways to support them. The government makes no reference to this extensive body of work, choosing instead to implement a low-level service of untrained Work Coaches accompanied by over-stretched advisers who ethically cannot dispense advice.

The research that has been undertaken confirms that there is a substantial body of people who are too sick to work. These are not people with unidentified back pain of up to three months’ duration, or moderate depression or anxiety. They are the participants in McCluskey’s research, with chronic, severe back pain that is not alleviated by strong opioids and has an identifiable, (risky) operable cause.⁶³ They are the people whose mental state is so low that they cannot take care of themselves on their own and are at substantial risk of ending their life. They are the people who cannot think clearly because of the severity of their pain. They are the people weak from vomiting, malnourishment and malnutrition. They are the people with uncontrolled epilepsy or unmanageable narcolepsy.

What chronically sick and disabled people primarily need is two things: firstly, the space to manage their illness or disability, which means an adequate income and freedom from mandation or reassessment; secondly, for the government to take ‘active action’ to provide suitably supported work for those sick and disabled people who can reasonably do some work, rather than the ‘passive action’ that places the activity on the sick or disabled person. It is not the government that should be telling sick and disabled people what they should do; it is sick and disabled people who should be telling the government what it should be doing to support them.

People who are too sick to work do not need support related to work. They need support to achieve the six benefits of employment outside of paid work.

People with disabilities or less severe illness who can do some work need extensive support. They need someone who can help them to do those activities they want to do; who can identify the barriers and possible solutions; who can understand where a limitation cannot be overcome. Additional funding for Adult Social Care would ensure that disabled people are not held back from work by the effort and time expended on personal and household care. Additional funding for Access to Work, improved administration and an increased remit would allow assessments to be provided before a work search begins, so that the necessary support is put in place as soon as work starts, rather than many months later or so late that an individual has had to leave employment.

Many sick and disabled people cannot ‘achieve their potential’ without retraining - which the government has neglected to do in last six years, and in some cases has made harder. The government hasn’t discussed in this report the value of providing free education/training up to pre-

⁶³ McCluskey et al., 2011, 2014, 2015

degree level (and tuition fees as per 1st degree) regardless of the highest qualification of the sick or disabled person, in order to assist people to move into a new area of work that better matches their illness or disability. Nor can sick or disabled people 'achieve their potential' without having the support they need outside of work, which the government of the last six years has decimated, knowing full well the harm it was causing, as the Equality Impact assessments show.

To suggest that those furthest from the employment market could be catered for is a clear case of failing at the first hurdle, and then trying for a hurdle that is much higher. The people furthest from the job market, and many of those who are not quite so 'far', are too ill to work. Spending money on trying to get such people into work is a waste of finances, and causes significant opportunity costs for people who already have significant constraints on their capacity for activity. What most people with chronic disabling illness or severe and enduring mental illness need is to be left alone to decide themselves when they need a personalised, tailored, practical support service, and in the meantime to focus on improving their health and well-being – which is after all a necessary prerequisite to work.

The government's perception of supporting sick and disabled people

The government's approach to supporting sick and disabled people into work is necessarily predicated upon its beliefs regarding chronic disabling illness, disability and the nature of the workplace in the UK. Thus, because it over-estimates the quality of the labour market, it over-estimates what a sick or disabled person could do. Because it under-estimates the severity and nature of chronic disabling illness, it under-estimates the support a sick or disabled person would need in order to be able to work and, even more crucially, it over-estimates the number of sick and disabled people who would be capable of work even in a suitable job with the necessary support.

We have already discussed the implications of the government's belief that public health measures in the workplace are an appropriate approach. The government trivialises both chronic illness, and the nature of the labour market. In doing so, it gives the impression to uninformed readers that it is taking significant steps to help sick and disabled people; in reality, the approach it offers is merely a continuation of the low-level income and low-level support that has characterised the Cameron/Osborne approach to sick and disabled people.

The government has claimed multiple times to want to make employment support person-centred:

- We need to develop a more personalised and integrated system that puts individuals at the centre (1:39; similar refs to personalised and integrated support in (1:41);
- We want to deliver services which enable people to... have more say in the health and employment support they may need (1:44);
- We want people to be able to access appropriate, personalised and integrated support at the earliest opportunity (2:73);
- the employment and health support they receive should be tailored to their personal needs and circumstances (2:74);
- The Work and Health Programme will offer a more personal, localised approach (2:95);
- this new package of support offered through JobCentre Plus will ensure more personalised, integrated and targeted approaches (2:108);
- We want people to be able to access a more personalised, tailored, practical employment support service (2:110);
- tailored employment support (3:117); personalised and tailored employment support (3:118);

- these two areas of reform [downgrading the role of the WCA, and increasing data sharing] are important to delivering the type of personalised and effective services we know [sick and disabled people] want to see (3:122);
- these people deserve a personalised, tailored, practical support service (3:129).

What it offers in this Green Paper is somewhat different:

- trained work coaches could have discretion to make case-by-case decisions (3:132);
- work coaches could have full discretion to tailor employment support (3:133);
- work coaches will be supported by specialist Disability Employment Advisers (2:87);
- Community Partners will be working with JobCentre Plus staff (2:88);
- we want to make sure work coaches can access the right specialist advice and support (2:91);
- work coaches... could access specialist advice such as occupational health and JobCentre Plus psychologists (3:132).

The Conservative party is traditionally considered to be the party that emphasises personal responsibility over government responsibility. In this report, the Conservative Party seeks to tell sick and disabled people that they are both ignorant and irresponsible, and that they must work. In so doing, it removes personal responsibility and prevents sick and disabled people from taking the action they consider to be best.

The new system

The government has not provided a clear explanation of its proposed process for sick and disabled people to claim sickness benefit. From studying the Green Paper, we understand that the process is as follows:

- An individual puts in a claim for ESA (or UC sickness component) by requesting an ESA50.
- The individual completes the ESA50 and sends it with a GP sick note to the DWP.
- The individual is required to attend a 'Health and Work Conversation' with a 'Work Coach' at the JobCentre - "if appropriate" (2.92). It is not explained how it will be assessed whether or not this is appropriate, given that the WCA - which was designed to make this assessment - has not yet occurred
- The individual signs a 'Claimant Commitment' according to the Work Coach's assessment of what the sick or disabled person can do. It is not mandatory to carry out the actions in the Claimant Commitment before the WCA has taken place.
- The individual continues to meet their Work Coach if they wish it.
- The individual has their Work Capability Assessment.
- The individual is given either £73/week or, if assessed as having limited capability for work-related activity, £113/wk.
- A person placed on JSA or ESA WRAG is now mandated to meet with the Work Coach and carry out the activities set by the Work Coach. A person placed on ESA SG does not have to meet the Work Coach.
- A person placed on ESA WRAG or ESA SG can receive employment support from a range of programmes (it is not made clear if some these are mandatory for ESA WRAG), including:
 - Work and Health Programme (for ESA WRAG with a less than 12 months prognosis)
 - Specialist Employment Support programme (for those "furthest away" from work)

- Group work and computerised Cognitive Behavioural Therapy (for people with mental illness)
- Unpaid work placements or internships (for young adults)
- Job Clubs (delivered by other sick or disabled people)
- New Enterprise Allowance
- Increased availability of Access to Work (for people with mental illness)
- Small Employer Offer

The Health and Work Conversation

The government wishes to see all sick and disabled people speak with a 'Work Coach' prior to an assessment of their capacity for work. It is this conversation that will determine what employment support the sick or disabled person is offered. The Work Capability Assessment, which despite ongoing significant criticism is not being replaced, will then determine only whether an individual gets the additional money of the ESA Support Group, or is restricted to the JSA income.

The Health and Work Conversion legally changes very little. Before the WCA, sick and disabled people cannot be mandated to any activity beyond this conversation. After the WCA, people placed in ESA SG still cannot be mandated to any activity. People placed in ESA WRAG can be mandated to any activity bar applying for and taking up job offers. This is the same as has always been the case.

The difference is that what was previously a 'Work Focused Interview' that occurred after the WCA has been shifted to before the WCA. This results in a one-off contact with a Work Coach that need not be followed up until after the WCA. It is questionable what, if anything, this will achieve that benefits sick and disabled people.

The government has not explained how it will determine when a Health and Work Conversation is not appropriate. A reasonable expectation would be that people who end up being placed in the Support Group would not be appropriate candidates for the Health and Work Conversation. But until the WCA has been carried out, we do not know who these people are. This is why the outcome of the Health and Work Conversation cannot be made mandatory. From the perspective of the people required to attend, it is likely to be perceived as nothing more than an unnecessary bureaucratic hurdle to pass on the route to a proper assessment. For those who should not attend but who have not been identified as such, it could be a detrimental barrier that at best sets back their health and at worst prevents them from continuing with their claim for the benefit they need and are eligible for.

The government hails the Health and Work Conversation as providing 'early' support for sick and disabled people. In fact, most people take several years of recurrent sickness presenteeism and then sick leave to reach long-term sick leave. 'Early' would mean intervening whilst someone was presenting at work with what is or is likely to become a chronic illness, not waiting until it has reached the point where the person is unable to sustain work at all.

The Work Coach

The government has invested a great deal of authority and responsibility in its JobCentre Work Coaches. All the discretion regarding what a sick or disabled person should do to retain their sickness benefit lies with the Work Coach, not with the sick or disabled person themselves. The sick or disabled person cannot refuse the Work Coach's decisions because ESA WRAG is a conditionality benefit. Thus there is no freedom for the person allegedly being supported; only for the Work Coach to tell the sick or disabled person what to do. If the government wanted employment support to be

personalised and tailored, it would be voluntary, so that sick and disabled people can choose to do what they know they need help with and are capable of taking part in.

Yet the Work Coach does not have the expertise necessary to determine what a sick or disabled person can do. They are not medics, and so cannot comment on the impact of an illness or disability on an individual's function; case law confirmed this when a Judge ruled that a physiotherapist's opinion has no probative value on the capacity of a person with a mental illness. Employment services in other countries have also established that professionals with the wrong specialism cannot advise on sickness or disability. For people with mental health conditions, research has shown that without both a "dedicated vocational specialist" and support from the Community Mental Health Team, employment support simply isn't good enough. Attempting to train one professional to do another's job is not adequate.

Nor is the Work Coach an Occupational Therapist, trained to understand how the environment impacts on an individual's capacity to do something, and the environmental pressures that can enable or disable a person. An OT seeks to "enable people to achieve health, well-being and life satisfaction through participation in occupation" where 'occupation' refers simply to those tasks and activities that occupy our time. It takes three years of university education to train an Occupational Therapist.

108. The work coach is the key gateway to this support within the Jobcentre Plus network and across local provision – transforming the way we engage with individuals with health conditions from the very start of their claim and testing direct referral into health services.

The government wishes the Work Coach to go further and actually diagnose illness or injury well enough to refer the person to health services. This is not acceptable. It takes a doctor to give a medical diagnosis. Work Coaches cannot diagnose ill people, and nor can they recommend medical treatment to sick people. Referral to health services is a role for GPs, and emphatically not for Work Coaches.

There are also ethical objections to the government's intention to allow a Work Coach to report to a JobCentre Plus psychologist. It is not ethically acceptable for a psychologist to advise via proxy, as this would imply.

Instead of having a sick or disabled person talk with a psychologist about the support they need, the government is intending to have Work Coaches seek psychologist's advice on the Work Coach's interpretation of the sick or disabled person's circumstances. But the Work Coach is not a psychologist, so is not trained to form an opinion on a person's mental health; he therefore can offer only an uninformed opinion to a trained psychologist. That psychologist cannot then ethically comment on the untrained opinion of the Work Coach. It is one thing to have a trained psychologist seek advice from another psychologist; this is standard practice to ensure the ongoing competence of all psychologists. It is quite another to suggest that a psychologist can comment on a non-expert's opinion.

DEAs and Community Partners

The Work Coaches will be assisted by Community Partners and Disability Employment Advisers to whom they (not the sick or disabled person) can go for advice regarding the person they 'coach'. The government considers these will have significant impact, although there are very few of either role and all their advice is based on, and reported back to the claimant as, hear-say.

The expansion of Disability Employment Advisers from 200 to 500 is an ostensible good that masks the underlying problem that the frontline staff for sick and disabled people are not trained for their role. It risks confusion between the previous DEAs, who directly advised Incapacity Benefit

claimants and were considered relatively helpful, with the new role which is to advise people who advise sick and disabled people.

74. Increasingly, our work coaches across Jobcentre Plus will assess an individual's needs and ensure that they access the right help. Work coaches will be supported by new Community Partners and Disability Employment Advisers.

The 500 DEAs is, in effect, one DEA for every 5 000 people on ESA, or about 25 minutes per person per year. The DEA has 25 minutes to offer 'specialist' advice on the capabilities of a person they have not seen, who could have any number and range of conditions, with varying severities of symptoms, and whose capabilities for work are additionally influenced by variables such as the transport links, children or other caring responsibilities, education level and work history. And all this is based upon the Work Coach's interpretation of the sick or disabled person's situation.

The Community Partners also face a challenging task. They are supposed to 'draw on their local knowledge' - where 'local' apparently refers to a region covering three or more constituencies. The alternative is that very few areas will get Community Partners, because the government simply isn't intending to recruit enough of them. Of course, one might expect every JobCentre to know intimately the area it covers, including all the forms of support - whether work-related or not - and the employers in its region. The identified need for Community Partners suggests that such a basic level of service is not currently in existence.

Personal Support Package

Following the WCA, WRAG claimants with an assessed prognosis of being able to work within twelve months used to be mandated to the Work Programme. In theory, WRAG claimants could go on Work Choice instead. However, despite nominally being for sick and disabled people, in practice the criteria (being able to work at least 16 hours a week in six months' time) meant that sick and disabled people were too sick or disabled for their own support programme. The new option of the Work and Health Programme seems to be a voluntary service for people with prognoses of under 12 months; it is not clear if JobCentre Work Coaches could mandate ESA recipients to the Work and Health Programme. And the level of funding the government has committed to it suggests it will result in only 20 000 (additional) sick or disabled people moving into work each year - whilst 350 000 have to leave work due to illness.⁶⁴

The government considers that its Fit for Work scheme (for employees who have been off work for four weeks or more) and its Health and Work Conversation (for people who have claimed ESA for four weeks) are 'early'. In fact, they are both late. The path to long-term sick leave is a long one, not the sudden event with critical (short) time periods that the government envisages. Consequently, moving a discussion forward by two-three months is not a significant improvement, especially when we know that the reason the Work and Health Focussed Assessment, which served the same purpose of discussing the claimants abilities and needs, was scrapped because it was deemed of no value before a decision on the claimant's benefit status had been made. The significant opportunity that has been missed is not the first three months of an ESA claim, but the preceding years of increasing illness and the six months of Statutory Sick Pay.

What is needed is support right at the start of the process - when people first become concerned about their ability to manage their health and work together. This means providing

⁶⁴ Gardiner, L. & Gaffney, D., 2016. Retention deficit: a new approach to boosting employment for people with health problems and disabilities. Resolution Foundation.

decent support to people in work, to enable them to remain in work, and hopefully prevent them from having to leave work all together. It also means focussing on people who are disabled but otherwise healthy. This is where the government's prime focus should be, not on people who are not going to be able to gain meaningful employment.

The only step change this paper provides is a significant step backwards. The Work and Health Programme has only 20% of the funding that the failed Work Programme had. The government talks about investing in innovation, rather than using what we already know about Individual Placement and Support, Access to Work and Job Brokers to support moderately ill and disabled people to obtain and sustain work. The government is ignoring substantial evidence on the harm the ESA WRAG causes to its recipients and the benefits for sick and disabled people of having a stable income without mandated activity. Plans to increase conditionality whilst reducing or ignoring suitable support measures is a retrograde step, not a step up.

Supporting young people

102. Gaining employment after leaving education should be a core part of the journey into adulthood for disabled young people and young people with health conditions yet successful outcomes are far too low... we will test a voluntary, supported Work Experience programme.

It is not acceptable to make young people with disability or chronic illness pay the cost for getting the support they need. Government should not make young people bear the cost of an education system that didn't give them relevant job skills. If employers cannot see a business reason why they should pay for the training of the workforce they need, then government should subsidise them full, rather than a partial subsidy from the government (wage paid as benefits) with the rest as a subsidy from the young adult (wage foregone because benefits are so low).

Young adults need access to adequate finance once they have reached adulthood, so that they can live independently and make their own choices in life. They need at least the ESA WRAG component on top of the over-25s JSA or ESA assessment phase rate. The expenses of getting to work, both travel, clothes and any other needs, must be covered. They do not necessarily need a job coach; what they need is the prompt access to Access to Work or Disabled Students Allowance to get the practical support measures they need at work. This includes support workers who assist them at work, and British Sign Language interpreters for deaf people

Complex illness

People with the most complex health conditions are those with the most severe and difficult to manage illnesses. These people typically do not have the capacity to work or to engage in mandated activity in an attempt to get them 'closer' to work. Nor is there any point from either the government's or the individual's perspective. These people should be 'left alone' from an employment perspective, and it is right to do so, although this is not an excuse to not provide the support needed at home and for social participation.

The government has already reduced the money for some people in the Support Group by changing the guidelines on what it means to be incapable of work-related activity. Many Support Group recipients will, therefore, lose out on their Support Group component at reassessment, without their illness or capacity for work changing. This is because the government redefined work-related activity as things such as phoning a JobCentre adviser once a week, keeping a record of activity, updating a CV (however unlikely to have changed) and making a list of previously enjoyed hobbies. These are very much lower than, and not reconcilable with, the level of activity the

government expects of WRAG recipients in this Green Paper. The guidelines on what work-related activity means must be the same as the multiple meetings and Claimant Commitment which the government intends, as otherwise people will be assessed as capable of work-related activity on the guidelines, but not be capable of it in practice. It is not acceptable to say that conditionality can be waived; if it is waived, the claimant should be in the Support Group.

Response by Paragraph

In this chapter, we take each paragraph in turn and respond to the smokescreens, misleading statements and inappropriate intentions in each one. The major themes that occur throughout the Green Paper are addressed in the preceding chapter, Significant Themes. This chapter brings in some additional detail as it pertains to each paragraph.

CHAPTER ONE: Tackling a significant inequality – the case for action

Being in work can help an individual's health and their overall wellbeing

16. This government is committed to helping everyone, whoever they are, enjoy the independence, security and good health that being in work can bring, giving them the chance to be all they want to be.

Sadly this wishful thinking is purely fantasy. Many very sick and disabled people wish to be in a different position - to be cured, to have equipment, care, assistance and adjustments. Sick and disabled people, when they themselves cannot provide their own independence and security, need the independence, security and wellbeing that a decent welfare state offers.

The transposing of cause and effect is a strong theme running throughout this report.

They have, in reality, no option for achieving independence as the Government has progressively removed or reduced the necessary support - removal of the Independent Living Fund, failure to ring fence payments to Local Authorities and the cuts to Adult Social Care have all restricted the opportunity for sick disabled people to be independent and secure.

For those who are in good health but have impairments or disabilities, these cuts have impacted on their employment hopes and opportunities. The support they need to work has never been available; the financial support they need to live is becoming increasingly precarious.

There are no 'cures' in work for those who are seriously ill. Good health is not a direct benefit of work - good health comes from many interactions, some of which may be found in work but are not exclusive to work. For example, those who have sufficient income to not work or claim benefits do not show the same levels of sickness as those who leave work due to sickness, then are plunged into poverty due to being dependent on benefits. This transposing of cause and effect is a strong theme running throughout this report, but the ill-health that makes people dependent upon welfare is not amenable to work. Crohn's, cancer and connective tissue disorders do not exclusively target people who were already out of work.

The statement "*giving them the chance to be all they want to be*" is both trite and untrue. Phrases such as these have no place in a Green Paper.

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17. The evidence is clear that work and health are linked. Appropriate work is good for an individual's physical and mental health. Being out of work is associated with a range of poor health outcomes. Academics and organisations such as the WHO, the ILO, the OECD, RAND Europe, the Royal College of Psychiatrists and NICE all recognise that work influences health and health influences work. The workplace can either support health and wellbeing and the health system can actively support people into work in a virtuous circle or the workplace can be unsupportive and health and work systems can work against each other.

Work and health are linked. However, as it is largely the healthy people that work, it's fairly self-evident. It is not a problem that people too sick or disabled to work are not in work; the problem is a State that declines to support them.

Health and income are linked. However, income and work are not always linked, noticeable by the large number of working people now needing to have their earnings 'topped-up' by benefits in order to reach a more liveable income.

In truth it is financial deprivation and poor health that are linked. "Poorer people live shorter lives and are more often ill than the rich."⁶⁵ A person on a low income is more likely to be and become ill, and placing people on low incomes makes them more susceptible to certain illnesses.

Placing a sick person on a very low, deprivation level income will exacerbate any condition they have, and increase the likelihood of co-morbid conditions.⁶⁶ However, this does not preclude the existence of severe, enduring illnesses that are not preventable through work, wealth or lifestyle.

The government writes that, "*appropriate work is good for an individual's physical and mental health*". Appropriate **activity** may be good for an individual's physical and mental health, but **work** can be damaging. This conflation of activity - including therapeutic activity - with paid or unpaid employment is disingenuous. It is the dearth of appropriate work or activity for people who are sick that impacts negatively on their health, and all the academics and organisations quoted in the Green Paper recognise that there are workplaces that damage health. It seems that only the government refuses to believe that work does not prevent most illnesses and nor does it cure most illnesses.

It seems that only the government refuses to believe that work does not prevent most illnesses and nor does it cure most illnesses.

The workplace can be more than unsupportive; it can be actively detrimental. This was a key finding of both the seminal Waddell and Burton paper⁶⁷ and the influential Marmot review.⁶⁸ The government must recognise that many jobs, particularly those at the bottom end of the labour market, are bad for health and wellbeing.⁶⁹

The government must recognise that many jobs, particularly those at the bottom end of the labour market, are bad for health and wellbeing.

⁶⁵ Wilkinson, R. and Marmot, M. 2003. Social determinants of health. The solid facts. Second edition. World Health Organisation, Denmark.

⁶⁶ Marmot, M. & Bell, R., 2009. How will the financial crisis affect health? British Medical Journal, 338:b1314

⁶⁷ Waddell, G. & Burton, A.K., 2006. Is work good for your health and wellbeing? DWP.

⁶⁸ Marmot, M., 2010. Fair society, healthy lives. Department for Health.

It must also be clearly understood that in reality most workplaces and employers cannot integrate sick people, with sickness at the level found consistently on ESA, into their workplaces. Sick people are not productive enough or reliable enough for most employers to invest in, and to generate a profit from. A person who cannot say how much work they may be able to do that day, week, month and year is not a viable employee. Frequent short-period sick leave is difficult for employers to manage, and usually leads to disciplinary procedures with a view to dismissal on health grounds.

“The workplace can either support health and wellbeing and the health system can actively support people into work in a virtuous circle or the workplace can be unsupportive and health and work systems can work against each other.”

Health and work systems do not work against each other in the way that the government claims. What we have is two systems neither of which the government is fulfilling its role to manage. The NHS is underfunded, meaning people do not get timely diagnoses or adequate treatment. Business is deregulated and so is not required to maintain healthy working practices, whilst ‘reasonable adjustments’ and other related laws are not monitored and enforced. Neither does the government actively assist through subsidies, incentives or the direct provision of Occupational Therapy. It should be no surprise that returns to work are delayed when employers do not provide the necessary adjustments and the NHS is unable to provide thorough healthcare.

18. We know that the longer a person is out of work the more their health and wellbeing is likely to deteriorate. So, every day matters. For every week, every month, every year someone remains outside the world of work, it is increasingly more difficult for them to return and their health and wellbeing may worsen as a result. We must address this downward spiral.

Not only does the government ignore bad work and bad health, it ignores the possibility that bad health endures. It ought to be self-evident that people who have incurable conditions and are too ill to work will not stop needing sickness benefits. Instead, the government says, “the longer someone is away from work, the harder it is for them to get back to work” - and in so doing turns a correlation into an unverified causation. In failing to even mention, let alone disentangle, the difference between ‘duration’ and ‘selection’ effects, the government miserably fails the people it is elected to serve.

Not only does the government ignore bad work and bad health, it ignores the possibility that bad health endures.

In the context of this report, it should be explicitly recognised that some people and in particular the majority of people on ESA are unable to work or should not work because of chronic illness. These people, from the moment they start sick leave, are going to be long-term unemployed.

The government has managed to write a paper on health and work that has never once discussed chronic incapacitating illness.

⁶⁹ Selenko, E., Batinic, B. & Paul, K., 2011. Does latent deprivation lead to psychological distress? Investigating Jahoda's model in a four-wave study. *Journal of Occupational and Organizational Psychology*, 84(4), p. 723–740.
Baumberg, B., 2014. Fit for work – or work fit for disabled people? The role of changing job demands and control in incapacity claims. *Journal of Social Policy*. 43(2):289-310 doi:10.1017/S0047279413000810

It is not that long-term unemployment makes them unemployable; rather, because they are chronically unable to work they remain unemployed. By not giving explicit recognition to this, the government has managed to write a paper on health and work that does not even try to consider how many people cannot or should not work, and has never once discussed chronic incapacitating illness.

19. Of course, work can also bring a range of other benefits which support mental and physical health and wellbeing. It is the best route to raising the living standards of disabled people and people with a long-term health condition and moving them out of poverty. But a good standard of living is about more than just income. Work can help someone to be independent in the widest sense: having purpose, self-esteem, and the opportunity to build relationships. Being in the right job can be positively life changing.

Work can be good for health, but it is not that simple - work does not inevitably and directly cause good health. The good health effects of work are mediated through various factors that are themselves beneficial, but are not unique to work nor inevitably delivered by work. These factors are called latent benefits (time structure, activity, collective purpose, identity/status and social interaction), and these latent benefits are available through non-work activity - hobbies, groups, sports etc.⁷⁰ The manifest benefit of paid employment is freedom from financial strain.⁷¹

Jobs at the lower end of the job market frequently do not provide either the manifest benefit of employment (minimum wage is substantially lower than the Minimum Income Standard⁷²) or the latent benefits of employment. Jobs at the bottom tend to be mundane, delivering no sense of collective purpose or any beneficial activity; high pressure, preventing social interaction; and with little to no self-esteem or opportunity to progress, corroding self-esteem. Thus people in these jobs are not "independent in the widest sense". Such jobs can be negatively life-changing, trapping people as they do into the low pay/no pay cycle, where bad work alternates with demeaning welfare.

"It is the best route to raising the living standards of disabled people and people with a long-term health condition and moving them out of poverty."

For people who are too sick to work full time, work is neither a cure nor the best route out of poverty. People who are too ill to work enough hours to earn enough to live off are not, and cannot be, lifted out of poverty by work. Without access to an earned income, it falls on the State to ensure that these people are provided for. It is neither inevitable nor unavoidable that they live in poverty merely because they cannot work or can only work a small amount; rather, it is entirely a political choice that ill people live in poverty in this country.

People who cannot work cannot benefit from the benefits of work, unless it is provided in another form. Without access to the latent benefits of work, it falls on the

It is entirely a political choice that sick people live in poverty in this country.

⁷⁰ Jahoda, M., 1981. Work, employment and unemployment: values, theories and approaches in social research. *American Psychologist*, 36(2), pp. 184-191.

⁷¹ Fryer, D., 1986. Employment deprivation and personal agency during unemployment: A critical discussion of Jahoda's explanation of the psychological effects of unemployment.. *Social Behaviour*, 1(1), pp. 3-23.

⁷²

State to ensure that it meets both personal care needs and the latent benefits of work such as socialisation, identity and fulfilling activity. The State currently does not provide even the personal care needs, so it has a very long way to go before its sick and disabled citizens will have the same substantive rights as able-bodied people.

20. But, whilst work is good for health in most circumstances, the type of work matters. Many factors such as autonomy, an appropriate workload and supportive management are important for promoting health at work. These factors can be very personal.

It is worth noting that in the DWP data used to create this report, 35% of people getting an ESA award on the grounds of mental health came from people who had been employed immediately before claiming. If work was good for mental health then these people should not, by the claims of this report, have become mentally ill whilst in employment.

This paragraph identifies that work needs to include features such as autonomy, an appropriate workload and supportive management if it is to be good work; but no suggestions are given on how good jobs with these attributes can be achieved, and no attention is given to the existence of, and necessity of eradicating, bad jobs.

21. As many stakeholder organisations like Scope have highlighted, many disabled people and people with long-term health conditions already work and many more want to access all the benefits that work can bring. We want to understand how to improve the current system of support to make this aspiration a reality. We also recognise that some disabled people and people with health conditions might not be able to work due to their condition, whether in the short or long term. This government is committed to ensuring that they are fully supported by the financial safety net that the welfare system provides and so this consultation does not seek any further welfare savings beyond those in current legislation.

Many stakeholder organisations do not work with, nor represent, the people who will be most affected by the “current legislation” of successive significant benefit cuts, including the recent reduction in financial support (benefits) for those people in the work related activity group. These are people who are chronically ill and may be unpreventably moving away from work rather than towards work. A long-term health condition is not the same as a chronic illness; in fact many health conditions are neither disabling nor incapacitating. For example, managed diabetes, epilepsy and spina bifida may have no disabling impact at all, because they are under control.

Scope traditionally represents people with cerebral palsy, a condition that typically causes disability and not chronic illness. It is presumptuous of the government to assume that a partially government-funded specialised charity is a significant authority on the barriers sick people face in employment. It is entirely beyond their remit. Some of the other major charities involved in discussions with the government are those that primarily are concerned with pensioners, because they are age-related diseases. But charities that help people with chronic illness that can exist throughout a person’s working-age life seem to receive less attention and fewer, smaller grants.

There is no evidence in this report that the Government recognises health conditions to be chronic incurable states of being, that chronic illness can be so incapacitating as to prevent work, and that employers - quite rightly - won't employ those too sick to work. Instead, the government presents chronic illness as minor health conditions (which wouldn't be eligible for ESA) which the report suggests will be cured by work, and it uses this presentation as a smokescreen for financial cuts, increased conditionality, further assessments and so-called work-related activity that has no benefit.

“We want to understand how to improve the current system of support to make this aspiration a reality.”

The system can be drastically improved for those who have a physical or sensory disability. Additional funding for Adult Social Care would ensure that disabled people are not held back from work by the effort and time expended on personal and household care. Additional funding for Access to Work, improved administration and increased remit would allow assessments to be provided before a work search begins, so that the necessary support is put in place as soon as work starts, rather than many months later or so late that an individual has had to leave employment.

No “system”, beyond medical intervention, can cure ill people, and no employer will hire someone too sick to work. The Government needs to recognise the difference between healthy disabled people with addressable barriers to employment, and people with chronic illness.

“This government is committed to ensuring that they are fully supported by the financial safety net that the welfare system provides and so this consultation does not seek any further welfare savings beyond those in current legislation.”

Whilst the actual level of the “financial safety net” may not be cut for some, in real terms it has fallen behind living costs, supplementary benefits have been capped, and under Universal Credit people will see further reductions. At the current level, social security benefits are inadequate to meet the needs of chronically ill and disabled people, covering as they do only 55% of the minimum income necessary to cover basic needs and allow participation in society.⁷³ It is therefore not a financial safety net, and promising merely to not drive sick people into deeper poverty is not acceptable.

Additional to this there is an indication that the DWP is considering further tightening of the criteria for entering ESA Support Group, as indicated under the heading “Explore reform of the Work Capability Assessment”, page 87 of the Green Paper. These criteria have already been tightened in January 2016, with no discussion in Parliament, and with significant impact on those people who otherwise would have been awarded the Support Group of ESA.

“Many disabled people and people with long-term health conditions already work.”

Whilst the government makes mention of the fact that some disabled people are in work, disabled people are only in work if their level of disability is sufficiently low relative to their value as an

⁷³ Davis, A., Hill, K., Hirsch, D. & Padley, M., 2016. A Minimum Income Standard for the UK in 2016. Joseph Rowntree Foundation.

employee. The more severely disabled a person is, the more valuable they must be as an employee if they are to be worth retaining. For example:

- Stephen Hawking is severely disabled and irreplaceable. He receives significant at-home and in-work support.
- Isabel Hardman, a successful journalist, is considered good enough to be worth allowing a few months' leave (as her own testimony shows) and a phased return to work following an episode of mental illness; ultimately, however, she is not irreplaceable.⁷⁴
- A data analyst needing recurrent sick leave is replaceable, although it may cost the government's estimate of £25-40k to recruit a new employee, and therefore the company may seek to retain the analyst for some time before deciding whether the cost of retention exceeds the cost of recruitment.
- A call centre has many alternative job candidates and can easily recruit more; there is nothing gained from attempting to keep a person who cannot maintain the expected pace of work.

There is a clear hierarchy of what an employer is prepared to 'trade' - the more valuable an employee, for whatever reason, the more accepting the employer is of temporary sickness, or disability. We cannot compare high-functioning individuals such as Stephen Hawking, high-functioning autistics or high-functioning drug addicts with lower-functioning individuals who do not have exceptional resources to overcome their condition or to 'trade' with the employer. Neither can we compare chronic illness with a non-disabling health condition or a period of acute illness.

Closing the DEG to tackle injustice and build our economy

22. This government is committed to building a country and an economy that work for everyone. The UK employment rate is the highest it has been since records began. Over 31 million people (nearly 75% of the working age population) are in employment.³¹ However, while there has been an increase of almost half a million disabled people in employment over the last 3 years, there are still fewer than 5 in 10 disabled people in employment compared with 8 in 10 non-disabled people.³² This disability employment rate gap, the difference between the employment rates of disabled and non-disabled people, has not changed significantly in recent years and now stands at 32 percentage points.^{33,34}

The disability employment gap cannot be accurately measured, and it is questionable if the government has chosen the best approximation. One can manipulate the disability employment gap by expanding or contracting the definition of disability unemployment.

- It can be narrowed by excluding those who should not work and are therefore not available for work.
- It can be expanded by including minor or manageable health conditions such as dyslexia, controlled diabetes and some types of arthritis.

⁷⁴ Hardman, I. , 28/10/2016. How we do (and don't but should) treat depression. The Spectator.

If one excludes those people who report a work-limiting illness or disability from the figures of disabled people available for work, the disability employment gap narrows to zero. This is too far - some people with conditions that limit the type or hours of work they can do can still do some work - but it illustrates the nebulosity of the so-called disability employment gap. Until it is defined, it cannot be measured, nor amended, nor 'halved'.

Further difficulties are caused when one considers the necessity of matching like with like - it is not disabled people vs non-disabled, but the difference that being disabled makes to an individual compared to someone who is not disabled but is identical in every other way. Of course, this is impossible, because having a chronic illness or disability will have had an historic impact, so that an individual's disability cannot be isolated from his or her education and employment history, for example. But one can make an approximation by comparing people who are the same across all (easily measured) characteristics - such as age, gender and education level - bar that of disability, and it is better to make at least some like-for-like comparison than to make none at all. Indeed, the government has available to it a report on the disability employment gap by Richard Berthoud, which makes clear that discussing disability without discussing the different types and severities is wholly inappropriate.⁷⁵

Some people should not work, and it would be inappropriate to include them in employment figures - whether this is people too sick to work, full-time caregivers or full-time students. They are not 'potential workers' and should not be considered as such. The DWP has made no effort to exclude from these figures those people who for health reasons should not work or who are occupied in other economic activity such as caring duties.

23. So 3.8 million disabled people are out of work despite a record breaking labour market. People with particular health conditions can be disadvantaged, for example only 32% of people with mental health conditions are in employment. This leaves people, and in some places entire communities, disconnected from the benefits that work can bring. This is one of the most significant inequalities in the UK today and the government cannot stand aside when it sees social injustice and unfairness. That is why we have set ourselves the ambition to halve the disability employment gap.

The 'record breaking labour market' needs more than a superficial analysis. It is a labour market based on low-skilled jobs, zero-hour contracts, underemployment and self-employment. It is one where a key 'skill' is the ability to work fast for long hours. This is not a labour market that is healthy for its members, and is not one which sick people can safely enter.

The disability employment gap is not one of the greatest inequalities in the UK. Of all the inequalities in the country, the fact that people who are too sick to work are not in work is not one of them. There are many forms of inequality; the five biggest ones are⁷⁶:

- political, civil and legal equality;
 - Access to justice has been decimated for poor people, through legal aid cuts and the introduction of fees to tribunals.
- income and wealth equality;

⁷⁵ Berthoud, R., 2006. The employment rates of disabled people. DWP.

⁷⁶ Mount, F. 2008. Five types of inequality. JRF.

- In the UK, the top earners - who receive not just a wage but also bonuses and more - receive vastly more than care workers and cleaners
- equality of opportunity;
 - Access to education and life opportunities differs dramatically depending on who you were born to.
- equality of treatment;
 - People in poorer areas receive poorer healthcare, despite typically having more health needs.
- equality of membership in society;
 - Sick and disabled people are trapped in their homes by cuts to public transport, libraries and day centres, ILF, social care, DLA/PIP and housing benefits.

These are the most significant inequalities in the UK - the lack of State provision that means that random luck propels some people into health and success, and traps others in illness and poverty.

“So 3.8 million disabled people are out of work despite a record breaking labour market.”

Cuts to social care, the delays to Access to work, and the lack of desire or need of employers to employ disabled people are all drivers of this situation. For chronically sick people, it is the simple lack of capacity for work, and the fact these people are not in work is not the problem.

The much vaunted Government initiative ‘Disability Confident’ is discussed further on in this report.

“People with particular health conditions can be disadvantaged, for example only 32% of people with mental health conditions are in employment.”

People with serious mental health conditions are unlikely to be employed. The disadvantage stems from exactly what is stated in paragraph 33. Yet there is no part of this report that suggests solutions for these inequalities - beyond the disingenuous claims that work is a cure for both ill health and financial deprivation.

“This leaves people, and in some places entire communities, disconnected from the benefits that work can bring.”

The ghettoisation occurs as people on low incomes are forced into low quality accommodation, and the benefit cap and LHA squeeze people further financially. Inevitably there become pockets of deprivation, where people who are ill and disabled are forced to live because they cannot afford anything else. Again, a result of Government legislation as regards what rent and living costs they will contribute to.

It is not worklessness that is the inequality for sick and disability. It is the deliberate refusal to care for their basic rights.

“This is one of the most significant inequalities in the UK today and the government cannot stand aside when it sees social injustice and unfairness.”

The Government is pivotal to the inequalities people experience, and with every cut to benefits and services they place people further from the employment market. There is a huge social injustice in cutting social care, thus meaning people cannot wash, dress and be fed at appropriate times and of their own choosing, and in particular be ready for work, and consequently are in financial and social deprivation and inequality. Similarly restrictions within the NHS mean people don't get the medical interventions they need. The sale of social housing stock forces people into hostels and low standard accommodation as the government refuses either to provide or pay for appropriate accommodation, and the benefit cuts since 2010 have made this worse.

The list goes on. Quite frankly the statement above is laughable.

“That is why we have set ourselves the ambition to halve the disability employment gap.”

Again, this unproven variable which is dependent on multiple other variables is to be ‘halved’, with zero recognition that this will in no way change the life outcomes of the vast majority of people concerned, bar exposing them to further assessments, further interrogation, and further stress, and creating co-morbid conditions. Whilst there is a chance that healthy disabled people may be helped into work - which would be good and right - the majority of those in the ‘*disability employment gap*’ are too ill to be employed, or will not receive the physical support they need due to financial constraints.

It is not worklessness that is the inequality for sick and disability. It is the deliberate refusal to care for their basic rights. Nor is it only worklessness that keeps communities out of the benefits of work. It is also because of the decision of the State not to give access to those benefits to people who are unable to obtain them via paid work.

24. This ambition is not only about tackling an unacceptable injustice for individuals. The disability employment gap also represents a waste of talent and potential which we cannot afford as a country: poor health and unemployment results in substantial costs to the economy.

Again the report conflates healthy disabled people with unemployable chronically sick people, and conflates disability in general with poor health. Whilst poor health may result in costs to the economy, the claimants on ESA have either significant disability, chronic illness, or a mixture of both. They don't have ‘poor health’ - they have serious and long-lasting illness.

<p>Chronically sick people should not be told that they are a burden the country cannot afford.</p>

It is not helpful to tell these people that they are a substantial cost to the economy which we cannot afford. Many already feel that they are a burden to their families; they do not need to be told they are burdens to the economy as well. That the government does so is sickening.

25. The cost of working age ill health among working age people is around £100 billion a year. The majority of this cost arises from lost output among working age people with health conditions not being in paid work. Economic inactivity costs government around £50 billion a year, including £19 billion of welfare benefit

payments, and lower tax revenues and national insurance contributions. The NHS also bears £7 billion of additional costs for treating people with conditions that keep them out of work. And there is also a cost to employers: sickness absence is estimated to cost £9 billion per year. And, of course, there is a cost to people and their families.

The DWP and DH appear to be saying that sickness is a problem not because it is unpleasant for the individual concerned, but because it prevents that person from being an economically productive unit. Healthcare, in the DWP's analysis, is provided so that workers can be patched up and returned to the workforce - not because they have a right to it. What does this say about the unborn disabled child, the disabled pensioner, and the sick young adult who will never become well enough to work? Healthcare and concern for others should not be based upon their economic worth.

Lost output due to a person being sick	sick leave	£15-20bn
	on sickness benefits	£73-103bn
	carer for sick person	£1bn
Government flow	NHS costs	£7bn
	ESA and related benefits	£19bn
	Lost tax and NI	£21-29bn

The DWP reports the cost of work-limiting sickness as £7bn/yr - but healthcare is an investment. It costs money upfront, but saves money in the long-term by restoring a person to a higher level of function. For most people, this means being able to return to work and earn money, pay tax on the earned income, and contribute to the support and wellbeing of the people around them, such as their family.

The DWP does not report on the cost of sickness presenteeism - thought to be several times higher than the cost of sickness absence.⁷⁷ By discussing sickness absence, rather than sickness itself, the focus is shifted from the problem - a person is ill - to their behaviour - taking time off work. The problem is re-contextualised as people taking sick leave, when actually the data says that people should take sick leave when they are sick - this will result in a faster and more productive return to work.⁷⁸ It is not how people behave when they are sick that is the problem, but the fact that they are sick in the first place. The solution, therefore,

Deliberate misdirection is a major problem of this report and of the government's approach and attitude.

Sick people, especially people with mental health conditions, already attend work whilst sick. But it is not making us better.

⁷⁷ Garrow, V., 2016. Presenteeism: a review of current thinking. Institute for Employment Studies.

⁷⁸ Ashby & Mahdon, 2010.

is not to change behaviour but to increase and improve healthcare. Such deliberate misdirection is a major problem of this report and of the DWP's approach and attitude.

Indeed, behaviour is changing - sickness presenteeism is on the rise.⁷⁹ Sick people, especially people with mental health conditions, already attend work whilst sick. But it is not making us better.

Action is needed now to prevent this situation getting worse

The NHS delivers prevention, as well as treatment, for potential illness, injury or impairment. Underfunding of the NHS significantly impacts its ability to engage in public health and prevention matters. Underfunding of the NHS is preventing timely treatment for many, with months of waiting time for chronic non-terminal illness or injury.

Whilst the Government may wish to control every aspect of a person's life, they cannot force people to take preventative action, or have treatment. What they can, however, do is ensure that the access to preventative measures and treatment are available to all those who need it. People cannot take full responsibility for managing their health if they do not have the option of accessing healthcare.

26. We have seen that the costs, to the individual and the economy, of the disability employment gap are already unacceptably high. Trends in demography and population health mean that we need to take action now to prevent these costs rising further.

We have not seen that the costs of the disability employment gap are unacceptably high. The government has not explained how, if there are jobs going unfulfilled because sick and disabled people are not doing them, there are nearly a million people looking for work on Jobseeker's Allowance, and more who are not claiming JSA. The government has not investigated how many people on ESA are unable to work regardless of the level of support from the government and employers because pain and fatigue are not mitigatable. Nor has the government investigated how many disabled people could work if they had the right support at home, in the wider environment and in the workplace, but are not getting it because the government is not funding it. .

The disability employment gap is not as simple or as large as the government states, and to carry this error forward is disingenuous. The employment gap is dependent on two variables, one of which is the percentage of employed people. If the number of employed people rises, then the disability gap grows if few of those people are 'disabled'. In this report, the government has included many unemployed people as employed, as its definition of employment shows:

The number of people in employment in the UK is measured by the Labour Force Survey (LFS) and consists of people aged 16 and over who did paid work (as an employee or self-employed), those who had a job that they were temporarily away from, those on government-supported **training and employment programmes**, and those doing **unpaid family work.**" (Green Paper data pack, emphasis added)

Including people not in work as employed, and including people who cannot work as unemployed, increases the apparent size of the disability employment gap. But it over-estimates the percentage

⁷⁹ Flores, P., 07/05/2013. Presenteeism in the UK workforce is on the rise. HR Review

of healthy non-disabled people in employment, and it misleads the government as to what is an appropriate percentage of 'disabled' people to expect to be able to help into work.

27. Older people will make up a greater proportion of the workforce in the future. Between 2014 and 2024 the UK will have 200,000 fewer people aged 16 to 49 but 3.2 million more people aged 50 to State Pension age.³⁹ Older workers can bring great benefit to businesses and drawing on their knowledge, skills and experience may help businesses to remain competitive and to avoid skills and labour shortages.

28. We also know that while life expectancy at birth has been increasing year on year, changes in healthy life expectancy have not consistently been keeping pace: we are living longer lives but some more years in ill health.⁴⁰ There is a known correlation between an ageing population and an increasing prevalence of long-term chronic conditions and multiple health issues.

Given we have an ageing population and the acknowledgement that people who are older tend to have more chronic illnesses, isn't it time the Government invested in the NHS to reduce the incidence of illness and help to bring more illnesses into the state of 'managed health conditions'? It seems the Government is demanding that people work with health conditions, and yet is neither providing the necessary healthcare nor considering the likelihood that these people will be rejected or dismissed by employers. This is particularly an issue at the bottom of the labour market. Entry-level jobs are not serving as the entrance to careers, but instead are forming the work side of the low pay/no pay cycle.⁸⁰ Consequently, many older people with illnesses are still engaged in low skilled work, in which their 'knowledge, skills and experience' is substantially less important than their health and ability to work fast.

29. We know that the world of work is changing. For example, new information and communication technologies have changed the nature of work tasks. This change may bring benefits, for example enabling more flexible working to help people with health conditions stay in work, but can also have less positive effects like work intensification that may affect people's ability to cope or adapt in work with a health condition.

The Government talks of old people and new technology, sedentary jobs, increased poor health and work intensification in three paragraphs, and yet apparently sees no contradiction at all with these scenarios and their planned cuts to sickness benefits. The Government is essentially saying "Yes, you will get ill, but we won't give you anything more than a subsistence income until you are almost 70, and we won't help you return to work either through direct practical assistance or through regulating

The contents of this paper show that the government does not intend to support people to live fulfilled lives through either access to paid work or support for social participation.

⁸⁰ Shildrick, T., MacDonald, R., Webster, C. & Garthwaite, K., 2012. Poverty and insecurity: life in low-pay, no-pay Britain. Bristol: The Policy Press.

against bad jobs". The contents of this paper show that the Government does not intend to support people to live fulfilled lives through either access to paid work or support for social participation.

30. The impact of poor health on work is not inevitable for people at any age. For example, advances in technology can assist people to remain in work where they might have been previously unable to do so. Lifelong learning can also offer the opportunity for people to gain new skills to change roles if they develop a health condition or disability, or an existing one worsens. And while many conditions are not preventable, the evidence is clear that the way we live our lives can influence health outcomes. Currently, 6 out of 10 adults are overweight or obese, nearly 1 in 5 adults still smoke, and more than 10 million adults drink alcohol at levels that pose a risk to their health. Public health interventions form a vital part of the health and work agenda to help reduce the prevalence of conditions that can lead to people leaving the labour market due to ill health.

The DWP write that, *"The impact of poor health on work is not inevitable for people at any age"* which contradicts their previous statement that, *"There is a known correlation between an ageing population and an increasing prevalence of long-term chronic conditions and multiple health issues"*.

Paragraph 28 clearly indicates a falling off of health as a person ages, but paragraph 30 suggests this health decline somehow fails to impact on work capability or productivity. Both capability and productivity are essential in the modern workplace to ensure that the employer makes a profit, and multiple health conditions associated with age are not compatible with this workplace.

People with chronic illness or disability do take more time off work than do healthy, able-bodied people. In many cases this may be due to their underlying illness, and they may take less 'true' sick leave for reasons that any person might. But the impact on employers is not dependent upon the exact reason why an employee took sick leave. The impact of sickness presenteeism, leaveism and absenteeism are all significant - if they weren't employers would not use sickness absence as a reason for disciplinary measures.

"For example, advances in technology can assist people to remain in work where they might have been previously unable to do so."

Sadly this is entirely untrue. If an aspect of a job can be replaced by technology then that aspect ceases to exist. For some people this will be their entire job, for some it will be part of their job. In manual jobs the availability of things that compensate for ageing, such as exoskeleton leg braces, are still not commercially viable given the value and replaceability of the average manual worker. Physical roles being replaced by sedentary roles is one outcome of new information and communication technologies, leading to a workforce that needs to take exercise in addition to, instead of as a result of, work. Whilst it is desirable that people look after their health, both for the economy and savings in the NHS, if being overweight or obese were a barrier to working then we would have much greater levels of unemployment.

“Lifelong learning can also offer the opportunity for people to gain new skills to change roles if they develop a health condition or disability, or an existing one worsens.”

This isn't an affordable option for most people. If the Government is to make lifelong learning a reality then it must commit itself to the provision of such learning and the costs involved, rather than blind the public to the true situation: that chronically sick people can't, and the government deliberately won't, invest in them. Many people 'down skill' or 'downsize' their employment as they age or as they deteriorate due to illness, and this is particularly common for chronically ill or disabled people.

“And while many conditions are not preventable, the evidence is clear that the way we live our lives can influence health outcomes.”

Many conditions are not preventable, as the government notes. Sickness prevention is a significant part of the NHS, along with health living advice, but the NHS is drastically underfunded. Suggesting that people are entirely responsible for the alleged 'prevalence' of conditions that lead people to leave work is both disingenuous and inaccurate - genetics plays a huge role in many cancers and other conditions; people 'wear out' at different rates; and the workplace is not a healthy environment for many.

People can only be 'advised' - specific treatments cannot be forced onto the population, not least because of the risk of causing harm. In particular, the idea that work should be mandated onto sick people as both a treatment and an outcome is dangerous and unethical.

“Currently, 6 out of 10 adults are overweight or obese, nearly 1 in 5 adults still smoke, and more than 10 million adults drink alcohol at levels that pose a risk to their health. Public health interventions form a vital part of the health and work agenda to help reduce the prevalence of conditions that can lead to people leaving the labour market due to ill health.”

This is dangerously misleading. People on ESA are not there because of obesity, smoking or alcohol addiction until they are substantially disabled from the consequences; or are on ESA for other reasons for which food, nicotine and alcohol may have become coping measures. But primarily, people are on ESA because of non-preventable conditions. By defining illness as the result of lifestyle, the government implies that people out of work because of illness are there through their own fault, and can be got back to work through health interventions. Thus it downgrades its own responsibility for providing healthcare and support for long-term sick people, who in fact are unable to work because of non-preventable illness such as multiple sclerosis, motor neurone disease and myopathy.

Underlying factors play an important role

31. To reduce the disability employment gap, we need to understand the reasons why disabled people might be unable to enter or stay in work, and to recognise the wide variety of conditions and circumstances they face. The disability employment gap is affected by a number of factors, for example people frequently move in or out

of disability and employment over time. It is therefore important to look at a wider group of work and health indicators to allow us to better understand the wider picture. The Work, Health and Disability Green Paper Data Pack accompanying this publication includes more statistics about the disability employment gap.

Again there is a conflation. Many people counted as disabled and employed may have only temporary illness combined with a job contract. Many of those counted as disabled and unemployed have no real likelihood of seeing the improvement in their illness that would be necessary for a return to work. Other people currently unemployed and long-term ill who move into work do so because of a recovery, and therefore move not into the 'disabled and employed' group but the 'non-disabled and employed' group, because they are no longer ill. There is little movement of sick people from disability unemployment to disability employment, because most have to recover first, which excludes them from the disability group.

Disabled people who are not ill often can work, if they get the right support. Assuming that the government is referring only to these people when it says "we need to understand the reasons why disabled people might be unable to enter or stay in work", we can offer the following reasons:

- Employer attitudes;
- Lack of reasonable adjustments;
- Lack of or inadequate Access to Work assistance, including substantial delays;
- Lack of or inadequate social care; and
- Lack of or inadequate extra-cost benefits.

"The disability employment gap is affected by a number of factors."

The biggest one may simply be how buoyant the employment market is, and the availability of support services. A large increase in the employment of non-disabled, healthy or non-disclosing people necessarily increases the employment gap if there is not an equal increase in employment of disabled people. The disclosure of mild disability or illness is influenced by a person's job status. Consequently, people with mild disability may switch from unemployed disabled to employed non-disabled without any change in health. These people however are not the ones at whom this paper should be addressed, because they are not the ones who are unable to compete in the open labour market and nor are they on ESA. The government's focus on public health measures unfortunately suggests that it thinks these people are the people on ESA, which would explain why its approach is so deeply inadequate.

Disabled people often cannot access work without the support mechanisms they need being in place, and cuts to Adult Social Care and the Independent Living Fund have created more barriers to work by reducing the support needed at home just to free up some capacity for work. Access to Work and/or reasonable adjustments is necessary for many disabled people, but an employer may not want to take on a person whom it has to pay out to employ, either because Access to Work doesn't cover those costs or because Access to Work is so slow. The government's proposals of £500 for small employers who recruit and retain a disabled person for three months may help, but the government has given no indication of whether £500 covers the reasonable adjustments for disabled people or whether a post-dated payment will actually help small employers.

“People frequently move in or out of disability and employment over time.”

The employment rates for both those classed as ‘disabled’ and for those who are non-disabled, or don't disclose, are both snapshots. They don't show individual movements of people, and to suggest *“people frequently move in or out of disability and employment over time”* lacks an evidence base – or if it has one, the government did not reference it, or explain its impact on their understanding of disability and their proposals for sick and disabled people.

“It is therefore important to look at a wider group of work and health indicators to allow us to better understand the wider picture”.

It would be far better for the Government to simply look at the actual health of people on ESA and counted as disabled in the Disability Employment Gap. Chronic illness is the ‘indicator’ that prevents work, that cannot be reduced by provision of equipment, that cannot be easily adjusted for, and that both prevents employers from employing sick people, and prevents sick people from being able to work. Being too ill to work in any realistic productive sense renders a person unemployable and unable to work, and should not be compared to the employment potential of a disabled person who can promptly access the appropriate physical support.

There are many factors involved with disability employment, as the DWP notes. For example, higher-educated people with a disability are, for the same level of severity, more likely to be in work. This is likely to be because higher-skilled jobs generally come with more discretion, which is often necessary for adjusting job role to illness or disability. Higher educated people are also much more likely to have skills and specialisms which are valuable to a company., and therefore worth the additional cost of mitigating for illness or disability. People competing for unskilled or low skilled work, however, are highly replaceable, and often such work is high pressure, which is unsuitable for sick people.

32. Almost 12 million working age people in the UK have a long-term health condition, and of these 7 million are disabled. A health condition does not, in itself, necessarily prevent someone from working. Indeed people with a long-term health condition who are not reported as being disabled have a very similar employment rate to people without any type of health condition – around 80%. However, employment rates are much lower among disabled people with only 48% in work.

For a health condition to be termed a disability under EA2010 it has to be a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on a person’s ability to do normal daily activities. ‘Substantial’ is more than minor or trivial, e.g. it takes much longer than it usually would to complete a daily task, and ‘long-term’ means 12 months or more. Consequently a ‘health condition’ that is compatible with life and work isn’t classed as disabled, and should not be the subject of the Green Paper. Again this is a conflation of minor conditions; discussing those who are not sick in a report about sickness benefit is just an intentional distraction. It serves no purpose beyond suggesting that mild health conditions are in some way relevant to the debate, when in fact they are not.

There is essentially no relevance of this paragraph to the Green Paper. It states only what is already known: non-disabled people have the same employment rate as non-disabled people. The only purpose of this paragraph is to raise 'health conditions' as a smokescreen to the true nature of chronic disabling illness, by writing that "A health condition does not, in itself, necessarily prevent someone from working." The government should not be talking about health conditions at all. It should be discussing disability and chronic disabling illness.

The health conditions that are not reported to be 'disabling' are simply very minor - hence they cannot be classified as disabling under EA2010, therefore it is of no surprise that the employment rate of people with these minor conditions is so high- there is no real reason for people with these minor 'health conditions' not to work.

33. This suggests that it is important to try to prevent long-term health conditions developing or worsening to the extent that they are disabling. We know that a person's health is affected by the conditions and environments in which they live. Fair Society, Healthy Lives provided evidence that the conditions in which people are born, live, work and age, are the fundamental drivers of health and health inequalities. Where people live can have a big impact on both health and employment outcomes. In England, men born in the most deprived areas can expect 9.2 fewer years of life, and 19.0 fewer years of life lived in good health than people in the least deprived areas. For women the equivalent figures are 7.0 and 20.2 years.

Long-term health conditions are not necessarily disabling - in part because the term 'health condition' can differ both from the health needed to perform an activity and the perception of ill-health. A person with well-managed diabetes, epilepsy, cholesterol or blood pressure may rightly consider themselves to have a 'health condition', whilst rightly also not considering themselves 'ill' or 'disabled'. It is important when using these terms to have a clear idea of what types of health conditions one is referring to, in order to avoid unwarranted conflation of non-disabling conditions and disabling illness; the former may not lead to the latter. In particular, the term 'health condition', which the DWP itself pointed out is not associated with additional unemployment, should not be used in place of the term 'illness'.

The government should not cite major reports if it does not intend to address the issues it cites. It is predominantly the government's spending policies that determine the deprivation in which a sick or disabled person lives. By linking GP funding to the age of the local population rather than illness, it overfunds areas with healthy elderly people and underfunds those where people die young from illness.⁸¹ By restricting benefits to poverty level income, it forces sick and disabled people to live in housing that makes their health even worse,⁸² and prevents them from purchasing the help and healthcare they need.

<p>Cutting the income of chronically ill people will increase their disadvantage.</p>

34. We also know that disabled people from more disadvantaged backgrounds are more likely to be out of work. For example, while employment rates can be as low as 16% for people with mental health conditions who live in social housing, for disabled

⁸¹ Hull, S. & Boomla, K. 2014. Is general practice in trouble? British Medical Journal. 349:g6814 doi: 10.1136/bmj.g6814

⁸² Shelter, 2015. Cuts and changes to Housing Benefit for private renters (LHA).

people who live in a mortgaged house and who have 1 or 2 health conditions, the employment rate is as high as 80%. This is similar to the overall employment rate for non-disabled people.

The data used for this question is extremely dubious as it begins by dividing people not by qualifications, reported illness or parental income, but by current housing status. It sets out to make an association between social housing and a certain health condition. Yet the indices of deprivation, which indicates disadvantage, are as follows with the following weights:

- Income Deprivation (22.5%);
- Employment Deprivation (22.5%);
- Education, Skills and Training Deprivation (13.5%);
- Health Deprivation and Disability (13.5%);
- Crime (9.3%);
- Barriers to Housing and Services (9.3%);
- Living Environment Deprivation (9.3%).

Income deprivation is weighted far higher than both disability and housing and services, and yet the data used in this example cherry picks to avoid the overwhelming fact that income is a huge driver of deprivation and disadvantage, and that to cut the income of chronically ill people will increase their disadvantage. Again the report attempts to distract the reader with false narratives, conflating chronic illness and disability with mild health conditions that don't preclude work, and conflating the government's provision or not of social security with the type of housing in which a person lives.

People in social housing are there for a reason - they cannot afford to buy or rent in the private sector. Hence there are already indicators that financial deprivation exists. Financial deprivation causes stress, which can lead to more serious mental health issues.⁸³ Poverty and ill health are recognised as being strongly linked. Financial deprivation causes reduced cognitive functioning, which hinders recovery,⁸⁴ and it causes physical deprivation of the essentials of food and warmth, causing people to choose between 'heating and eating', creating more illnesses and disabling conditions.

There is a rather unpleasant suggestion in paragraph 34 that those with adequate finances and minor health issues are somehow comparable to those who have entrenched and long standing financial deprivation and mental health issues. This is clearly not the case. A disabled person in a mortgaged house with one or two health conditions may easily be well enough to work - which is why they are in employment at such a high rate. A minor 'health condition' would not make a person either eligible for ESA or have a significant impact on the job market open to them. To make the cases anywhere near comparable one would first have to address the socio-economic disadvantage of the first group, as a further reduction in finances will only increase the disadvantage.

⁸³ Baer, J. C., Kim, M. & Wilkenfield, B., 2012. Is it Generalised Anxiety Disorder or poverty? An examination of poor mothers and their children. *Child and Adolescent Social Work*

Raphael, D., 2002. *Poverty, income inequality, and health in Canada*. Centre for Social Justice Foundation for Research and Education, Toronto.

⁸⁴ Mullainathan, S. & Shafir, E., 2013. *Scarcity: why having too little means so much*. Times Books.

The Government's "current legislation" will see a cut to ESA WRAG that will cause further, deeper financial deprivation, and hence hindering and delaying recovery, and placing additional burdens on the NHS.

35. In addition to the strong links between socio-economic disadvantage and poorer work and health outcomes, other factors can also be significant. Attitudes in society can have a significant impact: for example, people may have lower expectations of disabled people and people with health conditions, which may impact on whether an individual feels able to work. There may also be physical barriers to employment for some disabled people and people with long-term health conditions, such as difficulties accessing transport and buildings.

Primarily the socio-economic disadvantage must be addressed. It is not enough for a report that came into creation due to a reduction of the income of the poorest in society (the Green Paper was supposed to allay Conservative MPs' fears over the cut to ESA WRAG income⁸⁵) should see fit to state that a damaging situation exists, then move on without suggesting a solution.

"Attitudes in society can have a significant impact: for example, people may have lower expectations of disabled people and people with health conditions, which may impact on whether an individual feels able to work".

It is unlikely in this enlightened age that a substantial proportion of the public have lower expectations of disabled people. It is also unlikely that disabled people take the attitudes of others so seriously. Indeed, the only evidence we could find that might support this statement (an Opinion survey quoted by Scope⁸⁶) asked respondents to indicate if other people had a low expectation of them - which necessarily requires the disabled person to disagree with that expectation, which in turn necessarily requires that the disabled person has not imbued that expectation.

People may have 'lower expectations' of those who are chronically ill - as most people have experienced illness for short periods of time, this is a reasonable assumption that is based on personal experience. It is not so much about the natural ability of the sick person, but what use they can make of it given their illness. Chronic illness is incapacitating by its nature; if it weren't, it would be a 'health condition'.

The discussion of attitudes trivialises the barriers facing chronically ill people, which are predominantly fatigue and pain that cannot be cured or reduced. It's not the attitudes of the people close to a chronically ill person, it's lack of enough healthy time. The short intervals of time when a serious chronic condition may allow some normal activity are not compatible with the workplace.

"There may also be physical barriers to employment for some disabled people and people with long-term health conditions, such as difficulties accessing transport and buildings."

⁸⁵ Mortimer, C., 18/03/2016. Iain Duncan Smith: John McDonnell and Nadine Dorries lead social media in shock and amusement at resignation. The Independent.

⁸⁶ Hall, J. 30/10/13. Attitudes meet actions: how does Britain feel about disability? Scope.

Again this is conflating disability with non-disabling health conditions, and ignoring the existence of chronic disabling illness, by suggesting that a person with a chronic condition experiences the same issues as someone with a mobility disability. Many people with chronic illness have mobility difficulties as part of generalised pain and fatigue, but ramps and wheelchair-friendly vehicles are not enough to overcome fatigue that pervades every part of a person's body and mind.

Physical barriers are a sign of a badly built non-inclusive environment, and there is both legislation and assistance via Access to Work to overcome these barriers. However neither of these are instant solutions, and they are put in place only when requested, not as pre-emptive action. These barriers should be being addressed by the government, to make the environment systemically accessible to disabled people. But there is no evidence in this paper that the government intends to create and enforce legislation that all public places and workplaces be made accessible, even when it is a building or other public place that comes under the responsibility of central or local government.

36. We also need to recognise that some disabled people or people with long-term health conditions may face other disadvantages associated with worklessness. They may need a wide range of support, through different agencies working in partnership, to address all of the connected and overlapping problems they face. These might include drug or alcohol addiction, a criminal record, homelessness or caring responsibilities for young children. We recognise that these are complex problems, requiring a focused look at the factors that stand in the way of employment for these groups, which is why the government has asked Dame Carol Black to conduct an independent review into the impact on employment outcomes of alcohol or drug addictions, and obesity.

The phrasing in para 36, in the context of this report and given the author, risks implying that addiction, criminal behaviour, homelessness or young children are part of a package of deviant behaviour, in contrast to the well-behaved people who are not ill, not addicted, are fully law-abiding, are owner occupiers, aren't overweight and do not reproduce. There is no such association - in fact a main stream media outlet attempted to draw similar conclusions regarding chronically sick (and disabled) people on Incapacity Benefit by suggesting that there was a high rate of criminal activity amongst sick people. A fact check revealed that chronically sick and disabled people actually had a marginally lower rate of criminal behaviour than the general population.

Many chronically sick people do experience homelessness. Landlords usually stipulate no Social Security, or 'working people only'. Large deposits and hyper-inflated charges for credit checks often mean people cannot move into properties. The properties that are available to those out of work are often the 'beggar's choice' - the bottom end of the market and hence the least well maintained, leading to further health problems. However this is not due to worklessness - people on low incomes face the same problems.⁸⁷

Drug, alcohol addiction and obesity are rarely reasons why someone is awarded ESA. It is only when the effects of these becomes disabling, such as circulation or organ failure that an award would be made. At this point these people are very sick, and are likely to have other illnesses that are also disabling.

⁸⁷ Shelter, 2015.

It's extremely distasteful that this report has stooped to framing the problems society faces as being more pertinent to chronically sick and disabled people, and in some way attributable to the nature of sick and disabled people. Having periods of life that are difficult and complex is not limited to one demographic - these problems are found across the whole of society, and whilst *"some disabled people or people with long-term health conditions may face other disadvantages associated with worklessness"*, many don't. It is to be hoped that Carol Black does not set out to find policy-based evidence in an attempt to suggest correlation, as paragraph 36 has done.

37. Although factors unrelated to an individual's health condition or disability have a significant impact on their ability to work, there do appear to be some patterns in employment rates for people with certain conditions, or for those who have multiple conditions. For example, disabled people with mental health conditions have an employment rate of just 32%, which is significantly below the overall employment rate for disabled people at 48%. People who have more than one condition are also more likely to be out of work – disabled people with one long-term health condition have an employment rate of 61%, but the 1.2 million disabled people who have 5 or more long-term health conditions have an employment rate of just 23%.

It isn't helpful to lump all 'mental illness' together when there are multiple different types. When 'physical' disability includes people who are otherwise healthy, whilst 'mental' disability usually results in lower productivity, comparing the two is unhelpful and uninformative. The comparison is clearly flawed - a person sick with mental illness is clearly in the disability employment gap. A person recovered from a mental illness (or any other illness) wouldn't be classified as working with a disability.

Having more than one chronic illness is a proxy measure for severity. Having more than one illness necessarily increases the likelihood of having one fully incapacitating illness. Long-term health illnesses may also impact on each other, having not just a cumulative effect but a multiplier effect on severity and incapacity. Again, the government has made an uninformative statement.

38. Of course not all health conditions are static. Many, such as some mental health conditions, fluctuate over time, and affect people differently at different times. What is clear, though, is that once someone is out of work due to a health condition and claims Employment and Support Allowance their chance of finding work is slim. Only around 3 in 100 of all people receiving Employment and Support Allowance stop receiving the benefit each month, and not all of these people return to work. While the government recognises that some people will not be able to work and rightly need to receive financial support, for others this starts a journey away from work which can make their health problems worse and, in turn, negatively impact upon their employment prospects.

To actually be eligible for ESA a person has to be either very disabled, or have a disabling long-term unmanageable illness that creates huge barriers to work. It's incredibly difficult for an employer to make adaptations for illness - basic desirable attributes of the employee, such as reliability or working to deadlines, do not exist with seriously or chronically ill people. It is therefore no surprise

that people with severe and chronic conditions are not moving into work; they simply do not have the basic attributes an employer needs. An employer may disregard punctuality, reliability, attendance and performance if the sick person has an outstanding and rare talent, but these scenarios are extremely uncommon.

The suggestion that being ill enough for ESA in some way leads to some sort of further illness has foundation, but the government has not recognised its responsibility and fault for this situation. ESA is, under the “current legislation”, a financially depriving benefit, adding extreme poverty on to the primary illness. It is therefore the Government's choice to push people further from employment by adding poverty-related co-morbid conditions and not providing adequate healthcare for treatment of chronic illness. They are fully aware of this, and have chosen to proceed against a mass of evidence from charities, health professionals and other stakeholders that this is a damaging strategy.

There is a clear misunderstanding about ‘fluctuating conditions’, almost suggesting that people fluctuate between being well and being ill. The government’s implication is that these people should work when not ill, and not work when ill. But a person who needs repeated periods of sick leave is not desirable to an employer; this is why performance management focusses on sick leave as a reason for disciplinary action. In truth people fluctuate between being ill, and being very ill. A person may recover, only to relapse weeks, months or years later - but this is not a fluctuating condition, as recovery has occurred.

39. It is impossible to address this complex picture with a simple, one-size-fits-all solution. We need to change our attitudes and behaviours towards disabled people and people with health conditions, working with everyone from employers to schools, health professionals to community groups. We need to develop a more personalised and integrated system that puts individuals at the centre, and gives all individuals the chance to prosper and play their part in a country and an economy that works for everyone.

Cutting ESA financial levels, increasing financial deprivation, increasing demands on those who are chronically ill, adding further assessments and increasing claimant conditionality and hence sanctions, is not personalised and won't change society's attitudes or behaviours. The solutions people need are clear: faster and better medical treatment; greater access to care; affordable and healthy housing. Yet all of these are being cut.

The solutions people need are clear: faster and better medical treatment; greater access to care; affordable and healthy housing. Yet all of these are being cut.

It would be nice if any part of paragraph 38 were true; but it's just buzz words and spin. Sick people are not economic units of productivity, evading contributing to the economy due to some deviant behaviour. Sick people are those people who cannot work and whom employers cannot employ due to the nature of illness.

Tackling the systemic issues

40. The disability employment gap has persisted over many years and its causes are long-term, systemic and cultural. Efforts to help disabled people and those with

long-term health conditions have been hindered by a lack of vision and by systems which fail to join up and take people's needs properly into account.

There is no "cause" of the disability employment gap. It's a measure of the difference between two variables. There is a cause for chronically sick people being unemployed, and for disabled people to be unemployed. The former is considered unemployable by the employer, and the latter does not have sufficient support and legislation from either Government or employers.

There will always be sick people; there will always be disabled people. It's not a culture.

There will always be sick people; there will always be disabled people. It's not a culture. The failure to employ them may be long term, systemic and cultural - but the solution is with the government and with employers and their demands and failings to accommodate.

"Efforts to help disabled people and those with long-term health conditions have been hindered by a lack of vision."

There has indeed been a lack of vision; primarily the government's lack of ability to see and identify the significant differing needs of a very ill person to someone who may have a learning disability or minor physical disability, and a lack of understanding of what an employer wants and needs from his workforce.

There have been suggestions that sick and disabled people lack qualifications, skills or work experience - yet only 17% of people are born with a disability. If those born with this disadvantage are removed from the data, then the remainder are as skilled and experienced as any other person at the point they become sick or disabled. Making someone with a degree attend CV workshops is unnecessary. Forced attendance of any work programme or work experience is unnecessary; people who are sick are not deviant, not unskilled, not uneducated. They are simply sick.

Whilst paragraph 40 accepts that the previous systems have failed to identify the needs of people, this report suggests more of the same failed and flawed approaches. The work coaches will have no idea what Parkinson's, Motor Neurone Disease or unmanageable diabetes is like. These are not medically trained people - and yet apparently they will, at the four-week stage, assess a claimant's capability for work, via a Health and Work Conversation, some nine weeks prior to an assessment by a medical professional who will be determining the claimant's capability and capacity for work, all whilst the claimant has been stated as unfit to work by their GP.

41. A number of systemic issues hold back too many disabled people and people with health conditions:

- employees are not being supported to stay healthy when in work, and to manage their health condition to stop them falling out of work: in one report, mental ill health at work was estimated to cost businesses £26 billion annually through lost productivity and sickness absence;⁵⁶
- too many disabled people and people with long-term health conditions are being parked on financial support alone: over 60% of people on Employment and Support Allowance do not have access to integrated and personalised employment and health support which focuses on what they can and want to do;

- individuals are not getting access to the right support and treatment: for example, some evidence suggests that waiting times for musculoskeletal services can vary from between 4 to 27 weeks; and
- the health and welfare systems do not always work well together to join up around an individual's needs and offer personalised and integrated support to help them manage their condition.

“Employees are not being supported to stay healthy when in work, and to manage their health condition to stop them falling out of work: in one report, mental ill health at work was estimated to cost businesses £26 billion annually through lost productivity and sickness absence.”

The Government has the Fit for Work programme to help people to stay in work, and in touch with work. If this is failing, then it is a failure of Government.

Too many disabled people and people with long-term health conditions are being parked on financial support alone: over 60% of people on Employment and Support Allowance do not have access to integrated and personalised employment and health support which focuses on what they can and want to do.

This is referring to people in the Support Group - who do have access to employment support, should they need or want it. They are not 'parked' on financial support; they are placed in the group that indicates they are a considerable way from the employment market, and have conditions that are not expected to improve in the short or medium term or have the most complex and challenging disabilities.

The 60% is due to the length of the awards, not the frequency of this award type. People accumulate in the Support Group as they become more ill or disabled and consequently do not leave the benefit through either reassessment or recovery. Many are not just moving away from work, they are heading towards death. It's both highly inappropriate and quite unnecessary to mandate these very sick and disabled people into engagement with work providers who cannot find them work.

“Individuals are not getting access to the right support and treatment: for example, some evidence suggests that waiting times for musculoskeletal services can vary from between 4 to 27 weeks.”

Support and treatment are very different things; people with incurable chronic conditions may need support to manage their condition. Treatment, if successful, returns the claimant to work or JSA. Over the course of this Government the NHS has seen, in real terms, its funding cut. It's therefore incongruous to quote treatment and support waiting times as if this is some sort of problem that the Government cannot fix.

“And the health and welfare systems do not always work well together to join up around an individual’s needs and offer personalised and integrated support to help them manage their condition.”

The purpose of the welfare system is not to be part of the health system. A welfare system offers financial support and advice; the health system offers personalised support for people to manage their conditions, illnesses or injuries. ‘Joining up around’ an individual’s needs is not person-centred support. There can be very few occasions when it would be appropriate for the welfare system to join up with the medical professionals - they have no common ground.

This is an attempt to justify the sharing of data from medical sources to untrained work coaches, dressed in the language of ‘caring’. It is also an attempt to justify creating a system where work programmes and health treatments are one and the same, opening the door to mandatory treatment. This understanding of the government’s writing is supported by later paragraphs seeking to transfer assessment and treatment to Work Coaches in the JobCentre, and the overt intention of mandating GPs to consider work as a cure for all of their patients.

42. Our strategy is to provide support centred on the disabled person or person with a health condition. Disabled people and people with health conditions are the best judges of what integrated support they need to secure work or stay and flourish in work. To do this, we want to align systems better so that we can make a real difference to people’s health and work prospects. In this green paper we explore how we can encourage employers, the welfare system and health services to take a more joined-up approach to health and work:

- how we can encourage employers to be confident and willing to recruit disabled people, to put in place approaches to prevent people from falling out of work, and to support effectively those employees on a period of sickness absence to encourage their return to work;
- how we can create a welfare system that provides employment support in a more personalised and tailored way, with a simpler and more streamlined process for those with the most severe health conditions;
- how we can create a health system where work is seen as a health outcome and where all health professionals are sufficiently trained and confident to have work-related conversations with individuals to increase their chances of maintaining or returning to employment; and
- how we can better integrate occupational health type support with other services to ensure more holistic patient care.

“How we can encourage employers to be confident and willing to recruit disabled people,”

Having Access to Work packages prior to an interview, and specialised workplace disability advisors and job brokers to explain to employers what is needed and to assist in creating or modifying jobs suitable for disabled people.

“To put in place approaches to prevent people from falling out of work,”

Create legislation that prevents employers from discriminating against and terminating employees who have a health condition. Legislate that the conditions of the Fit note are legally binding, so that employers must put them in place or pay full pay to the employee.

“And to support effectively those employees on a period of sickness absence to encourage their return to work;”

When people recover from illness, they return to work as long as their job is still available and it wasn't the job that made them ill. ‘Encouraging’ a premature return to work, before the GP is prepared to declare them fit via a Fit note, is not in the best interests of either employee or employer, as presenteeism is both unhealthy and results in poor performance.⁸⁸

“How we can create a welfare system that provides employment support in a more personalised and tailored way, with a simpler and more streamlined process for those with the most severe health conditions;”

Primarily the system should look at health, and health and disability combined. Those who have a serious health condition, or a disabling illness or condition, are not going to be either employed or employable. Those who are healthy, but disabled are typically be more attractive to employers,

It is both cruel and futile to continue to harass those who cannot recover from their chronic illnesses.

although still less attractive than a healthy, non-disabled person. This is where employment support should be focused, on those healthy enough to work, but have significant barriers that need additional support to overcome. This support has to be expert support, given by people who understand both the world of work, and the disabilities of the people they are supporting. Access to Work and Social Care should be available and ready to be implemented when the disabled person goes for an interview.

Those with health conditions that are significant, incurable and disabling are moving away from work, and employers will rarely employ someone with a serious health condition unless they have significant other attributes to trade. It is both cruel and futile to continue to harass those who cannot recover from their conditions. Those with ‘the most severe health conditions’ are too ill to work, and neither need, nor will benefit from employment support.

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Those who are moving through recovery, and have no job to return to, should be offered employment support opportunities. The support should be determined by what the person wants to do and is interested in, as is best practice,⁸⁹ and should include access to properly supported retraining and job brokers.

⁸⁸ Ashby & Mahdon, 2010

Garrow, 2016.

⁸⁹ Joss, M., 07/05/2010. Occupational therapists and returns to work. Occupational Health and Wellbeing.

The assessment of capacity for work should consider a person's health first and foremost – the WCA is unable to do this, whatever changes are made to it.

“How we can create a health system where work is seen as a health outcome and where all health professionals are sufficiently trained and confident to have work-related conversations with individuals to increase their chances of maintaining or returning to employment;”

You can't, and neither should this be attempted. Medically trained people are trained to either get people better, or to help them manage their condition. They are taught to 'first do not harm', and to work with the patient to achieve the patient's goals. They are not, and cannot be, forced to impose on every person a government ideology that work is universally good and a cure for incurable illness. This approach has been tried before, and sick people simply stopped going to their GPs and other services as they felt that the GP was stepping outside of his or her remit, and not supporting the person to get better, as their primary concern. There is a real risk of damaging the patient-doctor relationship, and health deteriorating further as a result.

Work is not a health outcome; improved health, better-managed health and improved wellbeing are health outcomes. Work is a potential by-product of health, if healthy work is available.

“how we can better integrate occupational health type support with other services to ensure more holistic patient care.”

We hope that the government has made a mistake in referring to Occupational Health rather than Occupational Therapy. Occupational Therapy is a distinct profession obtained by a specific degree and which is able to consider the interaction of multiple barriers. Occupational Health focusses on the ability to safely perform a job, whereas Occupational Therapy focusses on promoting the function, independence and wellbeing of the individual. Occupational Health, however, is more in line with this Green Paper and its insistence on work as the answer, because OH is not about rehabilitating or improving the function of the individual, but only about reducing further harm in the workplace – correct manual handling technique, for example. Making work 'not harmful' fits with the government's intentions, which are less to do with helping the individual and more to do with shoehorning everyone into any job.

Occupational Therapy is what people with chronic illness and disability need, because the focus should be on maximising the individual's function, independence and wellbeing. This is about more than reducing harm at work; it is about doing what is best for the person. Whilst Occupational Health has a place in ensuring that health is preserved and damage limited in the workplace, Occupational Therapy is a medical intervention that is able to recognise that there is more than just work at play – there is the individual's underlying health or disability as well, plus the availability or otherwise of support at home and in the general environment.

Occupational Therapy should be provided by referral from a GP, and be provided under the NHS and emphatically not by the private sector. It must not be possible for companies to override the Fit note; rather, the role of Occupational Therapy should be to provide the detail that GPs and Occupational Health cannot, because of the limits of their training.

43. We also need to look beyond 'systems' to look at the important role played by individuals, carers and the voluntary and community sectors.

The role of individuals

44. Disabled people, people with long-term health conditions and those who may develop them are at the heart of our strategy. We want to deliver services which enable people to have more information about their care and support, be better able to manage any health conditions, and have more say in the health and employment support they may need. The patients organisation National Voices puts it clearly: personalised care will only happen when services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

Adult Social Care, and to some extent Continuing NHS Care, are both extremely limited due to lack of financial support and swingeing cuts. To receive either, a person would have to have substantial or critical need, and the provision is now very basic. Two out of three people who request Adult Social Care are denied any care at all.⁹⁰ The idea that there is either the financial support or the desire of this Government to change this situation is laughable. The devolution of social care budgets, large cuts to local government, the removal of the Independent Living Fund, and the failure to ring fence subsequent funding all mean that social care is now in crisis. Sadly it has become unsurprising that the government should cite evidence on what is needed, and then completely ignore its own culpability in this matter.

It has sadly become unsurprising that the government should cite evidence on what is needed, and then completely ignore its own culpability in this matter.

45. Individuals can also support employers to make workplaces more inclusive by working in partnership with them to deliver changes in recruitment and retention practices and promoting a healthy work culture.

Alternatively the Government could legislate for these changes, making them legally binding.

The role of carers

46. This government recognises that carers can play a fundamental role in enabling disabled people and people with long-term health conditions to be all they want to be. The support of carers can be crucial in supporting disabled people and people with a long-term health condition to return to or remain in work. According to a report from 2009, as many as 3 million people combine paid work with providing informal care to family and friends who might have a range of physical or learning disabilities, or who may have long-term health conditions related to ageing.

⁹⁰ Health and Social Care Information Centre, as cited by NHS Digital, 06/10/2015. New requests for adult social care support actioned by councils approaches two million.

The idea that an informal carer can enable people to *'be all they want to be'* is extraordinary. For those who have good physical health but complex physical disabilities a carer can, in the role of professional personal assistant, ensure that the disabled person has all their care and assistance needs met whilst they pursue their goals - but this level of care is not the informal care delivered by family and friends. It is

The government's implication that unpaid family carers should be performing these roles is another example of its desire to evade its responsibilities.

It is not the role of informal carers to micro-manage the workplace, negotiate with employers or legislate to protect the worker's right to have adjustments and time off. Neither is it the role of the informal carer to act as a job broker, or to make medically-based decisions on whether the person is ready to return to work. The government's implication that unpaid family carers should be performing these roles is another example of its desire to evade its responsibilities.

It is inappropriate of the government to refer only to learning disabilities, physical disabilities and age-related health conditions as reasons for needing care. There are substantial numbers of working-age people with severe chronic disabling illness who need care. That a paper on how to support chronically ill people should so persistently ignore their existence is appalling.

However, the Green Paper seems to suggest that these are part of the role of the informal carer, and not only that but an informal carer should have a full-time paid job as well.

47. Carers UK recently found that carers in England are "struggling to get the support they need to care well, maintain their own health, balance work and care, and have a life of their own outside of caring." The challenges of balancing paid work with a caring role can mean that carers have to reduce their working hours, pass up career opportunities, or leave employment altogether: an estimated 2 million people have given up paid work to care. Of these, there are currently 315,000 working age adults who, having left work to care, remain unemployed after their caring role has ended. These impacts are felt disproportionately by older workers, with around 1 in every 6 economically inactive people aged between 50 and State Pension age citing caring responsibilities as the reason for inactivity.

Carers are struggling. They have seen care packages cut, placing more responsibility on them. They have seen respite services cut, leaving them without a break, year in, year out. This year their permitted work allowance wasn't upgraded when the minimum wage was upgraded - meaning that they can work fewer hours and receive less money. Informal carers often are in poverty themselves, - unable to cope with a full time job plus provide the levels and hours of care needed.

The solution is to pay these informal carers for the work they do, to ensure that they are credited national insurance contributions at the same level as people in full time work, to give them sufficient respite care and to offer them free skills and education training.

To provide social care so that a family member can have the opportunity to work is a large financial commitment from a sector which currently cannot provide care at all for two thirds of the people who have a care need. However, the alternative is to place huge expectations on family members whilst failing to provide them with the support they need. Because not every chronically ill or disabled person has family who are able to help, it is the government's responsibility to provide for the care needs of sick and disabled people. Relying on family to be carers results in patchy and inefficient service, and the emotional, financial and physical strain may cause the carer to become ill.

48. Many of the challenges faced by carers in balancing their work and caring roles stem from the same issues faced by workers who are themselves disabled or have a long-term health condition, for example a risk-averse attitude among employers to recruiting disabled people and caring responsibilities, and a lack of flexible working arrangements in many organisations. Changing attitudes and behaviours towards disabled people and people with long-term health conditions should also have a positive impact on carers, but there is more to be done.

The report finally recognises that employers are risk-averse and that flexible working arrangements are not common. Most '*flexible working arrangements*' are for the benefit of, or abused by, the employer. But it is not the lack of truly flexible working arrangements that is keeping carers from work; it is the physical impossibility of combining two full-time jobs in a sustainable manner.

'Changing attitudes' is not what is needed. Employers rightly do not want to take on employees who are already over-burdened, whether through their own illness or through caring for others. What is needed, if these people are to work, is for the Government to bring forward legislation that requires employers to accept sickness absence without disciplinary action, and to create flexible working arrangements that benefit the employee over the employer. However the majority of jobs will always necessarily demand the employee to be present and reliable, and to create a profit for the employer. And there will always be people who cannot or should not work.

49. The government is committed to supporting carers. A key objective of our future work will be to support carers of all ages to enter, remain in and re-enter work. The government's Fuller Working Lives programme focuses on the challenges for older workers to remaining in or returning to work due to caring responsibilities, ill health or disability. As part of the programme a series of Carers in Employment pilots was launched in April 2015, to help support carers to stay in work or return to paid work alongside their caring responsibilities. Early next year the government will publish a new, cross-government and employer-led national strategy, which will set out the future direction of this Fuller Working Lives agenda.

This suggestion of carers working and caring is almost laughable - quite honestly who is going to do the caring, if the informal carer is out doing paid work? Who is going to ensure that lunch is prepared and served, and that

It is cavalier of the Government to demand that carers do two full-time jobs for one wage.
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medication is taken, and that people are safe? As previously explained, Adult Social Care cannot fill the gaps created when a carer goes to work. That is why so many carers leave work. If Adult Social Care was properly funded, then carers could work. It's quite cavalier that the Government should demand that carers do two full time jobs for one wage, to both save on social care costs and to provide an income for the exchequer, whilst offering nothing in return.

Carers are often unrecognised, following Adam Smith's error in not accounting for the unpaid work of women in the home as part of the national economy.⁹¹ Unfortunately, this error has continued, so that the government now expects carers to contribute twice - through paid work outside the home, and unpaid work within the home. Yet the carers themselves have only 24 hours

⁹¹ Marcal, K. 2015. Who cooked Adam Smith's dinner? A story about women and economics. Portobello Books.

in a day, some of which they have the right to dedicate to personal care, rest and leisure. Unless the government pays a different person to do that care - yet why not pay the current carer? - the carer will not be free to undertake other work.

The role of the voluntary and community sectors, local authorities and other local partners

50. We recognise that the voluntary and community sectors play a crucial role in helping more people to lead healthy and fulfilling lives, and that there are many organisations from these sectors, with broad reach and diversity, working to support and involve disabled people and people with long-term health conditions. These voluntary and community organisations embody a spirit of citizenship upon which our country is built, and we want to better harness their expertise and capacity in order to achieve the best outcomes for disabled people and people with long-term health conditions.

The Government is clearly expecting that any deficits in the system they are creating will be absorbed by these unidentified '*voluntary and community sectors*'. However these sectors are not always reliable or available at the point of need: a volunteer can, at any time, chose not to do

In central government's plan, local government bears the cost and central government gets the income.

a role; a funding provider may, at any time, decide to cut or withdraw funding. They have no responsibility for the outcome, as they are not under any obligation to do so. Many of these services are targeted at mental health - the provision of therapeutic services and activities for example, or for those with extreme or complex disabilities, such as day centre activity. Some of these groups focus on what are primarily age-related health conditions, such as strokes or dementia. To suggest they can be harnessed and their remit expanded to include other health conditions is not realistic. The sheer diversity of needs of people and their conditions is overwhelming, which is why people have carers and personal assistants.

Leaving aside the rather inaccurate reference to our country's heritage, it is to be questioned who are the workforce in this citizen's army - the government wants everyone to be working for an employer and contributing to the exchequer, not caring in an unpaid role or volunteering for charities. Or are we all supposed to work twice, once to earn money for the government and the second to do the government's job for it?

It is clear that local authorities are going to be expected to provide much of the finance for these proposals, to free up informal carers to become units of productivity. But central government has cut local government's funding by 40%.⁹² These cuts are so severe that, in the words of Lord Porter, "Even if councils stopped filling in potholes, maintaining parks, closed all children's centres, libraries, museums, leisure centres and turned off every street light they will not have saved enough money to plug the financial black hole they face by 2020."⁹³ It appears that in central government's plan, local government bears the cost and central government gets the income.

⁹² Local Government Association. Adult social care funding: 2016 state of the nation report.

⁹³ Lord Porter, Chairman of the Local Government Association, 2014. LGA responds to 2015 Spending Review.

51. As a government, we are already working to invest in, and partner with, the voluntary and community sectors, including: the Department of Health, NHS England and Public Health England, working closely with the sectors, have published a co-produced review of investment and partnerships in the sector. The review contains a range of recommendations for the department, the wider health and care system and the sectors. From this review, work is underway to progress recommendations and to promote more integrated working between the statutory and voluntary sectors to improve health and wellbeing outcomes; the Office for Civil Society is providing £20 million of funding through its Local Sustainability Fund, to help voluntary, community and social enterprise organisations review and transform their operating models to develop more sustainable ways of working; and the National Citizen's Service is a programme open to all 16 and 17-year-olds in England, giving them the opportunity to develop the skills and attitudes needed to engage with their local communities and become active and responsible citizens.

It's unclear what this has to do with the proposed cuts to ESA; however it is clear that after targeting informal carers and underfunding social care and the NHS, the Government plans to fill the gaping void left behind with voluntary, community and social enterprise organisations being bribed and guilt-driven into transforming their 'operating models'. It's a direct attack on the rights of disabled people to hand a duty of central government over to a voluntary organisation with no culpability, and in the case of the National Citizens Service with no experience at all. Chronically sick and disabled people have basic rights and it is the responsibility of the government to provide them and to incorporate the associated financial risk.

52. When it comes to unlocking the potential of disabled people and people with long-term health conditions, we want to build on these strong foundations, as well as on the many successful programmes and initiatives led by the voluntary and community sectors themselves, to deliver real change.

There are no strong foundations. A 16-year old child is not a foundation. A voluntary organisation is not a foundation. Neither is an underfunded NHS, nor an underfunded social care sector. Removing the support that sick and disabled people need will not empower them - it will put them at risk and place them further away from work. Absolving responsibility from the Government to local authorities, and then onto the voluntary sector is simply a cost cutting exercise, designed to damage the local authorities and place the Government one step removed from blame, with the expectation that underfunding will cause the system to fail.

Absolving responsibility from the government to local authorities, and then onto the voluntary sector is simply a cost cutting exercise, designed to damage the local authorities and place the government one step removed from blame.

53. By being close to their users, charities have 'a unique perspective on their needs and how to improve services'. As advocates and providers of services, the voluntary and community sectors form an essential part of achieving lasting change and

bringing about a new approach to work and health support. The voluntary and community sectors can help drive change by speaking out for people and their needs, both to the public sector and wider society. The sectors also have an important role in service delivery and have already demonstrated successful programmes such as peer support programmes and mentoring networks, which help people understand and manage their disabilities and health conditions, and explore ways to get into and remain in work. We want to build on these strong foundations to deliver real change.

There are few charities for the chronically ill, and almost none for those with rare illnesses. Many charities have no finances and 'help' is via a web page only. This is not advocacy or service provision or delivery.

Having '*a unique perspective on their needs and how to improve services*' doesn't mean that they can improve services. Quite often the '*unique perspective*' is ignored or rejected by the DWP when provided as evidence for a claim. Quite often their expertise is ridiculed by the medical profession, such as with ME. And almost always their calls for service improvements are ignored.

"The voluntary and community sectors form an essential part of achieving lasting change and bringing about a new approach to work and health support."

It is quite clear that essential services are going to be cut, with a Government expectation that voluntary and community sectors will fill the gap, regardless of the inherent danger of using voluntary services - staffed by people who are still children, are unemployed or are retired. Charities are reliant upon the goodwill of donors and volunteers. They are an inefficient, patchy and risky form of support compared to government provision. These voluntary and community sectors are to become the lobbyists - speaking out for people and their needs - competing for public sector finances to ensure those needs are filled. Yet the government banned charities (but not businesses) from sharing their experience via 'lobbying'.

Charities are an inefficient, patchy and risky form of support compared to government provision.
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In areas of mental health, gross underfunding has forced charities and community groups to attempt to provide support via cheaper mechanisms, often with mixed results. This use of voluntary sectors cannot be extrapolated and then expanded to deal with the wider sector – i.e. the whole spectrum of ill health and disability. Whilst there may be some success when dealing with curable conditions, it is to be questioned whether the same treatment based approach can ever have any success with incurable chronic illness.

These are not strong foundations for growth - and it is quite likely that forms of 'creaming' and 'parking' will occur, with tragic results.

54. Part of the reason the voluntary and community sectors are so important is because of their links with and reach within their local communities. Evidence shows that employment outcomes for disabled people and people with long-term health conditions vary across different regions in the country. There are significant opportunities to advance this agenda through a 'place-based' approach, unlocking

the political capital and resources needed to drive innovation and deliver the system-wide response needed to improve outcomes and local growth. It is also important that employment support for those furthest from the labour market plays an active role in helping people get back to work and unlocking productivity in places. Approaches to integrating work and health provision should draw on the strategic intelligence of Local Enterprise Partnerships and building on the existing strengths of local employers. Better outcomes for disabled people and people with long-term health conditions will require a concerted partnership between communities, central government departments, local authorities, Local Enterprise Partnerships, local providers, and devolution partners.

Voluntary and community sectors do have links with the community that they live and work in - but they are not job brokers, nor are they always experts in disability employment. Each one can cater only for the illness or disability for which it was set up, and many such local charities are geographically isolated. In contrast, the large national charities do not often appear to have local links beyond local or regional peer support groups. Often people have to travel hundreds of miles to see a specialist in their condition; it seems unlikely that such specialised knowledge will be found in a local voluntary group, and without it they are probably doomed to failure as a support mechanism.

Employment outcomes for disabled people do vary - in areas of high employment, low deprivation and adequate local authority finances, people with disabilities can be more readily absorbed into employment. However this is very much a postcode lottery, as the removal of the Independent Living Fund and the cuts to social care have demonstrated. It ignores also the 'ghettoisation' of illness, where those with substantial chronic illness can afford only to live in poor areas where local councils don't have the money to fulfil statutory duties.

A 'place-based' approach suggests that some degree of personalisation will be naturally present when considering the local jobs market, help, support and transport. However all previous systems were also 'place-based'; the work programmes for instance were based locally, and yet failed to understand the local employment market and the barriers to work, and failed to deal with the wide spectrum of conditions and disabilities they saw, or understand the personal barriers to work that people encountered. This proposed system has the exact same flaws, and will be using the same prime providers that failed under the Work Programmes.

The people furthest from the job market, and many of those who are not quite so 'far', are too ill to work.

To suggest that those furthest from the employment market could be catered for is a case of failing at the first hurdle, and then trying for a hurdle that is much higher. The people furthest from the job market, and many of those who are not quite so 'far', are too ill to work. Spending money on trying to get such people into work is a waste of finances, and leads to significant opportunity costs for people who already have significant constraints on their capacity for activity. Far better to let these people choose what to spend their energy and health on, and use the employment support to help those who can work at least 16 hours a week without harm or breaching of human rights.

It's unrealistic, and surely blatant pure hyperbole, to suggest that the end result of getting carers, sick and disabled people into a system (i.e. work) that essentially is dependent on the local economy is '*unlocking the political capital and resources needed to drive innovation and deliver the system-wide response needed to improve outcomes and local growth*'.

55. Ultimately, stronger engagement, partnership and co-production with the voluntary and community sectors forms a central part of our work if we are to reach disabled people and people with long-term health conditions within their local communities, better understand their experiences with services, listen fully to what they as individuals want to achieve, and offer them support that is rounded, tailored and easily accessible.

Charities and local organisations often have better insight and expertise than a Work Programme provider, by specialising in a particular sickness or disability, location and/or job type. But their expertise is limited to that specialism. Many do not combine expertise in the local area and job opportunities as well as in a specific illness, and vice versa. Whether they can make the quantum leap to be experts in the employment of people across more than one field of sickness or disability is dubious.

It is regrettable that, despite presumably being as aware of the potential value of specialised and/or localised charities in 2012 as it allegedly is now, the government did not make proper provision for these groups to access the funding they need to do this work. Instead the government is facilitating the same prime Work Programme providers to repeat the same system, albeit under a different name and with significantly less funding.

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The role of the devolved administrations

56. We recognise that services and support for disabled people and people with long-term health conditions needs to join up more effectively and holistically around the needs of the individual. Devolution, with the ability it brings to make decisions and formulate policy at a localised level, plays a key part in this ambition. The devolved administrations are important partners in developing appropriate local solutions, particularly because of their responsibilities for health as a devolved matter. The government is committed to working with the devolved administrations and devolution deal areas to improve the support accessible to disabled people and people with health conditions across the country at a regional, local and community level.

It has yet to be shown that devolution is anything other than a way to cut funding and then blame local authorities for being unable to provide statutory services at an adequate level on inadequate money. Devolution risks fragmenting services that ought to be nationalised, and creating postcode provision for services that ought to be universal.

Achieving lasting change: investing in innovation

57. Change on this scale will take time to achieve and not everything we try will work. Success demands we take an innovative, experimental approach to test a wide range of approaches in different environments and learn quickly, shifting focus early from any failures and moving rapidly to scale up successful approaches. It means working with a wide range of people to identify where we should focus our efforts. And we should look to capture the impacts across the whole of government, where possible, to build the case for future investment and help us influence a wider range of actors. Having a clear idea of what works in what context will enable us to:

- focus our resources on services and commissioning models which have the most impact;
- influence commissioners of services to make the right decisions to invest in different support to meet local population needs;
- and provide employers with information about successful approaches and spread best practice.

“Change on this scale will take time to achieve and not everything we try will work.”

In the meantime people on ESA will be on a deprivation level of income without having access to the superior employment support service that was used as the justification for the cuts.

“focus our resources on services and commissioning models which have the most impact;”

How is ‘impact’ going to be measured? There are cost savings from cancelling previous work programmes, there will be some benefit savings regardless (due to the current legislation to reduce ESA WRAG financial support and guidelines to reduce the number of Support Group awards), and some people will move into work from ESA (most often because of recovery from illness, or in-work support for disabled people). But to sustain disabled people in work will require ongoing support from social care and Access to Work, and these costs will therefore also be ongoing. However the report isn't clear which impact it considers to be a priority, or its main aim, due to its misleading nature.

People on ESA will be on a deprivation level of income without having access to the superior employment support service that was used as the justification for the cuts.

“Influence commissioners of services to make the right decisions to invest in different support to meet local population needs;”

There is scant detail about what the ‘right decisions’ are from the government’s perspective (or what are the ‘right decisions’ from an appropriate perspective), how this ‘influence’ is to be exerted, how the commissioners of services will identify those services which will best meet local population needs or what the metrics that measure this undefined ‘success’ are.

“And provide employers with information about successful approaches and spread best practice.”

Without legislation, ‘successful approaches’ run the risk of falling on deaf ears. There is no indication in the Green Paper that the government intends applying pressure to employers to improve.

58. We want to take early action to build our evidence base on what works in the areas that we already know are important. We start with a solid understanding of some of key principles based on evidence from past delivery. For instance, evidence suggests that when a person faces both health and employment barriers, both should be addressed simultaneously, since there is no evidence that treating either problem in isolation is effective. As an example, Individual Placement and Support, an integrated health and employment model, has demonstrated improved employment outcomes for those with severe and enduring mental health condition. A UK evaluation found that chances of finding employment doubles for those who received this service.

“We want to take early action to build our evidence base on what works in the areas that we already know are important.”

There are many papers on what works. For example, the IPS model has good success with learning disabilities and mental health conditions (provided the other support is also in place, such as Community Mental Health Team; disappointingly, the CMHTs have been so cut back that people who might be able to work if they had the input of CMHT and IPS are unlikely to be getting CMHT). We also know that Supported Employment works for deaf, learning disabled and mental health - but the government closed Remploy.

We know that good work is important - but the government wants to deregulate, rather than force bad employers to drastically improve the working conditions of their workers. We know that fast and adequate healthcare is important (but the NHS is in crisis). We know that good housing is important (but housing costs are too high, and homes are often unhealthy, stressful and inadequately heated or insulated). We know that not being in poverty is important (and that poverty causes and exacerbates ill health, but the government’s current legislation doesn’t protect sick people from poverty). We know that support at home is important (but Personal Independence Payment was designed to cut money from working-age disabled people, and social care is drastically underfunded). We know that the existence of a job is important (but it must be a ‘good’ job, and the government shows no interest in regulating for good jobs).

There is a lot the government could do without wasting time and money on expensive projects, which cannot work whilst all this necessary background support is not provided.

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“For instance, evidence suggests that when a person faces both health and employment barriers, both should be addressed simultaneously, since there is no evidence that treating either problem in isolation is effective.”

There is evidence that treating health in isolation can work - people have been recovering from ill health and returning to work without assistance for years, and will continue to do so. The government must not use this evidence to justify its apparent intention to make treatment a mandatory part of receiving sickness benefit. This would be a wholly inappropriate interpretation, reversing the actual conclusion - that the quality of work and of workplaces must improve if people are to be able to work without it making them ill – to justify tacking bad healthcare onto inadequate employment support.

The government appears to recognise that employment barriers exist, although it does not define them. The evidence is that treating a health problem is not enough to sustain a return to work if the cause of the problem - the workplace - is not addressed. The workplace may cause problems because of the nature of the work (e.g. manual work, and low-end work that is high pressure with low autonomy) or because of specific problems with that workplace (e.g. difficulties with colleagues or supervisors). Whatever the reason, it is necessary that the problem is removed. In order to do this, the government must legislate against working practices that cause harm and then enforce such legislation.

Although IPS relies on placing people in work before a recovery is made, there has been no analysis of why the success rate is not complete - a big factor will be lack of jobs, but another major contributor may be that a participant was simply too ill to work. We must not fall into the trap of thinking that every sick person can be made well enough to work, nor that putting several people through ‘employment services’ just to get one person into work is necessarily the best use of the government’s resources and the sick or disabled person’s time and energy.

59. We also know that evidence gaps exist, in particular:

1. how best to support those in work and at risk of falling out of work, including the part employers can play;
2. understanding how best to help those people in the Employment and Support Allowance Support Group who could and want to work (discussed further in chapter 2);
3. the settings that are most effective to engage people in employment and health support; and
4. how musculoskeletal treatment and occupational health interventions improve employment outcomes.

“how best to support those in work and at risk of falling out of work, including the part employers can play;”

The Government has created a Fit for Work scheme for exactly this reason. The results from the pilots showed that Fit for Work needed more investment, so that the advisers could give focussed, specific advice to employers. Once specific advice is given, it must be compulsory that the employer

put it in place or pay full pay to the employee. The advisers must be Occupational Therapists, not Occupational Health professionals.

Legislation should be created and enforced, and employment tribunals should have an affordable fee. Currently a standard wage employee cannot afford to challenge an employer and this results in poorer working practises and unfair dismissals, which create further barriers to employment for those who are sick even in the short term.

“understanding how best to help those people in the Employment and Support Allowance Support Group who could and want to work (discussed further in chapter 2);”

People in the Support group are the furthest from the employment market regarding capacity to work. Some are terminally ill, some have complex conditions and some have multiple disabilities. They largely cannot work, and consequently need no employment support, beyond the financial security and freedom to manage their health and lives as best they can.

Those who have good health could work, but they have to indicate they desire to do so, not be forced into any system. However there are few in the Support Group who have good health, and any move to include all members of the Support Group in any mandatory activity or ‘support’ will have tragic consequences.

If people in the Support Group do request help there must be help available. This will need to be very specialist help, and may include Adult Social Care, Access to Work and job brokers, and require a higher level of both initial and ongoing financial input. It has not been shown in the Green Paper that voluntary organisations or Local Authorities are in a position to offer the necessary level of expertise and finance. All that is apparent is central government’s apparent desire to transfer as much of its responsibility as possible onto other bodies, and then deny any ultimate or financial duty.

“The settings that are most effective to engage people in employment and health support;”

This presumably is a reference to combining health and employment services into one location, and even under one person – the Work Coach. This is wholly inappropriate. Healthcare is a necessity for everyone; employment support is only appropriate for those well enough to work and in suitable circumstances. Many people with chronic illness, whether physical or mental, have come to distrust the DWP through their experience of badly carried-out, flawed assessments and inadequate ‘support’ with requirements they cannot fulfil. These people must not be made wary of seeking healthcare by its proximity employment ‘support’.

The Health and Work Conversation, which is part of this system, happens at what is seemingly an arbitrary point in the process - after being defined as unfit to work by the GP and not yet having been found unfit for work by a WCA. This shows ignorance of the true nature of sickness and disability, and demonstrates the assumptions made in this report, and repeated as truths, that people have ‘health conditions’ that are easily managed or minor. In truth, people have major and chronic illness. This forced insertion of additional assessment is totally inappropriate without full knowledge of the challenges a person faces with treatment and recovery, and where they are on their health journey. An employment journey may never be started or restarted for many.

“and how musculoskeletal treatment and occupational health interventions improve employment outcomes.”

Occupational health interventions should happen before the illness or injury becomes severe or chronic; ideally, before any illness or injury at all. For example, common musculoskeletal problems could be prevented or managed by ensuring that every employee has a workstation set up specifically for them, and periodic re-training on manual handling techniques. However, many companies either don't have access to Occupational Health services, or fail to use them correctly and in a timely manner. Often a company will use an Occupational Health worker to override the instructions of a GP - we have heard of two cases today - and thus risking harm to the employee. Occupational Health should never be used to override a GP and force an employee back to the workplace, risking their health further. Occupational Health, in its role in prevention, could be doing more in the workplace, as opposed to its role of dealing with damage already done due to poor work environments.

Occupational Therapy is a therapeutic treatment - aiming to reverse or manage the damage and to aid recovery. Occupational Therapy, physiotherapy and associated medical services are underfunded by this Government, and hence conditions deteriorate and become chronic. An increase in funding in these areas is essential if any effect is to be seen on employment outcomes. However Occupational Therapy and physiotherapy are no guarantees of recovery – in some illnesses, all that can be done is to reduce the rate of deterioration, or increase function, without being able to stop deterioration or restore function. The Government has to accept that medical intervention does not mean recovery or cure, nor necessarily improvement, but that this is not a reason to not provide such care.

60. We have a range of activity underway that is focused on the evidence gaps we have identified, including access to services and levels of support we should offer. This will help us to develop new models of support to help people into work when they are managing a long-term health condition or disability.

It is indeed good news if the Government have finally recognised that access to services such as Adult Social Care and Access to Work are woefully inadequate. However this evidence-gathering exercise shows no evidence that the government does know of the lack of support that these two support mechanisms can offer at the moment, even though these two services are core to getting people back to work.

Huge investment in Adult Social Care and the NHS is what is needed. People are dying through lack of beds due to cuts - and yet this Government has built an entire back-to-work plan that relies on both Adult Social Care and the NHS being at the heart of it for it to make the difference it claims.

61. As part of this our £70 million Work and Health Innovation Fund, jointly managed by the Work and Health Unit and NHS England, will support promising local initiatives to drive integration across the health, care and employment systems. The first areas we will work with are West Midlands Combined Authority and Sheffield City Region. Seed funding will be provided to support the design trials to test new approaches at scale and understand if they can improve employment and

health outcomes. Following this design phase, we plan to review these proposals and decide if they are viable for implementation, with access to further funding and national support available to enable full implementation from spring 2017.

This level of trial funding, supporting ‘initiatives’, is paltry when the NHS is starved of cash, and local authorities cannot afford adequate levels of social care. Whilst closer working between social care and the NHS is necessary, underfunding the very mechanism that will bring this about is worse than doing nothing. The Government should, quite rightly, be accused of talking the talk without walking the walk. Without a fully funded NHS people will not recover in a timely manner, and will not have jobs to return to. Without a fully funded Social Care system, not dependent on Local Authorities precepts and business rates, both carers and the cared for face being unable to get into work. The funding available to the Work and Health Programme is so low that it has been estimated that the best it can achieve is an additional 20 000 sick or disabled people entering work each year.⁹⁴ At that rate, it would take 50 years to halve the disability employment gap, although this ignores the costs of sustaining sick or disabled people in work.

The cuts to ESA start in April, and yet the Government has not yet evaluated the trialling of the integration of the two underfunded kingpins of their plans. As a result of this people will be left in poverty without the support that the Government promised it would provide in order to get the legislation on ESA WRAG cuts through.

62. By bringing local Clinical Commissioning Groups, Jobcentre Plus and local authorities into new partnerships these trials will create new support pathways for people with common physical and mental health conditions to help them stay in or return to work.

These ‘support pathways’ are heavily dependent on recovery before people move into work. However the underfunding of the NHS delays recovery, and is placing people further from the employment market. The bringing together of different services for health and for work is laudable only if it is necessary. It may be that all three services mentioned here are underfunded and under

People on ESA have severe forms of what may or may not be ‘common’ illnesses, and cannot be meaningfully compared with people capable of full-time work.

resourced, and there would be to need to join them together if each service acted promptly and efficaciously. Advocacy from these agencies would be welcome, but they cannot create the finances needed to provide their own services well, let alone attempt to liaise more closely with others.

A project of this scale demands high levels of investment and political will, and it cannot realistically ever break even, because the savings don’t necessarily exist: people will continue to get ill, and for some there is no recovery.

It is clear from this report that the Government is prepared to legislate for cuts to ESA whilst passing the onus of responsibility for the claimant onto underfunded Local Authorities.

The government consistently conflates ‘common’ with ‘mild-moderate’. Cancer is common; it is rarely moderate. Aquagenic urticaria is rare, and usually mild. The government should talk about

⁹⁴ Gardiner, L. & Gaffney, D., 2016. Retention deficit: a new approach to boosting employment for people with health problems and disabilities. Resolution Foundation.

people with 'mild-moderate mental or physical illness' rather than using the inaccurate term 'common' as a misleading proxy – unless of course it only means to help people with 'common' illnesses, regardless of how severely ill and incapable of work some of these people may be, and how capable of work people with 'uncommon' illnesses may be if only the government provided the support they needed.

The chief intention of using the word 'common' seems to be to downgrade the severity of illness experienced by people on ESA by implying that it is no different to what many working people experience. In fact, people on ESA have severe forms of what may or may not be 'common' illnesses, and cannot be meaningfully compared with people capable of full-time work.

63. Alongside this, we are testing a range of approaches to improve outcomes for people with common mental health conditions, who make up 49% of those on Employment and Support Allowance. We want to rapidly scale up those which show they can make a real impact. Trials include testing interventions that offer faster access to treatment and support services, co-locating employment support in a health setting and building on the evidence for Individual Placement and Support to understand if this is a model which can work successfully for people with common mental health conditions.

Paragraphs 59 and 62 make the Government thinking quite clear - they are targeting those unpleasantly known as the 'bad back' and 'depression' groups, in a commonly held belief that these two groups are curable and therefore, if they are still suffering and out of work, must be adverse to being cured and thus 'work-shy'. The government also mistakenly believes that these people form a substantial proportion of those on ESA, ignoring the severity of illness that is required to be eligible for ESA.

The problem lies with the DWP data collection. It groups conditions such as Osteogenesis imperfecta, Ehlers-Danlos Syndrome and other connective tissue disorders with any musculoskeletal disorder. It groups unmanageable psychosis with anxiety. To suggest that the multitude of

This government's approach is to underfund healthcare, and then cut the benefits that people rely on whilst waiting for treatment.

mental health problems are 'common' is disingenuous; 'common' means it occurs a lot - it doesn't mean it is minor or curable, and some of the conditions listed under 'Mental Health condition' are not common. Furthermore, the 49% refers only to people where mental illness is the primary illness; it does not mean that the person on ESA has only depression or anxiety.

The 'outcomes' of the 49% are dependent on what type of mental health problem the person has, what other illnesses or disabilities they have, and whether all the illnesses are curable or manageable. However as mental health services are grossly underfunded, people who could be moving into recovery are instead waiting for treatment, having to claim ESA whilst they wait, and at risk of deterioration. Faster access to treatment is what is needed, but this government's approach is to underfund the services, and then cut the benefits that people rely on whilst waiting for treatment to occur and be effective. The cuts to ESA must be deferred, or revoked, until such time that the government can provide the necessary services - at which point the saving on benefits due to timely medical intervention will reduce the 49% considerably, which is after all what the government wants.

64. Examples of this approach include the Mental Health Trailblazers.⁹⁵ These combine a specific type of employment support, Individual Placement and Support, with psychological support provided through the NHS talking therapy services in three areas: Blackpool, West London and the North East.

The trailblazer in Blackpool reported that it was for JSA and ESA WRAG recipients with moderate mental illness, and presumably without a physical illness. It is unclear, given the strict criteria of the WCA, how many truly 'moderately' mentally ill people the trailblazer will be able to find from ESA WRAG. In Manchester, claimants had access to "talking therapies and/or lower level interventions of support" only. In the North East, it is billed as "individually tailored and intensive support", but as access is via JobCentres and the Improving Access to Psychological Therapies Service for mild-moderate sufferers, it is unclear if any people with severe mental illness will have access. In London, the scheme was for people with "common mental health problems", thus ruling out anyone with a mental illness or condition bar depression and anxiety. The 'mental health' side was to be delivered not by Community Mental Health Teams as successful implementations of IPS depend on,⁹⁶ but by the much-criticised Improving Access to Psychological Therapies service,⁹⁷ whilst the employment side was delivered by the JobCentre rather than by dedicated vocational specialists.

65. As set out in the 2015 Spending Review, there are opportunities to make use of Social Impact Bonds to help people with mental health problems. Social investment offers an exciting new opportunity to draw on both private capital and voluntary and community sector innovation to test and scale new forms of support. We are reviewing how Social Impact Bonds can be best used across our range of innovation activity and will invest up to £20 million on work and health outcomes. The Government Inclusive Economy Unit will explore the possible role of existing or new public service mutuals, which already operate to good effect in the health and care sectors.

SIBs are a method of borrowing money against a project. If it 'works' then the bond holders are rewarded. They are paid back by savings experienced by the public sector. These are clearly 'outcome dependant' or performance based contracts, and another Private Finance Initiative. This is commodifying of the sick and disabled to benefit private investors, as previously attempted via the failed Work Programmes. Changing funding models won't change the fact that essentially what is being offered is a work programme with some degree of treatment embedded in it.

Changing funding models won't change the fact that essentially what is being offered is a work programme with some degree of treatment embedded in it.

⁹⁵ <http://publicservicetransformation.org/news/latest/tags/577-mental-health-and-employment-trailblazer>

⁹⁶ Heffernan, J. & Pilkington, P., 2011. Supported employment for persons with mental illness: systematic review of the effectiveness of individual placement and support in the UK. *Journal of Mental Health*, 20(4), pp. 368-380.

O'Brien, A., Price, C., Burns, T. & Perkins, R., 2003. Improving the vocational status of patients with long-term mental illness: a randomised controlled trial of staff training. *Community Mental Health Journal*, 39(4), pp. 333-347

Schneider, J. et al., 2009. SESAMI study of employment support for people with severe mental health problems: 12-month outcomes. *Health and Social Care in the Community*, 17(2), pp. 151-158.

⁹⁷ Price, C., 24/10/2013. IAPT Programme struggling to achieve targets. *Pulse*.
Leader, D., 09/09/2008. A quick fix for the soul. *The Guardian*.

SIBs assume that savings will be made. But the cost of social care and Access to Work needed to sustain sick and disabled people in work may well exceed the cost of paying ESA, even if ESA were paid at a high enough level to meet minimum income needs.

66. We recently launched our Small Business Challenge Fund to encourage small businesses in developing small-scale innovative models for supporting small and medium-sized enterprises with sickness absence. This approach will allow us to use a small amount of funding to identify promising interventions and prototypes to take forward to more robust testing.

67. We aim to build on this Challenge Fund approach to develop small-scale innovative approaches to quickly understand which may work and fail fast on those which do not. Such an approach is likely to be most useful where there is limited evidence, such as supporting small and medium-sized employers with sickness absence, or where there is already a market of innovators, such as digital health technologies. We are particularly interested to use the consultation process to identify key areas where such an approach may be appropriate.

Such challenge funds would be appropriate if sick and disabled people received adequate, secure income whilst waiting for the government to decide what employment support achieves the best results. But when the government has already committed to cut the income of many sick and disabled people to less than 40% of what they need, it is wholly inappropriate to invest in anything other than the support we already know works – healthcare, specialist advisers, Access to Work and job brokers.

68. Finally, it is important we share information on what works widely to support local delivery. To do this, we will work with Public Health England to develop a set of work and health indicators and identify how we can best bring together and share the existing evidence for local commissioners and delivery partners. We will continue to draw on a range of internal and external evidence, including trials and research, the academic literature and relevant third sector organisations to improve policy making and delivery nationally and locally.

Health warning indicators and early intervention are theoretically very useful tools to reduce sickness absence, but in truth they are more likely to highlight the pervasiveness of sickness presenteeism in the UK. Presenteeism is undesirable - the employee is underperforming and at risk of becoming chronically ill and falling out of work. Presenteeism isn't the opposite of absenteeism, it is the precursor to it, and is neither mentioned nor accounted for in the Green Paper. If the Government wants earlier health condition detection then the culture of presenteeism and of leaveism (taking holiday rather than sick leave when ill) must be addressed.

The Government would be better served by encouraging the creation of models that react to presenteeism with early intervention, including measures for the reduction of work-place stress and pressure, than creating reactive systems to sickness absenteeism.

CHAPTER 2: Supporting people into work

Introduction

73. We want everyone to have the opportunity to benefit from the positive impacts that work can have, including on their health and wellbeing. Where people want to work, and have the potential to do so immediately or in the future, we should do everything we can to support them towards their goal. We want people to be able to access appropriate, personalised and integrated support at the earliest opportunity, which focuses on what they can do, builds on their talents and addresses their individual needs.

"Where people want to work, and have the potential to do so immediately or in the future, we should do everything we can to support them towards their goal."

This is a laudable goal and we praise the government for it. It is a significant duty which the government has recognised. There is a long way to go, made substantially more difficult by the ground the government has to recover just to get back to where it was before the Great Recession and the take-over of the government by the Conservative Party. It may well cost more now to put in place the means to fulfil a government's duty to its citizens than if these measures had been started six years ago. But this is no reason for a developed country to shirk its duties, especially with the example of other countries such as Canada, Germany and the Scandinavian countries to follow.

Fulfilment and independence are not rights earned by those who work; they are rights which everyone should be enabled to achieve.

The government is right to recognise that employment support should be for those who "have the potential" to work. But the rest of its paper does not suggest that it thinks there is anyone who does not realistically have the potential to work. Yet this is a crucial distinction to make, to ensure that sick and disabled people are neither harmed nor marginalised by government policies that insist everyone should work. Of course, people who cannot work and do not have the potential to work should also be given 'everything [the government] can to support them towards their goal[s]'. Fulfilment and independence are not rights earned by those who work; they are rights which everyone should be enabled to achieve.

74. Where someone is out of work as a result of a health condition or a disability, the employment and health support they receive should be tailored to their personal needs and circumstances. This support might be delivered by a range of partners in their local area, such as by Jobcentre Plus, contracted provision, local authorities or third sector providers. Increasingly, our work coaches across Jobcentre Plus will assess an individual's needs and ensure that they access the right help. Work coaches will be supported by new Community Partners and Disability Employment Advisers, who will be able to use their networks and expertise to work with local organisations, to support disabled people and people with health conditions to achieve their potential.

“Our work coaches across Jobcentre Plus will assess an individual’s needs.”

The Work Coaches do not have the skills necessary for this task. They are not medics nor trained in Occupational Therapy. They are therefore not capable of assessing a sick or disabled person’s needs and cannot be asked or expected to. Nor should the necessary expertise be delivered second-hand via Work Coaches; this is neither ethical nor appropriate. Sick and disabled people need better.

“should be tailored to their personal needs and circumstances.”

Yet all the discretion is with the work coaches, who set the plans and conditionality. We welcome the government's alleged intention that all the systems focus on the individual's own goals and wellbeing, but the government’s actual plan is to impose work as a goal for everyone, regardless of whether this is appropriate or the best outcome in terms of wellbeing and independence for the individual.

“achieve their potential”

Many sick and disabled people cannot ‘achieve their potential’ without retraining - which the government has neglected to do in last six years, and in some cases has made harder. The government hasn’t discussed in this report the value of providing free education/training up to pre-degree level (and tuition fees as per 1st degree) regardless of the highest qualification of the sick or disabled person, in order to assist people to move into a new area of work that better matches their illness or disability.

Nor can sick or disabled people ‘achieve their potential’ without having the support they need outside of work, which the government of the last six years has decimated, knowing full well the harm it was causing, as the Equality Impact assessments show.

Many people with chronic illness cannot fulfil the potential they had before they became ill, or would have had if they were not ill. It simply isn’t possible to overcome the disabling impacts of chronic illness in the way that static disabilities can be worked around. There are no aids for pain or fatigue.

75. Universal Credit is already making improvements which put people at the heart of the welfare system, giving more personalised and integrated support from a dedicated work coach in Jobcentre Plus to help claimants with a health condition move closer to the labour market and get into work. It will also, for the first time, help those claimants with health conditions who are already in work to progress in the labour market supporting them to earn more. Evaluation has found people receiving Universal Credit are more likely to move into employment and move into work quicker than similar individuals receiving Jobseeker’s Allowance. 69 To ensure that disabled people and people with health conditions receive the best possible support, we will introduce a new Personal Support Package for people with health conditions in Jobcentre Plus, with a range of new interventions and initiatives designed to provide more tailored support.

Evaluation has found that people receiving UC are no more likely to be in work nine months later than are similar people on JSA.⁹⁸ There is no significant difference in earnings. The initial difference in employment has been lost after nine months, suggesting that UC recipients are getting temporary or insecure work. Benefits that push people back into the low pay/no pay cycle are not a success.

Benefits that push people back into the low pay/no pay cycle are not a success.
Pushing people into debt is not a success.

The majority of UC claimants end up in rent arrears, compared to less than a third of JSA recipients.⁹⁹ Pushing people into debt is not a success.

There is no evidence that UC brings a substantial improvement in job-seeking support for jobseekers. It introduces the novel approach of placing conditionality on people who have jobs. This is a risky strategy, especially for sick and disabled people for whom there are no safeguards to ensure that non-medical Work Coaches do not require them to participate in activity that will harm them.

76. However, further action is needed to build on the principles Universal Credit has introduced. We cannot make significant progress towards halving the disability employment gap with a system that treats 1.5 million people – the current size of the Support Group in Employment and Support Allowance – in a one-size-fits-all way. The current approach does not do enough to treat people as individuals: more must be done to ensure that people do not miss out on accessing the wealth of local, integrated support available through Jobcentre Plus. We will achieve this by identifying evidence gaps, building on insights from trials and drawing on the knowledge of both service users and providers.

The current system is exceptionally flawed. The work capability assessment bears no relation to the capacity for work. It doesn't check if people are ill, neither does it look at whether recovery is likely. It fails to ask basic questions regarding sickness, and ignores the impact on illness on the ability to work consistently. A person can be too ill to work but assessed as fit for work.

The Support Group is not a 'one-size-fits-all'. It is a group tailored to the needs of people who are too sick to work, and too sick to engage in or benefit from work-related activity. Thus it provides these people with the financial security that allows them to manage their health to the best of their ability. The government needs to realise that ESA Support Group is an entirely appropriate benefit for the people who receive it, and for many who don't.

77. In this chapter we will discuss two key themes:

- Universal Credit is moving in the right direction, but there is still more to do to improve how work coaches systematically engage with disabled people and people with health conditions. We want to identify the most effective support based on a person's circumstances and the capabilities required in Jobcentre Plus to deliver these interventions. Work coaches will also be able to offer an

⁹⁸ Riley, R., 2015. Annex B: Independent NIESR Peer Review. In Estimating the early labour market impacts of Universal Credit – updated analysis. DWP ad hoc research report no. 28

⁹⁹ Barnes, S., 07/06/2016. Three in four Universal Credit tenants in arrears. Inside Housing

array of targeted support as part of the Personal Support Package summarised below; and

- The current one-size-fits-all approach to employment support is not appropriate. This is because people in the Employment and Support Allowance Support Group, and those with 'Limited Capability for Work and Work Related Activity' (LCWRA) in Universal Credit, do not routinely have any contact with a Jobcentre Plus work coach. We are committed to protecting those with the most needs, but want to test how we might offer a more personalised approach to employment support, which reflects the wide variety of conditions and needs within this group and is in keeping with Universal Credit principles.

Universal Credit reduces potential income levels for those in the Support Group, and for all who cannot work 16 hours a week due to circumstances beyond their control, such as chronic illness or caring duties. For many the move to Universal Credit represents a drop in income as the Severe Disability Premiums are removed, and as Universal Credit reduces to much lower levels than permitted work or tax credits then the deficit is carried through.

It isn't an outrageous concept that someone who can't work doesn't routinely see someone whose job is finding work.

People in the Support Group have a limited capability for work and work related activity, hence unless they request it there would be neither contact nor need for contact with Jobcentre work coach - whose role is to 'assist' people to find work. It isn't an outrageous concept that someone who can't work doesn't routinely see someone whose job is finding work.

There seems to be some sort of cognitive dissonance involved with understanding that the people in the Support Group are judged, examined, assessed and found to too ill to work - yet the Government wants to "test" this group with a personalised approach. Any degree of common sense would suggest that that focus should be placed on those people on JSA and some of those in ESA WRAG.

We are introducing the new **Personal Support Package** for people with health conditions. This is a range of new measures and interventions designed to offer a package of support which can be tailored to people's individual needs.

The offer, set out in more detail in this chapter, includes the following new forms of support for all Employment and Support Allowance claimants (and Universal Credit equivalents):

- personal support from disability trained, accredited work coaches. A particular focus of training will be mental health. Work coaches will also be better supported by an extra 300 Disability Employment Advisers and around 200 new Community Partners, with disability expertise and local knowledge. This will lead to better signposting to other local voluntary and public sector services; and
- a Health and Work Conversation for everyone claiming Employment and Support Allowance, as appropriate.

For new claimants in the Employment and Support Allowance Work-Related Activity Group (ESA WRAG), and the equivalent Universal Credit Limited Capability for Work Group (UC LCW), an **enhanced offer of support** will also include:

- a place on either the new Work and Health Programme or Work Choice, for all eligible and suitable claimants who wish to volunteer;
- additional places on the Specialist Employability Support programme; Job Clubs delivered via peer support networks;
- work experience places, with wrap-around support, for young people;
- increased funding for the Access to Work Mental Health Support Service;
- Jobcentres reaching out to employers, particularly small employers, to identify opportunities and help match people to jobs in a new Small Employer Offer;
- We will continue to develop the offer by: trialling the use of specialist medical advice to further support work coaches;
- working with local authorities to pilot an approach to invest in Local Supported Employment for disabled people known to social care, notably those with learning disabilities and autism, and secondary mental health service users;
- testing a Jobcentre-led alternative to Specialist Employability Support; and trialling additional work coach interventions.

The government has given no indication of who will train or accredit the Work Coaches. Nor has it given any consideration to the question of how a generalist Work Coach can hope to learn how to help sick or disabled people without taking a degree in Occupational Therapy. The 500 total DEAs is one per 5000 ESA recipients; the 200 Community Partners is less than one per three constituencies. It is unclear how the government expects so few advisers to cover all the necessary areas of expertise in the level of detail required.

At some point, someone has to stop sign-posting and actually deliver a service. Otherwise, people will be going round in circles from one organisation to another, never getting the support they need. The government needs to take responsibility for giving people the support they need, not 'sign-post' to voluntary organisations that cannot guarantee to have the necessary finance or staff.

The government says the new Health and Work Conversation will only be for people for whom it is appropriate. But because the Health and Work Conversation occurs before the WCA, the government has no way of knowing for whom it is appropriate. They are expecting to be able to determine the outcome of the WCA without ever gathering the evidence and presenting it to a medical professional.

In previous parts of this report, the government has indicated that it will be compulsory for ESA WRAG recipients to meet with a Work Coach at the JobCentre. It is not made clear whether the Work Coach will be able to mandate ESA WRAG recipients to the above programmes. In any case, the requirement to continue meeting the Work Coach is a higher level of activity requirement than what the DWP told assessors to assume was the case, such as one-off CV writing, making a list of previous hobbies or making a phone call to the JobCentre.

Action already taken

78. There is a significant amount of work already underway to strengthen and improve the employment support offer available to disabled people and people with health conditions. These activities are explored in more detail within the chapter, and include:

- Universal Credit – replacing 6 benefits with 1, the introduction of Universal Credit will make a significant difference in improving the level and quality of support offered to individuals with health conditions;
- expansion of the Disability Employment Adviser role – we are recruiting an additional 300 Disability Employment Advisers, taking the total to 500;
- permitted work – from April 2017, we will remove the 52-week limit on how long Employment and Support Allowance claimants placed in the Work-Related Activity Group (WRAG) are able to work for. This will improve work incentives for this group;
- the Work and Health Programme – following the end of the Work Programme, this provision will be available to disabled people receiving Employment and Support Allowance or Universal Credit on a voluntary basis from October 2017.

UC replaces six benefits, but not six benefits per person. Most people would be claiming Housing Benefit, plus one of income-based JSA, income-based ESA, Income Support, Working Tax Credit or Child Tax Credit. UC assists only with the transition between out-of-work benefits and tax credits. To complicate matters, contribution-based JSA and contribution-based ESA are not included in UC, although it would seem sensible to do so. Council Tax Support is also not included and, again to complicate matters, has been devolved to local councils and no longer meets the total cost of Council Tax. By combining Housing Benefit with income-replacement or top-up benefits, the government has made the system more complicated for calculating benefit changes between people who own their home outright, have a mortgage, rent their home but don't claim housing costs or rent their home and do claim housing costs.

The principle of having a single taper is good, although in other countries with a taper it is at 50% or 60%, not 65%. In comparison, the top-rate tax in the UK is 45%. The 65% taper becomes even higher once earnings reach the threshold for paying National Insurance.

Universal Credit itself is simply a payment mechanism. It has no 'support' mechanisms that are unique to Universal Credit or that cannot be provided for people on other benefits.

We welcome the removal of the 52-week limit on permitted work for ESA WRAG recipients. We recommend that the government improve further upon this by introducing a 50% taper once the Permitted Work earnings limit has been reached, rather than the current cliff-edge in which ESA is completely removed. Introducing a taper for ESA would be quicker than waiting for each ESA recipient to be transferred to UC.

Universal Credit and the financial benefits of work

79. It is essential to ensure that people are better off in work. Under Universal Credit, people can more clearly see the financial benefits of moving into work, allowing them to take small steps into the labour market and to work flexibly in line with their needs.

This is a disingenuous comment - for those who cannot work Universal Credit is lower for some due to loss of SDP, and the overall amount received is lower than the current system. Not everyone can work, and for people who are going to remain unable to work for a long time it is inappropriate and a breach of basic rights to restrict them to a poverty-level income simply because of an ideology that insists benefits must be substantially below the income from a full-time, minimum wage job.

80. In Universal Credit, for people who have 'limited capability for work' (LCW) or 'limited capability for work and work related activity' (LCWRA), there is a work allowance for earned income. This means that someone assessed as having LCW or LCWRA, with housing costs, can earn up to £192 a month, and a similar person, without housing costs, can earn up to £397 a month, in both cases without affecting their Universal Credit payment. For any earnings above these allowances, the Universal Credit 65% taper applies, which means that only 65% of the extra earnings above those allowances are deducted from the claimant's Universal Credit entitlement – a steady and predictable rate as people gradually increase their hours and earn more, rather than the cliff-edge approach of Employment and Support Allowance. This is particularly well suited for people whose disability or health condition means they can only work some of the time.

The cliff-edge of ESA did not require the introduction of UC as a remedy; it simply needs the government to introduce an appropriate taper such as 50%.

The disregards depending on housing costs complicate Universal Credit, creating a disparity in income depending on whether or not one claims housing costs.

UC expects people to continuously look for more work or higher pay. This is not appropriate for people with limited capacity work. It means putting pressure on people to do more than they are capable of, at the risk of losing the money they need to live.

81. Individuals on Employment and Support Allowance are allowed to work up to 16 hours and earn up to £115.50 a week and keep all of their benefit. If earnings exceed this amount, Employment and Support Allowance stops altogether. The permitted work rules allow people claiming Employment and Support Allowance to undertake some part-time work without it impacting on their benefit, to encourage them to gradually build their employment skills and return to work. However for those in the Work-Related Activity Group this is limited to 52 weeks. We will remove this limit from April 2017 to bring the Employment and Support Allowance rules more into line with Universal Credit and improve the incentive to work.

Early engagement

82. Being better off in work is not enough on its own if disabled people and people with health conditions are not being enabled to find work in the first place. Universal Credit ensures that people with health conditions still have an opportunity to engage with a work coach prior to their Work Capability Assessment, where appropriate. This approach builds on evidence that early intervention can play an important role

in improving the chances of disabled people and people with a health condition returning to work.

Making someone 'better off in work' by cutting benefits is wholly inappropriate when the necessary support to find, obtain and stay in work is not in place. Nothing is stopping ESA recipients from getting employment support before the WCA, bar their disabling illness and the lack of good quality JobCentre provision. Healthcare is needed to improve the health of people with incapacitating illness as much as is possible, and employment support needs only be good quality to attract those people who can do some work.

Making someone 'better off in work' by cutting benefits is wholly inappropriate when the necessary support to find, obtain and stay in work is not in place.

Being (financially) better off in work is no good if a person is too ill to work. It simply means making sick people even more marginalised by adding the impact of poverty to that of illness.

Early intervention is important, but waiting until someone is on ESA for four weeks is not 'early.' The results from the pilot Fit for Work schemes show that 'early' means during the stage of sickness presenteeism, before people start taking time off to manage their illness.¹⁰⁰

There is no evidence that a Work Coach has the level of expertise needed to help people with chronic illness or disability.

83. This is a significant improvement on the current process in Employment and Support Allowance, where people are not routinely having a face-to-face conversation with a work coach about practical support to help them back to work until after their Work Capability Assessment is complete – and this can be many months after their initial claim. Over 60% of the 2.4 million people receiving Employment and Support Allowance – those currently in the Support Group – do not get this opportunity and often have no contact at all with a work coach and therefore do not access tailored support when they need it. We are missing a significant opportunity to provide help to people when they could benefit most.

We are glad to see that the government recognises the value of providing support early in the sickness process. However, because sickness largely is a process not an event (with the exception perhaps of cancer), waiting until someone has put in a claim for ESA - even where this is without a prior six months of SSP - is too late. It typically takes six years for a person to progress from the initial need for sick leave to long-term sickness benefits;¹⁰¹ that is six years where support could and should have been provided. Consequently, moving a discussion forward by two-three months is not a significant improvement, especially when we know that the reason the Work and Health Focused Assessment, which served the same purpose of discussing the claimants abilities and needs, was scrapped because it was deemed of no value before a decision on the claimant's benefit status had been made. The significant opportunity that has been missed is not the first three months of an ESA claim, but the preceding years of increasing illness and the six months of Statutory Sick Pay.

¹⁰⁰ Hillage, J. et al., 2015. Evaluation of the 2010-13 Fit for Work service pilots. DWP.

¹⁰¹ Bratsberg, B., Fevang, E. & Røed, K., 2010. Disability in the welfare state: an unemployment problem in disguise? IZA.

84. This earlier engagement between an individual and a work coach in Universal Credit will also serve as a gateway to a wider, integrated system of support offered by the Department for Work and Pensions and other agencies, such as the NHS and local authorities. If a work coach identifies that someone has particularly complex barriers to work or complex health conditions, they will be able to advise individuals about other types of support in their local area – whether health services, skills courses or support with budgeting.

The government appears to be using a moderate and inappropriate definition of what ‘complex’ means when it refers to complex cases. It appears to think that ‘particularly complex’ cases are people who need health treatment, need to upskill or retrain, or have difficulty managing on a benefits-level income. People with these needs are not a minority group on ESA; they are the people on ESA. ESA claimants are sick, usually long-term, and apart from those who have exhausted all the current available treatments and haven’t recently developed a new illness, they tend to need health treatment.

A key gap identified by surveys of ESA claimants is the need to retrain because their illness prevents the individual from working in their previous line of work.¹⁰² Budgeting is always difficult when one does not have enough to live off, made worse by being ill and the impact of inadequate resources on cognitive capacity. These are not ‘particularly’ complex cases; these are the ESA caseload.

‘Complex’ should be used to refer to people who have some capacity for work, but are unemployable. For example, people who cannot work at all consistently and therefore make it impossible for an employer to rely on them for a predictable workflow or assurance of meeting deadlines. Another example of ‘complex’ would be the person who would benefit from work in one way, but would be harmed in another - for example, good work might help mental health, but severely harm physical health. The same principle applies to medication, treatment and potential aids, adaptations or adjustments: they may help one symptom whilst worsening another. Finally complex can mean multiple conditions, all of which combined result in many more barriers to work. This is what it means to have complex barriers to work.

85. This builds on the approach of Universal Support, which helps people make and maintain their Universal Credit claim, and will assist people with their financial and digital capability throughout the life of their claim. This is delivered in partnership between the Department for Work and Pensions and local authorities, and with other local partners such as Citizens Advice and Credit Unions. Through Universal Support we are transforming the way Jobcentres work as part of their local communities to ensure they more effectively tackle the complex needs some people have and support them into sustainable employment. The Troubled Families programme offers another example of an integrated approach, with local authorities coordinating wider support services for complex families, including those with health conditions, and in doing so, driving public service reform around the needs of

¹⁰² Benstead, S. & Nock, E., 2016. Replacing Employment and Support Allowance: Part One - support needs of people with chronic illness. Ekklesia.

families. The Department for Work and Pensions provides work coaches acting as Troubled Family Employment Advisers, based within local authorities, where they play an important role in integrating employment support with the wider services.

We welcome the government's recognition that it needs to help people with two of the main problems caused by UC (which were also pointed out to the government before UC was implemented, and confirmed by the results from pilot areas): that claimants may find budgeting on an inadequate monthly even harder than budgeting on an inadequate fortnightly income; and the recognition that claimants may struggle with managing claims purely online. It is disappointing that the response is to place burdens on local authorities and charities to help claimants cope, rather than correct the cause of the problems.

Building work coach capability

86. The relationship between a person and their work coach should be at the heart of each person's journey in the welfare system. To ensure that people with complex and fluctuating health conditions receive the most appropriate support, we will continue to build and develop the capability of our work coaches. We have introduced an accredited learning journey for work coaches, which includes additional mandatory training in supporting those with physical and mental health conditions. From 2017, we will introduce an enhanced training offer which better enables work coaches to support people with mental health conditions and more confidently engage with employers on the issue of mental health.

It is disappointing that the government does not appear to think that its Work Coaches will be capable of their job role when it is first rolled out. This is clear in the intention to introduce additional 'experts' from whom the Work Coaches can obtain advice, and the plan to introduce additional learning so that Work Coaches learn how to help those with 'complex and fluctuating conditions' - which may well be the majority of people on ESA, given the low level of the government's definition of complex and the typical nature of chronic illness.

It is not surprising, given the evidence from this and other countries of the importance of adequately trained professionals,¹⁰³ that the government recognises that Work Coaches do not currently have the capability they will need. It is surprising that the government expects sick and disabled people to be advised by people who are not qualified to advise them.

87. Work coaches will be supported by specialist Disability Employment Advisers. We are currently recruiting up to 300 more Disability Employment Advisers, taking the total to over 500. These advisers will work alongside work coaches to provide additional professional expertise and local knowledge on health issues, particularly around mental health conditions. The role will have a much stronger focus on coaching work coaches to help build their confidence and expertise in supporting individuals with a health condition or disability.

¹⁰³ Baumberg-Geiger, B., in press. Assessing work disability for social security: international models for the direct assessment of work capacity.

Baumberg-Geiger, B., in press. Benefit conditionality for disabled people: a review of international evidence and practice. *Journal of Poverty and Social Justice*, 25(2).

It is disappointing to see the low level of the government's ambition for its sick and disabled citizens. To think that one Disability Employment Adviser per 5 000 sick and disabled people is adequate is ludicrous. That amounts to half an hour per claimant per year of advice that the DEA can give - and that not to the sick or disabled person themselves, but second-hand via the Work Coach. This advice in turn will be based upon the Work Coach's non-medical opinion of the disability or illness experienced by the claimant.

88. We also recognise the value of bringing external expertise into Jobcentres and of working more effectively with the voluntary sector in our design and delivery of support. We know that voluntary organisations have unique insight and expertise about the people they work with and their conditions, and we want to harness this. So, we will recruit around 200 Community Partners across Jobcentre Plus. These will be people with personal and professional experience of disability and many will be seconded from a Disabled People's User-Led Organisation or disability charity. From next year, Community Partners will be working with Jobcentre Plus staff, to build their capability and provide valuable first-hand insight into the issues individuals with a health condition or disability face in securing and sustaining employment. Drawing on their local knowledge, they will identify more tailored local provision to ensure individuals with health conditions can benefit from the full range of support and expertise available. Community Partners will also engage with local employers to help improve the recruitment and retention of disabled people and people with health conditions.

The Community Partners also face a heavy burden - they have to cover more than three constituencies each. MPs can struggle as it is to address the varying needs of their own constituency. It seems far-fetched to think that a single person could have a 'local' perspective of a community over three times the size. Yet these people have to inform the JobCentre of not only the local employment situation, but also their own experience or knowledge of chronic illness and disability. At the same time, a person can only have experience of a handful of illnesses or disabilities, and cannot comment on the myriads of other illnesses and disabilities that exist. 200 such people is simply not anywhere near enough.

89. Our Community Partners will map local services available in each of our Jobcentre Plus districts. This will include understanding where there are peer support and patient groups which engage with disabled people and people with long-term health conditions who might otherwise find it hard to re-engage with employment, helping develop confidence and motivation. Where there are gaps in provision our districts may be able to make local decisions to fund any priority areas, using the Flexible Support Fund. We will be providing an extra £15 million a year in 2017/18 and 2018/19 for our Flexible Support Fund so that local managers can buy services including mentoring and better engage the third sector in their community. We will introduce a new Dynamic Purchasing System across the country by December 2016 which will allow third sector and other organisations to develop employment-related service proposals that Jobcentres can quickly contract for. Our

goal is to extend the reach of Jobcentre Plus into third sector support groups which are already well established.

The Dynamic Purchasing System sounds like a good idea if it works as intended, that is by allowing experienced employment support workers in third sector organisations to be funded to support sick and disabled people. Of course much will depend on the funding model - which experience shows needs to be based on an up-front payment so that organisations have the finances to invest in their clients¹⁰⁴ - and on the application process. One option could be to have a sum of money allocated to each person on sickness benefit, which goes to the organisation of their choice. This would allow true competition and swift response to success. This bottom up approach ensures that opportunities for fraud and coercion are limited, and puts the claimant in control of what they need.

90. Often, the best advocates of the positive impact of being in work are people who themselves have had the experience of managing a serious health condition, or overcoming an employer's prejudice about disability. We have already tested Journey to Employment peer support job clubs on a small scale, offering personalised support in a group environment delivered by people who have personal experience of disability, drawing on research by Disability Rights UK and the Work Foundation. These clubs often take place outside a Jobcentre as this provides an alternative setting which may be more effective for some individuals with health conditions. We are extending our Journey to Employment job clubs to 71 Jobcentre Plus areas with the highest number of people receiving Employment and Support Allowance, to further test the effectiveness of peer support job clubs at supporting those with health conditions.

People who can manage to work in good jobs with good support can of course share their positive story with those who are struggling to work, are in bad jobs, don't get the support they need, can't work or who are out of work and can't find an employer who will give them a good job with the support they need. However, it is not advocacy of the value of good work with good support for those with good enough health that is needed. Such 'inspirational' stories may boost morale and confidence for a short period, but this may drain away when an offer of employment remains unforthcoming. What people who can work need is good jobs; sick and disabled people who can work additionally need a country that will support them.

People who struggled on in work out of a strong work ethic until the impact on their health forced even them to resign are good advocates for the positive impact of not pushing one's body beyond its limits. Numerous researchers have reported that, under a variety of measures and workplaces, around 5-10% of the workforce would see their health improve if they left work.¹⁰⁵ It is puerile of the government to expect people who can work to, merely by sharing their experience, make other sick people capable of work.

¹⁰⁴ Nevile, A. & Lohmann, R., 2011. "It is like they just don't trust us:" Balancing trust and control in the provision of disability employment services. Canberra: Social Policy Action Research Centre.

¹⁰⁵ Waddell, G. & Burton, K. A., 2006. Is work good for your health and well-being? DWP.

Tveito, T. H., Halvorsen, A., Lauvålien, J. V. & Eriksen, H. R., 2002. Room for everyone in working life? 10% of the employees – 82% of the sickness leave. *Norsk Epidemiologi*, 12(1), pp. 63-68.

Tinnings, R. J., 1975. *Work, change and psychological wellbeing*. Nottingham, Ergonomics Society.

Fraser, R., 1947. *The incidence of neurosis among factory workers*, London: HMSO.

Overall we welcome peer support and any measure that assists non-disabled people to understand that helping their sick and disabled colleagues is simply fair treatment, not favouritism.

91. We want to make sure work coaches can access the right specialist advice and support, so they can understand how a complex health condition might affect an individual's ability to work, and access advice on how someone can better manage a health condition to be able to work. We therefore intend to trial access to specialist advice through a 3-way conversation between a work coach, healthcare professional and a person who has been placed in the Work-Related Activity Group, following a Work Capability Assessment. The trial will begin in 2017, with a view to rolling out provision on a wider scale in future years, depending upon results. Early intervention in Employment and Support Allowance

It is disappointing to see that the government wants to "make sure work coaches can access the right specialist advice and support" rather than making sure that sick and disabled people have access to specialist advice and support.

Allowing a non-medic to comment on a sick or disabled person's health to a medic who does not treat the person would be unethical.

The government's intention to trial a '3-way conversation' with a Work Coach, medic and sick or disabled people runs the risk of being unethical. It is not made clear in this whether a '3-way conversation' is mediated through the Work Coach, as the DEAs and CPs appear to be, or is simply a '3-person conversation' in which the Work Coach, medic and sick or disabled person come together for a discussion. In the former, allowing a non-medic to comment on a sick or disabled person's health to a medic who does not treat the person would be unethical. In the latter, allowing a medic to advise a person whom they do not treat sounds dubious and unwise.

Under Incapacity Benefit, a large number of Disability Employment Advisers were available to sick and disabled people who wanted their (direct) help to move into work. It is deliberately misleading for the government to allege that a smaller number of recently-recruited staff who advise via a Work Coach is comparable to the many experienced DEAs previously available directly to sick and disabled people. Surveys report some good experiences with the 'old-style' DEAs, but the system proposed in this paper is not the same level of quality and must not be confused as such.¹⁰⁶

It is deliberately misleading for the government to allege that a smaller number of recently-recruited staff who advise via a Work Coach is comparable to the many experienced DEAs previously available directly to sick and disabled people.

Early intervention in ESA

92. These improvements will place the relationship with the work coach and access to a network of integrated support at the heart of each individual's journey. We also want those receiving Employment and Support Allowance to benefit from the support that disabled people and people with health conditions who receive Universal Credit can already access as part of their Claimant Commitment discussion.

¹⁰⁶ Benstead and Nock, 2016.

To that end, we have developed a new Health and Work Conversation between an individual and their work coach. In the Health and Work Conversation, work coaches will use specially designed techniques to help individuals with health conditions to identify their health and work goals, draw out their strengths, make realistic plans, and build resilience and motivation. People will be required to attend the Health and Work Conversation, where appropriate, but the actions they subsequently agree to within the conversation will be entirely voluntary in the period before the Work Capability Assessment, and will be captured in a new Employment and Support Allowance Claimant Commitment.

As the government notes, the plans laid out in their Green Paper make the Work Coach central to the support the sick or disabled person receives - yet the admission of the need for additional expert advice is itself an admission that a Work Coach is not medically qualified to be the centre. A central support worker as indicated here needs to have the training and experience to weigh up potentially conflicting advice in order to determine, with the claimant, an appropriate approach. This is not an easy task and places considerable weight on the skill and discretion of the Work Coach. It is a task much more suited to degree-level trained and experienced Occupational Therapists.

The government says that the Health and Work Conversation is mandatory where appropriate, but no indication of how it is decided whether or not this is appropriate is given. It is not apparent how any such decision can be made before the WCA, which is the assessment that makes the decision on who can take part in such work-related activity by partitioning people into JSA, ESA WRAG or ESA SG - 'as appropriate'.

The Health and Work Conversation has no binding impact on the claimant before the WCA - any 'Claimant Commitment' is "entirely voluntary" which, given the government's abhorrence of voluntary access to employment support for people in the SG and the known irrelevance of a WFHRA before a WCA decision, begs the question of why this has been introduced at all. It does not appear to serve any goal of the government, bar that of having the appearance of doing something whilst actually doing effectively nothing for the least cost possible.

93. The Health and Work Conversation will focus on what individuals can do to move closer to work while managing or treating their health condition, rather than on what they are unable to do. This new conversation was co-designed with disabled people's organisations and occupational health professionals and practitioners and the Behavioural Insights Team. As a person and their work coach works together, the Claimant Commitment can be updated over time as the individual moves closer to being able to work. This approach will mean that a person will have an established relationship with their work coach and be able to explore the implications of their Work Capability Assessment with them after it takes place. They will also be able to review the Claimant Commitment actions they have jointly developed up until that point. We are exploring how we could integrate this approach into Universal Credit as well.

No 'Claimant Commitment' is relevant before the WCA and it seems unlikely that this will have a positive impact when the similar WFHRA could not.

Work Coaches are not trained to know what a person can or cannot do whilst managing or threatening their chronic illness. There is no way in which they can have the necessary training without undergoing either a medical degree with specialisation in Occupational Therapy, or a degree in Occupational Therapy itself. It is dangerous of the government to suggest that Work Coaches can perform such a highly discretionary role.

Employment support for disabled people and people with health conditions

95. Work coaches will increasingly be able to offer a wide menu of interventions tailored to people's needs. Building on what we have learnt from the Work Programme and Work Choice, the Work and Health Programme will offer a more personalised, local approach to supporting disabled people to overcome barriers to employment. The Work and Health Programme will be targeted at people who are likely to be able to find work within 12 months, with more specialist support. Disabled people can volunteer for the programme at any time. Providers will be expected to support people based on the needs, strengths and aspirations of the individual; deliver effective services which are integrated with local services; and connect individuals with local employers and place and support them in sustainable employment. From 2017 we plan to be able to offer a place on either Work Choice or the Work and Health Programme to all eligible and suitable new Employment and Support Allowance (Work-Related Activity Group) and Universal Credit (Limited Capability for Work) claimants who are assessed as being within 12 months of being able to start work, and who wish to volunteer. This commitment will not include a small number of claimants who will be placed into the control group of the Randomised Control Trial used to evaluate the performance of the Work & Health Programme.

The government says that providers must "integrate with local services" and "place and support [individuals] in sustainable employment. This is a big commitment. It is notoriously difficult to achieve, not least when the individual services themselves are underfunded and understaffed.

The government should not be offering shoddy services to its sick and disabled citizens in this way.

'Place and support' has echoes of the 'Individual Placement and Support' approach. But by not using the term IPS, the government implies that it does not intend to implement a full IPS model. It is well established that the further a 'place and support' approach is from the IPS model, the more poorly it performs.¹⁰⁷ The government should not be offering shoddy services to its sick and disabled citizens in this way. If it means to implement a full IPS, it should say so clearly, and not make vague statements that could mean an excellent service yet equally could mean a terrible one.

There is no clear indication at this point of the conditions attached after the WCA for people placed in ESA WRAG. The government writes that the Work and Health Programme and Work Choice are for people on ESA WRAG and who are assessed as being able to start work in twelve months' time and who volunteer. The government "plans to be able" (it appears to consider it may not have enough places available) to "offer" (not enforce or mandate) a place on either Work Choice or the

¹⁰⁷ Bond, G.R., Becker, D.R., Drake, R.E. & Vogler, K.M., 1997. A fidelity scale for the Individual Placement and Support model for supported employment. *Rehabilitation Counselling Bulletin*. 40(40):265-284

Work and Health Programme to those who are “eligible and suitable” (is no-one else permitted, regardless of their desire?) and who “volunteer” (is ESA WRAG to become an entirely condition-free benefit?). On the other hand, the government elsewhere implies that meeting with a Work Coach will be compulsory for people on ESA with a re-assessment period of under 12 months (it is questionable whether any ESA recipient should have a reassessment period under 12 months, but the government does not mention that issue in this paper). There will also be a ‘Claimant Commitment’, but no evidence of what might be mandated in this commitment or of any safeguards to protect sick people from non-medically prescribed activity.

96. The Work and Health Programme will not be suitable for everyone, as some people have additional and more complex needs. We currently offer additional help through the Specialist Employability Support programme. This provision focuses on helping those furthest away from the employment market and for whom other provision is unsuitable due to the complexities of their barriers to employment. Specialist Employability Support offers an individually tailored combination of advice, guidance, training, work placements and work experience. We are currently considering how we should continue this support in the future, including how to provide more places to individuals in the Employment and Support Allowance Work-Related Activity Group or assessed as having limited capability for work in Universal Credit from April 2017.

The SEP will, apparently, be for those “furthest away from the employment market”. This proposal exemplifies one of the major flaws in the government’s thinking regarding sick and disabled people: it necessarily assumes that those ‘furthest away’ from work are still, in fact, capable of work. This ought to be self-evidently false. There are people who are too ill to work, should not work, and cannot work to the overall benefit of either themselves or a prospective employer. Indeed, the government recognises this elsewhere in the paper (e.g. paragraph 21, albeit by saying ‘some’ people ‘might’ not be able to work), without apparently recognising the inconsistency of its intentions.

The government should be focussing its resources on people who have a realistic likelihood of being able to work - such as people on JSA with chronic illness, and people with disabling impairments but in good physical and mental health.

97. We will continue to support disabled people and people with health conditions who wish to start their own business. The New Enterprise Allowance scheme provides access to business mentoring and offers financial support to those in receipt of an eligible benefit, including those on Employment and Support Allowance and Universal Credit. The New Enterprise Allowance has so far supported around 90,000 people into self-employment, where 21% of these businesses have been established by individuals who have declared a disability.[

In various surveys sick and disabled people have reported that they would like to receive support to set up a business. They also report that the New Enterprise Allowance is not enough for them. They need a buffering income for when they earn less, whether through the vagaries of self-employment

or through worsened illness. They need help with the aspects of self-employment which they are less able to do, such as accountancy or dropping off parcels for posting. They need to be allowed to carry on even if the business does not become self-sufficient. None of these are currently provided.

98. We will also ensure we make better use of local support mechanisms. For those with a learning disability or autism who are known to adult social care, or those in contact with secondary mental health services, we will pilot an approach working with local authorities to deliver Supported Employment on an outcome-payment basis. Supported Employment uses a 'place then train' approach, aimed at moving people into paid employment. This will help us to test the effectiveness of locally-driven solutions to best support people with the most challenging conditions, and build on our learning of what works for them.

It is welcome that the government now recognises the value and importance of supported employment, although it is regrettable that the task has been made harder by the inappropriate and apparently now unnecessary closure of Remploy factories. It is to be hoped that learning disabled people not currently known to social care - or more appropriately, adult social services - will be picked up by JobCentre staff and referred to social services so that they do not have to miss out on supported employment because of failings or understaffing of social services.

It would be a bizarre twist if people too severely ill or disabled to work at all get the offer of supported employment, whilst those with some capacity for work are refused supported employment on the grounds that they are not getting the social or health input they need from understaffed services.

Similarly, people with mental health conditions often do not receive the secondary care they need because the NHS and mental health care in particular are grossly underfunded and therefore understaffed and under-resourced. It would be a bizarre twist if those people too severely ill or disabled to work at all get the offer of supported employment, whilst those who are ill or disabled with some capacity for work are refused supported employment on the grounds that they are not getting the social or health input they need from understaffed services.

99. We also want to support local areas to design new, integrated approaches to improving health and work outcomes at scale. We are using the Innovation Fund to develop large-scale health-led trials creating partnerships between local health service commissioners and providers, Jobcentres, and councils. These partnerships will test if health-led support services are effective at supporting disabled people and people with health conditions into work, how effectively they support people to stay in work and how to get a region to work collaboratively on the health and employment agenda, through the introduction and integration of services.

Again, it is inappropriate of the government to cut benefits on the grounds that there are good quality employment services, before those employment services exist. Of course, if there were good quality employment services, there would be no need to cut benefits artificially because people would naturally leave benefits and enter work.

Supporting people with mental health conditions

100. Improving our offer of support for people with mental health conditions will be integral to our approach. The Five Year Forward View for Mental Health and NHS England's Implementation Plan sets out a series of actions to prevent mental ill health, improve services and reduce stigma. Around half of Employment and Support Allowance claimants in the Support Group report a mental or behavioural disorder as their primary health condition – the most prevalent of these being depression, stress and anxiety. The government will invest in trials, proofs of concept and feasibility studies over the next 3 years to test ways to provide specialist support for people with common mental health conditions and ensure that we are providing access to the most effective health support when it is needed. As discussed in chapter 5, we are also increasing the number of employment support advisers co-located in talking therapy services. We are supportive of co-locating services where it can improve support and will consider whether there is wider learning on co-location we can draw from this work.

We already have good evidence on what type of employment support works for people with mental health conditions - the Individual Placement and Support model. This is, compared to what is suggested here for people with MH conditions, an intensive model. Yet anything less does not work. The IPS requires as a starting point that the individual concerned is receiving support from Community Mental Health Teams. But CMHTs are underfunded and overstretched; those people who do get CMHT involvement may be those who are so severely ill that employment support is not appropriate at that time, whilst people who might benefit from IPS may not get the necessary CMHT.

Employment advisers must not be co-located in talking therapy services. Mentally ill people are rightly wary of coercion and pressure to engage in activity that is beyond their capabilities. Many report that if employment advice is co-located with their healthcare, this will make it emotionally difficult for them to access the healthcare they need, risking losing their access altogether.

The government must stop its focus on mild-moderate versions of common mental health problems. Many people on ESA have 'uncommon' mental illnesses such as schizophrenia or schizoid disorders, or personality disorders. People with 'common' mental illnesses often have co-morbid physical illnesses that are also incapacitating. For someone to receive ESA purely because of anxiety or depression, it must be so crippling that they are essentially unable to look after themselves. This is not 'common'. The people who can recover from depression simply by attending a Job Club where they realise many people are worse off than themselves are not the people on ESA – the people on ESA are the 'worse off' ones to which people with mild or moderate illness can favourably compare themselves.

101. The new support we will test to establish what works best for people with mental health conditions who are out of work includes: Group Work – to test whether the JOBS II model, a form of group work, improves employment prospects and wellbeing; and Supported computerised Cognitive Behavioural Therapy (cCBT) testing whether early access to supported cCBT can support employment outcomes alongside recovery.

People on ESA because of a MH condition have to be very severely affected to qualify. It has been an ongoing theme of ESA that it is poor at assessing people with MH conditions, in that it over-assesses their capacity for work. These are not issues that are solved by CBT - CBT necessarily assumes that a person's condition is more affected by how one thinks than by the circumstances in which one lives, which is unlikely to be appropriate for people in ill health and poverty.¹⁰⁸ Computer-based CBT would be even more inappropriate when one considers that much of the success of talking therapies comes not from the method chosen by the skill of the counsellor but through the relationship established with the counsellee¹⁰⁹ - how can one have a relationship with a computer?

The government's plans would be welcome if it were delivering them to people assessed as fit for work by the WCA. They are wholly inappropriate and potentially dangerous for people who are on ESA.

Supporting young people

102. Gaining employment after leaving education should be a core part of the journey into adulthood for disabled young people and young people with health conditions yet successful outcomes are far too low. Young people who are out of work and begin to claim Employment and Support Allowance or Universal Credit early in their lives can face scarring effects of long-term unemployment if they do not move into work. To explore how to better support this group we will test a voluntary, supported Work Experience programme for young people with limited capability for work. This will enable young people to benefit from time in the workplace with a mainstream employer to build their confidence and skills, enhance their CV and demonstrate their ability to perform a job role.

It is not acceptable to make young people with disability or chronic illness pay the cost for getting the support they need. Young people should be able to access jobs, not be made to work unpaid. The government should subsidise employers for the cost of training young adults if employers don't otherwise think that there is a good business case for training up young disabled or chronically ill adults.

103. There are over 250,000 children and young people in education in England with a Statement of Special Educational Needs or an Education Health and Care (EHC) plan.⁷⁵ Most have a learning disability or autism and many do not get the support they need to move into work. These young people who have an EHC plan at age 15 are more than twice as likely not to be in education, employment or training at 18. Just 5.8% of adults with a learning disability known to local authorities are in a job. This must be addressed. We will work with organisations to listen to the views of people with a learning disability and their families to look at what we can do to improve employment opportunities for this group.

¹⁰⁸ Leader, 2008.

¹⁰⁹ Wright, J.H. & Davis, D., 1994. The therapeutic relationship in cognitive-behavioural therapy: patient perceptions and therapist responses. *Cognitive and Behavioural Practice*. 1:25-45
Lealy, R., 2008. The therapeutic relationship in cognitive-behavioural therapy. *Behavioural and Cognitive Psychotherapy*. 36(6):769-777.

Many people with learning disabilities enjoyed the type of work and the work environment that Remploy offered. The government should give serious consideration to supporting people with learning disabilities in the type of jobs and work environments that they want and enjoy.

104. We will open up apprenticeships to young people with a learning disability. For this group, we will make adjustments to English and maths requirements and draw on the £2.5 billion the government will make available for apprenticeships each year by the end of this Parliament. We will also work with social enterprises and disabled entrepreneurs to set up apprenticeships specifically for young disabled people. Jobcentre Plus will increase support in schools for young disabled people, by bringing in Supported Employment providers, business mentors and young disabled people who are in work to inspire young people to see employment as an achievable goal. This could include 2 weeks supported work experience.

Young adults need access to adequate finance once they have reached adulthood, so that they can live independently and make their own choices in life. Apprenticeships need to pay an adequate wage so that the apprentices can afford to live decently. If employers cannot see a business reason why they should pay for the training of the workforce they need, then government should subsidise them. Government should not make young people bear the cost of an education system that didn't given them relevant job skills.

105. A further way that young people with a health condition or disability can be helped while still in full-time education is through supported internships. These give 16 to 25 year-olds with an EHC plan (or equivalent) an unpaid work placement of at least 6 months, personal support from a job coach and a personalised study programme. The results can be impressive: evaluation found 36% of participants in the trial secured paid work.

We should be aspiring for more than 1 in 3 young work-capable disabled adults getting work.

The government has not said how these young adults are expected to fund themselves. They need at least the ESA WRAG component on top of the over-25s JSA or ESA assessment phase rate. The expenses of getting to work, both travel, clothes and any other needs, must be covered. They do not necessarily need a job coach; what they need is the prompt access to Access to Work or Disabled Students Allowance to get the practical support measures they need at work. This includes support workers who assist them at work, and British Sign Language interpreters for deaf people.

106. It is our ambition that all young people with an EHC plan should be able to do a supported internship but to achieve this we need many more employers to offer these opportunities. We suspect too few employers know where to go for information about how to offer a supported internship and do not understand the benefits, which can include: the flexibility to create opportunities that meet their needs; free support; and the chance to grow their employees of the future. We therefore want to help employers to link up with schools and colleges to increase the number of supported internships.

People who have a significant illness or disability before leaving education should be provided with a programme dedicated to supporting them into work that begins even before they leave education. This should have permanent funding from the government so that it can cater for all adults with learning disabilities and can plan for the future.¹¹⁰

It is however inappropriate to make people work in unpaid positions. An employer is getting work done, and training up employees is part of an employer's duty to those employees and to the society in which the employer participates. It is not enough for employers to assume that employees will turn up ready-made. If the government wishes to subsidise employers it may do so, but it may not make sick and disabled young people subsidise employers.

Supporting people in work

107. Universal Credit will also support disabled people and people with health conditions to not only get into work, but to progress in work as well. It is payable to those on a low income and aims to support those individuals to increase their earnings, progress in work and reach their full potential. This is the first time any country has attempted this approach. Therefore, it is crucial that we build the evidence base to understand what works. We have developed a substantial programme of trials as part of the wider test and learn strategy in Universal Credit. Evidence from these trials will be central to the development of our future in-work support service, and will provide a foundation for further development of support for disabled people and people with health conditions.

UC risks significant harm to sick and disabled people. By not placing a limit on how many hours these people can be expected to work, they can be pressured into exceeding their safe activity limits under threat of losing their income. The past six years show that the government has no interest in protecting people from excessive demands. People with mental health conditions or learning disabilities are more likely to be sanctioned, proving that JobCentre and Work Programme staff are not tailoring conditions to the person; if they did, these people would be less likely to be sanctioned in recognition of their reduced capability for work, work-related activity and mandated activity. People in ESA WRAG report that the conditionality applied to them makes their health worse, because it is beyond their physical, cognitive and/or emotional capabilities.

It is not clear if employers are able to provide the flexibility that Universal Credit assumes. Employers have control of the labour market and control over increasing or decreasing an individual's hours or increasing and decreasing the number of employees. This is why zero-hour contracts exist; so that the employer retains the flexibility over how many hours of work they pay for. It is not flexible for the employee, who typically wants more hours than are available and who is vulnerable to having their hours cut without any fault of their own. Universal Credit does not appear to recognise the vagaries and restrictions of the current labour market. It risks putting significant pressure on poor people without giving them the independence to choose for themselves - the very things that make work bad.

¹¹⁰ Conlon, L. 2014. Transition planning for young people with learning disabilities in Great Britain. Northern Ireland Assembly.

108. Whatever a person's needs, this new package of support offered through Jobcentre Plus will ensure more personalised, integrated and targeted approaches for disabled people or people with a long-term health condition. The work coach is the key gateway to this support within the Jobcentre Plus network and across local provision – transforming the way we engage with individuals with health conditions from the very start of their claim and testing direct referral into health services. We need to provide work coaches with additional tools to ensure that they are referring people to the right forms of support. We are therefore keen to hear from stakeholders about how best to support individuals, to inform our evidence base.

The Work Coach is not adequately trained to be a gateway to other services, and in particular to health-related services. It takes a doctor to give a medical diagnosis. Work Coaches cannot diagnose ill people, and nor can they recommend medical treatment to sick people. Referral to health services is a role for GPs, and emphatically not for Work Coaches.

There is no evidence in this paper of a true personalised approach, which would necessarily include supporting people who do not yet, or will not ever, have work as a goal. The government's approach is to impose work as a goal upon everyone, and to mandate people to whatever services it chooses via its generalist, non-medical Work Coaches. Personalised would mean allowing people to choose which services they went to, and to leave those services without penalty. Personalised would further mean the financial freedom to manage one's life appropriately, rather than be constrained by lack of income and thus forced to make choices between one negative situation and another.

There is no evidence in this paper of a true personalised approach.

The government's approach is to impose work as a goal upon everyone, and to mandate people to whatever services it chooses via its generalist, non-medical Work Coaches.

Improving access to employment support

109. The new Personal Support Package, along with the earlier intervention and changes that Universal Credit introduces, marks a step change in the approach to helping people move towards and into sustainable employment. In practice however, over the last 12 months we have seen on average 50% of Employment and Support Allowance claimants being placed in the Support Group following their Work Capability Assessment, meaning they will not access this support and risk facing long periods of time on benefits.

The only step change this paper provides is a significant step backwards. The Work and Health Programme has only 20% of the funding that the failed Work Programme had. The government talks about investing in innovation, rather than using what we already know about Individual Placement and Support, Access to Work and Job Brokers to support moderately ill and disabled people to obtain and sustain work. The government is ignoring substantial evidence on the harm the ESA WRAG causes to its recipients and the benefits

The only step change this paper provides is a significant step backwards.

for sick and disabled people of having a stable income without mandated activity.¹¹¹ A plan to increase conditionality whilst reducing or ignoring suitable support measures is a retrograde step, not a step up.

We have already explained that the Health and Work Conversation is inappropriate before the WCA, and that the only substantive changes brought in by Universal Credit are harmful ones – paying benefits monthly rather than fortnightly, reducing people’s income, and continuously putting pressure on people to increase their hours of work and earnings. These changes are not going to help people unable to take part in more activity than they already do, and already living in poverty.

110. We recognise the challenges of helping those with the most complex health conditions move closer to work, particularly when there is limited evidence of what works best. Our aim is not to reduce the amount of benefit those in the Support Group (or the Limited Capability for Work and Work-Related Activity Group in Universal Credit) receive or to change the conditions of entitlement, but we do want to ensure people are treated as individuals. We want people to be able to access a personalised, tailored, practical employment support service that recognises that someone might not currently be able to engage with employment support but that they may be able to access and make good use of that support in the future.

Again, we have evidence on what works best – full IPS models, properly funded and administrated Access to Work, support at home and the provision of job brokers.

People with the most complex health conditions are those with the most severe and difficult to manage illnesses. These people do not have the capacity to work nor

The guidelines on ESA WRAG are very much lower than, and not reconcilable with, the level of activity the government expects of WRAG recipients in this Green Paper.

engage in mandated activity in an attempt to get them ‘closer’ to work. Nor is there any point from either the government’s or the individual’s perspective. These people should be ‘left alone’ from an employment perspective, and it is right to do so, although this is not an excuse to not provide the support needed at home and for social participation.

The government has already reduced the money for some people in the Support Group by changing the guidelines on what it means to be incapable of work-related activity. Many SG recipients will, therefore, lose out on their Support Group component at reassessment because, without their illness or capacity for work changing, they will be reassessed as capable of work-related activity. This is because the government redefined work-related activity as things such as phoning a JobCentre adviser once a week, keeping a record of activity, updating a CV (however unlikely to have changed) and making a list of previously enjoyed hobbies. These are very much lower than, and not reconcilable with, the level of activity the government expects of WRAG recipients in this Green Paper. The guidelines on what work-related activity means must be the same as the multiple meetings and Claimant Commitment which the government intends.

People who cannot currently work or prepare for work may have illnesses that, particularly in the first two years, may improve with time. Over time this becomes less likely due to a natural selection effect. The government must bear this in mind when considering re-contacting people with illnesses that might, but won’t necessarily, improve.

¹¹¹ Hale, C., 2014. Fulfilling potential? ESA and the fate of the Work-Related Activity Group. Mind.

111. While we do offer employment support to individuals in the Support Group, this has historically received a very low take up, with very few people volunteering for this help. We need to do more to understand how we can best help this group and offer appropriate support.

People often want to work, even when they know that they are unable to work because of the drain it would put their health. This does not mean that they are capable of work or that they should take up offers of support related to work.

When chronically ill people want to try to do some work, they go to employment support services that have a good reputation. This may be a local charity that specialises in either employment support or the specific illness that the individual has. The government won't pick up on these figures because it is not accessed via the JobCentre or Work Programme. People who want to explore trying to work typically do not self-refer to the JobCentre or Work Programme because they are aware that these places do not provide the type of support that they need¹¹² and usually cause more harm than good.¹¹³

112. We will undertake comprehensive research to better understand how best to engage with people in the Support Group and those found to have limited capability for work and work-related activity in Universal Credit, and what interventions are needed to support them effectively. We will also develop a large-scale trial to test and learn from different approaches of offering employment and health support, and ways to increase the numbers of people taking up offers of voluntary support. We will explore how we can improve the nature of engagement with someone placed in the Support Group, and consider alternative ways of working with people which could include engagement outside a Jobcentre environment or through other local partners.

People in the Support Group typically do not have the capacity to work or prepare for work. What sick people in the Support Group need is the provision of decent healthcare, and an adequate, stable income that will give them the freedom to manage their health and wellbeing appropriately. People in the Support Group must never be mandated to employment support. If quality support is available locally, sick and disabled people who are capable of trying to return to work will naturally take it up. It is the lack of provision of quality support that is holding back those sick and disabled people who might be able to work.

Disabled people need an expansion of Access to Work so that it responds quickly to put in place what they need, and they need it to be available for interviews, training and education. They also need the government to commit to providing the support they need in their daily lives, both at home and in the public environment.

¹¹² Benstead and Nock, 2016.

Benstead, 2017. Replacing Employment and Support Allowance Part Three – A new sickness benefit. Ekklesia.

¹¹³ Hale, 2014.

113. This will help us to better equip work coaches to support individuals to fulfil their potential and allow us to target future support in better ways. We want to explore how to work more closely with the voluntary sector and local partners, to see if such organisations are better placed to offer individuals the right help. We will ensure that any additional support is effective for individuals, as well as offering affordability and value for money for the taxpayer. These findings will build on the range of interventions being trialled through the Work and Health Unit's Innovation Portfolio, which will help establish a stronger evidence base for what works and help inform how we might help disabled people and people with health conditions.

Local voluntary organisations often have much better expertise than do either the JobCentre or Work Programme. For the number of people they can reach, they are often effective in supporting them to a higher quality of life and wellbeing. However, they have limited resources and specialised local charities do not collectively cover the whole of the UK. Many people will be left without support if the government relies upon local charities to do its work for it.

As discussed above, we know what sick and disabled people need. To focus on innovation as the answer is to waste money and time that could and should be being spent now on effective employment support for those who can work.

Many people will be left without support if the government relies upon local charities to do its work for it.

To focus on innovation as the answer is to waste money and time that could and should be being spent now on effective employment support for those who can work.

114. As there is currently no requirement for people in the Support Group to stay in touch with the Jobcentre, besides engaging with reassessments, we could consider implementing a 'keep-in-touch' discussion with work coaches. This could provide an opportunity for work coaches to offer appropriate support tailored to the individual's current circumstances, reflecting any changes since their Work Capability Assessment. This light-touch intervention could be explored as a voluntary or mandatory requirement and we would consider our approach carefully, utilising digital and telephone channels in addition to face-to-face contact, depending on which was more appropriate for the individual and their circumstances.

Work Coaches lack the training and expertise to meaningfully have any discussion with sick or disabled people in the Support Group. There can be no mandatory activities for these people who have been assessed as unable to take part in such activities, or assessed as it being unreasonable for the government to ask them to take part. People in the Support Group should have access to quality employment support provided through a national Occupational Therapy service and supplemented by local specialised charities. The government must increase funding to such local specialised charities so that they can expand their borders to support more people. This must be on an entirely voluntary basis and with expenses repaid so that sick and disabled people can afford to access it.

Chapter 3 - Assessments for benefits for people with health conditions

Introduction

117. People who have recently developed a health condition or become disabled are likely to be facing a stressful and challenging period in their lives. Falling out of work because of their health is an added stress. We want people not only to be able to access tailored employment support available through Jobcentre Plus, but also to get the financial help they are entitled to in a simple, straightforward way – especially for people with the most severe lifelong health conditions or disabilities. Crucially, the financial support they receive should not affect their eligibility to accessing employment support.

People don't always “*recently develop*” a health condition. Evidence shows that people often move through gradually worsening health, until reaching a point where they cannot sustain work, sometimes moving to lower paid, shorter hour positions in an effort to stay in some type of work.¹¹⁴ The health condition has at this point become a serious illness.

“*Falling out of work*” is not the cause of stress - it is acknowledged universally that a major cause of stress is the sudden and drastic reduction of income, coupled with the stress of being seriously ill. People who become ill and have to leave work often have financial commitments they cannot immediately get out of, and cannot pay for with the low level of benefits available to them.

“We want people not only to be able to access tailored employment support available through Jobcentre Plus, but also to get the financial help they are entitled to in a simple, straightforward way – especially for people with the most severe lifelong health conditions or disabilities.”

The contradiction in this statement ought to be clear - whilst accepting that there are people who are too ill to work, and may have “*severe lifelong health conditions or disabilities*”, there is an insistence that these people engage with “*tailored employment support*” via the Job Centre. This engagement may not be possible, as people judged too ill to work or do work related activity by the Government are too ill to engage. This engagement therefore has to be totally voluntary, and requests for engagement should make this clear, and not be repeated continually.

The “*financial help they are entitled to*” is not accessible in a simple and straightforward way - the process often requires recourse to appeal, and the level of financial help is well below what people need to live sufficiently well in the long-term. The cut to WRAG “*financial help*” means people placed into WRAG in future will be on an even-deeper deprivation level of income despite being a significant distance from being able to work, and despite including many who will not recover and become able to work in the future. This additional stress exacerbates ill health and adds to co-morbid mental health conditions. Effectively, at a time when person needs less stress, this Government is intending to add financial stress, poverty and ‘engagement with employment support’ to chronic illness.

¹¹⁴ Bratsberg et al., 2010.

“Crucially, the financial support they receive should not affect their eligibility to accessing employment support.”

Currently the financial support a person receives does NOT affect their “*eligibility to accessing employment support*”. Under the current system those in WRAG who are clearly moving back towards health can be mandated to do work-related activity. All recipients can voluntarily access employment support, whatever financial assistance they receive. The different benefit groups do two things: they limit the conditionality that can be placed on a person (ESA WRAG cannot be mandated to look for or take up work; ESA Support Group cannot be mandated at all) and they limit the amount of money a person can receive. They do not bar anyone from accessing support to move towards or into work.

118. Universal Credit is already transforming lives, ensuring that individuals are supported when they have the most needs: both by accessing the financial support they need, and getting practical help to take the necessary steps to move back to work through an integrated support offer. Universal Credit goes a long way to simplifying the system, replacing 6 benefits with one, so it is easier for individuals to get the financial help they need without making multiple applications to different benefits or switching between benefits when their circumstances change, and offering personalised and tailored support from a dedicated work coach. But there is more we could do to build on these foundations to ensure that we are maximising employment opportunities for people, whilst also ensuring access to the appropriate financial support.

Universal Credit (UC) has been rolled out only to the least complex cases. It doesn't support people who have the most needs, because it is not the benefit that sickness benefit claimants receive. It hasn't proved a success or transformed lives for the better; UC claimants are no more likely to be in work after nine months than are JSA claimants, do not have any higher earnings, and are more than twice as likely to be in rent arrears.¹¹⁵ The steps to move back into work are often mandatory and the system uses financial sanctions to ensure compliance. The idea of “*integrated support*” when carefully examined breaks down into signposting to services such as CAB, data sharing of all data with numerous bodies including housing associations, and financial sanctions.

“Universal Credit goes a long way to simplifying the system, replacing 6 benefits with one, so it is easier for individuals to get the financial help they need without making multiple applications to different benefits or switching between benefits when their circumstances change, and offering personalised and tailored support from a dedicated work coach.”

Although it replaces 6 benefits, people do not receive all 6 benefits simultaneously and some are “linked benefits” due to means-testing. The suggestion that UC simplifies the system doesn't actually

¹¹⁵ Riley, R., 2015. Annex B: Independent NIESR Peer Review. In Estimating the early labour market impacts of Universal Credit – updated analysis. DWP ad hoc research report no. 28
Barnes, S.,07/06/2016. Three in four Universal Credit tenants in arrears. Inside Housing

benefit the claimant; the claimant will still have to prove they are entitled to UC for their own personal circumstances including claiming the sickness benefit element that replaces ESA.

“We want people not only to be able to access tailored employment support available through Jobcentre Plus, but also to get the financial help they are entitled to in a simple, straightforward way – especially for people with the most severe lifelong health conditions or disabilities.”

The government lays great stress on the idea of ‘decoupling’ financial and employment support, saying that, *“Crucially, the financial support they receive should not affect their eligibility to accessing employment support.”* But the financial support a person receives does NOT affect their *“eligibility to accessing employment support”*.

The WCA process leads to people being found either:

- fit for work, and placed on JSA;
- or to be found to have a limited capacity for work, and placed in the WRAG
- or be found to have a limited capability for work and work related activity, and placed in the Support Group.

The group a person is in, and therefore the WCA itself, determines two things: how much money the person gets, and the highest level of conditionality that can be placed on the recipient:

- A person assessed as incapable of work but capable of work-related activity cannot be mandated to apply for jobs;
- A person assessed as incapable of work-related activity cannot be mandated to any activity.

Apart from that, every person has access to employment support - no-one is banned from volunteering for an employment support service. Those in the Support Group can, at any time, engage with the employment support on offer, via the Job Centre and through the Work Programme and Work Choice providers, as well as through independent - typically charitable - support providers. No-one is prevented from participating or engaging in work focused activity, or from asking for help. The work coaches will work with a claimant from either group.

<p>No-one is prevented from participating or engaging in work focused activity, or from asking for help.</p>
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The contradiction in this statement ought to be clear - whilst accepting people are too ill to work, and may have *“severe lifelong health conditions or disabilities”*, there is an insistence that people engage with *“tailored employment support”* via the Job Centre. But this engagement may not be possible, as people judged too ill to work or do work related activity by the Government are likely to be too ill to take part in prescribed activity. This engagement therefore has to be totally voluntary, and requests for engagement should make this clear, and not be repeated continually.

“But there is more we could do to build on these foundations to ensure that we are maximising employment opportunities for people, whilst also ensuring access to the appropriate financial support.”

The report fails to explain what this *“more we could do”* is.

Benefits (financial support) are based on entitlement (except under sanctions, when the entitlement can be removed for alleged non-compliance). The statement therefore really states that they will

give people what they are legally entitled to, whilst harassing them to engage with a system that appears inadequate.

119. The **Work Capability Assessment process for Employment and Support Allowance and Universal Credit** does not lead to the individualised employment and health support service that we would like. We currently have an assessment system that places people into fixed categories for the purposes of engagement with local Jobcentres and specialist support programmes, with over half of individuals not receiving any systematic support towards employment as a result.

The WCA places people into groups that determine the maximum level of mandation and the maximum income. The groups and the WCA do not determine employment support; anyone can access employment support. Those in WRAG have mandatory work related activity, in anticipation of a return to work within a certain time frame, whilst those in the Support Group are not mandated, but are invited to voluntarily attend. Those who are the most ill, those who are not well enough to work at all and those who are terminally ill or incurably ill are not receiving systematic support towards employment because they are not employable or able to work. To suggest that this is a fault in the system is to suggest that those who are too ill to work are capable of work.

There is no 'employment and health support service'. There are employment support services, which are of low quality, and there is the NHS, which is underfunded. Health 'support' is not the remit of the DWP; it is entirely a matter for the claimant and the medically qualified people from whom they receive treatment and advice.

One of the government's key complaints in this paper is that people in the ESA Support Group are not mandated to engage in employment-related activity. It refers to this as being "one-size fits all", causing sick and disabled people to "miss out" on employment support. Yet surveys of sick and disabled people indicate that the best 'employment support' is often to have no 'support' at all - it is space and time that is needed, as the Support Group provides. The government has made no attempt in this paper to consider how many people are harmed, rather than helped, by the type of employment support it currently offers and intends to offer according to this Green Paper.

120. As Jobcentre Plus moves towards offering a Personal Support Package focused on early intervention, we believe it is wrong for these individuals to miss out on the personalised support Jobcentre Plus and other agencies, including health and voluntary sector providers, can offer. This support could help them manage, or overcome, health or other issues preventing them working.

By 'these individuals', the government presumably is referring to people who have such limited capacity for work-related activity that they are not required to take part in such activity. These people are the people for whom the Health and Work Conversation is not appropriate, and who should therefore not be participating in one. These people are not missing out on healthcare as a consequence of being in ESA Support Group, because the benefits system rightly has nothing to do with the provision of healthcare. It is the NHS that helps people to manage illness and injury, not the JobCentre or any other non-medical

People are not missing out on healthcare as a consequence of being in ESA Support Group.

professionals. The use of the word 'overcome' is wholly inappropriate and simply displays the government's complete ignorance of what chronic illness is like. It is emphatically not something that is 'overcome'.

Placing the Health and Work Conversation at a point where a person has not been assessed for the severity of their condition is pointless. They may be at a crisis in their health, or be anticipating medical intervention. All the Health and Work Conversation can achieve is a snapshot that has no medical evidence, and may be impossible to conduct. It is simply inserting yet another assessment into the process, and one that has no substantive purpose or benefit before the WCA. The Green Paper seems to assume that people can and will undergo another type of compulsory assessment, when in reality they may be unable to do so. The report is peppered with the assumption that people who are too ill to work are well enough to engage.

It is also rather duplicitous to attempt to portray these interventions as of benefit to the claimant; that the claimant is "missing out" on some intervention that could turn their lives around. When a person is ill, it is the role of the GP and medical team to provide medical solutions, and to signpost people to additional or alternative health solutions.

It is clear that if health is not the primary issue then interventions supplied by other bodies could be of benefit - those with barriers to work that are not health related would, in most cases, welcome assistance to overcome the barriers they encounter - and that form of assistance is to be applauded. However the reason for the Green Paper is to justify the cut to ESA - the only sickness benefit available when SSP is not - not to be a blueprint for helping those who are already able-bodied and well enough to work.

The types of support laid out in this paper, if conducted by appropriately qualified professionals, may well benefit people who are ill, but not ill enough to qualify for ESA. We know that there are many such people on Jobseeker's Allowance; they are particularly vulnerable to sanctions, for example. That the Green Paper does not actually discuss the support needs of sick and disabled people who are not on ESA is further evidence that it is just a smokescreen for cuts to ESA.

121. This consultation does not seek further welfare savings beyond those in current legislation. But there are ways that we can improve how the current functional assessment process for people with health conditions works, in particular in relation to employment and health support.

The "*current legislation*" is that those who are judged to be capable of work related activity, and thus capable of engagement in some form, will be paid a less-than subsistence income equivalent to Job Seekers Allowance. This will add financial stress, far greater than the already mentioned financial stress of being out of work with typical debts and financial commitments. This will cause further deterioration and reduced capability,¹¹⁶ and contribute to co-morbid conditions. This in turn will increase the burden on the NHS and move the claimant further away from employment.

The "*current functional assessment process*" doesn't work at all for people with chronic illness unless the regulations 29 and 35 are used, but the government altered these last year without recourse to legislation, in a clear attempt to reduce the number of people entering the Support Group. The questions on the ESA50 or UC50 are almost entirely about physical or mental

¹¹⁶ Mullainathan & Shafir, 2013.

functioning. There are no questions about health, which is why very ill people often do not get the only sickness benefit available to them after SSP.

The best improvement would be to consider the health of the person, the treatments they are receiving, any treatments that may be planned, their chances of recovery, the effect that their illness has on their ability to gain employment, and whether an employer would or could realistically employ the person. Despite five 'independent' reviews, the concept of long term sickness has still not been addressed, and sick people are still being refused sickness benefit.

Conversely healthy people with disabilities, such as a learning disability or sensory disability, may get the benefit, but don't get the support they need to leave benefits by entering employment.

122. In this chapter we want to explore 2 areas: the first area is whether we can improve how we assess entitlement to benefits; and the second area is the need to be able to share information more effectively across welfare and health systems. There are challenges to achieving this, but also significant opportunities for government departments to work together to share the information already available, to take the stress out of assessment processes for securing financial support and ensure we make timely, accurate decisions about financial entitlement.

There is a simple solution to improving assessment for sickness benefit: scrap the WCA, and replace it with assessment by Occupational Therapists who can determine whether a person can work in the open labour market without support for disability or illness-related needs.

There is no need to "share information more effectively across welfare and health systems". Such transfer of data would breach people's rights, particularly in regards to the high confidentiality of medical data. **Medical Data must not be shared.**

Will the claimant be forced to agree to data sharing in order to access "financial support" (benefits)? What safeguards will there be? How will a medically unqualified Work Coach understand the implications of a medical condition or interpret medical reports when they have no medical qualifications?

123. "These 2 areas of reform are important to delivering the type of personalised and effective services we know disabled people and people with health conditions, their families and stakeholders want to see. We want to hear your views about how we can best do this."

The first, replacing the WCA with a proper Occupational Therapy assessment, may be what sick and disabled people want – with certain provisos.¹¹⁷ This is in no way related to the government's bizarre belief that the amount of money a person gets determines what employment support that person gets. The government's hypothesis, which it then treats as fact, is entirely a smokescreen for the significant cut it has made to ESA WRAG.

The second area, of data sharing, is not one that sick and disabled people want to see. The public is rightly concerned about data protection. The government must stop making up hypotheses and then acting as though they are true, and in particular must stop claiming to be doing so in the name of sick and disabled people.

¹¹⁷ Benstead, 2017.

The role of assessments in determining employment and health-related support

124. Employment and Support Allowance was introduced in 2008 to deliver a more proactive approach to supporting individuals with health conditions into work, with an expectation that a significant proportion of those going through the Work Capability Assessment would be placed in the Work-Related Activity Group, where they would be offered practical support to prepare to return to work if and when they were ready. Those who were unable to engage with any type of employment-related support would be placed in the Support Group and those who were found to be 'capable of work' would claim Jobseeker's Allowance instead.

Any expectation of how many people were capable of work or of work-related activity is wholly irrelevant to the actuality of how many people are incapable. The WCA found that more people than the healthy MPs and civil servants expected are incapable of work-related activity, which says much about their understanding of chronic illness. But this is not a reason to claim without evidence that people assessed as incapable of work-related activity are in fact essentially capable of work.

The government's persistent and presumably deliberate misrepresentation of sick and disabled people and ESA must stop.

The Work-Related Activity Groups was not for people who would get support 'if and when they were ready', but for people who were capable of engaging with and benefiting from support immediately. The Support Group was for people who were not then 'ready', with dates set for reassessment in accordance with the assessor's opinion of when a person might be 'ready'. The government's persistent and presumably deliberate misrepresentation of sick and disabled people and ESA must stop.

The 'practical support' offered turned out not to be the provision of social care and timely Access to Work, including access to re-training and volunteering, but instead such irrelevant actions as updating a CV or making a list of hobbies.

125. We are already taking steps to improve the assessment process and have responded to a range of recommendations from five independent reviews of the Work Capability Assessment. Last year, the Centre for Health and Disability Assessments (CHDA) introduced a telephone support service to help individuals to complete their health questionnaire, known as the ESA50 or UC50. We are also sharing information from the Work Capability Assessment with Jobcentre Plus work coaches, to allow them to consider health conditions and barriers to work-related activity in order to better tailor support. Employment and Support Allowance and Universal Credit forms and letters are being reviewed with groups representing service users and CHDA to improve their clarity. We are revising the letter sent to GPs by decision makers when an individual is found to be capable of doing some work to encourage their collaboration and highlight the benefits of work. We are also launching an online Employment and Support Allowance claims process to give individuals and their representatives more flexibility in how and when they apply,

while also improving the quality of evidence received. We are already taking steps to improve the assessment process and have responded to a range of recommendations from five independent reviews of the Work Capability Assessment.

The recommendations from the five independent reviews have had mixed outcomes. It should be noted that not all evidence was provided (deaths and suicides) for those independent reviews, in particular from coroner's reports. The positive recommendations have to be weighed against the tightening up of the eligibility criteria.

"Last year, the Centre for Health and Disability Assessments (CHDA) introduced a telephone support service to help individuals to complete their health questionnaire, known as the ESA50 or UC50. We are also sharing information from the Work Capability Assessment with Jobcentre Plus work coaches, to allow them to consider health conditions and barriers to work-related activity in order to better tailor support."

It has long been a problem that the findings of the WCA were not made available to JobCentre or Work Programme staff, with the result that claimants could be required to take part in activities which they had been found incapable of doing. Sharing of such information must be predicated on the requirement that no Work Coach or other person can make a person take part in any activity which their WCA shows they cannot do. Even then, the flaws within the WCA and the way in which its descriptors are interpreted mean it still over-estimates individual's capacity. In reality, it takes an Occupational Therapist or experienced specialist to assess what a chronically ill person can do, and no amount of data sharing will combat a Work Coach's lack of expertise.

No amount of data sharing will combat a Work Coach's lack of expertise.

Data sharing of medical information with non-medical staff is, by definition, illegal and unethical. Permission will have to be sought from the claimant. It must be clear to the claimant what is being shared and why, and the claimant must be able to understand the consequences. Failure to agree to data sharing must not carry any penalty.

Medical evidence and medical notes are covered by data protection laws.

What type of appeal will there be if a work coach mandates, or demands the claimant to commit to a program that will not be beneficial, or may even be damaging to the claimants health? Who will be accountable for a negative outcome - such as a worsening of a claimant's health? Under the current system the assessment is managed by a private contractor. They, and their employees, are not accountable for wrong decisions. Neither are the DWP. This lack of accountability leads to additional costs of appeals, and more tragically, can lead to people dying whilst fighting for their benefits. Whatever else, nobody should be dying unsupported and in State-induced poverty.

"Employment and Support Allowance and Universal Credit forms and letters are being reviewed with groups representing service users and CHDA to improve their clarity. We are revising the letter sent to GPs by decision makers when an individual is found to be capable of doing some work to encourage their collaboration and highlight the benefits of work."

Care should be taken when communicating to GPs. The standard letter has advised GPs to not issue further Fit notes after a decision has been made. Whilst the DWP may not need the fit notes, they still have to be issued so that the claimant can have their claimant commitment tailored to suit their job search, for health and income replacement insurance and for their employer.

Encouraging GP collaboration has been attempted before, resulting in breakdowns in the patient-GP relationship as the patient feels the GP isn't considering their illness, and has no right to pressure the person back into work.

GPs do not need to be made aware of the benefits of good work for healthy people. In contrast, the government needs to be made aware of the harm of bad work, and the harm of any work for people with chronic illness who lack the capacity for consistent paid employment. Work is not a cure, and cannot be prescribed by a GP. The GP, or any other medical expert involved with the claimant's treatment, may prescribe exercise programmes or recommend alternative therapies or local community activities - if these actions are compatible with and of worth to the patient. The GP cannot highlight the benefits of work because work varies hugely, some is dangerous or damaging.

GPs are aware that often people have worked for years with a condition that degenerates to the point where work is not suitable, and that claimants have often 'downsized' work, to their financial detriment, in order to manage their condition better whilst attempting to stay in work. A GP who then suggests work is part of a cure risks not only damaging the relationship with the patient, but also harming the patient and exceeding his own professional competence.

GPs are not qualified to discuss work with an individual. They do not know what types of jobs are available, how different illnesses or disabilities impact the capabilities or capacity for the variety of work, or what support is available for people in the workplace. Nor can they mandate the provision of support from either employers or the government. They therefore cannot comment on an individual's capacity for work beyond the remit of the Fit Note, which allows GPs to confirm when a particular job is harming an individual or is incompatible with the individual's current health. GPs rightly do not want to risk harming the trust their patient has in them by giving poor advice on a topic they know little about. This would also be unethical.

"We are also launching an online Employment and Support Allowance claims process to give individuals and their representatives more flexibility in how and when they apply, while also improving the quality of evidence received."

Online claims could benefit some people, but only those claimants who have access to computers and the internet, including the scanning in of documented evidence, and are able to use such technology. The DWP should take responsibility for obtaining 'quality evidence', as per the findings of a coroner ruling on the death of an ESA claimant who dies after being assessed as fit for work.

126. However, it is clear that more needs to be done to improve assessments and ensure people are not being written off without support. At the time Employment and Support Allowance was implemented in 2008 it was assumed that less than 10% of those having a Work Capability Assessment would go into the Support Group and that, as a result of this additional support, there was an aspiration that 1 million fewer people would be on incapacity benefits (Employment and Support Allowance, Incapacity Benefit and Severe Disablement Allowance) by 2015. In practice, over the

last 12 months we have seen on average 50% of people going into the Support Group, as shown in Figure 1. While it is right that these people receive additional financial support, it was never intended that we apply a one-size-fits-all approach on accessing employment support to such a large group of individuals with a wide variety of conditions and differing prognoses.

People are not being “*written off without support*”. People in the WRAG had access to, and were often mandated to, Work Programmes, which the Government trumpeted as a success despite their poor performance and evidence of harm.¹¹⁸ Those in the Support Group could access the same

The government must respond to what people actually need, not what it wants them to need.

support if they wanted it. Those on JSA with an illness or disability could go onto Work Choice (in theory, Work Choice was for ESA recipients but in practice its criteria - that an individual be capable of 16 or more hours of work a week in 6 months’ time - ruled out the majority of ESA recipients because they were too sick). This is another example of the government attempting to trivialise the severity of the chronic illness experienced by ESA recipients by implying that they are likely to be capable of 16 hours of work within 6 months’ time.

All three groups could have seen a DEA at the Job Centre.

No one was written off. No one was disallowed support if they wanted or needed it.

The government’s aspirations and expectations have no relation to people’s needs and capabilities. The government must respond to what people actually need, not what it wants them to need.

“At the time Employment and Support Allowance was implemented in 2008 it was assumed that less than 10% of those having a Work Capability Assessment would go into the Support Group and that, as a result of this additional support, there was an aspiration that 1 million fewer people would be on incapacity benefits (Employment and Support Allowance, Incapacity Benefit and Severe Disablement Allowance) by 2015.”

The initial tender document stated that a figure of 15% was the expectation: “*Upwards of 85% of present claimants could be expected to look for work*”¹¹⁹ The fact that more people than expected were found to be too ill, sick or disabled to look for work is due to the fact that the 15% was based on the percentage who wanted to return to work, not the percentage who could return to work.¹²⁰ A large percentage, 57%, stated that their health or disability would have an impact on the type of work they could do, or affect them in work significantly. 24% reported they could do no work at all. Only a small percentage stated that their health or disability had no impact on their ability to work. The aspiration of 1 million people had no factual basis at all. It was plucked out of the air, as later admitted by the then Secretary of State for the DWP; “*...we are starting from 2.7-2.72 million. By 2015/2016 I would like to see that figure down to 1.72 million*”¹²¹

¹¹⁸ Hale, 2014.

¹¹⁹ Mulholland, H. 2006. Hutton defends incapacity benefit reforms. Guardian

¹²⁰ Beatty, Fothergill, Powell. 2008. Women on Incapacity Benefits. ESRC

¹²¹ Select Committee on Work and Pensions Third Report 2005

“In practice, over the last 12 months we have seen on average 50% of people going into the Support Group, as shown in Figure 1. While it is right that these people receive additional financial support, it was never intended that we apply a one-size-fits-all approach on accessing employment support to such a large group of individuals with a wide variety of conditions and differing prognoses.”

No “one-size-fits-all approach on accessing employment support” has been implemented. Those in the WRAG are expected, and often mandated, to engage with the Work Programmes. Those in the Support Group had the option to engage. The crux is that the Work Programmes were not effective, the providers unaware of the health of the claimants, and the support was basic and not tailored to the individual (so one size fitted no-one). However, the Government saw fit to continue to declare these programs were performing well, when they actually performed worse than if there was no mandated support at all, as under IB. (There were successful programmes – The New Deal for Disabled People[2001] had 20,400 job outcomes out of 57,800 participants¹²²)

The most successful intervention in getting sick people back to work is still no intervention.

The most successful intervention for getting disabled people back to work is still going to be the provision of social care, Access to Work and job brokers.

127. As a result of these trends, over 1.5 million people have been given the perception they do not have any capability for work and are unlikely to think about when and how they might start to prepare for an eventual return to work as a result of the Work Capability Assessment. This label may then apply for years and results in them not receiving any systematic contact with a Jobcentre Plus work coach. 69% of those in the Support Group have been on the benefit for 2 years or more: a high proportion not being engaged for a long period of time. And only 1 person in every 100 of those in each of the Work-Related Activity Group and Support Group leave Employment and Support Allowance each month.

People don't have a 'perception' that they have no capability for work - they know they are not well enough to work. It's about illness or disability, not an assumed perception. No one gives people a 'perception'. Again, the statement *“they...are unlikely to think about when and how they might start to prepare for an eventual return to work”* is an assumption. No one can state what a person is thinking, or not thinking. In fact, many sick people do look for work even when they know it is beyond them – sometimes out of financial necessity.

The result of the WCA (more correctly, the decision given after all the evidence has been considered) is more likely to bring relief to the claimant than to create false perceptions; relief that the claimant can reduce their financial worries by a small degree and focus on getting well or learning how to manage their illness. Many view the award length as a time to be spent in adjustment and recovery, because without recovery they will not be returning to work.

Some people have illnesses that will not improve over time, and consequently once they are so ill that they cannot work they are not going to return to the workplace. This is not a problem.

¹²² Bourn, J. 2005. Gaining and retaining a Job. NAO for DWP

The fact is that a huge number of people who are ill will never return to work because their illness prevents them working consistently. The labour market is a competitive place in which people who for whatever reason cannot maintain the required pace are left behind. Sick people know this from their personal experience of trying to keep working, and of their ongoing struggles in daily life even without paid work.

“This label may then apply for years and results in them not receiving any systematic contact with a Jobcentre Plus work coach. 69% of those in the Support Group have been on the benefit for 2 years or more... a high proportion not being engaged for a long period of time.”

It’s hardly a surprise that the most sick, ill and disabled people have been on the benefit for more than two years. The support group contains people who are terminally, incurably or unmanageably ill, have a degenerative condition, or have complex disabilities that create multiple barriers to work. These are people who have illnesses that will not improve over time, and consequently once they are so ill that they cannot work they are not going to return to the workplace. This is not a problem.

“And only 1 person in every 100 of those in each of the Work-Related Activity Group and Support Group leave Employment and Support Allowance each month.”

The off flow for IB was much higher. The people on ESA are further away from the job market, and are on average more sick or disabled than the IB group, because they have all been tested to higher criteria, and found too ill or disabled to work. If this thinking was taken to its ultimate extreme and ESA was given only to those with a terminal diagnosis under special rules, then none of them would be returning to work. By sifting out the ‘least sick or disabled’, as the WCA does, it sifts out those closest to the employment market, thus increasing the ‘average’ distance from the market of the remainder.

The fact that people in the Support group are finding work at the same rate as those on WRAG suggests two things:

1. The Work Programme and other interventions are not necessary, as those who are not “engaged” are as successful as those who are, meaning that the Work Programmes served no useful purpose beyond being a method of delivering sanctions;
2. The two groups are performing equally well, and this contradicts the assumption in this report that engagement with “systematic contact” improves outcomes.

128. The one-size-fits-all approach is inappropriate considering the wide range of primary conditions and needs within Employment and Support Allowance and the Support Group. Conditions in the Support Group can range from having a mental health condition (50%) to diseases of the musculoskeletal system (12%) or nervous system (7%). People might have fluctuating health conditions so they are able to engage with help one week but not the next. And survey data shows that 52% of people in the Support Group do want to work, although their health condition may be a barrier to this.

Conditions in both the WRAG and the Support Group range from mental health illness to diseases of the musculoskeletal system or nervous system. People might have fluctuating illnesses in either group. It's the severity, prognosis and level of incapacitation of the claimant that decides which group is most appropriate - not the illness. There is no use in being able to engage in employment support one week and not the next - what employer wants someone who can at best only do a few hours a week every other week? What is the point of the government mandating people to take part in activity that does nothing for them but remove the opportunity to do something productive, fulfilling, beneficial or enjoyable?

Data showing that 52% of the most sick working-age people in the UK want to work contradicts the government's unfounded perception that "*people have been given the perception they do not have any capability for work*". It's a shame that most of them won't ever be able to find an employer – or apparently a government - who can accommodate and support their complex needs, such as the need not to work when they are too ill to work.

Clearly 52% are kicking back at that particular gift of perception...

129. Alongside their entitlement to additional financial support, these people deserve a personalised, tailored, practical support service as outlined in chapter 2. For instance, someone might be unable to engage with employment support at the point they undertake their Work Capability Assessment, but at a later point they could benefit from light-touch contact with a work coach who could provide advice on the health or employment services that might benefit them.

It should be noted that "some" (who subsequently end up in the Support group) will be unable to engage with the Health and Work Conversation at four weeks, or any form of employment support at the time of their WCA. Indeed many are so ill that the DWP doesn't even consider it necessary to assess them in person, and instead make an award based on written evidence. Given that the people in the Support group are terminally ill, incurably ill, unmanageably ill, have a degenerative illness or have complex disabilities that have multiple barriers to work, and they may be awarded ESA without a face-to-face assessment at all, is it really appropriate to try to frame additional assessments as a deserved reward of "*personalised, tailored, practical support service*"?

What the most sick people 'deserve' – and need – is to be left alone to decide themselves when they need a personalised, tailored, practical support service, and not to burden them with yet another assessment they may not be able to attend. After all, 52% of them want to work, and are therefore quite capable of asking for help when they are ready.

"someone might be unable to engage with employment support at the point they undertake their Work Capability Assessment".

Yet it's proposed that these people are capable of engaging in a Health and Work Conversation at four weeks. How is it decided who can safely or reasonably participate when the outcome of the WCA isn't known, but the person is eventually awarded the Support Group? The Support Group are the terminally ill, incurably ill, unmanageably ill, people with degenerative illnesses and people with complex disabilities that have multiple barriers to work. Suggesting that these people engage in a Health and Work Conversation at four weeks is a badly thought out idea - many are simply too ill to engage at four weeks, as proven nine weeks later by the WCA.

“at a later point they could benefit from light-touch contact with a work coach who could provide advice on the health or employment services that might benefit them.”

Yes, they could. Just as they **always have been able to** do when they feel it's appropriate. A light-touch contact at a later point might be a very positive experience, as long as it's requested by the Support Group claimant, and not mandated by the DWP.

No Work Coach can provide advice on health services that might benefit a person. That is a role for the NHS and the NHS only.

Crucially, however, no Work Coach can provide advice on health services that might benefit a person. That is a role for the NHS and the NHS only. The government must stop trying to de-medicalise illness for no apparent better reason than that it disagrees with doctors that severely sick people are too sick to work.

Reforming the assessment process

130. In order to realise our ambition to ensure individuals can access personalised support while still receiving the additional financial help they need, we need to consider whether the Work Capability Assessment is the right vehicle for deciding access to personalised employment support. This process initially included a Work-Focused Health-Related Assessment to explore with individuals their perceptions about work and to identify potential barriers to employment, but this was suspended in 2010 after we identified it was not as effective as had been hoped. This means we have a single functional assessment that tries to do two things: deciding both financial entitlement and also levels of systematic contact with Jobcentre Plus. We need to consider whether this is the right approach for the future. “

The WCA is flawed, but replacing it with a Health and Work Conversation conducted by JobCentre Work Coaches would be even worse. Assessments of sick and disabled people's capacity for work must be conducted by health professionals, because such assessments unavoidably require an ability to understand medical conditions as taught through degrees and years of clinical practice.

The WCA is flawed, but replacing it with a Health and Work Conversation conducted by JobCentre Work Coaches would be even worse.

The WCA does not try to determine levels of systematic contact with the JobCentre or Work Programme; it determines the maximum level of conditionality. Employment advisers are then meant to tailor the 'support' they provide to the needs of the person – which results in sick and disabled people being sanctioned at an excessive rate¹²³ and having their health made worse by the requirements placed upon them.¹²⁴ It appears that JobCentre and Work Programme staff are even worse than the WCA at determining who is capable of what.

¹²³ Oakley, M., 2014. Independent review of the operation of Jobseeker's Allowance sanctions validated by the Jobseekers Act 2013. Her Majesty's Stationery Office.

¹²⁴ Hale, 2014.

The WFHRA failed because it was on the same day as the face-to-face WCA. Most people simply could not do both. This is because they were seriously ill, as shown by the awards they were given some weeks later, from the assessment they had had immediately prior to the work focused interview. People were found to be far too ill to benefit from the WFHRA. However, scrapping the WCA and upgrading the WFHRA to an Occupational Therapy Assessment would have been far more appropriate than just scrapping the WFHRA. What the government proposes in this paper however is to take us to an even worse system than we have ever had before.

JobCentre and Work Programme staff are even worse than the WCA at determining who is capable of what.

Again there is the spectre of ‘perceptions’. Most people hope they get well and return to work - if only to fulfil their financial obligations. No one expects to get ill, no one expects the diagnosis that ends their working lives, or destroys their careers. People anticipate getting better. People don’t usually understand about the multiple barriers to work, they simply know through their daily lives that their illness is the barrier to work, i.e. the simple inability to be well enough to go to work and complete their job and fulfil their employers expectations.

131. Instead, it ought to be possible to build a more effective approach to assessing entitlement to financial and employment support. For instance, establishing entitlement to financial support could still be decided by an assessment, but that assessment could be used solely to determine whether an individual should get additional financial support. Decisions on whether someone should engage with Jobcentre Plus or specialist programmes could then be made through a separate process. This would avoid the current situation where someone’s entitlement to additional financial support can also result in them being given no employment support.

Under the new “current legislation” people in ESA WRAG won't get any additional financial support, so the statement is really trying to smokescreen that fact away by conflating health with financial support. Everyone is entitled to employment support. This report is about denying people financial support, and suggesting that employment support will compensate for this cut.

This report is about denying people financial support, and suggesting that employment support will compensate for this cut.

When the social security system was set up, it was intended that all benefits be universal. This would ensure that people who paid in the most – the rich – did not find that they were paying into a system from which they received nothing in return. The intention was that everyone was protected against income loss, whether from lack of jobs or ill-health, by giving everyone an income adequate for social participation. This should still be the case. When a person is too sick to work, the government should pay the Minimum Income Standard to that person, regardless of the person’s other income or relationship status, in recognition that there is no value in blocking those who contribute most from benefiting from their contributions.

“Decisions on whether someone should engage with Jobcentre Plus or specialist programmes could then be made through a separate process. This would avoid the current situation where someone’s entitlement to additional financial support can also result in them being given no employment support.”

Again, everyone can access employment support. In the ESA WRAG group this may be mandated, in the Support group it is voluntary. Everyone is given employment support: the terminally ill, the incurably ill, the unmanageably ill, those with a degenerative condition, and those with complex disabilities can all access employment when they feel they need and would benefit from it. This continual denial that employment support is available to all is a lie.

There is no ‘current situation’ where financial support determines the provision of employment support. Consequently, there is no need to ‘avoid’ it.

132. For instance, trained work coaches could have discretion to make case-by-case decisions about the type of employment support a person is able to engage with. To do this effectively, they would work closely with the person, building on information gathered at early discussions such as the Health and Work Conversation to ensure they are signposted to help that is appropriate to their needs. Work coaches will be able to draw on additional advice where needed, from Disability Employment Advisers and Community Partners, and could access specialist advice such as occupational health and Jobcentre Plus work psychologists where individuals have more complex health conditions.

Work Coaches are not capable of making case-by-case decisions. They have demonstrated this by consistently placing excessive demands on sick and disabled people.¹²⁵

Having discretion about the type of support a person is able to engage with is an inaccurate way to describe the workings of a work coach. These work coaches will not know the conditions the claimant presents with, because they have no medical training. They will not be able

to understand the physical or mental limitations of the claimant, because they have no medical training. They won’t be able to remove the barriers that sick people face, because they have no medical occupational training.

The issue of the Health and Work Conversation again is erroneous - it’s already been established that the claimant themselves may be unaware of the outcome of the medical intervention they are currently receiving, or the severity of their condition. Claimants will not find it beneficial to attempt to explain their often complex circumstances, illnesses, treatments and potential treatments to a person with no medical training and clinical experience.

Work Coaches are not capable of making case-by-case decisions. They have demonstrated this by consistently placing excessive demands on sick and disabled people.

¹²⁵ Oakley, M., 2014. Independent review of the operation of Jobseeker’s Allowance sanctions validated by the Jobseekers Act 2013. Her Majesty’s Stationery Office.
Hale, 2014.

“Work coaches will be able to draw on additional advice where needed, from Disability Employment Advisers and Community Partners, and could access specialist advice such as occupational health and Jobcentre Plus work psychologists where individuals have more complex health conditions.”

This suggestion - that a non-medical Work Coach can discuss medical illness and disability with a claimant, and then repeat what they assume are the salient facts to a third party – is abhorrent. That such a third party would be prepared to discuss a patient they have never met nor spoken to is, if not illegal, then highly dubious and unprofessional.

Of course, this entire situation would be avoided if the government did what it should be doing in the first place, which is to provide trained Occupational Therapists to assess and advise sick and disabled people.

133. That important relationship with a work coach would then continue beyond the assessment, ensuring those assessed as needing the most financial support can still access the holistic health and employment support and signposting offered by and through Jobcentre Plus. Work coaches could have full discretion to tailor any employment support to each individual claimant. This approach would be truly responsive, allowing the work coach to adjust requirements and goals dependent on changes in a person’s condition or circumstances. This is particularly important for people with fluctuating health conditions, as the support available would always be reflective of their needs.

“That important relationship with a work coach would then continue beyond the assessment.”

There is no evidence that this is an important relationship. The report is trying to suggest that the relationship between the work coach and the claimant has some value - and yet we know that a non-medically trained Work Coach may actually damage the health and wellbeing of the claimant.¹²⁶ There are no safeguards suggested in this report to prevent abuse, or misunderstandings.

“...those assessed as needing the most financial support can still access the holistic health and employment support and signposting offered by and through Jobcentre Plus.”

Those who need the greatest financial support, and by this we assume those with the most complex disabilities and illnesses, are already accessing all appropriate and available health support via their GP and secondary healthcare services. This is nothing to do with the JobCentre. It is not something that can be shared with the JobCentre. The JobCentre is simply there for employment advice - which is available for all.

The term “holistic” used in this context is meaningless. A holistic health programme includes many interventions of differing natures – but prescribed work is not, and never can be, part of that.

¹²⁶ Hale, 2014.
Benstead, 2017.

A GP may suggest 'activity' but it is not in the remit of the DWP to prescribe work to sick or disabled people.

Signposting should be just that - signposting. It should have no compulsory element and no mandation or sanctioning of benefits (financial support). In fact, many good employment services, such as the Christians Against Poverty Job Clubs, refuse to let JobCentres mandate claimants to their services, because they are aware of the harm of mandated services and want nothing to do with them.

"Work coaches could have full discretion to tailor any employment support to each individual claimant."

Again and again we come back to this simple issue that the work coach is not medically trained to understand the claimant's disability or illness, and as such should NOT be 'tailoring' any mandated activity (employment support). The claimant should be deciding what support they need, as they know their limitations better than a work coach would – something the government briefly notes, and then goes on to completely ignore. Indeed, the phrase "full discretion" suggests that a work coach will decide independently what is 'good' for the claimant, without any medical knowledge or reference to the claimant's personal knowledge of his or her abilities. Any mandating of subsequent activity could be damaging to the claimant.

This is a suggestion that the work coach knows best - and that the claimant will be treated as a passive entity to be discussed and directed. This sounds like the basis for a claimant commitment where the claimant cannot alter or contribute to the commitment, and may be mandated or sanctioned, regardless of how inappropriate the "employment support" activity is – because of course the DWP and non-medical Work Coaches know better than patients and their GPs.

"This approach would be truly responsive, allowing the work coach to adjust requirements and goals dependent on changes in a person's condition or circumstances. This is particularly important for people with fluctuating health conditions, as the support available would always be reflective of their needs."

It is clear from this statement that the nature of fluctuating conditions is not understood by the writer. A fluctuating condition is usually random. A person cannot control when a health crisis will happen, or know how long it will last. The idea that a work coach can plan anything for the claimant is pure fantasy. Fluctuating conditions are conditions that cannot be managed. People cannot decide to have a multiple sclerosis relapse on a day of their choosing, or a person with cystic fibrosis cannot deduce when they will get a respiratory infection, a person with fibromyalgia cannot time when they have a flare, and a person with osteogenesis imperfecta does not choose a time to break a bone. The work coach would, as claimants do, have to wait and see what each day brings, or each hour.

It is clear from this statement that the government does not understand the nature of fluctuating conditions.

Any person who needs their 'claimant commitment' reduced to cope with flare-ups should not have had their commitment set at such a high level in the first place.

In between these random episodes a person will not be well, healthy and functioning. That is not how fluctuating conditions work. The illness varies in severity, between partially limiting to total incapacitation. That is the fluctuation. Any severity that isn't limiting and above would not be eligible for ESA.

134. This would mean that people are really offered a personalised service that takes appropriate account of their needs while still receiving the same financial support as under the current system – rather than having the offer of employment support determined by a fixed category. We would of course put safeguards in place to ensure that work coaches do not require someone to attend an appointment where this would not be reasonable.

Again - employment support is available to everyone currently. There are no rules that say a person of any mental or physical state cannot ask for help in finding and keeping a job.

There is no evidence that the work coach can create a personalised service.

There is no evidence that the work coach can create a personalised service. They are not trained in medicine, nor in Occupational Therapy. They therefore lack the necessary expertise to help people with chronic illness or disability.

Again this 'employment support cannot' compensate for the cut in financial support. Even for those who recover and find work there are a huge majority who won't, regardless of the interventions. The non-specialised interventions described in this paper will not help people to find work.

The non-specialised interventions described in this paper will not help people to find work.

135. There are a number of principles to how a new assessment approach could work which we would want to test. For instance, any assessment for financial support should draw as far as possible on existing information that has been gathered from the NHS, the adult social care system or through other benefit applications, such as from a Personal Independence Payment application, where this is appropriate and relevant. And it should still focus on the impact that an individual's health condition has on them – recognising that those with the greatest level of disability have the biggest labour market disadvantage.

It is understandable that cross-referencing of evidence could reduce fraud, however cross-referencing runs the risk of introducing data that is irrelevant to the claim, and therefore should not be used. There is also the issue of the timing of data submission - data from different benefit applications at different times, for different benefits, and assessing different needs, may conflict with more recent and applicable other data. Whilst this helps to 'build a picture' it is also an onerous and time consuming task. The data from an ESA is about sickness benefit - the lack of ability to be capable of work in the typical employment market. This is totally different to a PIP application which indicates the level and severity of a disability, and the expected additional costs of disability for transport, assistance and equipment.

An NHS report may state the illness or disability that a person has, but have no reference at all to management, the effect on the person's ability to carry out day to day tasks or the ability of the person to work.

An Adult Social Care assessment may artificially downgrade the severity of a person's illness or disability in order to reduce the cost of the support that the council has to provide. Social Care assessments in particular may be subject to many disagreements as 67% of all requests for help are turned down, and only critical and super-critical categories are supported. These categories are for those people whose lives are strongly at risk without intervention; even then, many receive very little support.

"...it should still focus on the impact that an individual's health condition has on them – recognising that those with the greatest level of disability have the biggest labour market disadvantage."

Again we have the conflation of sickness with disability. A sickness becomes a recognised disability after a year of it having a significant impact on day to day living. At the point of the Health and Work Conversation people will primarily be one or the other, because 'sick' people may legally have to be out of work for a year for it to be considered a disability.

A disabled person who is healthy is far closer to the employment market than the person who is too ill to work. The disabled person could be helped by Access to Work, the provision of social care, and the assistance of a job broker. In contrast, a sick person has to recover, which occasionally requires only time, but for long-term illnesses requires medical intervention. So one demographic is entirely capable of being helped by 'employment support', and the other depends on a well-funded NHS.

This tiresome conflation and constant interchanging of terms is entirely deliberate.

136. An assessment which only considered financial support would also align to the principles of Universal Credit, meaning that an individual would continue to receive the 'limited capability for work and work related activity' rate of Universal Credit even if they moved into work, which would taper away as earnings increased.

This is deliberately suggestive that there is some drastic change to the current system. There isn't. The WCA will still decide which group a person goes into. The only difference is that now a person in the WRAG will not get any additional financial support above the level of JSA.

"an individual would continue to receive the 'limited capability for work and work related activity' rate of Universal Credit even if they moved into work"

The statement is deeply concerning. It clearly indicates it is talking about people in the Support Group - the group judged as having a limited capability for work and work related activity. If these people have that degree of limitation then employment support can only be an offer, as it is at the moment.

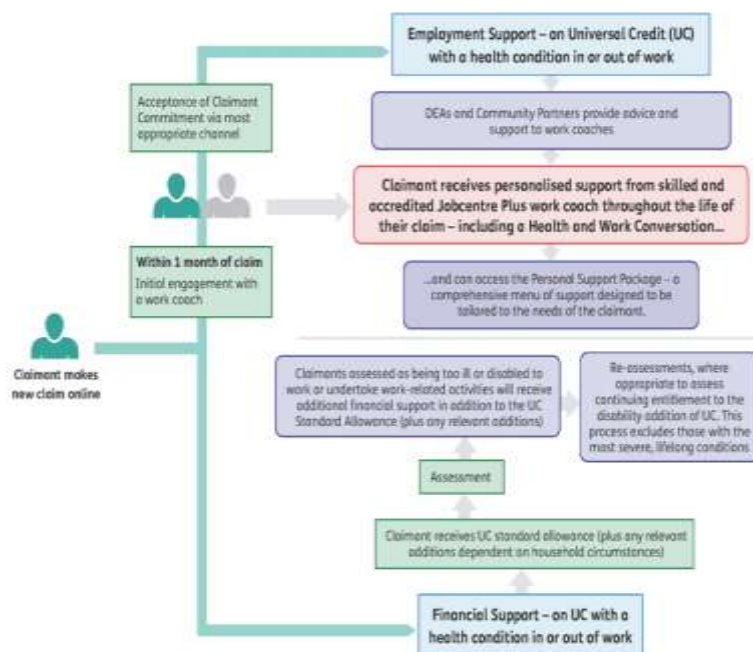
So what is this really suggesting? Is it suggesting that WRAG becomes some sort of JSA, and Support Group becomes some sort of WRA group?

There may be disabled people in the Support Group who would benefit from assistance with finding work and getting adaptations, but most people in this group are very ill, too ill for work or work related activity. Disabled people in this group are there because conditionality is more harmful than helpful for disabled people.¹²⁷

It should be noted that the tapered financial support results in less take home pay than under permitted work, less than under Disability Tax credits and, combined with the proposed loss of the Severe Disability Allowance, means people are far worse off under Universal Credit.

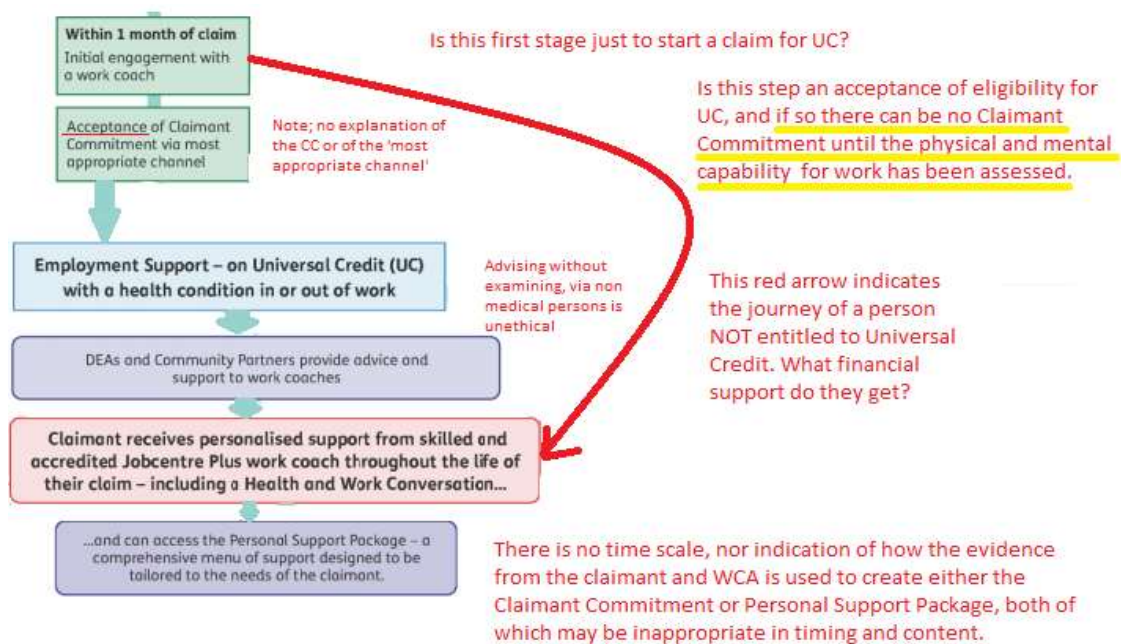
The government is persistently ignoring the reason for differences in benefit level between a jobseeker's benefit and a sickness benefit. JSA assumes that individuals will return to work quickly and therefore only need to cover basic short-term costs - no repairs or replacements of white goods, for example, and no participation in culture and social activity. ESA recognises that individuals will be out of work for longer and so need a higher level income to cover random significant expenses - such as the repair and replacement of white goods; it is however still too low to cover the cost of participating in society. The benefit level is therefore crudely associated with how long someone is likely to need it. If the government wishes to decouple the assessment of financial need from the assessment of employment support need, then the appropriate measure would be to link the level of benefit to the time away from work - raising all jobseeker's to the level of ESA after three months, for example, and having an additional raise at a later point, such as after two years' of being out of work. Dragging sick people down to the poverty that jobseekers have to endure is not an acceptable policy decision.

137. This diagram illustrates a possible model for how this proposed approach could work in future – it does not describe the current system. We would like to hear views on whether this model would work, or whether there are alternative options we should explore.



¹²⁷ Benstead, 2017.

This diagram is two diagrams of two journeys for more than one claimant type. The 'work support journey', which is also the journey for Universal Credit is shown below:



Improving the data we use to assess financial support

139. People rightly expect public services to work together with each other, and to use the information they have provided to ensure the best possible service. This is even more important for services that provide essential financial support when someone is in need, such as when they have developed a health condition, or lost their job and their source of income.

People do not expect public services to share data. They expect their personal data to be kept confidential within the service that collected it. The only 'service' that provides finance when a person has become ill is sick pay, whether occupational, statutory or social security. This service requires initially only the medical confirmation from the GP, and not any other information. For social security, a more detailed assessment is carried out, at which point medical evidence should be sought from a person's GP. At no other point is any data sharing necessary or appropriate.

140. For example, the Armed Forces Covenant helps ensure that service personnel, veterans and their families are supported and treated fairly, and recognises that special consideration is appropriate in some cases, especially for those who have given the most, such as those who have been injured. The Department for Work and Pensions uses Service Medical Board evidence where it can so a severely disabled person doesn't have to undergo additional examinations for Employment and Support Allowance purposes.

141. However, there may be opportunities to use this evidence more widely in Employment and Support Allowance and Universal Credit assessments for all members of the armed forces which would result in speedier benefit awards and a less burdensome claiming process for the individuals.

142. If a person falls out of work as a result of a health condition or disability, they might already be accessing NHS services and potentially support from their local authority such as adult social care. They might also apply for financial assistance from a range of NHS schemes, such as the Healthcare Travel Costs Scheme. In addition, they might also claim a number of benefits, including Employment and Support Allowance or Universal Credit, and Disability Living Allowance or Personal Independence Payment.

A person is very unlikely to be receiving support from NHS schemes or social care, because of how tight the criteria for these are. If a person is receiving them, they are so severely ill that it is likely that the current system of written evidence is adequate.

It is unclear what the government intends by saying that people may already be claiming ESA or UC. Is it not discussing the provision of data for assessments for ESA? In which case, information from previous assessments may be helpful, provided that any tribunal data is also included.

143. In order to receive both Employment and Support Allowance or Universal Credit, and Personal Independence Payment, people will take part in 2 separate assessment processes. Around half of those who claim Employment and Support Allowance also receive Personal Independence Payment (or Disability Living Allowance), and 64% of those in the Employment and Support Allowance Support Group claim Personal Independence Payment or Disability Living Allowance. This means that these individuals have to make 2 separate benefit applications where they often have to provide much of the same information, which might be in addition to applying to the NHS, local services or other bodies to receive specific support. For those who claim both Employment and Support Allowance and Personal Independence Payment, as at April 2016, around 70% applied for Employment and Support Allowance first.

PIP and ESA are different benefits that therefore require different information. It should be no surprise that people typically apply for ESA first; a person can apply for ESA with a short-term illness or injury, but has to have an illness or disability that has existed for at least three months and is likely to last at least a further nine to be eligible for PIP.

144. Different schemes provide financial support to meet different needs. For instance, Employment and Support Allowance and Universal Credit are paid to replace and supplement someone's income while they are out of work or in low-paid work with a health condition. However Personal Independence Payment is designed to contribute to additional costs arising from a disability. It is sometimes appropriate that individuals might receive one and not the other, so to some extent

it may be unavoidable that more than one application and assessment is required to determine eligibility for these different schemes.

145. However, where there are opportunities to share common information across processes and where information is up to date and relevant, we should reduce the burden on the individual of providing the same details over and over again should they claim both. This could also improve the accuracy of assessments to ensure individuals get the financial support they are entitled to, by making more effective use of data already held within the welfare system.

It is unlikely that any available information will be up-to-date. Even two months' difference is enough to make a change for people with deteriorating illnesses.

146. For example, subject to establishing that any data to be shared is up to date and relevant, we can consider sharing of data between the two assessments for Employment Support Allowance/Universal Credit and Personal Independence Payment. This could mean sending relevant sections of the Work Capability Assessment report to Personal Independence Payment assessors should an individual in receipt of Employment Support Allowance/Universal Credit, subsequently claim Personal Independence Payment. This could simplify the process so that once someone has provided information about their health condition to one part of the system, that information is used if they make a claim to a different benefit. This would ensure a person receives what they are entitled to without having to submit the same information again.

The government has asked this question before, when it was consulting on replacing DLA with PIP. The answer it received then was no. Asking again is unnecessary.

147. We will also explore how the assessment process could use data already gathered by the NHS or local authorities where appropriate, to ensure people do not have to repeatedly provide the same information. There are inevitably important sensitivities around how an individual's data is used, and Dame Fiona Caldicott's Review of data security and consent / opt-outs has explored how we achieve the right balance between protecting an individual's data, and using it to improve services. However, if we can strike the right balance, there is a valuable opportunity to create a more seamless journey for people with the most needs, using data in a way that improves their access to services, and promotes more integrated services.

People would prefer to provide similar information multiple times than to allow sharing of data outside of their control.

Those with the most severe lifelong conditions

148. Some people have been diagnosed with the most severe health conditions and disabilities from which they will never recover, and which require high levels of day-to-day care. People in these circumstances are likely to already have significant engagement with the NHS or social care services and in many cases they will already have had detailed and up-to-date NHS or local authority health or care assessments.

149. As these people's conditions are extremely unlikely to improve, we have recently announced that they will no longer be required to take part in reassessments and are engaging with experts to design the criteria for deciding to whom this should apply. They are still currently expected to take part in an initial Work Capability Assessment to determine if they should have access to increased financial support and to decide their access to employment support.

150. We are therefore consulting on whether we should introduce a **more appropriate process for people who have severe health conditions and disabilities**, who represent a small proportion of those in the Employment and Support Allowance caseload. For instance, we could consider whether a simpler assessment process could be developed, that means that people do not need to provide as much information as required under the current system. It may be possible to achieve this, with an individual's consent, by using data already held in the NHS to determine severity of condition and functional impact where this is appropriate. 88

These people typically already have a simpler system, because they go through on paper only.

The government's perception that people with lifelong illnesses or disabilities that will not permit a return to work is a "small proportion" is further evidence of its gross misunderstanding of the realities of people who on ESA.

151. In order to test the feasibility of this approach we will be conducting a case review exercise in our Assessment Centres to determine whether a healthcare professional could have completed a shortened assessment process using, for example, pre-existing NHS or local authority evidence such as care plans to make their recommendation. This would avoid placing any further burdens on the individual to fill in additional questionnaires or attend a face-to-face assessment to determine their eligibility. As part of this and the data-sharing work, we are also looking at wider opportunities to reduce bureaucracy and improve individuals' experiences of assessment processes.

Such a case review can only occur with the individual's agreement, because NHS and social care information cannot otherwise be shared with the DWP. More appropriate may be to simply permit a GP waiver for people with very severe illness or disability, so that they do not have to go through assessment at all.

Chapter 4 - Supporting employers to recruit with confidence and create healthy workplaces

Introduction

154. We want to create a country and an economy that works for everyone, in which disabled people and people with health conditions are given the chance to be all they want to be and employers can benefit from a large, valuable and under-used section of the labour market.

It is disingenuous to suggest that people with chronic illness and disability can all be “all they want to be”. Life does not work like that. We all have responsibilities to one another and at times have to sacrifice our desires to their needs. Sick and disabled people experience additional limitations which can unavoidably prevent them from being and doing all they want.

“large, valuable and under-used section of the labour market”.

We are not tools to be bought and sold. We are people with difficult lives.

155. Employers are important partners in this enterprise. Many are already creating healthy, inclusive workplaces and our vision is for this to become normal practice for all employers. This chapter sets out an ambitious view of what employers can do. We first consider why it is in the interests of employers to act and then consider the foundation step of embedding good practices and healthy, inclusive cultures – which will underpin our efforts to help disabled people and people with health conditions to move into, stay in, progress in, or return to work.

It should not be a vision of the government to have employers realise the benefits of a healthy workforce. It should be a legal right that workplaces do not make people ill or exacerbate illness. It is well known that high pressure, low autonomy jobs are bad for health; even so far as to be ‘toxic’. It should not be legally acceptable for employers to overwork their employees; it should not be legally acceptable for governments to not protect their citizens against exploitative working practices.

It should not be a vision of the government to have employers realise the benefits of a healthy workforce. It should be a legal right that workplaces do not make people ill or exacerbate illness.

156. We then focus on the tangible things we could do now to move towards an employment culture that recognises the contribution that disabled people and people with health conditions make to the workplace and where investment in health and wellbeing is the norm. We particularly want to know how to support, encourage and incentivise employers to adopt good practice, particularly among small and medium-sized businesses.

The government writes as though it is acceptable for them to allow employers to run unsupportive, unhealthy, discriminatory workplaces. They write of wanting to know how to “support, encourage and incentivise” employers to run what is in essence an ethical business. It should not be legal or culturally acceptable to do otherwise. If the government wanted to protect its poorest citizens it would legislate for it - ‘good’ employers would not be affected, as they would already be carrying out the now-legislated good working practices; employers who are uninterested in behaving ethically would be forced to do so - as they should.

If the government wanted to protect its poorest citizens it would legislate for it – good employers wouldn’t be affected, and bad employers would be made to change.

The case for employer action

157. Businesses drive our economy and are rightly focused on growth, productivity and delivering a return on their investments. Investing in workplace inclusivity, health and wellbeing is critical to these goals:

- employers will have access to a wider pool of talent and skills if they have inclusive and disability-friendly recruitment, retention and progression policies, and may also be able to serve their customer base more effectively;

The government speaks of chronically ill people as a ‘pool of talent and skills’ which they encourage employers to tap. But this is not the case for people who lack the health to access their own talents and skills. People who are too sick to work, or too sick for it to be reasonable for them to work, must not be treated as latent labour. The government harms us when it talks as though most people on ESA are latent labourers: it implies to the public that we do not need the support that in fact we do need; it marginalises us as unworthy unless we work; it allows the government to reduce and restrict our access to non-work income under the smokescreen of ‘helping’ us; and it hides from employers the true cost and extent of the support that those chronically ill people who could work would need in order to enable them to do so.

The government harms us when it talks as though most people on ESA are latent labourers.

- organisations that promote and value health and wellbeing benefit from improved engagement and retention of employees, with consequent gains for performance and productivity. Highly engaged employees are less likely to report workplace stress, take fewer days sick absence and make the most productive and happiest employees;

Employers have no reason to promote the health and wellbeing of people in unskilled and low-skilled jobs, because they are competing with businesses in countries with even less regard for basic human rights, because the regulations regarding hire and fire policies are very loose, and because Trade Unions are non-existent or rendered all-but powerless by deliberate government policy. This won’t change unless the government legislates for change.

- employers lose out when people go sick: 139 million sick days were taken in 2015 and the direct cost to businesses of sickness absence has been estimated at £9 billion per year. One survey put the median cost at £622 for each absent employee;

The government mentions sickness absence - but not the cost of sickness presence. It is not the leave that is the problem, but the fact that they are sick. Does the government oppose holiday leave and maternity leave as well? The focus on leave rather than illness as a cause of costs suggests that the government would like to remove or reduce non-illness leave as well.

It is not sickness absence that causes lost productivity. It is sickness, period. People work less well or cannot work at all when they are ill. The remedy is to engage in public health for prevention and to promote quick recovery. People who attend work whilst ill prolong their recovery, which can result in more lost productivity than if they had waited until they were well enough to return to work.¹²⁸ The government notes that the median cost of a sick employee is £622, but does not note the cost of sickness presenteeism. More concerning, by presenting median figures and figures for skilled employees, the government washes over the plight of unskilled workers, who typically can be hired and fired so easily that the employers have no concern about sick leave; they fire sick employees and hire fresh ones very easily and cheaply.

- the challenge will become greater as the working age population gets older – the workforce is projected to increase by roughly a million in the coming decade, with the majority of this increase in the 50 to 64 year old age group. With health conditions and disabilities more prevalent in this group, employers will increasingly need to support their employees to remain healthy and manage their conditions if they are to make the most of their skills and experience;
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Again, people in unskilled and low skilled jobs are not protected by appeals to a business case or to skills and experience. Skills and experience are not relevant for these people who have been trapped in the low pay/no pay cycle by lightly-regulated businesses and a punitive benefit system.

- by helping someone who is having difficulty in work due to illness or disability or intervening early in a period of sickness absence, employers can retain skilled employees and avoid additional recruitment costs. One study found that the average costs of replacing a worker earning more than £25,000 ranged between £20,000 and £40,000;

The government is being misleading and disingenuous about the benefits of retaining sick and disabled employees by referring to skilled employees worth over more than £25 000. They have taken the upper extreme to refer to the lower demographic. They are inconsistent with their own business policy of deregulation, which makes it easier and cheaper for companies to hire and fire. They are inconsistent with their own benefits policy, which is all based upon people earning only the National Minimum (living) Wage per hour.

¹²⁸ Ashby & Mahdon, 2010.

- in addition to being bad for employers and the economy in general, a prolonged period of sickness absence is bad for individuals – early intervention is important, the longer someone is away from work, the harder it is for them to get back to work, and the greater the risk of them missing out on all the benefits that work can bring; and
- beyond the workplace, there are benefits to employers from investing in health and disability: households including disabled people have a combined spending power of around £212 billion and we know that there is scope for businesses to better serve disabled consumers and communities and therefore capitalise on this spending power.

It is unclear what the government means by this sentence. Is the government saying that employers should employ sick and disabled people to advise them on how to make their otherwise generalist products attractive to sick and disabled people? But sick and disabled people don't necessarily have different interests in, say, clothes or furnishings, than non-disabled people. When it comes to disability-specific products, there are businesses already that specialise in these.

The government trivialises the issue of health at work by assuming that all work is at least not actively harmful in and of itself. It ignores the existence of "toxic" workplaces that actively make people ill. These workplaces are normally at the bottom of the job market, where the main 'selling point' of an employee is their ability to work fast for long hours. Unskilled and low-skilled workers have little to nothing else on which to sell themselves to employers. The unskilled nature of the work means there is little discretion or autonomy within the job; such prioritising and decision-making skills tend to be by definition higher-skilled jobs.

Unskilled and low-skilled jobs are typically competed for on the basis of productivity - who can work fastest for longest. In these sectors, 'willingness to work hard' is a frequent attribute cited on job adverts. Such employers, in a country with many workers unemployed or underemployed, have access to a substantial labour pool of people competing for any work they can get. Employers hold the power, and use it to keep wages and working conditions down. They have no incentive to invest in the health of their workforce, because they can easily dismiss a sick employee and hire a healthy one, on the grounds that the sick employee can no longer perform the job role. Sick and disabled people often have no 'edge' to offer to make the employer desire them specifically over a different, healthy person. No amount of research on the business case for employers recruiting and retaining skilled or higher professional staff will cause employers at the bottom of the market to take on less productive workers.

Action already taken

158. Employers already have to take certain actions to comply with health and safety and equality laws and the government has recently appointed Matthew Taylor to lead an independent review to look at how current regulations may need to change in order to keep pace with the growing number of people who are registered as self-employed, on zero hours contracts or in temporary work. The review will look at job security, pay and rights and it will also examine whether there are ways to increase opportunities for carers, disabled people and older people.

159. Employers can also access government support to recruit and retain disabled people and people with health conditions in several ways:

- **Disability Confident** is a campaign that challenges negative attitudes to disability and disability employment and aims to help disabled people achieve their potential. We want the Disability Confident badge to become a recognised symbol of a good employer and for the list to be published so disabled jobseekers can find supportive employers;

Disability Confident is in essence a scheme that praises companies for obeying the law. There is no requirement or even expectation for exceptional performance such as deliberately creating jobs to match a sick and disabled person, or making adjustments that are beyond what is

Disability Confident is in essence a scheme that praises companies for obeying the law.

legally termed reasonable (such as permitting a slower working pace or giving paid disability leave at full pay). In essence, there is no requirement that a 'Disability Confident' employer be an employer that provides for the main 'adjustments' of chronically ill people. As a result, sick and disabled people are unable to have any confidence in 'Disability Confident'.

The scheme brought itself into further mockery by offering the term to the first 'Disability Confident' city - Swansea. The city had done nothing to make the public environment of Swansea fully accessible to all disability types, and nor did it have a wealth of employers who went beyond 'reasonable adjustments' to employ sick and disabled people. In fact, there is no feature of Swansea to mark it out as any better for sick or disabled people than any other town or city in the UK

- **Access to Work** supports the disability-related needs of individuals in the workplace where they go beyond reasonable adjustments required under the Equality Act 2010. Last year Access to Work invested around £100 million to support over 36,000 disabled people. Additional funding announced in 2015 will mean that we will be helping over 60,000 people per year by the end of the Parliament. It has also seen a new focus to respond to those with hidden impairments like mental health conditions and learning disabilities;

Access to Work is considered one of the government's 'best kept secrets'. Instead of actively seeking ways that Access to Work funds could assist sick or disabled people to work, the government does not require JobCentre or Work Programme staff to offer its services. It cannot be used for training, volunteering or work experience, and consequently cannot be used for people to test their capacity for work and prove to not only themselves but also a prospective employer that they can sustain that level and type of work. Apart from arranging taxis, which having proven the need is speedily put in place, it is painfully slow - so slow, that sick and disabled people have to leave work or are unable to take up job offers because the support is not there when they need it. Because it is so slow, it is not possible to get Access to Work support in time for a job interview.

Access to Work has been severely limited in scope. Instead of supporting employers to take on new sick or disabled staff, the government has made it more difficult by refusing to fund certain forms of support any more. It is well known that the more barriers there are in place for employers,

the less likely they are to take on disabled staff. For example countries which place stronger duties on employers to care for their current staff are also countries where employers are less likely to take on new sick or disabled staff. But loosening the duty of employers to employees means employers are less likely to support and thereby retain staff that become sick or disabled. An appropriate response would be to place stronger duties on employers for current staff - with grants or other such assistance for small employers - whilst the government funds support for new sick or disabled staff who have moved into that job from unemployment. If an employer recruits someone from a job, the employer should be responsible for the necessary support, in order to prevent employers circumventing the support measures by taking other businesses' staff.

- **Fit for Work** provides a free, expert, impartial work and health advice service for employers and a targeted occupational health assessment for employees who are off sick for 4 weeks or more;

Fit for Work is a recent scheme to offer independent Occupational Health assessments to employers when an employee has been off work for four or more weeks. As explained elsewhere, an employee who takes four weeks off work is typically not at an early stage of sick leave (however if they had no sick pay for whatever reason, then they would be applying for ESA and being asked to a Health and Work Conversation, even though they have a job to return to). Support should be offered sooner, including for employees who are struggling in work but have not yet taken sick leave. This is particularly important given the extent of a sick-work culture in the country.

Sadly, because the Fit for Work scheme offers only an assessment, not actual provision or requirement to provide, and even that assessment is over the phone, the scheme in practice is expected to do very little. It is disappointing that, when provided with the opportunity to affect real change, the government so half-heartedly responded that it would have done better to have refrained and used the money for even a small amount of something that could work. It is even more disappointing that, in this paper on supporting sick and disabled people - the paper that the government used to bargain with its MPs concerned by the extent of social security cuts - the government merely praises itself for the existence of this service, rather than committing to investing the funds and resources that would make it really be effective.

- a **Small Employer Offer** is being rolled out to support smaller employers to create more job opportunities for disabled people and people with health conditions. Advisers based in Jobcentre Plus will work with employers to create tailored in-work support for employees, and provide advice and support for employers on workplace adaptations. Small employers can apply for a payment of £500 where employment continues for 3 months;

Without any information on the typical costs of reasonable adjustments (and necessary adjustments) we cannot comment on whether a three-month backdated payment of £500 is adequate to compensate and support small employers to take on sick or disabled people.

- the **Small Business Research Initiative** aims to solve challenges by harnessing creative ideas from business. A competition launched in October 2016 looks at

innovative ways small and medium-sized businesses can manage sickness absences and support early returns to work. A decision on successful bids will be made in January 2017.

As before, the government should not have cut financial support for sick and disabled people before it had firm plans in place for the employment support it would provide.

Embedding good practices and supportive cultures

160. We know that the right organisational culture and practices can enable more disabled people and people with health conditions to get into and stay in work. Many employers already have a strong track record in this area and we want to learn from their success and support others who need to do more. In this section, we set out the steps we will take to encourage inclusive cultures which have supportive employment practices by focusing on:

- the public sector leading by example;
- addressing stigma and encouraging disclosure;
- providing guidance and helping employers to learn from each other; and
- incentivising action and encouraging innovation.

The public sector as an employer

161. The public sector is a large employer, and we are committed to ensuring that it leads the way in developing employment practices that allow disabled people and people with health conditions to flourish. There are a number of activities already underway to support this ambition. For example:

- all central government departments provide support to help all employees to stay well and manage their health conditions at work. This support includes a variety of programmes like occupational health support, online cognitive behavioural therapy, counselling support and the Civil Service reasonable adjustments service;

The government is grossly under-representing the severity of the impact of chronic illness and disability on a person's capacity for work if it thinks that a little bit of emotional support or computer courses will make someone well. It must have a wildly inaccurate view of chronic illness if it thinks that such work-limiting illness is a problem solved by a different diet or reduction in weight.

- departments also have a variety of employee networks focused on health and disability. These are supported by senior managers and allow employees to support and learn from each other; and
- work is also underway in other parts of the public sector. The NHS employs 1.4 million people and NHS England, through its Healthy Workforce Programme is providing healthy food options, NHS health checks and voluntary initiatives such as weight watching to NHS employees. It is also working to improve recruitment of people with learning disabilities.

162. This investment has proved effective in bringing down civil service sickness rates: for example, sickness rates in the Department for Work and Pensions have fallen from 11.1 days per staff year in 2007 to 6.2 in 2016. However, it is clear that more needs to be done. Sickness absence in the wider public sector stands at 8.7 average working days lost per person compared to 6.1 in the Civil Service and 5.8 in the private sector. Just under 12% of those who work in the public sector report having a disability, compared to an overall disability prevalence rate of 17% within society overall.

The government must pay attention to the harm caused by the programmes it espouses. The civil service performance management scheme has been found to be discriminatory¹²⁹ and corrosive.¹³⁰ It is not enough to know that a scheme has led to improvement on some measures; it must be understood how that improvement has occurred, and at what cost.

163. We are committed to the public sector leading by example and will take action to:

- ensure public sector employers monitor and review their recruitment, sickness absence and wellbeing activities and take action where issues are identified. The ambition is that inclusive recruitment, tailored wellbeing and ill-health prevention activity to support and sustain people in work is the norm.

It is disappointing that the government discusses monitoring of sick leave (does this not already occur? 'Too much' sick leave is a standard reason for dismissal) without mentioning the more serious sickness presenteeism and sickness leaveism. Monitoring the sickness absence without monitoring sickness presence or the use of holiday pay as a cover for sickness serves simply to encourage employees to attend work whilst sick and continue to hide their illness, to the detriment of their health and the company's productivity.

- ensure all government departments are signed up as being Disability Confident by the end of the year. In addition, we will extend this expectation across other public sector employers over the next 12 months.

As explained earlier, Disability Confident is a scheme with little to no value.

- explore whether the use of procurement, which has been simplified and streamlined since 2015, can deliver wider objectives as well as value for money. For example, whether the Department for Work and Pensions' initiative that encourages suppliers to provide employment and other opportunities to disadvantaged groups, including disabled people, could be expanded to other government departments or employers who receive public funding.

¹²⁹ Foster, M., 14/04/2016. Performance management may be discriminating against BME, disabled and part-time civil servants, warns Prospect. Civil Service World.

¹³⁰ Dunton, J., 11/07/2016. Controversial civil service performance management to stay until 2018 "at earliest". Civil Service World.

Contracted companies should provide good quality employment, including the full and prompt provision of statutory rights, and work environments that do not place excessive pressure on employees. Employees should not be at risk of repetitive strain injuries, 'burnout', stress-related illness or excess 'wear and tear' as a consequence of their jobs. Privatisation should not be an excuse to cut costs by paying lower wages to employees in poorer working conditions.

Addressing stigma and encouraging disclosure

164. Of course any employer, whether public, private or voluntary and community sector, can only help someone start or stay in work if they are aware of a health condition or disability. Many conditions can be hidden and a person's decision to disclose a disability or health condition to an employer can hinge on a number of factors. These include the extent to which they feel able to have a conversation with their manager, whether they fear disclosure might result in stigma or discrimination and the level of support they feel their manager, employer or colleagues might give them. Broaching the subject of disability and health may feel too sensitive or off-limits for many managers and employers who fear saying or doing the wrong thing.

There is an inherent risk to the government's assumption that people currently on ESA would, if in work, have 'hidden' disorders. Chronic illness that is severe enough to qualify for an award of ESA tends to result in an individual having little capacity for work overall and an inconsistent capacity for when work can be done. The result of this would often mean that, in the workplace, a person needs rests more often than is usual; work performance might be variable; and the person may take more sick days than is typically accepted. All of this would mean that, whilst the specific cause is unknown, colleagues and line managers are likely to 'see' that there is an issue. In order to reduce bad feeling, it is important that a sick or disabled employee has access to an independent advocate who can support them in the workplace. The key issue, however, in the context of this report is the government's apparent lack of awareness - again - of how sick a chronically sick person on ESA is.

165. Yet in many instances open and supportive conversations about disabilities and health conditions will help employees and employers work together to enable someone to fulfil their potential at work, and remain in work if a condition fluctuates or develops. It is also important for employers to understand the profile of their workforce both through individual conversations and by analysing data they hold (for example on sickness absence and from worker health surveys) to plan for, and address, issues it may present.

The government has given no references for this statement. It may be true for 'many', but how many is 'many', and to what illnesses, public health conditions or disabilities does it truly apply? What does the impact of a person's job have on their worth to the employer and the possibility for retaining an employee? It is known, for example, that it is very difficult for an employer to redeploy a manual worker. What does the government expect to happen to these people – does it intend to place them on JSA without any support for getting a new career as an older, effectively unskilled worker?

166. Currently UK employers are not required to know the details about disability or sickness in their workforce. If we are to realise our ambition of a healthy UK workforce with fewer people dropping out of work because of ill health, then **we need to see all employers creating environments where employees feel able to disclose health issues and where employers act on that information to improve employee health.** We would like to hear how best employers can be supported to create environments that support disclosure and what it is reasonable to expect employers to do as regards monitoring and acting on the health needs of their workforce.

Yes, employers should be happy to talk about illness and disability with their employees. But this assumes that an employer is both willing and able to do something about it. Employers may prefer not knowing if it means they do not have a duty to carry out reasonable adjustments. Some people report that when they do disclose an illness or health condition they end up being ‘performance managed’ out of their job. It would be better to have an independent service, similar to but more developed than the Fit for Work scheme, which could advocate for sick and disabled employees and liaise with employers on their behalf, as well as monitor the actions of employers.

Providing and publicising guidance and supporting employers to work together

167. Employers may be prevented from creating a supportive culture by a lack of expertise, support or capacity. This can be a particular issue for smaller businesses, where they might be facing the issues for the first time. There is already a wealth of information about how employers can support disabled people and people with health conditions, but the extent to which it is known about, used or found useful is unknown. So we want to consider how we can bring this information together, make it accessible and support employers to work together.

As well as guidance, we want to provide more information on the business case for employers to be more inclusive for their employees and their customers. Although the evidential case for employer action on health and work is already compelling, we believe there is scope for it to be stronger still, and particularly so for smaller employers. We believe there is a case for research to build and illustrate the business case for employer action in a number of areas. These could include:

- the benefits of wellbeing, prevention and rehabilitation activities, including occupational health support for employers and others;
- the return on investment for employers who purchase income protection insurance; and
- effective recruitment methods across different disabilities and health conditions.

The government in this paper has relied heavily on the ‘business case’ for employers to look after their employees generally, and their sick and disabled employees in particular. However, in a just and true society, caring for other people should not be done based upon the gain it brings us. It should be done as a right of all people to good health and good workplaces – no-one lacks the right

to be kept from exploitation, and damaging work practices cannot be considered as anything other than exploitation.

Small employers often report that they cannot compete with large employers if they are to provide such rights as the basic right to an adequate income off which to live, enough time away from work to provide for the right to rest and leisure, and statutory rights such as sick pay, holiday pay and maternity/paternity pay. It is unlikely that small employers will find the means to pay for these simply because research indicates that, on average and in the long-term, it would benefit their business. Small employers need financial support from the government such as top-up wages for their staff and subsidies for statutory rights (via tax breaks for employers or tax credits for employees, for example), so that small businesses can afford to run without exploiting their employees. The government should support small businesses in recognition of the value of a diverse industry base for economic stability.

Employers of low skilled and unskilled workers may also not have a business case for healthy work environments. They have a ready supply of labour which they face little need to attract, due to the punitive benefits

The government needs to have due regard for people at the bottom of the labour market.

system that does not provide the option to refuse bad jobs. The government needs to have due regard for people at the bottom of the labour market, who often also have other disadvantages such as poorer access to healthcare.

168. Many organisations have recommended consolidating some of the evidence on the business case for change, as well as practical information, into a one-stop shop for employers. This could include case studies, examples of reasonable adjustments as well as running awareness sessions. We agree that there could be benefits to this and so **we will undertake research to find out what employers would find most useful in a one-stop shop on health and work.** We also seek your views on this as part of the consultation.

169. Partners have also suggested that government should be more proactive in making businesses aware of the information and support that is available to them, rather than expecting them to find it themselves. We agree, and so **we will work with partners to develop and run information campaigns on key topics around health and work to help employers access existing information and adopt good practices.** We want to hear from employers about how best to do this, for example, who employers are influenced by and how to reach different sectors.

In terms of guidance and support, access to an independent Occupational Therapy-style service, building upon the Fit for Work scheme, could allow employers to contact an independent specialist for advice on the specific needs of a current or prospective employee. Employers have previously indicated that advice specific to their situation is much more valuable than generic advice, so knowing that specialist advice was available when needed could go a long way to reassuring employers.

Realising potential

170. Seeing more disabled people and people with health conditions get into work is important but on its own it is not ambitious enough – we want to see these employees reaching their full potential, making their fullest contribution and going as far as their talent and drive can take them. Senior, executive and board positions should be within their reach.

Sick and disabled people are hindered not only in being less likely to be in employment, but also by being more likely to be in lower-skill jobs, less likely to work full-time and less likely to progress. This is despite many sick and disabled people holding Bachelor degrees or higher. The consequence is that sick and disabled people not only earn less than their non-disabled counterparts at each age, they also have a significantly lower lifetime income with severe implications for their ability to purchase the care services they likely need even more as they grow older. Sick and disabled people are thus trapped in poverty for the entirety of their lives.

Because of this, it is as the government notes important to consider the issue of career progression for those sick and disabled people who can, and do, do some work. However, it is also important and necessary to care for the people who remain at the bottom, and who face life-time poverty unless the State improves the financial and practical support that it provides.

The government must care for the people who remain at the bottom, who face life-time poverty unless the State improves the financial and practical support that it provides.

171. Evidence suggests that seeing employers have success in hiring disabled people and people with health conditions can be a powerful way of motivating other employers to act. Employer-employee networks and business-led initiatives therefore have a big role to play in influencing employers to recognise the talents of disabled employees and employees with health conditions and creating the momentum to support these employees excel.

172. Some organisations already support networks that stimulate the exchange of new ideas and good practices. The Business Disability Forum brings together business people, disabled opinion leaders and government while Purple Space focuses more specifically on employee networks, providing learning, networking and professional development opportunities.

173. Business-led initiatives can also have great influence. For example, from 2010 to 2015, the number of women on the boards of FTSE 350 companies more than doubled, following the business-led Lord Davies Review set up by Government into women on boards. The Davies Review worked with key stakeholders including businesses, investors and executive search firms, and we saw the target for 25% women on boards of the FTSE 100 by 2015 exceeded, and all-male boards in the FTSE 100 eliminated. Work continues under the new Hampton-Alexander Review, with the increased target for 33% women on FTSE 350 boards by 2020.

174. The Review created a culture change in business, with companies recognising that achieving a better gender balance at these levels will not only help to close the gender pay gap, but companies will also benefit from better decision making, accessing the widest talent pool and being more responsive to the market. Increasing the number of women at senior levels is about improving performance and productivity.

175. We believe there is much more we can do to achieve the same results for disabled people. Although representation of disabled people and people with health conditions in senior positions is unknown (noting employers are not required to collect data on this), it is reasonable to surmise that with a disability employment gap of 32 percentage points, representation at senior levels is also likely to be lacking. So we want to know what the role of employers and government should be in helping disabled people and people with long-term health conditions progress in work and secure senior roles.

The government must be careful not to conflate disability with the other protected characteristics. Many sick and disabled people do have skills that are valuable in senior positions, but it needs more than an attitude change to get sick and disabled people into such positions. It requires also a commitment to pay for the adjustments needed – including working that is so flexible that no one knows what work will be carried out when by the sick senior employee.

For people with disability that is not work-limiting, we should fully aspire to seeing these people represented proportionately in all ranks of occupation, including senior positions. But we must not forget that such ‘aspiration’ actually requires a financial commitment on the part of the government and/or employer, to provide the necessary adjustments.

176. We want to see businesses leading the way and creating the same sort of momentum as they have to increase the number of women on boards. To achieve this, **we will establish a Disability Confident Business Leaders Group who will work alongside ministers and officials to increase employer engagement around disabled employment, starting with FTSE 250 companies.**

177. In addition, we think there is scope to do more, especially among small and medium-sized employers, **to establish supportive networks between employers, employees and charities around health and work**, and would like your views on the best way of doing this.

The government throughout this paper has spoken of ‘encouraging’, ‘supporting’, ‘motivating’ employers - but not of requiring or mandating. In contrast, the social security system in its current state is one of mandating, at the threat of loss of income, those people who are so unfortunate as to not have a job. This is a massive disparity and inequality for which the government is entirely responsible. No other body can address the power imbalance between businesses and individuals; such a responsibility is one of the core reasons for having a government.

Only the government can address the power imbalance between businesses and individuals.

Incentivising action and stimulating innovation

178. We want to know whether financial or other incentives would encourage employers to try new and creative things to support more disabled people and people with health conditions in work. The reality is that in order to halve the disability employment gap, all things being equal, we need to see around a million additional disabled people in work and we want to explore how we can incentivise employers in creating new roles for disabled people and people with long-term health conditions.

The government needs to establish first what is appropriate: how many disabled people and people with long-term illness have a substantial capacity to work, such as the ability to consistently work at least 16 hours a week? These are the people the government should be focussing upon, but by not attempting to find out who these people are, or where they are, it also does not know how many people not currently working are capable of being in work if they had the right support. Furthermore, it does not know the depth or duration of support that is needed, particularly for people with illnesses that may be amenable to treatment if adequate treatment were provided.

Several financial incentive schemes around health and work and stimulating employment more generally already exist:

- to encourage employers taking action to prevent employee ill health, employers can claim tax relief on up to £500 of the cost of treatment for an employee recommended by an occupational health practitioner and can claim corporation tax relief on their premiums when they purchase income protection insurance products for their employees.
- to encourage job creation, particularly among young people, the Employment Allowance scheme allows businesses to employ 4 adults, or 10 18–20 year-olds, full-time on the National Minimum Wage without paying employer National Insurance contributions.
- a small grant promoting the employment of disabled people and people with health conditions is being trialled through the “Small Employer Offer” mentioned at paragraph 159 above. Small and medium-sized enterprises who sustain such employees at work for 3 months will receive £500 to provide on-going mentoring and support for employees.

179. We recognise that the evidence about the effectiveness of such initiatives in sustaining people in or supporting them into employment is mixed. However we believe that, given the scale of the challenge ahead of us, it is right to consider if they have a role to play.

180. Partners have suggested, for example, using financial incentives to encourage large employers to share their HR, occupational health or employee assistance services with smaller employers; or encouraging employers to provide occupational health support to their employees. Schemes like this may help build capacity among small and medium-sized employers.

The government has not provided evidence that occupational health schemes as provided by either large employers or the government's Fit for Work scheme are actually effective. It may be that a more in-depth service, such as Occupational Therapy or a multi-disciplinary centre, would be more effective. When it comes to health, the cheapest service is not necessarily adequate or appropriate.

181. More broadly, we know that employer indexes such as Stonewall's Equality Index can support changes in employer behaviours. The mental health charity Mind launched its Workplace Wellbeing Index earlier this year. It may be helpful for the Disability Confident scheme to include an index of employers on how inclusive of disability they are. We would like your views on whether there is a role for these and other incentives in helping more disabled people and people with health conditions to move into or stay in work.

Disability Confident should only apply to inclusive employers, where inclusive means employers who, amongst other things, make job roles available specifically for sick and disabled people, and who provide 'disability leave' (sick pay due to a person's chronic illness that is therefore not counted in performance management). This might best be done in partnership with specialised job brokers who have good relationships with local employers and thorough knowledge of the disability or illness of the people they serve.

Moving into work

182. A supportive inclusive culture is demonstrated in practice at 2 critical points – the recruitment of disabled people and people with health conditions, and how they are supported to stay and progress in work. In this section, we set out some existing good practice for inclusive recruitment and consider how we might improve existing government schemes to support employers to recruit disabled people and people with health conditions.

183. The Disability Charities Consortium has identified that employers who are good at recruiting disabled people consider the challenges such candidates may face and take innovative steps including offering "working interviews" and providing supported internships and apprenticeships to help disabled people gain skills and experience. Disability Confident suggests other ways of making recruitment practices more inclusive include making online recruitment more accessible and providing additional training for recruiting managers. We would like to establish what good practice employers are already taking and how government schemes can support this.

We are concerned that 'working interviews' may cause more harm than good if they are not set up with the necessary adjustments at the start. But when an employer has not yet decided to take on a potential employee, they may be unlikely to invest in adjustments, adaptations and assistive technology. The government may need to pay for those, and ensure that they are put in place quickly.

Many sick and disabled people report that if they disclose their illness or disability before an interview offer, they won't get an interview. If they report it at interview they don't get a job. If they report it during employment, they end up being 'performance managed' out of their job. Sick and disabled people need to be confident that when they apply for a job, the employer will be interested in supporting them.

184. There are already a number of government schemes that support employers or employees to manage health conditions and disabilities at work, such as Disability Confident and Access to Work. Various organisations have suggested ways in which the remit and operation of some of these schemes could be changed to support employers to recruit more disabled people and people with health conditions. We would like to hear about the ways these schemes could be enhanced to help even more disabled people move into work.

Staying in or returning to work

185. A person who falls ill in work or who has an existing condition or disability that worsens may face a critical point where the right support from their employer can make all the difference between them remaining and flourishing in work or struggling to cope and falling out of work. An inclusive culture, where health is promoted and action taken to prevent or manage ill health supports the interests of both employer and employee. Yet some employers focus on compliance with health and safety legislation without necessarily considering wider health and wellbeing.

It is not typically the case that a person faces a 'critical point'. More likely is that there has been a gradual decline into ill-health,¹³¹ sometimes from what are commonly termed 'public health' conditions, other times from illnesses that are not influenced by lifestyle. Whatever the cause, support should have been available much earlier, through comprehensive health and occupational therapy services. It is too late to wait until someone is unable to carry on working.

Again, the government must not make the mistake of thinking that every employer has a business reason to care for every employee. In a competitive, capitalist world, there simply is not a good reason for employers to care for low or unskilled employees, particularly when an employer can move operations abroad to countries that have even less care for their citizens. If low skilled employees are to be cared for, it must be the government that provides the care.

It is deeply concerning that this government has, in this paper, focussed almost exclusively on public health conditions. If the government wanted to write a paper on public health, it should have done so, and in that paper it could have talked about prevention measures, employers' role, its own role, and how to properly support people who, having developed several public health conditions, are left essentially unskilled and without the 'key skill' of speed and stamina that is needed for many low-end jobs.

A paper on chronic illness and disability should put its focus on those conditions that are not 'preventable'. It should be talking about sensory impairment and limb loss; uncontrolled epilepsy and degenerative myopathy. This paper has conspicuously failed to do this simple task.

¹³¹ Bratsberg et al., 2010.

186. A true preventative approach requires a focus on both physical and mental health and support for those having difficulty in work due to illness or those who have gone off sick. In this section, we consider:

- how employers can proactively promote health and wellbeing and preventing ill health;
- managing sickness absence and the role of Statutory Sick Pay in supporting phased returns to work; and
- how insurance products could better support employers to manage the potential costs of ill health.

Promoting health and wellbeing and preventing ill health

187. Given the time most working people spend in the workplace it should be a key place to support health and wellbeing. Investing in the health and wellbeing of employees can bring business benefits by reducing sickness absence rates and improving productivity. To be effective, initiatives will need to be tailored to the organisation, although various organisations and studies have identified several core components which positively embed health and wellbeing in the workplace. These include:

- **the right culture and leadership** such as supportive company values and standards, the right working policies and practices, a commitment to health and wellbeing at all levels but particularly among senior leaders and effective communication and consultation with employees;
- **the right physical environment** through safe and appropriate working conditions;
- **effective people management** where managers have the confidence and capacity to deal with workplace health and wellbeing issues. Where in place this has been linked with improved performance and wellbeing; where it isn't it creates pressure among those who continue to work despite illness and has been linked with stress, burnout and depression.

We return to one of the common problems in this paper, which is that low-skilled or unskilled jobs have so much competition for them that there is no reason for employers to seek to retain staff. The flaw in basing good working practice on the impact on profit is that where a business would not see an increase in profit, or would see a decrease, it is then much less likely to insist on good working practices. Good work should be a right, not an aspiration.

Good work should be a right, not an aspiration.

The government must recognise its duty to its citizens, and actively protect them from exploitative workers.

Encouraging employers to take on additional roles in public health will have no impact when employers are not even providing decent work places. There are many toxic workplaces in the UK,¹³² which the government does not mention in this report. It does not even suggest that a major

¹³² Marmot, 2010.

Equality and Human Rights Commission, 2010. Inquiry into recruitment and employment in the meat and poultry processing sector.

Jenkins, C., 13/12/2016. 'I've sacked people for sitting down': undercover inside JD Sports. Channel 4 News.

contributor to reducing work-related ill-health would be to regulate employers against the type of high-strain jobs that have contributed to the rise in worklessness due to mental illness, or due to physical strain. The government must recognise its duty to its citizens, and actively protect them from exploitative workers. No amount of public health measures at work will compensate for or mitigate the damaging practices endured by people in the low-end jobs.

188. These are not new concepts and build on the key elements of effective health and safety management. Advice and support for employers on how to embed these elements is readily available (although we are considering how we can ensure it is more effectively organised and made available) and there are many practical ways employers can support workforce wellbeing.

189. Interventions should be based on the specific health needs of each organisation's workforce and employers may find it helpful to work with their local NHS and local government to identify needs and deliver interventions. These could include initiatives like healthy food, support with weight management, stop smoking schemes or mental health or physical opportunities like cycle-to-work schemes. Employee assistance providers can also help employees with wider life issues that can impact health such as bereavement, domestic violence, debt and relationships.

Again, employers who have no interest in providing good workplaces will have no interest in caring for non-employment issues. Nor is it their place to do so. Many may find it a breach of privacy and their right to a private life to have employers inquiring into their home lives. These sorts of services should be provided universally, independent of employers or employment status, funded either directly or by government grants to successful charities.

190. As part of creating healthy workplaces employers can do a great deal to help and encourage their staff to be physically active. The physical and mental health benefits of physical activity are well established, with Public Health England's *Everybody Active Every Day* report from 2014 setting out the evidence and making a powerful case for creating an active society with active environments. The benefits of physical activity are most pronounced for those who are currently inactive. Disabled people and those with serious health conditions are much less likely to be physically active than others.

In many low end jobs, the problem is that a person is too 'physically active' – Amazon warehouse workers report walking 15 miles in a day,¹³³ and JD Sports workers report being sacked if they sat down during a shift due to exhaustion.¹³⁴ For workers that predominantly work sat down, being allowed to stand up and move away from the desk frequently is important.¹³⁵ There are many such Occupational Health matters at work, but apparently no monitoring or enforcement of even basic OH from the government.

¹³³ Cadwalldr, C., 01/12/2013. My week as an Amazon insider. The Guardian.

¹³⁴ Jenkins, C., 13/12/2016.

¹³⁵ NHS Choices: Back pain at work.

191. The government's sport strategy, *Sporting Future: a New Strategy for an Active Nation*, which the Department for Culture Media and Sport published last December, set out the benefits for employers and staff of a physically active workforce, including greater levels of staff engagement and commitment to the organisation. Government will be working with others to establish an employers' network to promote physical activity. In addition, as part of the public sector setting an example, we have established a Civil Service Physical Activity Workplace Challenge which is currently being piloted across a number of departments.

The government's sporting strategy is somewhat ironic given the bad working practices at sports factories in the UK.¹³⁶

Again, until the issue of bad working places have been addressed, public health matters will have little impact. It still remains questionable whether people want employers to be commenting on their lives in this manner. Support from outside an employer for within-employer sports groups may be more appropriate than direct employer support, but even then there has to be interest from colleagues to sustain any such programme.

192. There are various assessment and accreditation schemes available to help employers identify suitable actions to take on workforce wellbeing and standards endorsed by Public Health England. Schemes include Liverpool City Council's Workplace Wellbeing Charter, London's Healthy Workplace Charter and the North East's Better Health at Work Award. The Health and Safety Executive's Stress Management Standards also provide well-evidenced support with mental health issues.

193. We want employers to do more to promote health and wellbeing and believe there is a place for a proactive good practice information campaign. To support this, we would like to know what good practices are already taking place and seek your views on what the campaign might cover below.

The government should also be seeking evidence on bad practice, why and where it occurs, and what the government needs to do to stop it. This is a far more urgent issue than expecting employers to pay out for public health measures on the government's behalf.

194. Occupational health services can help employers promote health and wellbeing and also support employees to manage a disability or health condition at work. Although our understanding of the effectiveness of different types of occupational health support in different settings is incomplete, there is some evidence that providing such support can lead to reduced sickness absence, boosted productivity and increased employee satisfaction.

¹³⁶ Business, Skills and Innovation Select Committee, 2016. Employment practices at Sports Direct. House of Commons. Jenkins, C., 13/12/2016.

Occupational Health should be provided at the start of every person's new job to ensure that the person is set up with a workstation adjusted for them, and to explain appropriate working practices and posture. Working practices should include frequent rest breaks in which the person sits or stands, whichever is opposite to their usual workstation position, for up to five minutes. Where manual labour is involved, work should not be so high pressured that workers cannot take time to ensure they are moving and lifting with correct technique. Occupational Health advice should be available to all employees and enforceable on all employers, to prevent bad working practices like those referred to earlier.

195. There is scope for employers to be doing significantly more to provide this support in the workplace. A 2014 survey found 72% of public sector employees had access to occupational health support compared to 52% in the voluntary sector and 39% in the private sectors.

196. Of private sector employers, 80% of large employers provide occupational health provision, demonstrating their recognition of the role it can play. Yet even then awareness and usage appears inconsistent – only 65% of employees of large employers claimed to have occupational health access. In addition, only around a third who had been in work prior to claiming Employment Support Allowance reported having access to occupational health support at work.

197. Chapter 5 discusses our vision for occupational health in more detail, but we would like your views on how we can encourage more employers to provide occupational health support.

Managing sickness absence and the role of Statutory Sick Pay in supporting phased returns to work

198. Supportive absence management processes are key to helping people stay in work or return to work after a period of sickness absence. Offering periods of flexible working in particular may help people to manage or recover from a health condition. This is in the interests of employers who benefit from keeping employees in work and avoiding the costs associated with lower productivity, disruption and replacing employees. However we know that too few people return from a period of sickness absence. 45% of Employment and Support Allowance claimants who had worked at some point in the 12 months before their claim had a period of sickness absence before they left work.

Altered duties, whether reduced hours or lighter tasks, are not always easy for employers to provide, as the government's own reviews into the use of Fit Notes showed. Employers in fact reported that they disliked the fit note, because it 'raised expectations' amongst employees about possibilities for returning to work sooner. It would appear that, far from reluctant workers and misguided GPs that the government alleges are the problem, it is employers that hold employees back the most. The government needs to reconcile its current conflict between expecting employees to return to work swiftly – or not take sick leave in the first place – with its policy of low employer regulation that allows employers to continue bad working practices and not make adjustments for sick employees.

199. We know that the longer someone remains out of work the less likely they are to return. So keeping up contact between employers and employees is critical in retaining a person in employment. Furthermore, evidence shows that phased returns to work from sickness absence can see employees return quicker and stay in employment longer.

Conversations do not need to be between employer and employee. Employers have an incentive to seek a fast return to work with as little effort from themselves as possible, including requiring a person to wait until they are fully recovered. Employees feel pressure to relieve the burden on colleagues, get on with their own work burden and return to a higher income. At the same time, for their health it may be better to wait longer, or to insist upon the adjustments that would make work more sustainable and less detrimental for them. And financially, a person may prefer a return to some work over remaining on SSP for longer.

This creates a conflict between employer and employee. This cannot be properly mediated solely between the employee and the employer; the employer ultimately has the power because the employee needs the income to live, but the employer typically does not need that employee specifically. These discussions should be mediated through an independent Occupational Therapist, whose role is to promote the health of the employee, and whose recommendations are legally enforceable on the employer.

200. Some countries take the approach of mandating contact between employers and employees when the latter is off with ill health, requiring employer action to support employees back into work or ultimately to pay for sickness or benefit costs if this is not achieved. Such approaches would represent a shift to the current UK landscape with new requirements placed on employers where retention is unsuccessful, although success in sustaining these employees in work could bring gains from retained skills and experience and avoided replacement costs.

Such a shift would be welcome, to require employers to look after their employees. This may help reduce the prevalence of bad jobs in the UK, by incentivising employers to keep their employees healthy.

Greater requirements on employers to look after their employees can result in employers being even more unlikely to take on sick or disabled people. Although healthy disabled people are unlikely to need more sick leave than able-bodied healthy people, it is the case that people with chronic illness take more sick leave – because of their chronic illness. The government needs to recognise this and provide adequate out-of-work support for people with chronic illness so that they are not pressured to hide their illness from potential employers and consequently end up over-working relative to their capacity.

201. Although it is likely that many employers are already having supportive contact with their employees who are off with illness, we also know that managers can shy away from such conversations because of a lack of confidence, lack of knowledge or a feeling that it is not their role. We also hear anecdotally that some employers feel unable to have such conversations during periods they are paying Statutory Sick Pay,

or during the period specified on a fit note, because they perceive these as allowances of leave that people are allowed to exhaust.

202. We are clear that the systems around fit notes and Statutory Sick Pay should not discourage conversations between employers and employees, or the exercise of flexibilities, that support employees to remain in or return to work. We discuss the issues around fit notes in chapter 5 but believe that **we should reform the Statutory Sick Pay system so that it better encourages supportive conversations and phased returns to work.**

203. Currently, Statutory Sick Pay is paid by employers when a person does no work at all. This means that people who are low paid may be deterred from returning to work on reduced hours because they would not qualify for Statutory Sick Pay and their earnings may prove to be less than the amount provided by Statutory Sick Pay. Or alternatively it may encourage them to return to their usual hours before they are ready, potentially leading to further absence or falling out of work altogether.

204. One approach to reforming Statutory Sick Pay to allow phased returns would be that where an employee would earn less than the Statutory Sick Pay rate of £88.45 per week in returning on reduced hours, the employer would be able to 'top up' their wages to the Statutory Sick Pay level (see example below).

205. This would mean that the maximum amount of Statutory Sick Pay and/or pay spent by employers and received by employees during a period of transition back from sickness remains constant. It would also allow for an earlier, albeit phased, return to work which could be good for the employee and employer. Of course this approach would not prevent an employer from paying Statutory Sick Pay on a pro-rata basis alongside wages. In this case a person's income would reflect a proportion of Statutory Sick Pay for hours not worked, and paid wages for the period worked, potentially offering an income above the basic allowance, and a greater incentive for the individual to return to work as part of a phased return.

We agree that phased returns to work can be hindered by the cut-off with Statutory Sick Pay. As recommended, it would make sense to continue to pay a proportion of SSP to top-up to at least the SSP level. More appropriate would be to have a tapered removal of benefit, so that those people who only receive SSP (typically people in lower-paid jobs that do not provide additional sick pay) always see a financial benefit of a phased return to work. This is particularly important for people on low incomes with financial costs of commuting, who will see a drop in disposable income if their income does not increase in line with the number of days at work

206. As regards contact during sickness absence, **we would like to see regular conversations between employers and their employees who are off ill to agree steps that can be taken to support a return to work.** We seek views on what it would be reasonable to expect of employers and employees in this regard.

Sick notes already provide employers with an indication of when there is something the employer can do to enable a sick employee to return to work sooner. GPs are able to indicate that an employee could return to work via a phased return, or could return to altered duties or reduced hours. It would be useful to know what percentage of employers provide this support and, for those who don't, why not - the government's report that employers "perceive [sick notes] as allowances of leave that people are allowed to exhaust" does not logically apply to sick notes where the GP has indicated that reasonable adjustments could assist an earlier return to work. Some, for example, prefer to ask the employee to wait until full recovery rather than support a phased return to work. Thus, it does not seem that the sick note itself needs to be reformed; rather the issue lies with employers not providing the necessary reasonable adjustments.

Where employees want a phased return to work, altered duties or reduced hours, it should be legally required that employers provide these. This is especially the case for mild-moderate mental illnesses where a phased return may help build confidence without overwhelming, or a physical illness where the capacity for work is not known and requires caution. Making the sick note a legally enforceable direction document that cannot be overturned would help - a person could not legally work if they were under a sick note, so the same legislation should extend to the GP directions on a fit note.

It is not clear that the government can achieve anything for sick and disabled people if it does not either do it itself, or make it compulsory for businesses - particularly big business - to take responsibility for its role in and impact on society. Other countries do this successfully, so it is not impossible or impracticable. This may be much easier, quicker and more effective than hoping for a 'change of heart' amongst business leaders. This is particularly the case for the bottom end of the labour market. The UK is becoming increasingly dichotomous and it is unlikely that companies who compete with labour forces in parts of the world with no regard for employee health will discover a business case for looking after their own employees.

Encourage better provision by the insurance industry, and take-up by employers, of income protection insurance

207. There are various insurance policies that employers and employees can take out to support them in addressing the risks and impacts of ill health: life insurance, private medical insurance, critical illness cover or personal accident or sickness insurance. This final element can be taken out by individuals, in the form of Individual Income Protection, or by employers on behalf of their employees as Group Income Protection.

208. Group Income Protection insurance generally provides 3 elements: a financial element which pays an income to employees who cannot work because they are ill or injured after an agreed period (usually 6 months); ill health prevention programmes; and specific support for employees and the employers for example physiotherapy, mental health support and HR support.

209. The benefits of Group Income Protection to employers and their staff may vary, but analysis by the Centre for Economics and Business Research indicates that employees who have access to early intervention and rehabilitation services and use

them tend to have shorter duration long-term absences compared to those that do not. On average, the duration is shorter by 16.6%.

210. Although Group Income Protection policies have the potential to support employers to retain disabled employees and employees with health conditions, uptake is low: only 7–8% of the working population is covered by such a policy. Coverage is particularly low among small and medium-sized employers. In part this might be because some insurance providers do not offer products to very small businesses, but cost and awareness of the products are also thought to be a factor (between £250–£450 per employee per year).

The government is ignoring - presumably deliberately- the history of this country. National Insurance was brought in because it was recognised that private insurance is patchy, expensive and inefficient. There is a conflict of interest between insurers and insurees, as both want the most they can get for the lowest expense. In contrast, there should be little conflict between State and citizen, as both want the citizen to be as well and able to contribute to society as possible – albeit the State sometimes overlooks forms of contribution that aren't paid work.

Employees and employers should not be fighting for access to healthcare from insurers who do not want to pay out.

Insurers want to insure those people who are likely to have the fewest costs. Employers want to insure their most valued employees. Those employees who can afford private insurance are those with the highest wages. Thus the most insurable people are the highly paid healthy people - those who least need it. The least insurable people are those who are low-skilled, low paid, and likely to become ill - the very people who need income protection and healthcare the most. The majority of citizens cannot afford the cost individual income protection insurance

211. As this paper sets out, we want to see employers doing more to invest in their employees' health and wellbeing and to thereby reap the benefits that such investment brings. We think group income protection insurance policies have a much greater role to play in supporting employers in taking this action and **therefore want to explore why larger employers are not making better use of these products and what would encourage them to do so.**

There is a very simple reason why employers rarely use insurance for their employees: because it is not cost-effective for a competitive employer to do so. In contrast,

The government must stop just hoping that employers will pick up the tab for it.

the government does have a cost-effective mechanism for insurance, through tax and national insurance revenue. Any business case that does for an employer applies far more to the government. A government can raise taxes, and the majority of its citizens cannot go elsewhere to pay their taxes elsewhere (those that do try to do so could be blocked much more effectively by closing loopholes in tax legislation and enforcing the laws that do exist). In contrast, for a business to cover the cost of insuring its employees, it must first raise prices, or lower wages (which is not possible at the bottom of the labour market). But a business is in competition with other businesses, and cannot raise prices for an all-but identical good without losing sales to other businesses.

Instead of hoping that employers will pick up the tab for it, and ignoring the position of low skilled workers, the government should use its own powers for 'group insurance' schemes to invest in the NHS and social security. In doing so, it promotes the health of its citizens and protects them – and their children – against the harmful effects of poverty.

Of course, employers already do insure their staff – through national insurance. They might reasonably expect that having bought this insurance, the body they bought it off – the government – would then fulfil its side by providing decent, timely healthcare and income protection.

We cannot expect all employers to voluntarily purchase additional, private insurance for all of their staff; for lower paid and lower skilled staff, who are of low value and easily replaced, insurance is not worth the cost. Many employers avoid national insurance, let alone private insurance, by having their workers be 'self-employed'. Indeed, insurance schemes may typically be used to attract highly-skilled workers, rather than because they are cost-effective; the packages of insurance and sick pay and private health are inducements that are only offered to those with the highest skill sets and who are expecting the highest salaries.

Employers already do insure their staff – through national insurance.

212. Smaller employers are also important: they represent the vast majority of UK businesses and employ around 36% of the UK workforce. We are working with the insurance industry to explore the viability of group income protection insurance products for smaller employers and, if there is sufficient interest, could look at how such employers could be supported to pool resources to purchase existing products as a collective.

213. We therefore want the insurance industry to develop group income protection products that are affordable for, and tailored to meet the needs of, smaller employers, including micro businesses, and for them to raise awareness and make access to such products easier.

There already is group protection insurance; it's called National Insurance. It is the simplest, most efficient and most effective insurance possible. To make income protection dependent upon one's job - as private employer's insurance would do - is to divide society between those with good jobs, and those without jobs or in bad jobs. Yet it is the people in poverty and in bad circumstances that most need access to adequate non-work income.

When the goal is to cover everyone - as it must be - then a national or social insurance scheme is the most efficient, efficacious and effective method. Private insurance will simply result in a patchy scheme that leaves out those who most need it - the people with employers who do not care about the health or wellbeing of their employees. We cannot ask or expect business to take on the responsibility of the State.

Chapter 5: Supporting employment through health and high quality care for all

Introduction

216. By now, we hope that the case is clear that appropriate of [sic] work can have a positive effect on an individual's health and that having the right health support can have a positive effect on an individual's ability to work and progress in their career. While many factors affect a person's health and employment, in this chapter we concentrate on how people, whether in or out of work, can access the right health and social care support in the right place and at the right time to enable them to enjoy the benefits of work.

What is clear so far is that the government appears to have little to no awareness of the existence of chronic illness outside of what are typically considered 'public health' conditions; and little to no awareness of disability outside of learning disabilities; that it intends to abrogate its responsibilities as far as possible by claiming that the responsibility lies with charities and businesses; and that it intends to downgrade healthcare for chronically sick people to the provision of basic physiotherapy and CBT as delivered by Work Coaches in the JobCentre.

The government, by ignoring the existence of bad work places and chronic illness, has failed to make a good case for the benefits of good work for people in fair-good health. It has laid itself open to accusations of ignorance which undermine all of the policies it wants to bring in. We can have no faith in the government's ability to support sick and disabled people appropriately when it cannot even see the existence of anything other than mild-moderate cases of public health conditions, let alone distinguish between them and their different needs.

Much of what the government has proposed here may be appropriate for people with mild-moderate public health conditions: those who are overweight, not obese; who drink, but not excessively; who smoke, but don't have COPD or emphysema; who have back pain, but haven't taken time off work for it (bar any medical appointments); who are depressed, but only mildly so. We can't say for sure, though, because the government hasn't acknowledged that these people aren't the people on ESA, so has also failed to explain how it will identify these people for support. Furthermore, its focus on transferring healthcare away from the NHS towards JobCentres is fundamentally wrong and irresponsible, and it leaves us unable to trust any of the government's plans, however well-intended.

217. We know we still have a long way to go to ensure that people get the right health and employment support when they need it. Services do not always work well together. Decisions can be taken in isolation rather than recognising that we may have different needs at different times, and that work and health are importantly linked. This is frustrating for people who are forced to navigate complex and fragmented systems and who may miss out on support.

There is no 'health and employment support'. There is the NHS, and there is employment support. People need both, but under separate organisations, not under one umbrella. The problem is more that neither service is adequately funded, and so neither performs as well as it should or as quickly

as it should. This leads to delays, which can cause further harm. The NHS needs to be properly funded so that people can get timely, thorough healthcare. Having returned someone to adequate health – if possible – it is then time for employment services to ensure that if the cause of the illness was the workplace, then that is rectified; if it was benefit conditionality, then that also is rectified; and if a person has ongoing health problems, that support is given to help a person in their search for suitable work. During this time, a third service – social security – should be providing adequate finances without fear of deprivation through reassessment or sanction.

People who need input from multiple services (such as NHS, social care, benefits, job brokers and Occupational Therapy) may benefit from having a claimant advocate whose role is to oversee the provision of the different forms of support, to ensure that they are all brought in, and to discuss any conflicts. In practice, a conflict may be that a service won't provide what is needed, or that the government or an employer is pressing for a return to work before the person is ready or the necessary support has been put in place.

218. We also know that the health service is facing significant challenges of preventable ill health and health inequalities and variable quality of services, as set out in the NHS Five Year Forward View which set out a vision for the future of the NHS. The Five Year Forward View highlighted how important it is that we get serious about prevention, deliver the right care in the right place, and build a more engaged relationship with patients, carers and citizens.

It is irresponsible of the government to refer to the significant underfunding of the NHS as though this is a problem totally divorced from the government.

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The government discusses some increase in funding to the NHS, and some funding going to local authorities that might be better placed within the NHS, but does not discuss the severe funding restrictions that have been imposed on the NHS over the last six years. It mentions 'Sustainability and Transformation Plans', well-known to be a cover for the severe underfunding of the NHS, yet says these will improve health and care services. This is disingenuous in the extreme.

219. We want to look at health in the broadest sense and do more to encourage employers, Jobcentre Plus staff, and those working in the voluntary and community sectors to support health through promoting health, preventing ill health, early intervention and ensuring access to joined-up services. Individuals, as partners in their care, can also do more to look after their own health and manage their care. It is when these groups work together that we will see real benefits for individuals, for the health of the population, and for the economy.

The government has said nothing here regarding its role promoting health, preventing 'public health' conditions and ensuring prompt and thorough treatment by adequately funding the NHS and refraining from costly, time-consuming

All responsibility, apparently, lies upon other organisations and upon individuals who, without access to properly funded support, cannot make full use of that responsibility.

reorganisations. All the responsibility, apparently, lies upon other organisations and upon individuals who, without access to properly funded support, cannot make full use of that responsibility. The government does not exist merely to advise; it exists to protect and care.

220. In this chapter, we set out our plans to improve care and support so that it starts with the individual, and meets their health and employment needs. This isn't something government can achieve on its own – those working in health services and employment support, especially commissioners, will play a critical role – so we also want to hear how we can support and encourage the changes we wish to see.

The government appears to want to see a dramatic reduction in public health conditions without any input from itself, including in regards to the proper funding of the NHS. Those working in the NHS, it seems, have a 'critical role' but not a critical need for finance to fund that role.

Nor does the government appear to have any intention to meet people's employment needs through the provision, direct or otherwise, of enough good quality jobs for everyone who needs and is capable of work.

221. This chapter focuses on key opportunities when the right health and care support can make a difference to, and be considered alongside, an individual's employment needs. These include:

- the importance of promoting health, and recognising that work can make a significant contribution to someone's health;

Work does not improve the health of the people whom this report should be about – people with static disabilities, with chronic illness, and with severe public health conditions. Disabled people are typically in good health, the same as non-disabled people. People with chronic illness never had the kind of illness that responds positively to work. People with severe public health conditions are beyond the point where merely getting work would result in a substantial improvement in health.

The government must meet people where they are, with the support they need in that position, not where it thinks they are or wants them to be. It is irresponsible to treat severely ill people as though they have mild or moderate illness.

The government must meet people where they are, not where it wishes they were.

- ensuring an individual can access health services, which consider their employment needs, particularly for common conditions which affect an individual's ability to work – especially musculoskeletal and mental health conditions; and

Health services have no role in considering employment needs. Occupational Therapy, the profession most closely aligned to the government's idea of 'health and work', has as a key principle the recognition that 'occupation' refers to the activity in which the person wishes to engage, not to paid work or any government-imposed ideological goal. Being able to work is a natural consequence of having good-enough health. The health services have no further role, other than to advise a patient on the health-related capacity for activity.

- strengthening the role of occupational health and related professions and services, so that people's health and employment needs are considered together to help them get into, and stay in, work.

Occupational Health can have a preventative role, ensuring that workplaces follow the guidelines for healthy, non-injurious working practices. However, this would require the government to make Occupational Health a required feature of every workplace, with enforced recommendations. If a person needs their health and employment status to be considered together, then the only appropriate professional to see is an Occupational Therapist.

Support does not need to be joined up; it needs only to be available, appropriate and adequate.

Work is not a health outcome.

In general, however, the two services do not need to be united provided that both are adequately funded. If one or neither is inadequately funded, joining the two will not help.

222. For the right joined-up support to be available at each of these times, this chapter then explores how we need to create the right conditions, and reinforce the recognition across the health and care system that appropriate work can promote good health – that work is in itself a 'health outcome'.

Again, support does not need to be joined up; it needs only to be available, appropriate and adequate.

Work is not a health outcome.

Until the government addresses the problem of toxic workplaces, it will achieve nothing. Whilst work continues to make people ill, people will continue to become ill through work. This should be so obvious that it does not need saying, but the government's complete disregard of bad working practices, its role in preventing them and their impact on public health conditions shows just how far its perception is from reality.

223. Throughout this chapter is the fundamental principle that individuals are partners in their care, and that innovative approaches, including digital ones, can help people look after their health and manage their own care.

The government has not laid out any plans that would allow an individual to be a 'partner' in their care. For a person to be a 'partner', they must have free and easy access to healthcare. Instead what they face is long waiting times just to see a GP, and weeks of waiting for a referral to secondary care to come through. When a referral does come through, support may be time limited and at a lower level than is needed. Where more than one referral is made, for example to physiotherapy and to counselling, treatment may be more effective if all are provided at the same time, but this cannot happen in an underfunded NHS.

Fundamentally, for a person to be responsible for acting as a partner in their own care, they must have the substantive freedom to act on it¹³⁷ – which is not the case if healthcare is not accessible when needed.

¹³⁷ Sen, A., 1999. *Development as Freedom*. Oxford: Oxford University Press.

Action already taken

224. The government has already taken steps to support work through measures to improve health.

We have:

- put in place ill-health prevention measures including the diabetes prevention programme, national immunisation and screening programmes, and public health campaigns such as the 'One You' campaign;
- funded local authorities to commission a range of public health services to improve the health of their populations, including health checks, stop smoking services and drug and alcohol treatment services;
- invested in early intervention for psychosis, and improved access to talking therapies;
- set out plans to increase recurrent funding in primary care, including to support mental health in primary care, by an estimated £2.4 billion a year by 2020/21 and a 5-year 'turnaround' package of £500 million; and
- encouraged health and care services to plan their Sustainability and Transformation Plans on 'footprints' which bring together health and care leaders to support the delivery of improved health and care based on the needs of local populations.

Promoting health

225. Health issues can prevent people from getting into work, and fulfilling their role at work, and can be a factor in people falling out of employment or taking early retirement. But this does not always have to be the case and there are several areas where we could do more to prevent ill health or disability becoming a barrier to people achieving their potential in work and in life in general.

226. There are primarily two types of health conditions that impact on an individual's potential to participate in work and wider society:

- a long-term condition which may be fluctuating but once developed may last throughout an individual's life such as diabetes, arthritis or some mental health conditions. Some conditions, may of course, be present from birth; and
- a sudden health event like a heart attack or a broken leg where the event happens and then there is a recovery phase to either full health or a new normal for the individual.

There are more than two types of health conditions, at least in the context of this paper. These include:

- 'sudden health events' which do not have long-term impacts on the majority of people, such as minor infections or injuries;
- 'sudden health events' that lead to a long-term reduction in capacity, such as post-viral fatigue that develops into ME, or a severe heart attack that requires a reduction in activity;
- 'public health' conditions, which may be preventable, manageable and resolvable;

- chronic illness, such as auto-immune disorders and genetic disorders, that are not preventable and not curable, and typically reduce a person's capacity for activity; and
- static disability, that causes an impairment but is not a 'health' problem.

All of these can exist in mild forms that have no impact on capacity, in moderate forms that impact work-related activity and or activities of daily living; and severe forms that impact both work-related activity and activities of daily living.

The government's perception that illnesses can be divided into two groups is perhaps part of the reason why this Green Paper is irrelevant to so many people on ESA.

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227. Some conditions are preventable, or manageable, and promoting healthy lifestyles can prevent or delay conditions developing. The workplace can play an important role in promoting health, and minimising risks to health, for example through encouraging staff to take action on obesity and smoking, as set out in chapter 4. Where an individual experiences health issues, such as a sudden health event or a long-term condition, there is the potential for earlier action to support individuals better to remain active in society and participate in work to retain their financial independence and the health benefits of employment.

Whilst public health can be quite generic - smoking, drinking, diet, exercise - it is still necessary that any advice comes from a healthcare professional. People without medical training are not qualified to comment on the suitability of changes in lifestyle for an individual at that particular moment in time. For example, they cannot comment on a Crohn's sufferer who uses tobacco to alleviate her pain; a person who has gained excess weight because her MS means she struggles to exercise; an abuse survivor who uses drink to get through her life and override her suicidal impulses; a person with gut dysfunction who cannot eat high-fibre foods and struggles to eat at all. These people cannot make changes to their current management mechanisms without medical support to remedy their problems in a different way.

It is the role of the government through the NHS to invest in public health. It is not the role of employers, and nor can the government absolve itself of responsibility by attempting to pass it on to employers.

The government cannot keep assuming that work has health benefits. Work in the bottom end of the labour market can be so harmful to health that Sir Michael Marmot, in a report on health inequalities, referred to it as 'toxic'.¹³⁸

228. Preventing health-related worklessness means taking a proactive approach to engaging and supporting people to talk about their concerns about work and signposting and supporting them to access help or reasonable adjustments.

¹³⁸ Marmot, 2010.

The government must follow its own advice and take a proactive approach in providing people with independent support with which they can engage to discuss their health- and stress- related concerns with work. This may include services such as independent Occupational Therapy and Trade Unions, where people can go when they have concerns about their ability to work. Sign-posting is not endlessly appropriate; at some point, someone has to provide support, and the ultimate responsibility for such support lies with the government.

229. Clinicians, patient support groups and charities all have a role to play in supporting people with health conditions to achieve their potential. For example, simply asking about work in routine clinical consultations may open an opportunity to identify individuals who might be at risk of falling out of work due to ill health where this could be prevented. Indeed a fear of falling out of work may make a health condition worse.

The government really must stop transferring its responsibilities onto other people. The role of clinicians is to provide healthcare for their patient and to assist that patient to achieve maximum wellbeing. How that wellbeing is achieved in practice differs from person to person. The role of patient support groups is to encourage one another through shared experience and to share advice on what has or has not helped a person. The role of charities is to fulfil whatever is in that charity's stated purpose.

None of these groups have, or can have, a role of imposing a government ideological goal.

230. Helping people achieve their potential is important for everyone. For young people with long-term conditions, mental health issues and physical and sensory impairments, there are opportunities to integrate careers advice, education support and clinical management to give this group of young people the best start in life and the best chance at gaining employment.

Improving discussions about fitness to work and sickness certification

231. When an individual first becomes ill, or an existing condition worsens, their first port of call is usually their general practitioner (GP). Discussions about work and health and an assessment of a patient's fitness for work provide an opportunity for doctors to discuss ways in which a patient may be helped to stay in work by, for example, advising on workplace adjustments or a phased return to work. It may also lead to a referral to Fit for Work for patients who are off sick for 4 weeks or more.

232. The Statement of Fitness for Work, or 'fit note', was introduced in 2010 to encourage fuller discussions about work and health. Fit notes are used to support payment of Statutory Sick Pay by employers or as medical validation to make a claim to health-related benefits. The information they provide can be used by employers or work coaches within Jobcentre Plus to support a return to work.

233. The fit note has the potential to be a key tool to identify a person's needs and help them to manage their condition and stay in or return to work whilst working

with an employer or work coach. This could shorten periods of sickness absence and ultimately reduce the need for repeat fit notes, reducing pressures on GPs and potentially reducing costs over the longer term. It can also act as a prompt for the GP to consider a referral to Fit for Work if appropriate.

234. However, although over 60% of GPs agree or somewhat agree that the fit note has improved the quality of their return to work discussions with patients, and over 90% agreed that helping patients to stay in or return to work was an important part of their role, the fit note is not fully achieving what it set out to do. Although the fit note includes the option for the doctor to use a 'may be fit for work subject to the following advice', this option is rarely used.

Reporting that the fit note 'is not fully achieving what it set out to do' raises the necessary and important question of what it was the government wanted the fit note to achieve. Many people are genuinely not fit for work. The fit note necessarily refers to either the specific job a person has, or the conditionality regime of JSA, because its purpose is to provide a therapeutic exemption from an individual's contracted activity for a period of time. For that reason, it cannot be used as an 'all-work test' for that reason. Therefore, it is not unreasonable to see that GPs find a person unfit for work relative to their usual work or job-seeking activity.

The government's expressed concern over how GPs use the Fit Note, but not over how employers do, or rather don't, respond to the Fit Note implies an ideological intention: that people be assessed more often as fit for work, regardless of their actual capacity.

235. Decisions on whether a person is able, or not able, to work may be made without the recognition that many people can work with the appropriate support. This means that opportunities to influence someone's understanding around what work is possible for them to do can be lost, from the first GP consultation onwards. This increases the risk that the individual falls out of work altogether or moves further away from securing employment.

It is not the case that GPs do not recognise that 'many people can work with the appropriate support'. GPs are well aware that jobs take different forms and include a variety of roles, and that for most people work is an appropriate activity. The fit note has four clear options for reduced hours, phased return to work, altered duties and the provision of aids or adaptations. This clearly provides an opportunity for a GP to indicate that a person may not be wholly unfit for work, even if they are still unfit for their specific job in its current form.

The government's problem seems to be more to do with its ideological goal of more sick people being in work than with any evidence that GPs are not using the Fit Note properly.

The government provides no evidence that allowing a person a therapeutic break from work in a first consultation then leads to the GP continuing to sign the person as unfit for work at every following consultation. Indeed, an initial therapeutic break may help a GP to suggest at a subsequent consultation that work 'may' now be possible 'if' certain adjustments are made (bearing in mind that this does not mean that the person will definitely be fit to work in an adjusted job).

The government's problem seems to be more to do with its ideological goal of more sick people being in work than with any evidence that GPs are not using the Fit Note properly.

236. Evidence from GPs suggests that they may, on occasion, find it difficult to refuse to issue a fit note. The value of the initial discussion between a healthcare professional, individual and employers about the work an individual can do would then largely be lost, with the fit note process seen as an administrative burden rather than an opportunity to provide work and health-focused support.

GPs have a role as patient advocates, to help and not to harm their patient. They do not know the varying roles of different jobs, nor the underlying culture and working practices at a patient's workplace. Nor do they know what forms of assistance exist, and what an employer can provide or the government will provide. They therefore are able only to indicate that they don't think work will necessarily be harmful, provided adjustments are made, or that work at that time is harmful. It is the job of a trained Occupational Therapy professional to then assess what those adjustments need to be, acknowledging that a patient cannot return to work without them.

The fit note is a valuable therapeutic tool and simple to use. There is no evidence that it is seen simply as an administration task, any more than signing a prescription is.

237. We want to ensure that people are better supported to understand their health condition, treatment needs and how this might impact on their ability to work, and employers have access to information which will enable them to support their staff. That means developing a system where:

- healthcare professionals have the right skills and knowledge to provide early advice about functional ability to work and the ability to provide, or easily access, the right support so that individuals, employers and work coaches have the necessary information at the earliest opportunity to expedite treatment and support;

GPs cannot have "the right skills and knowledge to provide early advice about functional ability to work" for the simple reason that this is an entirely different profession. Some GPs have additional training in Occupational Health, but this is not the same as having a degree in Occupational Therapy. GPs are already over-burdened and underfunded for their primary purpose of providing healthcare; they cannot take on additional roles for which they are not trained.

Employers have a role because it is up to them to put in place the adjustments identified as necessary by an Occupational Therapist.

Work Coaches have no place, because they lack both medical and occupational therapy degrees and ongoing professional experience and training.

- we reinforce the beliefs of the primary and secondary care workforce that work is important for health and encourage them to take a leading role in changing behaviours – so that work becomes an integral part of an individual's life, where appropriate;

The government again is misleading the reader as to the actual problem, i.e. that many chronically ill people are too ill to work. Instead, it seeks to malign doctors as ignorant of the role of work in people's lives, and to malign individuals as having deviant behaviour. In reality, doctors know that work is harmful for chronically ill people and that bad work is harmful for everyone - key caveats to the general 'work is good' which the government appears to have missed.

- healthcare professionals feel confident to use their skills and knowledge to issue fit notes only when appropriate and make full use of the “may be fit” option that is available to them;

Doctors have a key role in their patients' lives in helping them to manage both acute and chronic illness. This is about more than just work; it is about the whole health and wellbeing of the individual. What doctors need is not a government directive to override their professional discretion, but the option to refer patients to an independent Occupational Therapy assessment wherever the doctor has reason to believe that a complete break from work is not necessary for therapeutic reasons, but further assistance is still needed to return a patient to work.

- healthcare professionals recognise the value of a referral to Fit for Work for occupational health advice and return to work support and make referrals routine for eligible patients when appropriate; and

GPs need, and want, the opportunity to refer patients to a decent independent assessment of their ability to work and the support they need in order to work (if they can work at all). This has theoretically been the role of state sickness benefits, which decide whether people have enough capability for work to go back to or look for work, or don't have enough capability for work to be expected to work. This binary distinction has proved unhelpful for decades, over-assessing some people whilst not providing adequate support to anyone. Governments, whilst claiming to want to help sick and disabled people, have instead successively cut both financial and employment support.

Doctors need a better system than the current Fit for Work service. The service is underfunded, and as a consequence most discussions are a one-off telephone conversation that results only in generic and vague advice to an employer.¹³⁹ What is needed is an in-depth Occupational Therapist who, unlike an Occupational Health, is able to advise on more than just basic changes. The Occupational Therapist must also visit the employer, to find out what the employer can do to assist the employee and what the employer needs to do to ensure that its working practices are not harming its employee's health.

Occupational Therapy can't work if it is restricted in what it can deliver. For people with job contracts, therefore, the Occupational Therapist must have the authority to require an employer to put necessary changes in place. This may overlap into Human Resources when a person needs altered hours or duties. Occupational Therapy is more than just Occupational Health, which might provide a footrest or an anti-glare screen but can't provide a Braille computer or help a person to find the most appropriate hours of work and job roles. Occupational Health assumes a job role and hours are known, and then can make basic recommendations as to what to do with them; but sick

¹³⁹ Hillage, J. et al., 2015. Evaluation of the 2010-13 Fit for Work service pilots. DWP.

and disabled people need advice primarily on what hours and roles are possible, and then how to best carry them out.

- we continuously learn about people's health and employment needs so that we can gather evidence and target future investment and support in the most effective way.

238. The government intends to review the current operation of the fit note, and in line with the General Practice Forward View published in April, review whether fit note certification should be extended from doctors in primary care and other settings to other healthcare professionals. The review will look at the current system and whether it meets the needs of its users – doctors and other healthcare professionals, employers, patients/claimants and the benefits system.

Mental health and musculoskeletal services

240. Too many people with mental health or musculoskeletal conditions fall out of work each year, many end up on sickness benefits and few return to work. Individuals with such conditions represent 62% of people claiming Employment and Support Allowance, huge cost and unfulfilled potential.

The language the government uses has a huge impact on the perception given to the reader of what the problem is. This language says that people with mental illness or musculoskeletal problems are able to work and should work. Phrases like 'too many' and 'unfulfilled potential' imply that leaving work was not necessary or right. But who is judging what 'too many' is? How is it judged? Paget's disease, osteogenesis imperfecta, fibrodysplasia ossificans progressiva, scoliosis and the Ehlers-Danlos Syndromes are all musculoskeletal conditions. Schizophrenia, multiple personality disorder, emotional instability disorder and suicidal depression are all mental health conditions. This is a huge diversity of illnesses, none of which are suitable for the generic, relatively low cost approach that may help people with mild-moderate back pain or depression.

It is not appropriate to talk about these people as a "huge cost". These people cannot help having limiting illness or disability. They must not be made to feel that they have no worth because they are not economically productive units.

241. A key factor which could help address this problem is timely access to support. Evidence shows that offering early support to individuals, including people with a health condition or a disability, can improve their chances of getting back to work. Yet too often services for people with common conditions are not available when an individual needs them.

People need quick access to good healthcare, but the NHS cannot afford this in its underfunded state. This is the case regardless of whether the person suffers from a common condition or an uncommon one.

People need workplaces that are healthy and that do not consist of high pressure, low autonomy, insecure

People need quick access to good healthcare regardless of whether their illness is common or uncommon.

work. People who have illness caused by the workplace need government legislation that is enforced to protect their rights and to stop damaging working practices. They need Occupational Therapy to help them manage their work as best they can, and Occupational Health to ensure that workstations and working practices are not physically detrimental. People being bullied or badly treated by other employees, whether managers or not, need advocates to support them.

These are the services that all people need, before they become ill, so that they know they have access to support as soon as a problem starts and before it causes long-term harm.

Mental health services

242. Almost 1 in 5 working age people have a common mental health condition in England rising to almost 1 in 2 among people on out-of-work benefits. There are around 1.8 million out-of-work disabled people of working age with a mental health condition in the UK. Mental health conditions are the most commonly reported primary conditions among the total 2.4 million people who claim Employment and Support Allowance; around 1.2 million cite a mental health condition as their primary health condition but many of them may not be accessing the support that might help them. Having a mental health condition is also associated with many physical health conditions. The Work, Health and Disability Green Paper Data Pack which accompanies this paper provides more information about the population with mental health conditions.

243. As the Five Year Forward View for Mental Health sets out, the evidence is clear that improving outcomes for people with mental health problems helps them to improve wellbeing and build resilience as well as reducing premature mortality, but service provision can be patchy and access difficult.

This is tautologous. It essentially amounts to saying that treating people with mental illness results in improvements in mental health.

The patchy, inaccessible mental health service is due to the funding commitments and priorities of governments. It is therefore down to this government to remedy it, not the NHS to do even more on the inadequate money it has.

244. The increasing access to psychological therapies programme has been successful in increasing access to NICE-approved treatments for common mental health conditions. But there is variation across England in terms of access to these talking therapies.

IAPT has been much criticised for its low success rate. It has a high drop-out rate. Of those that continue to the end, very few see a 'reliable recovery'.

IAPT is not appropriate for everyone. It is specifically designed for people with mild-moderate depression or anxiety. These are not the people on ESA. People on ESA for mental health reasons either have a different mental illness, or have depression/anxiety that is so crippling that they have been found to be unable to work.

Programmes that attempt to modify people's perceptions of their situation when their situation is genuinely bad are Orwellian and inappropriate.

IAPT is not an adequate service. It uses low-trained 'psychological wellbeing practitioners' able to offer only low-level CBT to people with mild or moderate depression or anxiety. There is a high drop-out rate, and apparently no data on the outcomes for these people. People who do receive the service are clinically no better 18 months later than people who do not. CBT, let alone at a low level from a single-method, lowly-trained person, is not appropriate for many conditions. In particular, it is not appropriate for people whose low state of mind is a rational response to a negative environment; for these people, it is the environment they are in that needs changing, not their thoughts regarding their situation.

Programmes that attempt to modify people's perceptions of their situation when their situation is genuinely bad are Orwellian and inappropriate.

245. The government will further **increase access to psychological therapies** and improve how these services join up with other services. By 2020/21, at least 25% of people (or 1.5 million) with common mental health conditions will access services each year. Alongside this we will consider how individuals at risk of job loss or recently unemployed can gain early access to talking therapies to prevent worsening health and drift away from the labour market.

If everyone is prioritised, no-one is prioritised. We cannot tell people who are long-term out of work that they are less worthy than those recently unemployed. We cannot tell people not at risk of immediate job loss that they do not need treatment for an illness until it has become so severe that they are at risk of immediate job loss.

Healthcare should be available to everyone, at the point they need it, regardless of their employment status and likelihood of moving swiftly into work.

Are we going to tell cancer patients that we will only treat them if and when it makes a substantial difference to their employment status? Or dialysis patients that they have to wait in a queue behind the recently unemployed, essentially putting them further and further away from treatment the longer they wait? Would we refuse to save the life of a homeless person because we think it isn't worth the cost, given the low likelihood of a quick entrance to employment following treatment?

Healthcare should be available to everyone, at the point they need it, regardless of their employment status and likelihood of moving swiftly into work.

246. We are **more than doubling the number of employment advisers in talking therapies** to help people in that service retain, return to and secure employment. This will be a significant boost to the talking therapies workforce and ensure many more services have a clear employment offering that can improve pathways between employment services and talking therapies services. We are evaluating the impact of this provision and the elements that bring greatest results. We also have a number of trials underway to identify new and innovative ways mental health and employment services could support people to return to work.

People with mental illness are vulnerable to pressure. Healthcare must remain a safe place for them, where they feel free to discuss whatever they are thinking and feeling without an imposed goal from a government agency of returning to work.

Employment advisers must not be combined in location with counsellors and other mental health professionals. Many people with mental illness already feel vulnerable, particularly in relation to people considered to have some form of authority or power over them. Therapeutic relationships require a safe environment and a degree of trust in the therapist; this cannot occur if there is overt pressure to get into work as fast as possible.

The government says that increasing the number of employment advisers in talking therapies “will be a significant boost to the talking therapies workforce” - are they saying that employment advisers will be retrained as counsellors or psychologists? A lower level of training would not be appropriate to discuss mental health with people with severe mental health conditions. No level of training would be compatible with imposing an external goal upon a patient.

Research has shown that people with mental illness need the expertise of both a Community Mental Health Worker and a specialised mental health employment support worker. A generalised employment support worker who has either retrained as or works alongside a low-level counsellor is neither appropriate nor adequate.

The goal for a doctor is, as far as possible, the improved health and improved well-being of their patient, however that may be achieved. It is not for the doctor or government to tell people that work has to be a goal, let alone the prime goal.

The goal for a doctor is, as far as possible, the improved health and improved well-being of their patient, however that may be achieved. It is not for the doctor or government to tell people that work has to be a goal.

247. The talking therapies programme has demonstrated that we can collect and publish extensive data about outcomes. Such data is an important driver to improve outcomes. We would like to see this go further, with data on employment status routinely recorded and published as a matter of course across all mental health services.

Musculoskeletal services

248. Over 32 million of the 139 million working days lost to sickness absence in 2015 were due to some form of musculoskeletal condition, and around 2 million of the 3.8 million working age disabled people out of work suffer from some form of musculoskeletal condition which may be associated with other health conditions. 309,000 of the total 2.4 million people on Employment and Support Allowance report a musculoskeletal or a connective tissue condition as their main disabling condition.

There are many, varied forms of musculoskeletal problems. There are idiopathic back pains, caused often through the strain of manual work or sitting for too long at workstations. This may be considered a ‘public health’ condition where the prevention is for the government to regulate

against damaging working practices, and provide Occupational Health support for all businesses so that employees are properly supported to look after themselves.

There are conditions that cannot be cured, such as osteogenesis imperfecta and Ehlers-Danlos Syndrome. These can be managed as best as possible. There are conditions that may be managed in some people, and crippling in others, like the various forms of arthritis. There are unexpected injuries that never completely heal.

The government must bear this in mind whenever it develops 'plans' for people with musculoskeletal conditions. It is not possible to form 'plans' that work for everyone. It must be tailored to each person – which means have a system so comprehensive and thorough that no-one falls through the gaps.

249. Despite the impact on individuals of musculoskeletal problems, some evidence suggests that waiting times for musculoskeletal services can vary from between 4 to 27 weeks depending on where the person lives, and Arthritis UK highlighted in their 2014 report that only 12% of people with musculoskeletal conditions had a care plan. This is unacceptable, when we know that earlier diagnosis and treatment of musculoskeletal conditions would, in many cases, prevent further deterioration in the condition and enable the individual to stay in work.

In an important paper such as this one, the government should not simply acknowledge that people do not get fast-enough access to healthcare. It should find out the prime cause of this – inadequate funding – and commit to provide adequate funding, including measures to attract back to the UK those medical professionals who have left to get better quality jobs.

250. We are supportive of new ways of providing musculoskeletal care, which are being developed in a number of local areas. These include physiotherapists working from general practice surgeries and self-referral to musculoskeletal services. These have benefits of affording patients wider access, lowering levels of work absence and empowering patients to self-manage their care.

251. A preventive approach and encouraging early self-care and exercise is often appropriate to avoid over-medicalising some conditions for which the best treatment may be self-care and a return to normal activities, often including work, with workplace adaptations where needed.

The government complains about 'one-size fits all' for people in the Support Group, even though for many people leaving them be (from an 'employment support' perspective) is the best thing the government can do. To attempt to address the wide variety of mental health conditions and musculoskeletal conditions in a few short paragraphs is even worse.

For many people, 'encouraging' early self-care, exercise and a return to work is not enough. Whilst they may be capable of work if they take early self-care and exercise, there may be co-morbid conditions, including mental health conditions, which make this difficult for them. For such people, a combined physiotherapy and counselling (not IAPT or CBT) course may be what they need to get the most out of their physiotherapy and to support a sustained return to work. However the work they

normally do may still need modification, such as less lifting, less heavy loads, less time on their feet or less time sat down without moving away from the workstation.

The government needs to look at ways to support people who are approaching retirement age and have predominantly worked in physical jobs. These people cannot easily change into desk-based jobs, because these are not the skills they have. But as they get older, the wear and tear of a physical job takes its toll, and they may not be able to continue in their previous line of work, or may need to take reduced hours with some form of top-up income. The government needs to give serious consideration to how to support its ageing manual workers; the conditionality regime of JSA for people who have paid in all their lives but now have nowhere to go is simply unfair, unjust and inappropriate.

Many other people do not have musculoskeletal conditions caused by their form of work. They simply have musculoskeletal conditions. Ehlers-Danlos Syndrome, osteogenesis imperfecta, spina bifida, systemic sclerosis, ankylosing spondylitis, systemic lupus erythematosus and myopathy are all 'musculoskeletal conditions'. But they can be severely disabling, and 'self-care, exercise and an early return to work' is not helpful advice. The government should make explicitly clear about whom it is speaking in order to avoid giving the impression that it thinks people on ESA have mild-moderate, common, idiopathic back pain which the person concerned should have prevented.

252. NHS musculoskeletal services need to link better to work and people's needs for employment support. Initial assessment and access should include an integrated assessment of health and work needs. This may not always be best provided by a GP, who may not have the time to give the work-related support needed, but they should be able to refer to other professionals or services which can help.

As the government notes, employment support should not be provided by a person's GP – not merely because the GP does not have time but because, even if the GP did have time, he or she is not trained to give employment support.

No healthcare will be effective if the employment practices that caused the problem are not changed.

NHS services do not need to link better to work. They simply need to be in place when a person needs them. If the government wants a link to work, then it needs to provide Occupational Therapists, in this case trained in musculoskeletal conditions, to make that link. But no healthcare will be effective if the employment practices that caused the problem are not changed. And the government has given no indication of any intention to make employers correct bad working practices.

253. As well as encouraging the new types of provision already being developed, we wish to **trial new kinds of approach for musculoskeletal services so that people's health and employment needs are met in the best possible way**, including the further development of community based pathways and developing better links between treatment and employment support. This will include exploring different referral routes, including how Jobcentre Plus staff can refer claimants into services.

JobCentre staff do not have a role in referring people to healthcare. It is for GPs to diagnose, as far as possible, the best secondary service to refer the patient to. For example, what may appear to a JobCentre staff member to be 'simple' back pain, may in fact be a tumour that needs picking up as quickly as possible. What looks to the JobCentre staff member to be a problem with dexterity and clumsiness may be the onset of Multiple Sclerosis. What a JobCentre staff member thinks is age-related stiffness may be the start of Parkinson's. Patients should attend their GP surgery, not the JobCentre, for medical advice.

Patients should attend their GP surgery, not the JobCentre, for medical advice.

254. There is also a lack of detailed information about what kinds of musculoskeletal services are currently commissioned, and the extent to which the services meet local need. The government will therefore work with NHS England to **identify opportunities for regular collection of data** about incidence.

Tailored and integrated work and health services

255. Occupational health and vocational rehabilitation, consisting of physiotherapy and occupational therapy, and related professions and services, can play a pivotal role in supporting people to get into work, and preventing them from falling out of work due to health reasons or disabilities. Offering the right support at the right time can make a real difference to people's ability to manage their condition and continue to play their part in society.

The government may find that there is no 'right time' so much as an ongoing period, from prevention to full, irremediable incapacitation. At any point along that scale, support could have made a difference; the cost of that support, and the length of time it is needed for, increases as one heads towards permanent harm. It is not enough for the government to provide support after harm has become so great that a person has been unable to work for four weeks. There must be access to support that is of such quality and timeliness that people believe it will make a difference, and therefore attend of their own accord.

256. However, occupational health and related services are currently variable and fragmented. Provision can be inconsistent, not easily accessible for all, and not well tailored to the different needs of individuals.

The provision of 'tailored' support is completely dependent upon the skill and discretion of the medical professional. Less skilled professionals, for example Psychological Wellbeing Practitioners, are less able to 'pick and choose' between the advice, treatment and therapy they might provide. Partly this is a lack of knowledge; only being trained in low-level CBT, for example, prevents a person from being able to help their patient via Acceptance and Commitment Therapy, Gestalt therapy or Transactional Analysis. Partly it is a lack of skill in diagnosis, along the lines of Maslow's maxim: when all you have is a hammer, every problem looks like a nail. A person who has trained to provide only a limited range of treatments lacks the sophisticated knowledge to know the difference between 'common' musculoskeletal conditions and the onset of MS or Parkinson's, or the growth of a tumour. A person who has trained only to provide CBT will, upon meeting a patient with a history of

physical or sexual abuse, be at grave risk of opening a 'can of worms' which he or she is wholly unable to 'put back in again' before the end of that session.

257. Some employers, particularly larger organisations, do provide some occupational health support, but this is not universal. Survey data suggests only 51% of employees have access to occupational health through their employer which can vary depending on their size. There is also no standardised approach to the support that is offered.

Occupational Health, where provided, may still be inadequate. It may be perceived solely as a source of stress, as a person with an external goal of getting the employee back to work as fast as possible. When problems with this goal arise, such as an employee not being able to keep pace with the OH's timetable, the employee may then be referred on to Occupational Therapy – so why wait until a problem arises? Occupational Therapy at the start could have removed the stress and ensured a programme of increasing activity that matched the individual's idiosyncratic path to recovery.

The key to success, with any programme, is to ensure that the professionals employed within it have the necessary training, ability and experience to be able to look for, identify and respond to the differences inherent in each and every person, no matter how 'common' their presenting problem is.

258. For people who cannot access occupational health services through an employer, provision is patchy. Elements of occupational health provision such as physiotherapy are provided by the NHS, but services are rarely commissioned specifically for work-related health. There is a great deal of variation in the types of services available, where they are offered, and how many people can access them.

259. There is also a shortage of health professionals with occupational health expertise. In 2016, The Council for Work and Health highlighted that the UK is short of over 40,000 of the full range of occupational health related specialist practitioners, and the situation will only get worse – "recruitment into specialist training is inadequate and will not replenish the existing workforce". Dame Carol Black's 2008 review raised concerns about a shrinking workforce, a lack of good quality data, and a detachment from mainstream healthcare.

The government has not at any point identified to which professionals it is referring when it says 'Occupational Health'. Is it referring to Occupational Health nurses, Occupational Health doctors (who clearly have a greater knowledge base, and therefore expertise, than OH nurses), or some other form of Occupational Health professional? In paragraph 255, the government spoke of "vocational rehabilitation, consisting of physiotherapy and occupational therapy." Is this what it means by Occupational Health? For people who have already had to take four weeks of leave from work, 'vocational rehabilitation' is likely to be far more appropriate than 'occupational health', because it is that much more of a skilled profession – and we already know from mental health

support that 'dedicated vocational specialists', as well as specialised mental health care workers, are necessary to get even a third of participants into work.¹⁴⁰

260. The government established the Fit for Work service to support employees who are off sick for 4 weeks or more. We want to explore how we can promote referrals to occupational health services and advice.

Transforming the landscape of work and health support

261. This government is determined to transform the landscape of occupational health and related services. Provision needs to respond more closely across the spectrum of need, including the needs of those who are self-employed or out of work, as well as those who are currently off sick from work.

262. Our vision is of a whole person approach to occupational health and related services, which meets the differing needs of individuals. We want to cover:

- integrated, expert and impartial advice that meets the needs of the 'whole person', through an approach that covers work-related health and social issues to support the individual, employers, GPs, work coaches and other professionals, delivered in an equitable and accessible way (perhaps through local commissioning and provision); and
- timely and appropriate access to support (such as occupational health and vocational rehabilitation) adjusted according to need, and whether someone is employed or not;

We agree with the sentiments expressed in paragraphs 261 and 262. We agree that healthcare, including occupational therapy, needs to be able to respond to the needs of the patient, as can only occur when the NHS is adequately funded and thus able to offer a comprehensive range of treatments and therapies from expert medical professional. We agree that advice needs to be expert, and that it needs to be independent of both an employer and the government. We agree that healthcare needs to be timely, in all areas, so that a person with multiple needs is not held back by being unable to access different specialities where they impinge on a related issue. We agree that there are many other issues influencing an individual's life, which can include problems at work, damaging workplaces, relationship problems, financial difficulty, substandard housing and problems with neighbours. People need to be able to access support for the full range of problems they may experience in their life, provided independently of the government and of employers.

People with chronic illness and disability need a range of support types, both in their daily lives and at work. They may also have other needs, unrelated to their illness or disability, which need addressing to improve their daily lives, capacity for work and wellbeing. In terms of health, however, support may be needed from physiotherapists, occupational therapists, general practitioners, a range of consultants, counsellors, community support and psychiatrists. Each of these job roles is its own profession for a good reason - that to be effective in providing a service in that area, one needs

¹⁴⁰ Heffernan, J. & Pilkington, P., 2011. Supported employment for persons with mental illness: systematic review of the effectiveness of individual placement and support in the UK. *Journal of Mental Health*, 20(4), pp. 368-380.

O'Brien, A., Price, C., Burns, T. & Perkins, R., 2003. Improving the vocational status of patients with long-term mental illness: a randomised controlled trial of staff training. *Community Mental Health Journal*, 39(4), pp. 333-347.

Schneider, J. et al., 2009. SESAMI study of employment support for people with severe mental health problems: 12-month outcomes. *Health and Social Care in the Community*, 17(2), pp. 151-158.

to be specialised in it. It is not possible, for example, for an occupational health worker to diagnose the underlying medical reasons why a person has problems sitting at a work station and using a computer; the OHW can only recommend alternative equipment that corrects poor posture and work station design, correct manual handling or and suggest strategies such as pacing. A physiotherapist does not know what range of supportive equipment is available, but can advise on exercises, or explain why the 'correct' manual handling isn't actually appropriate either.

What people need is access to all the different professions, so that a professional who knows the usual advice but is not trained to comment on specific cases is not put in a position where they advise someone to do something that is harmful. This would require significant investment from the government. Without it, however, the government cannot ask sick or disabled people to engage in activity that may be harmful for them. A Work Coach can no more tell someone that work will be good for them than they can prescribe medicine or make diagnoses.

A Work Coach can no more tell someone that work will be good for them than they can prescribe medicine or make diagnoses.

Much of medicine is a trial-and-error approach. A doctor, physiotherapist or counsellor recommends a course action, and the patient reports back on how well it worked and any problems that occurred. Not everyone responds to the same medicine, and side effects vary from person to person. Some of diagnosis is made based on what helps and what doesn't help a symptom. Similarly, it is not possible to say that a person can definitely work given particular circumstances of support. It can only be tried, and tried in an environment that does not overload the patient if the recommendation was wrong and that allows for swift rejection of approaches that are making things worse.

This caution must be used across all the services that exist to support people, whether in their health, at home or in the workplace. Health must always have the over-riding priority, because health is vital to life and good health underpins one's ability to do any activity. This does not mean that no-one tries anything, but where there is a significant conflict of opinion over a patient's ability to work it must be the patient's doctor who has the over-riding decision. It may be more appropriate to trial some work-related activity on a much smaller, less risky scale, as a test of what is possible.

263. We want to support:

- health and social care professionals so that the benefits that can come from work are an ingrained part of their training;

Health and social care professionals are well aware of the benefits that can come from work. They do not need government ideology imposed upon them, in an apparent attempt to make them believe that toxic workplaces are healthy.

- work coaches and employability professionals to provide positive work and health support; and

No non-medical professional has any role in providing any health support, positive or otherwise.

- appropriate delivery models, including those that are locally driven.

264. The government is therefore consulting on how we can develop a new approach to work and health support that will fulfil this vision. Whilst a transformation to occupational health will take time, we will explore options which could lead to early changes:

- to increase the access to occupational health assessments and advice, we will explore how we can make it the default position that everyone who would benefit from occupational health assessment and advice is referred to such services, except where it is inappropriate or unlawful to do so. We will test whether changes to GP computer systems would be successful in raising awareness and use of publically funded services. We will develop the detailed design and implementation of this by taking account of views in response to this green paper, and in further discussion with stakeholders;

We assume that in speaking of 'occupational health' in this – and other – paragraphs, the government actually intends to refer to Occupational Therapy, with additional multi-service centres that provide skilled physiotherapists and counsellors as well as Occupational Therapists.

- we will explore models of integrating occupational health within NHS primary and secondary care services provision, re-orientating a part of the NHS occupational health workforce to provide patient services directly. This will enable a greater focus on work as part of an individual's care pathway within mainstream healthcare. Potentially it may also be possible to expand availability of occupational health, at least for people with more complex needs who do not have occupational health provided by their employer, are self-employed, or are out of work; and

Work is not part of an individual's care pathway. It is particularly concerning that the government has previously used this phrase in relation to musculoskeletal services. Does it intend to create 'care pathways' for people with musculoskeletal conditions that include work? As we have oft-repeated, the only professional able to comment on both health (to a limited degree) and employment is an Occupational Therapist.

- we will develop a partnership with one or more NHS occupational health providers in England to test how we can integrate services within different clinical pathways.

Nor is work a health outcome. It is a natural outcome of health, but is not a health outcome in and of itself. Many people in good health choose not to work - they may have an inheritance or partner's income to live off, or may choose to raise their own children. Some people in bad health have to work out of financial necessity. A person could recover fully from illness and not gain work; a person could have not recovered on any health outcome but go back to work. Work for some may be a positive side-effect of being well; for others work may be a negative side-effect of being chronically ill and not receiving the level of social security they need.

Creating the right environment to join up work and health

Integrating local health and employment support

266. We want to support joined-up health and employment services that are locally designed and delivered. Reviews of the research evidence by the King's Fund and the Nuffield Trust conclude that "significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated".

Health and employment services do not need to be joined up. People who need input from multiple services (such as NHS, social care, benefits, employment support, job brokers, Access to Work and Occupational Therapy) may benefit from having a claimant advocate whose role is to oversee the provision of the different forms of support, to ensure that they are all brought in, and to discuss any

conflicts. In practice, a conflict may be that a service won't provide what is needed or is too slow to respond, or that the government or an employer is pressing for a return to work before the person is ready or the necessary support has been put in place.

If both the NHS and employment support services, including the provision of Job Brokers and Access to Work, were properly funded and accessible, then it is unlikely that any further 'join-up' or integration of health and employment would be needed. The government must not mistake the problems caused by its lack of funding for the NHS and its punitive approach to employment support for a problem arising from services not being 'joined up'.

The government must not mistake the problems caused by its lack of funding for the NHS and its punitive approach to employment support for a problem arising from services not being 'joined up'.

267. There are different ways of providing this joined-up support. It may involve providing a single service that covers both health and employment support, such as the 'Individual Placement and Support' model for people with severe and enduring mental health problems. Or it may involve linking up existing local services so that individuals get seamless support without creating a new single service, the approach taken by the Troubled Families programme.

The government implies that the Individual Placement and Support model means 'joining up' health and employment support. In reality, it means simply the contemporaneous provision of quality specialised employment support ("dedicated vocational specialists") and quality specialised community mental health workers. This is not 'joined up' It is simply providing good services at the same time.

268. At a national level, we can still have fragmented thinking which sees systems rather than people, and commissioning arrangements which, in some areas, get in the way of joined-up support. We want to build on existing examples of best practice to create the right environment for local commissioners to develop services that work differently and work together to achieve complementary outcomes.

269. This will involve encouraging local leadership through Sustainability and Transformation Plans and other mechanisms (such as Joint Strategic Needs Assessments) which bring partners together around a shared vision, and sharing good practice. It will also involve the effective sharing of data. Not only can better sharing of data mean that individuals don't have to repeat their story to different services, it also means that providers can more accurately oversee the commissioning and governance of services and support and track a range of complementary outcomes.

The Sustainability and Transformation Plans are well known to be a euphemism for 'transforming' the NHS to provide less healthcare in order to be 'sustainable' by remaining within its inadequate budget.

270. Innovation and local networks encourage the delivery of person-centred care across health, social care, employment and voluntary sector boundaries. The government is **calling for evidence on good examples of co-ordinated services** and of the factors which contribute to successful collaborations so that we can learn from them.

Increasing data transparency to improve outcomes

271. Increased data sharing can help improve both health and work outcomes for individuals. **We will work with NHS Digital to create a new information standard for data on employment status in healthcare data sets**, to enable useful data collection and analysis by employment status at both a national and local level in England. The proposed information standard will be subject to consultation.

272. If work is truly to be seen as a health outcome, we may need to support the recording of occupational status in all clinical settings, for example by:

- developing an agreed terminology, as an aid to communication and analysis; and
- encouraging and incentivising its use through software prompts and through regular clinical audit.

Work is not a health outcome, must not be seen as such, and thereby requires no such terminology.

273. There could be real benefits. Encouraging and enabling the reporting of employment as an outcome of clinical intervention should help normalise discussion of whether one treatment or another will help a patient to be well enough to return to work. We would be interested in further suggestions on how we could encourage the better use of data.

Treatment must not be decided based on whether or not it enables a patient to return to work. It should be decided solely on the impact it has on the patient's health, well-being and quality of life,, and the patient's choice based on the advice of his or her medical team. We are not robots to be patched up and sent back to work as soon as possible; we are people to be cared for.

There is no need to 'normalise' the idea that work is generally desirable. The medical profession is, like the majority of people, well aware that good work is usually a good thing for sufficiently-healthy people, and something to be desired.

We are not robots to be patched up and sent back to work as soon as possible; we are people to be cared for.

274. Where data are available, indicator sets or outcomes frameworks can help to increase transparency and accountability across services. In England work outcomes already feature in two indicators in the NHS Outcomes Framework and the Public Health Outcomes Framework and one indicator in the Adult Social Care Outcomes Framework.

275. We will also **work with Public Health England to develop a basket of work and health indicators to support improved health and work outcomes in place-based systems and make them available through Public Health England's open data access platform or 'fingertips tool'**. This tool will be part of Public Health England's wider determinants of health profile, recognising that health and work are connected with other aspects of life and will be based on the use of aggregate data. The indicators could cover:

- labour market outcomes, for example, employment rate gaps between disabled and non-disabled people, and information on health-related benefits recipients;
- health outcomes related to working age people and health services generally, for example, disability-free life expectancy, and markers of quality, such as emergency admissions for acute conditions that should not usually require hospital admission; and the proportion of people feeling supported to manage their long-term condition; and
- wider issues related to the health of working age people – on which we would welcome suggestions and evidence.

We trust this comes under the government's previous statement that "the proposed information standard [and the collection of employment data with health data at all] will be subject to consultation.

276. A wealth of evidence and knowledge exists from a variety of sources that can support improved outcomes, including evidence reviews on specific interventions, as well as evidence which support our understanding of population needs. **Working with Public Health England, we will explore how to bring existing evidence and knowledge on health and work together in one place for commissioners and local delivery partners**, for example by creating a single website.

Reinforcing that work can promote good health

278. Underpinning all of the above actions is the conviction that work promotes health and should be seen as a health outcome. We cannot achieve change without positive attitudes towards work and health from a wide range of people, particularly health and care professionals and disabled people and people with health conditions.

The government cannot assume that work promotes health, let alone hold a 'conviction' that it does. Workplaces in the UK have become increasingly high-strain in recent decades, with knock-on effects for mental and physical health.¹⁴¹ There are many damaging workplaces in the UK, so damaging as to be called toxic. The government has no business telling anyone, let alone doctors and sick or disabled people, that work is good for them.

Supporting an individual into appropriate work is not part of, let alone central to, effective and personalised healthcare. It is the job of government-funded employment advisers and job brokers.

279. Evidence shows that being in appropriate work is good for health and that being out of work can have a detrimental effect on health. For health and care professionals, therefore, supporting an individual to be in work appropriate for them is central to delivering effective, personalised care and addressing a key social determinant of health.

The evidence is highly caveated, as the DWP should know through its own commissioned research.¹⁴² Bad work is not good for people, and work in general is not good for people whose capacity for activity is limited by sickness.

Supporting an individual into appropriate work is not part of, let alone central to, effective and personalised healthcare. It is the job of government-funded employment advisers and job brokers.

280. For clinicians this could be described as considering work as part of an individual's 'health outcome'. For example, the Faculty of Occupational Medicine highlight the positive relationship between work and physical and mental health, noting "the importance of returning to work as a healthcare outcome". The National Institute for Health and Care Excellence (NICE) clinical guidelines recognise that a range of outcomes from interventions should be considered, including impact on functional ability and return to work.

The Faculty of Occupational Medicine may well note work, as a form of occupation, as an outcome. This does not make work an appropriate outcome in any other healthcare role. Occupational Medicine professionals, in particular Occupational Therapists, are unique in having the professional expertise to comment on both work (occupation or activity) and health. However, all medical professionals, unlike the government, know that no external goal can be imposed on any patient, let

¹⁴¹ Baumberg, 2014.

¹⁴² E.g. Waddell and Burton, 2006.

alone the goal of good paid work – which is a goal over which the patient does not have sole control, influenced as it is by national and local economic and employment factors.

Again, work is not a health outcome. This cannot be stressed enough. If work were a health outcome, what would we do with children, parents, volunteers, students and pensioners?

If work were a health outcome, what would we do with children, parents, volunteers, students and pensioners?

281. We are already taking action to promote the importance of work in the health system. **By November 2016, Public Health England and the College of Occupational Therapists will have recruited and started evaluation of a pilot group of Health and Work Clinical Champions, with the aim of promoting work as a clinical health outcome within their health trust.**

282. We want to make the benefits of work an ingrained part of the training and professional approach of the health and social care workforce. We will work with Health Education England, Public Health England, professional regulators, Royal Colleges and the Welsh and Scottish Governments, to address capability and capacity issues for the NHS workforce, including:

- **building upon the educational curriculum** for medical and nursing/allied health professional undergraduate training programmes;
- **training current healthcare professionals on the links between work and health** and how to embed as part of care plans; and

Any such training must include the impact of bad work, of which this country currently has many examples. It must also include the impact of excess or inappropriate activity on people with chronic illness, the impact of external pressure on people with chronic illness, and the impact of stigma and marginalisation – particularly when it comes from the government.

- exploring the option to **encourage nurses and allied health professions who may have left clinical practice to return** to utilise their expert skills within a different setting.

283. NICE has already committed that it will, at the point of guidance update or new development, take into consideration any available employment outcomes across conditions which affect primarily the working age population. We are actively considering with **NICE the development of guidelines to support improved employment outcomes among people out of work due to ill health.**

284. To support local decision makers, in 2017 **Public Health England will publish a report on worklessness, estimating the potential cost-savings for health and social care services, wider government savings, and benefits to the individual (and to the local economy) of moving a person into work.**

Moving a person into work is a natural consequence of a person recovering from an illness or injury sufficiently to move into work. Thus what the government is saying here is simply that Public Health England will publish a report on the cost-savings of treating people.

The government's ideology must not be imposed upon sick and disabled people. Work is not a health outcome. Achieving good health or managing chronic illness are health outcomes.

Health professionals cannot prescribe work to sick people. They can prescribe medical treatment or therapy, because this is what they are trained and qualified to do. They are not trained to understand the health requirements and impacts of different forms of work and work place. That is a separate profession; Occupational Therapy. Different professions exist because of the necessity to have a sufficient degree of expertise in an area in order to be able to adequately advise and assist others. Therefore, a medic cannot prescribe work, nor advise on the suitability of different forms of work, nor support an individual into work.

The role of the NHS is to provide treatment to sick or injured people. It is not to provide the UK economy with a healthy-enough workforce. The NHS provides treatment for people who won't recover and people who will not work again (whether because of age, illness severity or choice). It provides treatment for people with illness that does not currently limit their work. It is right that the NHS does this.

The health system does not need to actively help people into work. Its role is to actively help people to stay healthy, recover from illness or injury, or manage a chronic condition. Where this is achieved, most people will retain or recover capacity for work; the health system has no need to expand into services beyond its remit or expertise. Being able to work is a natural consequence of being in good or good-enough health.

Patients as partners

286. We also need to do more to recognise that patients and those who use services should be partners in their care. The Kings Fund points to the 'growing body of evidence which demonstrates that individuals who are empowered to manage their own condition are more likely to experience better health outcomes'.

Having spent 77 pages of Green Paper so far in accusing patients of having bad attitudes and not exercising enough, disparaging their doctors as ignorant of the benefits of good work for sufficiently-healthy people, imposing the ideology of work on every person and organisation it thinks might be at all related to sickness or disability, and ensuring that all discretion, ability to mandate and access to expert advice lies solely with the Work Coach, it is dishonest and hypocritical of the government to now pretend that it has any interest in what people themselves want.

287. Individuals can be supported in different ways: through having better information about navigating the employment and healthcare systems, having the ability to self-refer to an increasing range of services, and being able to improve their health literacy with a particular focus on the link between work and health.

288. Innovative digital services will have a role here. We are relaunching NHS Choices as NHS.UK with a fuller range of online services including booking appointments and ordering and tracking of prescriptions. **By autumn 2017 the**

Department of Health, NHS England and NHS Digital will have developed the tools to enable instant, downloadable access to personal health records, making it easier for patients to access their health information and share it with people concerned with their care. In addition to this, **NHS England will approve a set of selected of apps by March 2017, offering support to patients, including those with long-term conditions, in managing their health.**

289. We will also use innovation funding to look at new ways, including digital tools, of providing integrated health and employment support for disabled people and people with health conditions to stay in work or enter work.

Government Misperceptions

In this chapter we look in more detail at some of the government data and sources it uses to justify its position. In doing so, we show how the detail that underlies data on illness and unemployment do not support the government's position that work is all-but universally good for health or that GPs do not understand the role that work has in relation to health; nor does it support their approach to supporting chronically ill people which appears to centre on cutting benefits, underfunding the NHS and transferring the care and control of sick and disabled people to JobCentre Work Coaches.

Looking after unemployed people

18. "We know that the longer a person is out of work the more their health and wellbeing is likely to deteriorate."

The government cites a paper that reports that physical health deteriorates over time.¹⁴³ Unfortunately, the abstract for the paper does not say what pattern this deterioration takes: is it a linear relationship, showing continuing deteriorating as unemployment continues? This seems unlikely, as that would require a deterioration to death. More likely is that an initial deterioration levels off over time, as is reported elsewhere for mental illness.¹⁴⁴

It is important to understand why this occurs, particularly given the contrast with recent retirees who show an improvement in health after they retire.¹⁴⁵ The improvement in health amongst retirees occurs partly because of "relief from work-related stress and strain"¹⁴⁶ – it would be interesting to investigate whether a lack of such effect amongst working-age people is because of the levels of 'benefits-related stress and strain'.

The government would do better if it presented evidence from both sides (improved and deteriorated health after leaving work) and the reasons why (such as Jahoda's latent benefits of employment, and the impact of 'toxic workplaces' as reported by Sir Michael Marmot).

The government ignores the conclusion of one of the papers it cites – "An increased risk of death from external causes implies a need for support for those experiencing unemployment, particularly susceptible individuals."¹⁴⁷ Other papers on illness and unemployment have concluded that it is necessary to invest in healthcare,¹⁴⁸ a conclusion that this government does not make, despite the severe underfunding that has driven the NHS into crisis. Still others have found that low benefit levels worsens the health of unemployed people, pushing them further away from

¹⁴³ Maier R, Egger A, Barth A, Winker R, Osterode W, Kundi M, Wolf C, Ruediger H. Effects of short- and long-term unemployment on physical work capacity and on serum cortisol. *International Archives of Occupational and Environmental Health*. 2006;79(3): 193–8.;

¹⁴⁴ Warr, P.B. and Jackson, P., 1985. Factors influencing the psychological impact of prolonged unemployment and of re-employment. *Psychological Medicine*, 15, 795-807

Schaufeli, W.B., 1992. Unemployment and mental health in well and poorly educated school leavers. In *On the mysteries of unemployment: causes, consequences and policies*. Eds. Verhaar, C.H.A., Lammert-Gosse, J., de Goede, M.P.M., van Ophem, J.A.C., de Vries, A. ISBN: 978-90-481-4206-4

¹⁴⁵ Eibich, P., 2015. Understanding the effect of retirement on health: mechanisms and heterogeneity. *Journal of Health Economics*. 43:1-12 doi: 10.1016/j.jhealeco.2015.05.001

Gorry, A., Gorry, D. and Slavov, S., 2015. Does retirement improve health and life satisfaction? NBER Working Paper No. 21326

Ding, D., Grunseit, A.C., Chau, J.Y., Vo, K., Byles, J. and Bauman, A.E., 2016. Retirement – a transition to a healthier lifestyle? *American Journal of Preventative Medicine*. 51(2):170-178

¹⁴⁶ Eibich, 2015.

¹⁴⁷ Voss, M., Nylén, L., Floderus, B., Diderichsen, F. & Terry, P. D., 2004. Unemployment and early cause-specific mortality: a study based on the Swedish Twin Registry. *American Journal of Public Health*. 94(12): 2155–2161.

¹⁴⁸ Herbig, B., Dragano, N. & Angerer, P., 2013. Health in the long-term unemployed. *Deutsches Arzteblatt International*. 110(23-24):413-419 doi: 10.3238/arztebl.2013.0413.

reemployment.¹⁴⁹ Furthermore, the greater financial stress a person is under, the less likely they are to find work, even if they put more effort into looking for work.¹⁵⁰ The government needs to seriously consider whether its goal is for people to find work – in which case higher benefit levels may help – or whether it cares only about the strenuousness of the individual’s actions, regardless of how futile the government has made them.

A focus on work as the only source for an adequate income and a meaningful life marginalises those who aren’t in work,¹⁵¹ whether because of illness or because of the prime reason for worklessness amongst healthy working-age people – i.e., not enough jobs.¹⁵² Stigma is well known to have corrosive effects¹⁵³, and the government’s apparent policy of demonising unemployed people as ‘scroungers’ seems directly contrary to any intention to support unemployed citizens to find and retain work.

The government’s approach seems deliberately intended to cause as much harm to unemployed people as possible: stigmatise unemployed people, including those on sickness benefits, as scroungers and fraudsters, thus corroding their mental health and self-esteem; provide punitively low levels of benefits, thus making it less likely that those people who could work will find work, even if they increase their levels of work search; mandate people to engage in essentially futile activity, at the cost of meaningful activity that would not only promote mental health but also increase the likelihood of obtaining work; and decimate the NHS, so that there is not adequate access to healthcare to keep people healthy and able to work.

Poverty, stress and the negative role of Cortisol on health.

Why are so many people ill?

In the Green Paper the Government highlights certain conditions:

- depression, stress & anxiety,¹⁵⁴
- mental ill-health (94 mentions)
- obesity¹⁵⁵, musculoskeletal conditions¹⁵⁶, drug and alcohol use and addictions¹⁵⁷

Poverty and Stress

There is a correlation between poverty and stress: when you are struggling to heat your home and pay your bills, and to eat sufficiently well you are struggling to fill the most basic physiological needs of survival. This insecurity creates huge amounts of continual stress. Yet the Green paper talks about higher needs such as self-actualization, whilst refusing to recognise that until basic needs are met people cannot be “all they want to be”.¹⁵⁸

¹⁴⁹ Rodriguez, E., 2001. Keeping the unemployed healthy: the effect of means-tested and entitlement benefits in Britain, Germany and the United States. *American Journal of Public Health*. 91(9):1403-1411

Bartley, M., Blane, D. & Montgomery, S., 1997. Health and the life course: why safety nets matter. *British Medical Journal*. 314:1194-1196.

¹⁵⁰ Skärlund, M., Åhs, A. & Westerling, R., 2012. Health-related and social factors predicting non-reemployment amongst newly unemployed. *BMC Public Health*. 12:893.

¹⁵¹ Abberley, P., 1999. *The significance of work for the citizenship of disabled people*. Dublin University Press.

Grover, C. and Piggott, L., 2013. A right not to work and disabled people. *Social and Public Policy Review*. 7(1):25-39.

¹⁵² Shildrick, T.

¹⁵³ Dean 2003

Schafer, M.H., Ferraro, K.F., 2011. The stigma of obesity: does perceived weight discrimination affect identity and physical health? *Social Psychology Quarterly*. 74:76–97.

Kahan, S. and Puhl, R.M., 2017. The damaging effects of weight bias internalization. *Obesity*. 25(2)280-281 doi: 10.1002/oby.21772

¹⁵⁴ 33, 39, 40, 49, 58, 62 Improving Lives The Work, Health and Disability Green Paper

¹⁵⁵ Pg 15, pg 66

¹⁵⁶ Pg 5, 68, 70, 71

¹⁵⁷ Pg 14, 15

¹⁵⁸ Pg 10, 17, 48

Living on a low income is stressful. At the same time people in disadvantaged situations are unlikely to have support available to draw on to help them cope, because of government cuts to welfare advisors, social care, the NHS and third-sector organisations, and suffer more from increased assessments, work programmes and 'treatments'.

Poverty and ill health

The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.¹⁵⁹

Maslow argued that the failure to have needs met at various stages of the hierarchy could lead to illness, particularly psychiatric illness or mental health issues. Individuals whose physiological needs are not met may die or become extremely ill. When safety needs are not met, posttraumatic stress may occur. Individuals who do not feel love or belonging may experience depression or anxiety. Lack of esteem or the inability to self-actualize may also contribute to depression and anxiety.¹⁶⁰

Without the lowest levels of need being consistently met, for example due to insufficient or deprivation levels of income, people become more ill and less employable.

Stress and ill health

Cortisol is a steroid hormone which regulates a wide range of processes throughout the body, including metabolism and the immune response. It has an important role in helping the body respond to stress.¹⁶¹ When a person experiences short term stress, cortisol assists in the fight-or-flight reaction. Good stress (eustress), such as a deadline, creates short term cortisol to release glucose to the brain and muscles, and reduces when it is no longer needed.

However, there is also bad stress (distress): chronic enduring stressors that result in the body *continuously* releasing cortisol. Chronically elevated levels of cortisol create serious health issues. Physiological symptoms of distress include an increase in blood pressure, rapid breathing and generalized tension. Behavioural symptoms include overeating, loss of appetite, drinking, smoking and negative coping mechanisms.¹⁶²

And there are worse effects. With chronic stress, cortisol is overproduced, and the immune system becomes resistant. In the absence of the 'off switch', inflammation lingers long after the original cause is gone. The breakdown of communication between the various aspects of the immune system that occurs during times of chronic stress may be responsible for triggering flare-ups (or new cases) of various autoimmune diseases such as Crohn's disease, psoriasis, rheumatoid arthritis, lupus, multiple sclerosis (MS) and other similar conditions.¹⁶³

When stressors are always present and you constantly feel under attack, that fight-or-flight reaction stays turned on.

The long-term activation of the stress-response system — and the subsequent overexposure to cortisol and other stress hormones — can disrupt almost all your body's processes. This puts you at increased risk of numerous health problems, including:¹⁶⁴

- Anxiety
- Depression
- Digestive problems
- Headaches
- Heart disease Heart attacks

¹⁵⁹ WHO 2008. Social Determinants of Health

¹⁶⁰ <http://www.goodtherapy.org/blog/psychpedia/maslow-hierarchy-needs>

¹⁶¹ The Society for Endocrinology, 2017.

¹⁶² Brock University; Eustress vs Distress

¹⁶³ Mills, H. Reiss, N. Dombeck, N, 2008. The Long-term Consequences of Negative Stress. Mental Health.net

¹⁶⁴ Mayo Clinic, 2016. Chronic Stress puts your Health at risk

- Cardiovascular disease
- Cancer
- High blood pressure
- Stroke
- Diabetes
- Exhaustion
- Bone loss, osteoporosis
- Compromised immune function
- Sleep problems
- Weight gain (especially abdominal fat)
- Memory and concentration impairment

Conclusion

The Governments solution to the cycle of; ill health -> poverty -> stress -> raised Cortisol -> greater ill health is to increase poverty, and hence increase the prevalence of the very conditions it believes stop people from working. Not only will poverty and stress increase the prevalence, it will also increase the severity of these conditions.

The removal of the Work Related Activity component will place people already sick in an increasingly vulnerable position; not being able to support even its target group, and having no plans at all for the 51% who are not going to get work programme 'treatment'.

The Disability Employment Gap

The government used the Labour Force Survey data from Q2 2016. This survey has changed the questions relating to 'disability' twice in recent years; once in 2010, and again in 2013. The survey has also found that it gets different responses when surveys are conducted by telephone vs face-to-face. People respond differently to the terms condition, problem and illness. It is important to attempt to understand why different phrasing elicits different responses, in order to understand who is included in this group and why, but the government has made to attempt to do this, nor shown any recognition that this is a major issue.

The most recent change, in April 2013, was from the phrase "disabilities or long term health problems" to the phrase "physical or mental health conditions or illnesses". This resulted in many working people who had cardiovascular problems or diabetes no longer reporting 'yes' to the question.¹⁶⁵ In essence, when people are asked if their health problem is an illness or disability, they report 'no' when it is adequately controlled by medication. At the same time, more people who were not in work now answered 'yes'.

Other surveys have historically returned different numbers of people reporting as 'disabled'. The Life Opportunities Survey, for example, has previously returned almost 5.5 million working-age people reporting as 'disabled'. After it introduced the new "physical or mental health conditions or illnesses", the number reporting 'disabled' in this survey dropped to 2.5 million.¹⁶⁶ What question is asked, how it is introduced and positioned in a survey, and how the survey is carried out all effect the total number of people reporting as 'disabled'; although the effect is weaker the more severely disabled a person is. In essence, people with mild illness or disability are more sensitive to the exact phrasing and context of a question.

The most recent LFS (Apr-Jun 2016) found that 46.4% (3.33 million) of people who are defined as disabled using the "physical or mental health conditions or illnesses" are economically inactive and 48.3% (3.47 million) are in employment.

¹⁶⁵ Hankins, M. and Chandler, M., 2015. Measuring disability in the Labour Force Survey. Office for National Statistics.

¹⁶⁶ Ibid.

But as is explained elsewhere, there is little value in such numbers – what we need to know is how many people have disabilities that limit their ability to work and, crucially, to what extent. Many people in work with a health condition – even if it affects them daily – don't self-identify as disabled or having a work-limiting illness. This is crucial. A person who is ill and unemployed who recovers, or who has a mild-moderate illness in the first place, does not then report as 'disabled' if he or she gains employment. Such a person moves from disability unemployment to non-disabled employment – not to disability employment. This person does not change the disability employment gap, despite moving into work.

This is something the government has not addressed in its Green Paper.

What is the gap?

Those out of work due to disability are either:

- Sick;
- Disabled; or
- Sick and disabled.

Those who are sick are either;

- Curable; or
- Incurable.

Consider John.

John works. He gets ill and leaves work. He spends a year being ill. During that time John has increased the DEG, because he has increased the number of disabled people who are out of work, and hence the percentage of disabled people in work drops and the gap increases. John is classed as disabled under EA2010, because his illness has lasted for a year.

John gets better. He returns to work. Well done John!

But John has recovered – he is no longer classed as disabled – so he doesn't count as disabled anymore. He has reduced the number of disabled people unemployed, so he has reduced the employment gap back to its original position.

The Government is going to 'cure' people who are currently 'disabled' by illness by offering, or compelling them to have, treatment. The Government is confident this approach will work. However, if these people are cured, then they also won't reduce the employment gap – as they are no longer disabled. Of course there are other factors influencing the gap – but the actual percentage of people who don't work due to sickness has never changed. The Government cannot understand why.

Perhaps they haven't met John, or the hundreds of thousands like John, who get ill, and get better. Let's look at the maths:

- Take a snap shot of 100 sick and disabled people. 48 are in work, 52 are not (48%);
- Take a snap shot of 1000 healthy people. 850 are in work and 150 are not (85%);
- The DEG is 37 percentage points.

But then:

- 100 people become sick and leave work;
- Sick and disabled people now - 48 in work, 152 are not in work (24%). Note – no sick or disabled people have left work – the DEG has increased due to people leaving the 'healthy and working' group;
- For people who are healthy, there are now 750 in work, and 150 are not (83%);
- The DEG is 59 percentage points.

Suppose that then:

- 100 of the sick and disabled unemployed people get better;
- Sick and disabled people now - 48 are in work, and 52 are not in work (48%);
- For people who are healthy - 850 are in work, and 150 are not (85%);
- The DEG is 37 percentage points.

The point the Government misses is that there is a flow of people; they flow out of work when they are sick and when they flow back into work it's because they have recovered.

This will not affect the DEG. It will not halve the DEG, as the people will not be joining the 48 in work classed as sick and disabled – they will be joining the 'Healthy working group' figures.

What will close the gap?

Clearly if more sick and disabled people go into work without losing their disability status under EA2010 then the gap will close. But as common sense and the Spartacus response shows, employers won't employ people who are so sick that they qualify for ESA, although employers might employ healthy disabled people.

So why, if the Government wants to 'halve the employment gap' is it targeting people with chronic illnesses and not those who are healthy and are disabled?

It's because the DEG is another smokescreen. A sound bite. A way that the Government can convince each other that it's ok to cut ESA, because it will get disabled people into work. It won't – because there is nothing in this Green Paper that suggests helping healthy disabled people.

The ideological approach of bundling all mental health conditions together, and then declaring them as 'common' health conditions, insinuating that these conditions are minor, and providing pound shop therapy under pressure, will neither cure all those in WRAG, nor will it 'halve the employment gap'.

The Government appears to have some form of Anosognosia by proxy.

Mental Health and Musculoskeletal.

The Green Paper focuses on two groups - Mental Health and Musculoskeletal, or in tabloid terminology the 'depressed and bad back brigade'.

However the following shows that both these classifications have multiple subdivisions:

Mental and behavioural disorders:

1. F01-F09 Mental disorders due to known physiological conditions - a demonstrable aetiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction
2. F10-F19 Mental and behavioural disorders due to psychoactive substance use - disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances
3. F20-F29 Schizophrenia, schizotypal and delusional, and other non-mood psychotic disorders - The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted
4. F30-F39 Mood [affective] disorders - disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation
5. F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders - disorders in which anxiety is evoked only, or predominantly, in certain well-defined situations that are not currently dangerous.
6. F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors – Eating disorders, sleep disorders, mental disorders associated with the puerperium not covered elsewhere
7. F60-F69 Disorders of adult personality and behaviour - frequently, but not always, associated with various degrees of subjective distress and problems of social performance
8. F70-F79 Mental retardation - A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.
9. F80-F89 Pervasive and specific developmental disorders - The disorders included in this block have in common: (a) onset invariably during infancy or childhood; (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system; and (c) a steady course without remissions and relapses.

10. F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

11. F99 Unspecified mental disorder

It's quite clear that those with mental health and behavioural disorders are not all depressed or anxious. Some have learning difficulties, some have brain damage, some have dementia, autism, unmanageable psychosis. However ALL are counted as being part of the 49% identified in the Green Paper.

Musculoskeletal disorders:

- M00-M03 Infectious arthropathies - This block comprises arthropathies due to microbiological agents.
- M05-M14 Inflammatory polyarthropathies – including but not limited to RA, Seropositive RA, Psoriatic and enteropathic arthropathies, juvenile arthritis, crystal arthropathies
- M15-M19 Osteoarthritis - the term osteoarthritis is used as a synonym for arthrosis or osteoarthrosis
- M20-M25 Other joint disorders – Joint deformities and derangements.
- M26-M27 Dentofacial anomalies [including malocclusion] and other disorders of jaw
- M30-M36 Systemic connective tissue disorders – incl. but not limited to Auto-immune and collagen conditions, including genetic conditions
- M40-M43 Deforming dorsopathies- conditions of the spine, congenital, exc. injuries
- M45-M49 Spondylopathies -
- M50-M54 Other dorsopathies
- M60-M63 Disorders of muscles – incl. Paraplegia, muscles wasting and diseases
- M65-M67 Disorders of synovium and tendon
- M70-M79 Other soft tissue disorders – Myositis, Calcification and ossification of muscle,
- M80-M85 Disorders of bone density and structure - Osteoporosis with/without pathological fracture & in disease, Adult osteomalacia, disorders of bone density and structure.
- M86-M90 Other osteopathies
- M91-M94 Chondropathies
- M95 Other disorders of the musculoskeletal system and connective tissue- acquired deformities
- M96 Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
- M99 Biomechanical lesions, not elsewhere classified

To focus, as the government does, on those who reported having “problems or disabilities (including arthritis or rheumatism)” connected with arms, hands, back, neck, legs or feet is clearly highly misleading and suggestive. As the above list shows, there are many other conditions that come under the heading ‘musculoskeletal and connective tissue disorders’. Yet again the government in this Green Paper attempts to diminish the severity of the conditions that are in this category.

Again, many of these are very serious conditions. Most demand management and intervention beyond pain relief and short or low levels of physiotherapy. Some are part of a condition that affects more than just muscles or bones, affecting organs and systems as well. Many are incurable, irreversible, and inoperable, and are degenerative. The Government use of the ICD codes doesn't give a real picture of what conditions are included in these groups.

Dishonesty

This lack of honesty, this ideology, this desire to justify the cutting of ESA, means 100% of people going onto WRAG, and indeed all those currently on ESA, will be subject to a carpet bombing approach of possibly compulsory (and apparently low-level) treatment. Not only is this an unjustifiable expense, it's also a waste of resources, and potentially harmful – unlocking emotions

without any capacity in the system to repair any damage caused. The wrong therapy is bad therapy, which will make people worse, not better.

In table 2a of the government's data pack, they attempt to select the target groups of depression and bad backs. This table breaks mental illnesses down into 'depression, bad nerves or anxiety'; 'mental illness, or suffer from phobia, panics or other nervous disorders'; and 'severe or specific learning difficulties (handicaps)'. It is not clear where psychoses and personality disorders are supposed to fit. The government pretty much undermines its own argument by showing that 42% of people with depression, bad nerves or anxiety are actually in work, and the entire caseload of people who may be helped by low level treatment is only 20%.

By using the ICD codes when they calculate ESA 'mental health' figures they pull in many people who have non-depression or anxiety mental illnesses and behavioural difficulties to justify their plans. So a maximum of 20% of people are to be offered mental health support, but 100% of WRA component is to be cut. It should be noted that only 20% of all conditions fit the target of the Government proposals, rising to 27% if musculoskeletal is included, however this also would be reduced by removing those whose Mental Health or MSK is unmanageable and incurable. These are not 'easy-fix' conditions - they are enduring and complex.

By using ICD codes to calculate ESA 'musculoskeletal' figures there is no indication of who is actually in the groups – or what their barriers are. The Government attempts to use these codes on a like-for-like basis and, ignorant of the reality of these conditions, decides to target the largest group as though it is the only type of illness or injury. This is sloppy logic.

Consider the ICD code XVI - Certain conditions originating in the perinatal period. It is primarily a classification for children, at the point they are diagnosed. As adults, under ESA, they would be moved to a different code if applicable, but many of the sub-divisions no longer apply in adulthood. Hence this group is very small and highly specific, compared to mental and behavioural disorders, which may stem back to childhood or develop in adulthood, but encompass a wide range of conditions.

- P00-P04 Foetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery
- P05-P08 Disorders related to length of gestation and foetal growth
- P10-P15 Birth trauma
- P20-P29 Respiratory and cardiovascular disorders specific to the perinatal period
- P35-P39 Infections specific to the perinatal period
- P50-P61 Haemorrhagic and haematological disorders of foetus and newborn
- P70-P74 Transitory endocrine and metabolic disorders specific to foetus and newborn
- P75-P78 Digestive system disorders of foetus and newborn
- P80-P83 Conditions involving the integument and temperature regulation of foetus and newborn
- P90-P96 Other disorders originating in the perinatal period

Another comparison would be Chapter VIII, Diseases of the ear and mastoid process (H60-H95). This chapter contains the following blocks:

- H60-H62 Diseases of external ear
- H65-H75 Diseases of middle ear and mastoid
- H80-H83 Diseases of inner ear
- H90-H95 Other disorders of ear

It's quite clear why this group isn't bigger – it is highly specific, whereas mental health and behaviour is much less so, including such wide ranging conditions as dementia and autism, or musculoskeletal conditions which includes deformities, genetic conditions, multiple bone conditions and soft tissue conditions.

The Government has to do much more to identify those who are disabled from those who are sick, and those who are curable from those who are not, and those conditions that are stable from those that are fluctuating or degenerating, and conditions that are manageable from those that cannot be effectively managed. A 'health and work conversation' with an employment advisor cannot achieve this.

This failing to understand that it's the healthy disabled who are most employable, and most in need of help, can only lead to poorly targeted support and yet another failed Government intervention.

Interpreting employment support research

Psychological Wellbeing and Work

The government refers to a paper by van Stolk et al.¹⁶⁷ to explain how both healthcare and employment support need to be provided at the same time. The paper quoted does not actually say that there is no evidence for treating either in isolation or, if there is, what the reason is. The reason for treating the two together is not because work is necessary for mental health. It is because if the causes of mental illness are not removed – whether for that particular person it is a bad benefit or a bad job, or something else – then no 'cure' will last. Addressing employment means taking steps to improve the workplace so that it neither causes nor perpetuates mental illness. It does not mean assuming that 'work' is good enough to serve as the remedy without addressing the nature of the work.

The government must be very careful when talking about illness and disability. Not all illness is the same. Back pain from poor manual handling, and corrected by anti-inflammatories and strengthening exercises, is very different from back pain that requires surgery and is unalleviated by opioids. Moderate depression, anxiety or stress caused by the workplace are not the same as severe psychosis. The 'review' conducted by van Stolk et al. was shallow and essentially meaningless because it did not break down the difference between mental ill-health such as depression, anxiety and stress caused by a negative environment (such as poverty or bad working conditions), and mental ill-health that is severe and enduring regardless of circumstances.

The Improved Access to Psychological Therapies service, praised in this paper, has come under significant criticism for its deliberately shallow design. CBT is not appropriate for all mental health conditions; it was designed for depression and anxiety where the environment is not a prime cause (if the environment is negative, no change in attitude regarding it can be sustained), and is not the appropriate therapy for people with psychoses, personality disorders and other mental illnesses.

Addressing the causes of illness

The government is drawing the wrong inferences from the data available to it. We know that bad environments – such as poverty, high pressure and low autonomy – are bad for mental health. These three factors occur in the workplace, particularly in low-end jobs, and in the benefits system for people on Jobseeker's Allowance. It is clear from the conditionality of JSA that individuals face high pressure (they have to have 35 documented hours of work search, apply for six jobs each week, and comply with any direction the JobCentre gives them) and low autonomy (the discretion and power lies with the JobCentre). All three benefit groups (JSA, ESA WRAG and ESA SG) put people into poverty.

We know that people are trapped in the low end of the job market, in a low pay/no pay cycle that never allows them to leave the entry level jobs they started their working lives in, subject to the high pressure, low autonomy environments that we know are harmful. We know that

¹⁶⁷ van Stolk, C., Hofman, H., Hafner, M., & Janta, B., 2014. Psychological Wellbeing and Work: Improving Service Provision and Outcomes

conditionality and sanctions push people into these bad jobs. We know it is not inevitable that worklessness replicates these features of bad jobs, and it is not inevitable that work brings freedom from such toxic environments. We know that what matters is not work per se, but freedom from financial strain and access to activity that is fulfilling, delivers a sense of identity and collective purpose, and provides a time structure and meaningful things to do.

We know that healthcare alone cannot help every person with mild-moderate 'common' mental illness¹⁶⁸ – because treating the symptoms is useless if the cause is not removed. People develop depression, anxiety and stress in response to harmful situations and the long-term impact of short-term physiological coping responses. Treatments, such as Cognitive Behavioural Therapy under the 'Improving Access to Psychological Therapies' service, have a limited effect of around 18 months. Barrett wrote that, "Many of the clients of the new IAPT services will be the casualties of a brutal capitalism that cares little for its workforce or for those who are disheartened and disillusioned by work." Hall and Marzillier concluded that "the assumption that mental health problems are exclusively attributes of the person ('symptoms' in the language of medicine) and that with appropriate help individuals can overcome their problems ('get better') needs to be challenged... For many, depression and anxiety are products of the society in which they live and are not an individual fault or pathology... Sometimes it is a realistic perception resulting from social and economic deprivation or being trapped in an abusive relationship".¹⁶⁹

What needs to change is not the symptoms of illness, but the cause – and the cause is the poverty and strain of bad jobs and bad benefits. The response therefore is not to make the goal to get people into work. Using 'work' as the goal is a poor proxy for what is actually needed, and one that allows politicians to claim to deliver the support people need whilst actually serving only to perpetuate the causes of harm. By focussing instead on the six benefits of employment, coupled with the need for an appropriate balance between pressure and autonomy, we can ensure that government policy does not either deliberately or unintentionally make people ill. We must stop using 'work' as a smokescreen for neglect.

Individual Placement and Support

IPS can help more people with mental health conditions into work compared to other employment support measures, but the fact that it performs better than other approaches does not mean that it is right for every person with a severe and enduring mental illness. In fact, the paper the government cites reported that 78% of participants in the trial had not obtained employment after two years.¹⁷⁰ It also reported that implementation of IPS in the UK may be difficult, because of difficulties linking the employment service with the mental health service. The joint provision of employment support specialists and mental health care (Community Mental Health Team) is vital to the success of IPS.¹⁷¹ Unfortunately, since the article cited by the government was published (2011), the provision of mental healthcare in the UK has deteriorated further. The government needs to significantly invest in mental healthcare, primarily as a human right, but also as a necessity if it truly wants to help some people with mental health conditions into work.

The government must be realistic about the outcomes it can achieve. When a dedicated, specialist and thorough employment support programme can only achieve a 22% job outcome after two years of work, it raises serious questions about the viability of work for the majority of people with chronic illness. Most people on ESA consider it would take more than four years for them to get work, if they are able to return to work at all

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¹⁶⁹ Hall, J. & Marzillier, J., 2009. Alternative ways of working. *The Psychologist*.

¹⁷⁰ Heslin, L., Howard, M., Leese, P., McCrone, P. & Rice, C., 2011. Randomized controlled trial of supported employment in England: 2 year follow-up of the Supported Work and Needs (SWAN) study. *World Psychiatry*. 10:132–137.

¹⁷¹ Schneider, J., Slade, J., Secker, J., Rinaldi, M., Boyce, M., Johnson, R., Floyd, M. and Grove, B., 2009. SESAMI study of employment support for people with severe mental health problems: 12-month outcomes. *Health and Social Care in the Community*. 17(2):151-158. doi: 10.1111/j.1365-2524.2008.00810.x

Most people want to work

What is important here is not who wants to work, but who can work. By reporting on who wants to work¹⁷² when it should be reporting on who can work, the government grossly over-represents the capacity of sick and disabled people for work.

It is disingenuous to report that the most common barrier to work is a lack of job opportunities or transport, when one has already established that the majority of people on ESA are too ill to work – especially when ‘too ill to work’ or related phrases are not provided as response options. The same survey reported that In ESA WRAG, 73% were too ill to work and in ESA Support Group it was 86% (it is worth remembering that some ESA recipients are ‘disabled’ rather than ill, and consider themselves able to work if only an employer would provide the support they need). The tables in this report are highly informative. A third of ESA WRAG recipients, for example, have been on ESA for more than two years; one in five have been claiming for over five years. It has to be questioned whether these people have illnesses or disabilities that are compatible with work, and whether it would be more appropriate for them and for the country to place them in the Support Group.

The tables also show the diversity in opinion of what it means to be ‘disabled’. Some people with chronic disabling illness, for example, consider themselves ill rather than disabled, and reject the term ‘disabled’. The survey results also show that some people consider themselves to be “not disabled all of the time” if they consider their illness to be non-permanent, common, or manageable with treatment. Yet the vast majority of respondents also reported significant limitation in activity because of their illness. It therefore isn’t possible to say that someone is or isn’t capable of work based on whether or not they use the term ‘disabled’ in reference to themselves. Discussion of disability generally, and work-limitation in particular, require a deeper understanding of what chronic illness is.

Enabling work

The government writes that, by employing sick and disabled people, “employers will have access to a wider pool of talent and skills”, citing a report by Scope.¹⁷³

Scope writes that disabled people “have the same talents and aspirations as everybody else, present enormous untapped potential”. This is misleading. Whilst some disabled people only need the right support in order to be able to work full-time at the same speed and quality as if they were non-disabled, many others – particularly people with chronic disabling illness – are not ‘untapped potential’. It is necessary to remember that most people on ESA are there because they are chronically sick, not because they are healthy but have a disability such as sensory impairment or cerebral palsy. For sick people, support measures at work can’t overcome the fundamental barrier to work, which is the lack of the necessary health. We cannot be treated as ‘untapped potential’ when we are unable to work and may never become able.

Scope say, “historically, periods of economic growth have not had the same positive impact on disabled peoples’ employment rates as on non-disabled people” and lead on from this to, “It is time to start looking at the structural inequalities that prevent many disabled people from being active in the labour market.”

But there is more than just structural inequalities keeping chronically sick people from work – there is the simple fact of people not having sufficient capacity for work. This is a crucial reason why people who are disabled by chronic illness are not in work, and have not moved into work despite years of tightened access to sickness benefits, reduced income and increased conditionality.

Later on Scope say, “Disabled people who are willing and able to work are a sizable proportion of the population, with the same potential skills and abilities as everyone else. But many disabled people face specific barriers which need to be addressed. In the next section, we consider how these barriers can be overcome.”

¹⁷² Cole, L., 2013. A survey of disabled working age benefit claimants. DWP.

¹⁷³ Gulliford, J., 2015. Enabling work: disabled people, employment and the UK economy. Scope.

Here, they recognise that being able to work is crucial. For those who are able and healthy albeit disabled, there often are specific barriers that need to be addressed – specialist software, physically adapted workplaces, supported employment, suitable trades.

Scope say, “These changes need to be underpinned by the understanding that increasing the disability employment rate requires recognition that this issue is integral to the UK’s continued economic success, and to the goal of full employment.”

Supporting people who can work to work is about more than economic success and political goals. It is about human rights. Every person who can work has the right to work, and has the right that it be decent work. Currently, the UK overlooks these rights, preferring instead to focus on economic reasons for business practice. The UK permits “toxic workplaces” that overwork their employees without adequate pay, security or autonomy. The UK only requires “reasonable” adjustments to be put in place, where ‘reasonable’ means that the employer thinks it’s affordable. The government doesn’t pick up the tab (Access to Work is poorly advertised and very slow to act), and employees who think they have been denied their rights can rarely afford the £1200 of an Employment Tribunal. It is more than time that the government switched its focus from the ‘business case’ to the basic rights of its citizens.

Fit notes

In the Green Paper, the government shows that it believes that GPs view work as bad for people, that GPs are therefore holding people back, and that GPs therefore need to be educated – even mandated – on this matter. The government wants its “conviction” that work is (universally) good and that it promotes health to be a viewpoint that all doctors are required not only to have, but to force onto their patients. Only in this way will the government’s goal that everyone work be reached.

In reality, the problem is not that GPs don’t recognise the benefits of work for people. It is that the government utterly fails to realise the existence of toxic work and workplaces, and of incapacitating chronic illness. Thus the government, in a paper it alleges is about patient choice, seeks to impose its ideological, one-goal-is-perfect-for-everyone opinion onto every person in the country.

One of the papers it cites is an analysis of the use of Fit Notes by GPs.¹⁷⁴ The paper, and the government’s interpretation of the paper, appear biased against GPs. Interestingly, the government makes no reference to one of the sister papers, on the use that employers make of fit notes, in which the researchers found that employers sometimes dislike the fit note because it makes employees expect to return to work sooner, when in fact the employer won’t, can’t or doesn’t want to make it possible for the employee to return before the employee has reached 100% health.¹⁷⁵

GPs hold strong positive attitudes towards work: they agree that, in general, work is good for people and worklessness is not good. They consider themselves to have a proactive and important role in supporting their patients to remain in work where possible. The new sick note, the fit note, has proved of some assistance to GPs in helping them discuss work with their patients, and especially in using phased returns to work. GPs were also capable of seeing when time off work was valuable for what might be termed ‘social’ reasons, but which arguably would also come under the ‘medical’ reason of stress. GPs who had good job satisfaction were more likely to agree that work is in general good for health. The authors stipulated that an underlying reason, such as personal experience of work causing harm, could not be inferred from this result.

GPs are less confident about their knowledge of support available for sick or disabled people in work, and about the benefits system. GPs generally felt that they were not qualified to make

¹⁷⁴ Fylan, B., Fylan, F. & Caveney, L., 2011. An evaluation of the statement of fitness for work: research with General Practitioners. DWP Research Report no. 780.

¹⁷⁵ Lulami, M., Meadows, P., Metcalf, H. & Rolfe, H., 2012. Evaluation of the statement of fitness for work: qualitative research with employers and employees. DWP Research Report no. 797.

recommendations on aids and adaptations; that required an Occupational Health specialist or a GP with Occupational Health training. This was particularly the case with patients whom the doctor knew less well. Research has previously shown that GPs value having an independent assessment service to which they can refer their patients. This is of value when the GP disagrees with the patient's self-assessment, or where the GP and patient both feel that some work is possible but need assistance in identifying the type and hours of work, what support is needed and what support is available.

GPs showed good understanding of how to use a fit note to best help their patients. They recognised that individuals with naturally short-term illness or injury did not need a discussion of how to return to work; their illness or injury would naturally resolve to full health. Other individuals with severe conditions were not in a position to discuss work; a break from work was therapeutic and provided space to manage health and wellbeing before adding in the pressure of the workplace. Still other individuals, particularly those with mild or moderate conditions, could do some tasks or reduced hours. The fit note allowed GPs to help these patients access suitable work for an appropriate number of hours per week. GPs were also able to identify when some people had significant support needs, such as people with drug addiction, and that attempting to make these people work whilst not providing the support they needed to manage their lives and addictions was not appropriate or likely to be helpful.

GPs recognised that suggesting a person is fit for work when the particular job role or workplace is detrimental was not appropriate. There is no value in treating a symptom - such as stress, anxiety or musculoskeletal injury - without also removing the cause - such as a job requiring heavy manual labour, or a pressured and negative working environment. Failing to address workplaces that cause illness makes it impossible for the treatment of symptoms to effect a long-term cure.

GPs were aware of the difficulties patients experience with the benefits system, in particular the low income available for jobseekers. They recognised that where a person would significantly struggle to get a job, telling them they were able to work could not help that person. It simply pushed the person into deeper poverty, which in turn has negative impacts on health. GPs found the lack of support for unemployed and sick people undermined the efficacy of the fit note.

Similarly, GPs found that employers' unwillingness to make necessary changes also undermined the success of the fit note. Patients who could do some work were prevented from doing so by their employer. In some cases, this might be reasonable; for example, it is well established that it is very difficult for employers to redeploy a manual worker into a non-manual job. Placing these people on Jobseeker's Allowance is unhelpful as it simply places them in a demoralising, stressful and financially deprived situation without providing any means of escape from such destitution.

In other situations, GPs found that employers were pushing them to sign their patient as fit for work, to make the patient come back to work before he or she was able to. This was particularly an issue amongst people employed in low-skilled jobs. GPs reported that they often struggled to get these patients to take enough time off, because of the pressure created by the risk of losing one's job. Once patients had taken sick leave, however, they could be reluctant to return to work before they were confident of being able to sustain it, because of the negative emphasis their employer puts upon the number of periods of sick leave that are taken.

GPs did report that some people appeared to be over-stating their illness or injury, or under-estimating their capacity for work. In these cases, it was difficult for GPs to make progress in discussing work, because they don't have the Occupational Therapy expertise or the time to invest in working with someone over time to establish what might be possible. GPs sometimes felt unable to help a patient effectively when the person didn't want to work and was 'GP-hopping' or adding new symptoms every time they saw a GP. This makes an independent assessment particularly necessary so that GPs are not left trying to make a judgment on an individual's capacity when there is some ambiguity regarding the patient's symptoms and capacity for work.

A system for referring patients to a proper Occupational Therapy assessment would benefit doctors, employees, and employers in a number of ways: Employees would receive expert advice on what they can safely do. Employers would receive the detailed advice they want, rather than the vague and generic recommendations from fit notes and the Fit for Work occupational health scheme. Doctors would have their time freed up to focus on the health of their patient, knowing that the problems with work are being dealt with by an appropriate specialist.

Sometimes the changes that employees needed, and GPs recommended, were not possible for employers to implement. For example, staff who carried out work that required heavy lifting, such as care work and linen deliveries, could not be reassigned to 'light duties' because there were no such duties. Similarly, staff who had a 'front of house' role where they interacted with customers could not alter their jobs to avoid customers, because that would mean a different job altogether.

Employees reported differences in the response from colleagues to their sick leave and return to work. Some had very supportive colleagues who helped out and were willing to do so. Others found that their colleagues resented the adjustments made for the sick individual, because of the burden placed on colleagues to cover the rest of the work, and because healthy colleagues were not given access to the types of flexible working that they might have benefit from, such as working from home.

Some employees returned to work before their health could withstand it, and this set back their recovery and could cause them to need further sick leave. Work was helpful for well-being, because of the activity and purpose it provided, but did not directly improve health. Pain and exhaustion hindered their productivity in the workplace and caused a deterioration in health or reduced rate of recovery.

Case Studies

In this chapter we comment on some of the case studies used by the government and their relevance to people with chronic incapacitating illness or disability.

Case study – Susannah

Susannah was diagnosed with osteoarthritis and rheumatoid arthritis in 2010, she had lived with symptoms for more than 6 months before getting a formal diagnosis. She has lived a very active life and was working on a farm in France at the time of diagnosis. Following diagnosis, Susannah returned to the UK and now works as the personal assistant at a country house and estate. Upon receiving her diagnosis, her employer was quite understanding of the impact rheumatoid arthritis was having on her. Her manager spoke with the HR team who provided her with reasonable adjustments to her workplace. Fatigue is also a major issue for Susannah, as with many others with rheumatoid arthritis, she feels very tired after a day at work and this limits her from socialising in the evenings or at weekends. Nevertheless, she admits she does have some difficulties with her workload but she does not feel comfortable asking her employer for further adjustments to it. In light of her current difficulties she is planning to retire early, having originally planned to retire at 66. She says she has accumulated enough earnings to have a reasonable retirement. When asked if anything could accommodate her to remain in work and thus not retire, she says working 3 days rather than 4 would probably be sufficient, however, she says this would amount to a job share which would be impractical for her employer and something she is not prepared to ask for. “Retiring early isn’t ideal and I would like to keep on working but I just can’t perform all of the roles of the job anymore and my work-life balance has suffered due to my tiredness and pain at the end of each day. I don’t see my friends much anymore and it’s something I really miss. If I could work a three-day week I could probably carry on, but I don’t feel that is something which could be accommodated. Before my diagnosis I never contemplated having to retire early but now I see it as almost inevitable.” Provided by National Rheumatoid Arthritis Society

Response:

- Susannah has a health condition that limits her work capacity to three days a week (if she wishes to have some energy for her right to rest and free time)
- This is very unlikely to qualify her for ESA, given that she is currently able to carry out a computer-based job for around 30 hours a week (four days of 7.5hrs/day). Susannah would NOT qualify for ESA as she has the capacity to work for three days a week, but not four, and her criterion for working three days is based on her desire to have no limitations on her social life.
- Susannah has chosen not to ask for the reasonable adjustments (going down to three days a week) which she is entitled to, and which would allow her to keep working. Instead, she chose to retire.

Case study: Working with children with a hearing impairment

I lost my hearing progressively from early childhood and as it deteriorated it became harder to participate and I felt increasingly isolated and dependent. I became acutely aware that people had different expectations of me because I was deaf. However, I didn’t see myself, or my capabilities, as any different from my hearing friends.

I struggled in the workplace as I was increasingly unable to use the phone and found meetings challenging. I was fortunate to have excellent support from colleagues that I worked with

in the civil service and from speech to text reporters, made possible by the government's Access to Work scheme. In 2006, I had cochlear implant surgery and thanks to the technology and the habilitation support that I received afterwards, I was able to 're-enter' the hearing world, grow my confidence at work and in social situations. This enabled me to have a successful career in the senior civil service.

The speech and language therapists at St Thomas' Hospital in London provided me with the support to make sense of the new sounds that I was able to access through my hearing technology. Without such support, I would not benefit from the investment that the NHS makes in these wonderful devices. Habilitation is key.

I am now Chief Executive of a charity that works with deaf children and their families to provide critical support in the early years of their lives. This includes enabling them to develop the listening and spoken language skills that gives them an equal start at school and enables them to access the same opportunities in life as their hearing peers. Auditory verbal therapy is a parent coaching programme delivered by highly specialist speech and language therapists who have undergone an additional three years of training in auditory verbal practice. Our oldest graduates of the programme are now entering the world of university and work – equipped with the skills to succeed.

Anita Grover, Chief Executive, Auditory Verbal UK Provided by the Royal College of Speech and Language Therapists Achieving lasting change: investing in innovation

Response:

Anita Grover gives no indication that she has ever not worked because of her hearing impairment. It is very unlikely she would have qualified for ESA. As an example of genuinely early and adequate intervention, Anita is very good. But she is not an example of getting a job for an unemployed profoundly deaf person whose first - and predominant - language is BSL. Good employers put in place adaptations to retain employees; but not everyone has the luxury of a job contract with a good employer.

It should be noted that Anita had a medical intervention to 'cure' her deafness. The only message of this case study is that a cure can make you more employable and lead eventually to career progression - though Anita remained in the sphere of her disability - which is also her area of expertise. This is rare - and again is an example of a unique quality that made Anita ideal for the job, ahead of candidates who didn't have the same impairment or a cure.

Case study: Journey to Employment (J2E) Job Club

Jayne was employed, but life events affected her health and changed everything. Jayne joined the J2E Project in 2015 and she started her journey to recovery. Describing her time before the Job Club, she said, "I shut down to protect myself and drew inward trying to block things in work. I didn't feel I was functioning on 'all cylinders', my confidence was shot, I was checking up on what I was doing constantly and this spiralled out of control.

I felt I was in limbo I didn't really know what I wanted to do, I could not afford not to work so felt confused about where to go and who to seek help from. I was suffering with anxiety and terrible panic attacks, I was also depressed and can recognise now through help I have received and my own research that it was all due to the environment I was in.

I suffer mainly with anxiety and this escalated due to having to make the decision to leave my job to protect my mental health. Life was still awful, leaving work meant my fear increased and I was really down and family noticed the change in me. I wasn't getting up in the mornings and I was confining myself to my room.

I had a good supportive GP and work coach called Janis. I needed support to attend the appointment with Janis and felt that Janis really listened, had empathy and was so supportive. I felt

she was on my side, she indicated different choices and J2E sounded ideal to give me structure and at last it felt good to know where I was going.

I felt nervous going to see Louise my Community Employment Specialist, but once I met her and had a chat I knew that attending the J2E training course would be beneficial for me.

Attending the course gave me insight into my options, it helped me to manage myself better. Being amongst others that understood what I was going through, having balance and hearing about other people's lives gave me a perspective on my situation. By that I mean that, it made me see that some people were struggling with a great deal more than I was.

All my concerns, talking about my situation with other people were eased, because I felt the others in the group understood. I also completed a mindfulness course via my GP which lasted for 6 to 8 weeks, this also helped me self-manage."

Provided by Merthyr and the Valleys Mind

Response:

Jayne had an episode of depression and anxiety. It is implied that this was caused by a combination of life events and a bad environment, and not by a recurrent illness. Jayne resigned from her job and got support from her GP and a Work Coach. There is no indication of a need for medicine or counselling, bar a mindfulness course. Jayne felt helped by seeing that "some people were struggling with a great deal more" than her. It does not seem as though she applied for ESA. Taken together, this suggests that whilst Jayne's difficulties were acute, they were not so severe or enduring as the typical ESA recipient. They certainly were not chronic, and would not count therefore as a disability.

Case study – a community employment specialist

I am a Community Employment Specialist and really enjoy making a difference and changing attitudes, I have worked in a variety of roles and in various sectors, including small community development projects supporting people with multiple barriers to the workplace and managing a large branch of Waterstones booksellers. For most of my early life I struggled with a mental health condition and ended up claiming Employment and Support Allowance as I was not prepared to acknowledge or seek proper treatment for my condition. My mental health reached a crisis point and I ended up homeless and living in my car, at that point I did seek help.

After 9 months of this situation, I managed to secure a council flat and slowly began a recovery journey. I joined the Fed Centre for Independent Living because I wanted to work in a role where my experience and situation could actually help others instead of feeling like something I was always trying to hide.

I was thrilled at the opportunity of delivering a Journey to Employment (J2E) job club and support others. Working directly in Jobcentre Plus has enabled me to support work coaches, build relationships and provide advice to people with health conditions.

I also deliver J2E training which I deliver in a very flexible, person-centred way building the course content around each group of participants. I have support in the job club from a colleague who also has lived experience of managing a health condition, and exploring development of different coping mechanisms. This allows us to provide insight into the recovery journey, provide support wellbeing, resilience and respond to the changing needs of the people we work with so that we can support them on their journey back into employment."

Provided by Journey to Employment in Brighton Supporting young people

Response

This Case Study example reports that he or she "was not prepared to acknowledge or seek proper treatment for my conditions". This is a dangerous example to use as it suggests that a significant proportion of people on ESA are there because of their refusal to be treated. A Case Study should be chosen based on the extent to which it is representative of the people it is supposed to reflect. It is

rare to find someone with a chronic illness who does not wish to be well. Complex emotions may be involved, particularly where this is uncertainty about one's ability to cope, but it is simplistic to present this as being resistant to help. In this person's case, it may have been a desire to continue in work that kept them from admitting their illness or seeking help, or a perceived stigma against admitting mental illness. This is an attitude that is lauded in a country where sickness absenteeism is condemned, and sickness presenteeism barely mentioned.

Case study Robert

Robert, a secondary school teacher had a very severe stroke in September 2012. This led to paralysis of the right side of his body and his speech and reading abilities were affected by aphasia. He was determined to return to work, but even if the school could accommodate his wheelchair, he could not resume teaching until his speech was at the level required in the classroom to be understood.

Subsequently, Robert received individual speech therapy and also joined the local aphasia group where he presented weekly topics to the group and received feedback on his intelligibility. After 18 months of therapy, Robert began a phased return to work. During the first academic year, this was based around sixth form supervision and the following academic year it included a return to some teaching of younger years pupils. Robert's speech and language therapist completed the "Allied Health Professions Advisory Fitness to Work Report" to guide his employers on the level of support which was required for his return to work. For example, he needs extra time for written work so as not to compromise on accuracy.

Today, Robert works four short days per week and teaches whole classes of year 7 and 8 pupils. He also attends after school meetings and parents' evenings as required.

To get to this point, Robert received community speech therapy for some 18 months. This sounds like a long time to invest resources in the rehabilitation of an individual. It is but as a direct result, not only has Robert's life been transformed it has also saved him living on 20 years' worth of sickness benefits.

An account from his treating speech and language therapist – Provided by Royal College of Speech and Language Therapists

Response:

This is a good example of the type of support that should be available to all sick and disabled people, whether an illness is acute or chronic. It should also be available as a right, as the morally right thing to do. The government says that eighteen months is "a long time to invest resources" as though it should be praised for providing a decent level of healthcare and rehabilitation. There is nothing praiseworthy in doing one's duty. This case study is not exemplary; it is simply what should be provided for everyone who needs it, whether or not they work.

Expert Analyses

In this chapter, we include four contributions from people who are expert in particular areas that relate to sickness and disability policies. **Caroline Richardson**, an engineering graduate, writes on the proper process for designing a new system from an engineering perspective. **Catherine Hale**, author of *Fulfilling Potential? ESA and the fate of the Work-Related Activity Group* and service user of Seetec's Work Programme provision, writes about her concerns regarding the government's Work Coaches based upon her professional expertise and personal experience. **Jonathan Hume** analyses the distribution of ESA awards and shows how the WCA fails to be consistent, reliable and objective in the results it gives regarding a person's capacity for work. **David Gillon** looks at the 'Disability Confident' scheme and explains how it is essentially meaningless.

Design failure

Identifying the need

The Government has failed the basic rules of design. By starting out with an ideological goal of cutting social security it has had to rely on numerous falsehoods being established as fact in order to support its position.

The first falsehood is the attempt to portray all people in WRAG as curable, due to them having minor 'health conditions'. The report then moves through various other falsehoods:

1. Work is all-but universally good for people;
2. Work is a cure for illness and disability;
3. GPs are gatekeepers to benefits;
4. GPs don't use Fit Notes properly;
5. GPs don't engage patients with respect to work;
6. Individuals on ESA incorrectly believe that they are not well enough to work, or
7. incorrectly believe that they are not able to work without additional support;
8. These incorrect beliefs come from the (therefore also incorrect) judgement made in accordance with the WCA criteria;
9. These incorrect beliefs stem also from the incorrect beliefs of a person's GP,
10. and from the incorrect beliefs of a person's family and caregivers.
11. All health conditions are minor, common and curable with few exceptions;
12. All persons with mental health conditions and behavioural disorders are curable;
13. The NHS is not the place for cures;
14. A JobCentre Employment advisor renamed as a Work Coach can triage, diagnose and treat/advise on health conditions during a Work & Health Conversation and any further conversations;
15. Charities, third-sector organisations, carers and individuals are all responsible for ensuring that sick people know that they are capable of work;
16. Employers should look after the public health of their employees;
17. but there is no need to regulate against toxic workplaces or bad jobs;
18. The government has little to no responsibility beyond telling others how to behave.

Underfunding to create need

The Government has deliberately underfunded the support systems that are in place, partly to create a need that can be filled by the private and voluntary sectors. The NHS and social care in particular are grossly underfunded and are in crisis, unable to help people who need them. Systematic cuts to social security have removed the 'safety net' upon which people rely. Failure to

build affordable, decent housing and failure to provide diverse, good quality jobs across the whole of the UK leave people trapped in 'ghettos', unable to afford to live where the jobs are.

People are dying as a consequence of the spending cuts.

Because the public sector no longer provides for the needs of the poorest citizens, the government is able to allege a need for the private sector (employers) and third sector (charities, volunteers and informal carers) to fill its place. This is equivalent to telling these bodies to make bricks without straw – having first burnt the straw to create a smokescreen for the real problem, which is government cuts.

Design parameters and funding

The design of the system is limited by the funding - a drop of over 80% in work programme provision - and by redirecting funding away from medical expertise and into private provision.

Testing and reworking

Most designs involve testing the system for failure and risk analysis. There has been very little testing. The testing that has occurred shows that the best results are achieved by using the most expensive systems. The testing the government wants to see other organisations try means that instead of putting money into what works – and thus properly mitigating the cut to benefit of people awarded ESA WRAG – the government has made this cut before knowing what it is going to put in place to make this cut acceptable.

Limited open market testing

The Government should be testing the system via volunteers, where the data is kept anonymised, and the testers are rewarded for participation. This should be a larger sample size than the failure and risk testing group.

Rollout

Only when the system is proved to have no damage and shows clear success should the process be rolled out nationally; and only when there is clear evidence for the success of employment support methods should the financial situation (cutting the ESA WRA component) be addressed.

Design Failure

It is clear from the Green Paper that the suggested system is in disarray. Some elements have had limited and isolated testing, and many have not been tested at all. To reduce the spend on ESA the Government has decided to act as though it has a fully successful, safe system of employment support, when in fact it hasn't even tested the majority of the approaches it wants to see put in place for failure and risk.

Design success

If the system succeeds then there is no need to cut the WRA Component, because the desired savings will occur due to system success.

Work Coaches

The case for training in long term physical health conditions

The Department has rightly identified the need for training in mental health for work coaches, given the high number of ESA claimants with mental and behavioural disorders. However, there is an equally large gap in awareness and training around long term physical health conditions and the impact these have on work capability, which the Green Paper does not address. There are gaps in the policy measures designed to support people with fluctuating physical health conditions to work.¹⁷⁶

Long term physical health conditions are more difficult to classify and quantify as a group of ESA claimants using ICD codes than mental or behavioural conditions. They include chronic infections such as hepatitis and HIV; inflammatory bowel diseases such as Crohn's Disease and ulcerative colitis; neurological conditions such as multiple sclerosis (MS), myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and Parkinson's; rheumatological disorders such as fibromyalgia, repetitive strain injury (RSI), rheumatoid arthritis and systemic lupus (SLE); and hormonal disorders such as diabetes.

Within ICD classification, diseases of the nervous system, circulatory and respiratory diseases and musculoskeletal and connective tissue disorders, along with certain infectious diseases and diseases of the blood together make up **almost 30% of the total ESA caseload**.¹⁷⁷ Many of the conditions included in these disease categories have been described as "fluctuating conditions." Patient representative organisations for these conditions report that some of the key impairments in these conditions involve fatigue, pain, cognitive dysfunction and multiple impairment and that these features are inadequately captured by the WCA descriptors.¹⁷⁸

It is likely that these features will also be poorly understood by work coaches in Jobcentres. In a conditionality system based upon discretion and personalisation, people with long term physical health conditions will be at risk of unreasonable conditionality and inappropriate sanctions if the impact of their health condition is not well understood by work coaches.

How prevalent is impairment related to fatigue and pain?

A third of disabled people of working age report difficulty with stamina, fatigue or breathing.¹⁷⁹

In a convenience sample of over 500 ESA claimants in the Work Related Activity Group (WRAG) in 2014, 55% reported "symptoms of fatigue, pain, breathlessness or nausea" to be a "main factor" in their limited capability for work (LCW); a further 23% said these symptoms affected them "to some extent". 33% cited cognitive dysfunction ("problems with concentration", often referred to by patients as "brain fog") as a main factor in LCW; with a further 50% saying it limited them "to some extent".¹⁸⁰

These findings are echoed in a survey of 300 disabled people's views of the ESA system from 2015.¹⁸¹ More than half reported severe or fairly severe difficulties¹⁸² with work due to pain (60%), fatigue (76.5%; 56% with severe fatigue) or poor concentration (67%) arising directly from their health condition. The side-effects of medication can cause the same problems, with over two in five respondents experiencing severe or fairly severe difficulties with work due to pain, fatigue and concentration arising from the side-effects of medication.

¹⁷⁶ The Work Foundation, 2015. Fluctuating Conditions, fluctuating support: improving organisational resilience to fluctuating conditions in the workforce.

¹⁷⁷ <http://tabulation-tool.dwp.gov.uk/100pc/tabtool.html> Data on ESA claimants as of May 2016.

¹⁷⁸ MS Society et al., 2011. Employment and Support Allowance Work Capability Assessment: making it work for fluctuating conditions.

¹⁷⁹ Family Resources Survey, Disability Data Tables, 2014/15.

¹⁸⁰ Hale, C., 2014. Fulfilling Potential? ESA and the fate of the Work Related Activity Group. Mind.

¹⁸¹ Benstead, S. & Nock, E. 2016. Replacing Employment and Support Allowance: Part One - support needs of people with chronic illness. Ekklesia.

¹⁸² Unless stated otherwise, all figures in this section are for the percentage of respondents reporting severe or fairly severe difficulties with work arising from a particular symptom.

Recommended content of training for long term physical health conditions

The challenges for work coaches in tailoring claimant commitments and work related activity plans for people with long term physical health (LTPH) conditions are:

- Understanding the impact of impairment due to fatigue, pain, loss of stamina and breathing difficulties on work capability;
- Understanding the impact of variability of impairment over days, weeks and months on employability;
- The invisible nature of this type of impairment and difficulties of objective assessment; and
- Understanding the impact of work or work related activity itself on this type of impairment.

In order to support people with long term physical health conditions effectively, work coaches should be trained in:

- **Understanding the spectrum of impairment found in LTPH conditions.** In some people, severe fatigue limits their daily activity to self-care only (some even need support with self-care) meaning no work-related activity in addition to self-care is possible. Some may manage a few hours of work-related activity per week in addition to self-care; others may manage part time employment with adjustments. It is vital that the work coach can accurately determine the impact of fatigue-related impairment on daily living before designing an appropriate Claimant Commitment.
- The measures which may support people with LTPH conditions at the higher end of this spectrum to remain in or take up employment, e.g. reduced hours, flexible working and home working.
- The importance of shared decision making, empowerment, flexibility, open communication and trust between a prospective employee, employer and work coach when supporting someone with a LTPH condition into work.¹⁸³
- Advising claimants who have the capacity to retain or enter employment on the relevant **legislation and programmes** which could support them:
 - The right to request flexible working, including home working, for existing employees. This is explained in detail in the SEE M.E. Toolkit for Professionals which is relevant to a range of other physical health conditions;¹⁸⁴
 - The role of the Equality Act 2010 in protecting them from discrimination;
 - The right to reasonable adjustments under the Equality Act 2010; and
 - How the Access to Work scheme can support employment for people with LTPH conditions¹⁸⁵
- **Understanding the impact of work related activity on health and wellbeing.** Whilst work is generally good for health, this depends on the nature of the health condition as well as the nature of the work. With some fluctuating physical health conditions, exertion may increase impairment, usually temporarily (known as “payback”) or sometimes more permanently if over-exertion is sustained over a long period. With invisible, fluctuating conditions, the impact of a particular activity is usually not apparent at the time, and only becomes apparent subsequently. For example, the activity of attending an appointment with a work coach may cause a person to become significantly more incapacitated for subsequent days as a result of exertion and have difficulties with their usual self-care activities. In this case the advantages of engaging with work coach support would be outweighed by the substantial negative impact on health and wellbeing as a consequence. This understanding is vital if work coaches are to offer tailored and personalised support and conditionality; and
- **Understanding the impact of work on health and wellbeing on people with LTPH conditions already in work.** Under Universal Credit arrangements, work coaches will have

¹⁸³ The Work Foundation, 2015.

¹⁸⁴ Action for M.E., 2016. Support, empower and employ people with M.E.: a toolkit for professionals

¹⁸⁵ Ibid.

contact with people working part time as a strategy to manage their health condition and remain in employment. It is vital that these people are not subject to pressure to increase their working hours where this would be detrimental to their health and wellbeing.

For better or worse: changes in ESA prognosis

I've had *far too many* Work Capability Assessments. I think I've had something like 8 since 2010, mostly done on paper. Between each one, my condition has either not changed substantially, or has become worse. It struck me that this has *never* been reflected in the results of my WCA.

My original prognosis (as given by the assessor, not my consultant) was 2 months, then went up to 2 years and finally became "indefinite" (I have an incurable condition). But I was still being placed in the 'Work-Related Activity Group', despite being assessed as unable to work and unable to become able to work (the 'indefinite' prognosis). My health got worse, and on the urging of relevant people, I tried to get into the Support Group. I failed - and my prognosis was *reduced* to 18 months. The council's advisor said this was likely a punishment for daring to question them (no, really.)

I did what I always do when I'm annoyed - moan on Twitter. After that, I had a look for data on changes in ESA prognosis, to see if other people had had experiences like mine. There wasn't any, so I began an annoyingly drawn out Freedom of Information case against the DWP. It ended up with the Commissioner having to intervene to get them to give me the data after ignoring me for months on end.

Eventually, this is what I got:

Table 1. Prognosis and WCA outcomes for people originally assigned to ESA WRAG:

	SG (#)	WRAG (#)	FFW (#)	SG (%)	WRAG (%)	FFW (%)
No change	56,500	12,100	91,700	17.91	3.84	29.07
Increase	78,200	37,300		24.79	11.83	
Decrease	24,400	6100		7.74	1.93	
Terminal		600			0.19	
Unknown	6,200	2,300		1.97	0.73	

Table 2. Prognosis and WCA outcome for people originally placed in the Support Group.

	SG (#)	WRAG (#)	FFW (#)	SG (%)	WRAG (%)	FFW (%)
No change	47,700	6,400	23,400	23.18	3.11	11.37
Increase	90,400	8,600		43.93	4.18	
Decrease	13,900	4,800		6.75	2.33	
Terminal	2,600			1.26		
Remain	1,100			0.53		
Unknown	5,900	1,000		2.87	0.49	

Table 3. Changes in prognosis across all groups

Prognosis Change	Fit for Work	No change	Increase	Decrease	Became terminal	Remain terminal	Unknown	Total
Total	115,100	122,700	214,500	49,200	3,200	1,100	5,900	511,700
Percentage	22.49	23.98	41.92	9.62	0.63	0.21	1.15	100

You'll notice a few things that seem a little bit off. For example, 4.2% of people in the Support Group are reassessed and placed into the WRAG, but their 'prognosis' (when they should be reassessed as possibly fit for work) has increased? 2% of people being placed in the Support Group after being in the WRAG have a decreased prognosis - their condition is worse, but more likely to improve?

20% of WRAG claimants and 25% of Support Group claimants are given the same prognosis in later assessments, despite the fact that the prognosis was evidently wrong the first time. 50,000 people (around 10%) had their prognosis reduced - the assessor decided that they were likely to improve in a shorter length of time, despite being unwell for longer than the previous assessor had estimated they would be.

The DWP says that the prognosis given is just how they schedule assessments, but if you've seen a WCA report, you will know that the prognosis is the time at which the assessor thinks the claimant will be able to get a job. In any case, if it isn't related to when the assessor thinks the claimant will be able to work, what is the point of a re-assessment?

The prognosis system is important for claimants. It determines the frequency of assessments (a massive strain in itself), but also the claimants' conditionality. Lower prognoses trigger the claimants' "eligibility" for the Work Programme. This data shows that there is little consistency or logic in how prognoses are determined. In 10% of cases, the assessor is predicting a faster return to work than previously, despite no improvement in health or even a significant worsening.

Ticked Off – Going through the Motions of Replacing Two Ticks

The Disability Employment Gap

The UK workforce features a prominent Disability Employment Gap. In 2015/16 80% of non-disabled people of working age were employed; for disabled people of working age that figure is only 47%. Disabled people want to work; the problem arises in the recruitment and retention of disabled people by employers and recruiters. Disabled people face a systematic disadvantage in recruitment that has remained constant across decades. To use a starker phrasing, disabled people face institutional disablism in recruitment and in the workplace.

In 2014 the government committed itself to halving the disability employment gap by 2020. This commitment is now the Disability Employment (Gap) Bill [HL] 2016-17.

Two Ticks to Failure

Positive About Disability, better known as *Two Ticks* from its logo, was the UK government's scheme intended to encourage the recruitment and retention of disabled people within the workforce. Introduced in 1990, and administered through DWP's JobCentre Plus offices, Two Ticks required employers to commit to five simple measures:

- to interview all disabled applicants who met the minimum criteria for a vacancy;
- to meet with disabled employees, at least once a year, to ensure all their needs were being met;
- to make every effort to ensure employees who become disabled could stay in their jobs;
- to ensure the disability awareness of all employees necessary to these commitments; and
- to review the five commitments annually, plan how to do better and report back to both employees and Jobcentre Plus.

It rapidly became clear to disabled people that *Two Ticks* was a sham. The scheme was supposed to be administered by Disability Employment Advisers at local Jobcentre Plus offices, but DEAs were overloaded with a far higher client/adviser ratio than other JobCentre Staff and the scheme was rarely policed. The reality for disabled people was that employers would sign up to *Two Ticks*, add

the logo to their headed paper in order to impress their customers and the great and the good, and then carry on not employing disabled people in just the same way they always had.

A Freedom of Information request to DWP in 2012 (FoI 402 08.02.12) produced a list of slightly under 4,400 organisations then registered with Jobcentre Plus as *Two Ticks* employers. However, this list contains many duplicate entries. Figures quoted in an article in *Recruiter* in June 2014¹⁸⁶ suggested that around 8,400 organisations had been awarded the *Two Ticks* logo over the lifetime of the scheme. Government figures stated that there were 4.9 million private sector employers in the UK in 2013, 99.9% of which were Small or Medium Sized Employers (SMEs), giving *Two Ticks* a sign-up percentage of around 0.0017% after a quarter of a century of existence and without counting Public Sector employers. The *Recruiter* article additionally noted that less than half of FTSE 200 firms, theoretically the leading employers in the UK, were *Two Ticks* employers.

By the early 2010s, *Two Ticks* was in thorough disrepute. In January 2013, the then Minister for Disabled People, Esther McVey, announced an inquiry into whether *Two Ticks* was fit for purpose. In 2014, research by Professor Kim Hoque, of Warwick Business School, and Nick Bacon, of London's Cass Business School,¹⁸⁷ showed that, of companies displaying the *Two Ticks* symbol, only 15% - less than one in six - carried out all five commitments. 38% carried out only one of the commitments, and 18% - almost one in five - carried out none of the commitments whatsoever, yet continued to display the logo. Results were consistent across both Public and Private Sectors. Taken together, over half of companies displaying the *Two Ticks* logo carried out either only one, or none, of the five commitments.

The Business Disability Forum criticised the research for using Trade Unions to report back on the reality of *Two Ticks*, claiming only 15% of private sector employers with more than 10 employees are unionised. However, the research itself noted that percentages were consistent across both Public and Private Sectors and even a cursory glimpse at the list of employers resulting from the Freedom of Information request referred to above shows that the majority of *Two Ticks* employers are Public Sector organisations or otherwise likely to be unionised. Professor Hoque identified the failure to police the scheme as a fundamental reason for its failure.

In response to the research, even the DWP admitted that *Two Ticks* had become 'outdated'. However, they tried to suggest that the issue was insufficient support for employers, rather than employers wanting the kudos of the logo without being forced into any actual change in their employment practices. The intent of the scheme, to support disabled employees and applicants, was not addressed.

The *Two Ticks* requirements were hardly major commitments. Most could be incorporated into existing procedures for recruitment or annual appraisals, yet the research showed that disabled people approaching a company displaying the *Two Ticks* logo, or employees who became disabled while working for a *Two Ticks* company, were more likely to find the logo was a façade behind which nothing had changed, than to actually find the support the employer had publicly committed themselves to. The research concluded that employers were using *Two Ticks* for 'impression management purposes' rather than to improve the employment, and employment conditions, of disabled people.

Disability Confident - or not?

In July 2013 the government launched *Disability Confident* as the latest in a line of DWP schemes intended to encourage employers to take on more disabled employees. The focus of these DWP schemes has long been the subject of criticism from disabled people, with heavy featuring of supposed role-models in a manner that almost inevitably strayed into outright inspiration porn and a refusal to address the real life experience of workplace disability discrimination. Unlike previous

¹⁸⁶ Cottell, C. 2014. Two-ticks scheme loses value and meaning with employers. *Recruiter*

¹⁸⁷ Hoque, K. & Bacon, N., 2014. Employer Disability Practice in Britain: Assessing the Impact of the Positive about Disabled People 'Two Ticks' Symbol. *Work, Employment and Society*.

schemes *Disability Confident* was much higher profile, and much more blatant in its inspiration porn, using Paralympians and prominent disabled ex-servicemen to draw business people into its events. That this thoroughly denormalizes disabled workers, and focusses attendees on how ‘inspiring’ we are, is something Disability Confident and its advocates have consistently refused to address. Arguably worse was its oft-stated position that the reason for the Disability Employment Gap was that employers are ‘embarrassed’ about disability. Any mention of workplace discrimination has been notably absent from Disability Confident material.

The Disability Confident scheme has been heavily criticised by disabled people since its launch, at one point a Disability Confident event was invaded by Disabled People Against the Cuts, and its 2015 declaration of Swansea as the first (and so far only) Disability Confident City came in for widespread derision, with the DWP unable to explain what a Disability Confident City was, or why Swansea qualified.

Disability Confident has also faced consistent criticism for its low level of sign-up, with the overwhelming majority of organizations signed-up to it being either charities or organisations with a business interest in the employment of disabled people. Despite Iain Duncan Smith declaring in a speech at the 2014 Conservative Party Conference that 1000 organisations had signed up to Disability Confident, Disability News Service showed that the number signed by June 2016 was only 126,¹⁸⁸ with perhaps as few as 40 of those being mainstream employers. Sign-up of small and medium-sized employers was almost non-existent.

Originally due to run for only two years, Disability Confident was extended in 2015 and in 2016 there were rumours that it was due to be relaunched.

Ticked Off

After Two Ticks came under increasing criticism in 2013/14, the DWP announced that it would be replaced. Following publication of the Hoque/Bacon research, a DWP spokesman was quoted by Disability News Service as saying: “*We are seeking to reform the accreditation to make it a more dynamic and effective system.*” It was also reported that the revised scheme would see wider publicity, different levels of accreditation, a more rigorous assessment process, and improved information and guidance. It was also speculated that there would be provision for disabled employees to provide feedback on actual performance of registered employers.

In July 2016, Disability News Service reported that there had been an unannounced replacement of Two Ticks by a refocussed Disability Confident. By August 2016, DWP webpages were referring to Disability Confident rather than Two Ticks, but there had been no formal launch or publicity.

Disability Confident V2.0, Ticking all the Wrong Boxes

When Disability News Service pointed me to the relaunched Disability Confident and asked for my opinion, my expectations were low. The scheme has consistently failed to address the core issue of the Disability Employment Gap, which is recruiter and workplace disablism. Yet I was still unprepared for what I found.

Two Ticks had fallen into disrepute because only one in five of the employers displaying the logo actually lived up to their commitments, a failure that had been attributed to the lack of active policing. DWP’s solution to this was to slash the commitments needed in order to display the new logo, and to remove any pretence of monitoring.

Under the new Disability Confident Level 1, employers can now display the new Disability Confident Employer logo by making a single commitment, to interview qualified disabled applicants, and no one will check them on it.

Under the new Disability Confident Level 2, employers make several more commitments, and again no one will check them on it. However, the majority of these commitments would be

¹⁸⁸ Pring, J. 2016. Disability Confident attracts just 40 mainstream private sector partners. Disability News Service

considered ‘reasonable adjustments’ under the Equality Act 2010, and employers are required by EA2010 to make reasonable adjustments for disabled employees or potential employees, unless they can show that these are not reasonable. Disability Confident is therefore allowing employers to declare themselves Disability Confident Level 2 employers by committing to do no more than they are already legally required to do. And having seen what is considered a Level 2 commitment, it follows that Disability Confident Level 1 is actually being granted for committing to do less than is required by law.

Disability Confident Levels 1 and 2 together appeared roughly equivalent to the original five Two Ticks commitments, so I initially hoped that Level 3 would actually represent a step forward over Two Ticks. I was wrong. Level 3 is available simply by getting an external organisation to check your implementation of Level 2. While this could be a valid audit carried out by a specialist disability access advisor, that isn’t actually required. Level 3 accreditation can also be granted by any disabled people’s user led organisation (a DPULO), or by any other Level 3 organisation. To reduce it to its most absurd possibilities, one organisation could be audited by a DPULO that knows nothing about disability employment issues, say one focussed on disability sport, and that organisation could then go on to audit every other Level 2 company in the country and accredit them at Level 3, without any of them ever coming into contact with anyone who understands the issues faced by disabled people in the workplace.

Level One is self-policed and grants the logo for doing less than is required by law. Level 2 is self-policed and grants the logo for doing no more than is required by law. Level 3 is externally assessed, but has massive potential for abuse. It is as though someone looked at Two Ticks and said ‘this is how it’s being abused, how do we legitimise that behaviour?’ I would have said it was impossible for a scheme to be worse than Two Ticks, but the DWP have proven me wrong.

And of those 2014 predictions for what the revised scheme would feature:

- **Wider publicity:** So little publicity people thought the relaunch had been cancelled;
- **Different levels of accreditation:** Provided, but by splitting up the existing commitments rather than extending them;
- **More rigorous assessment:** Replaced by self-assessment;
- **Improved information and guidance:** Discussed below; and
- **Feedback from disabled employees:** Completely absent.

The Disability Confident Commitments

A side by side presentation of Two Ticks, the two new levels of Disability Confident and legal (Equality Act 2010, EA2010) requirements is revealing. The original text has been paraphrased to cut multiple pages down to a manageable format.

To establish a baseline, Two Ticks is first considered separately from Disability Confident.

Two Ticks	EA2010	Commentary
Interview all disabled applicants who meet the minimum criteria.	Applicants cannot be excluded on the basis of disability alone.	This was notoriously unpoliceable. Companies simply claimed disabled applicants did not reach the minimum criteria.
Meet with disabled employees to ensure needs are met, at least once a year.	Disabled employees are entitled to reasonable adjustments as and when needed.	A standard annual performance review could be claimed to meet this.
Retention of employees who become disabled.	Disabled employees are entitled to reasonable adjustments as and when needed.	In many cases exactly the opposite happened: disabled employees were forced out even in companies displaying Two Ticks.

Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination (either direct or indirect) against a disabled employee and they fail to address it.	Easily addressable during induction, but rarely done.
Review the five commitments annually.	Not required by law. However, not monitoring performance relevant to employment law is a business risk.	So trivial to meet, but so rarely done.

Level 1

Based on observed behaviour in relation to Two Ticks, in particular the tendency to do the minimum possible, Level 1 of Disability Confident is likely to be the level pursued by the overwhelming majority of applicants. The table therefore compares the single Level 1 commitment with the five Two Ticks commitments.

Disability Confident L1	Two Ticks	EA2010	Commentary
Interview all disabled applicants who meet the minimum criteria.	Interview all disabled applicants who meet the minimum criteria.	Applicants cannot be excluded on the basis of disability alone.	This is notoriously unpoliceable. See Comment 1.
Not required.	Meet with disabled employees to ensure needs are met, at least once a year.	Disabled employees are entitled to reasonable adjustments as and when needed.	Even the bare minimum legal obligation to consider reasonable adjustments is not required by L1.
Not required.	Retention of employees who become disabled.	Disabled employees are entitled to reasonable adjustments as and when needed.	A Disability Confident L1 employer can force out an employee who becomes disabled.
Not required.	Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination.	You can claim Disability Confident L1, yet have staff with no disability awareness training.
Not required.	Review the five commitments annually.	Not required by law. However, not monitoring performance relevant to employment law is a business risk.	So trivial to meet, but so rarely done.

Comment 1: I've already seen employer comments saying, paraphrased, "We're committed to interviewing them, but there's no way we're employing someone with that disability, how do we get out of this?"

Level 2

Level 2 is divided into two tables here, one for each of its two themes (Recruitment and Retention/Development). The requirements are condensed down from some 20 pages.

Theme 1: Recruitment

Disability Confident L2	Two Ticks	EA2010	Commentary
Actively look to attract and recruit disabled people.	Interview all disabled applicants who meet the minimum criteria.	Applicants cannot be excluded on the basis of disability alone.	More proactive than Two Ticks, but simply asking for JCP's help would count. There is no requirement to actually employ someone.
Provide an inclusive and accessible recruitment process.	Ditto	Disabled employees are entitled to reasonable adjustments as and when needed.	Reasonable adjustments, it's the law!
Interview all disabled people who meet the minimum criteria.	Ditto	Applicants cannot be excluded on the basis of disability alone.	Already required by L1, and still notoriously unpoliceable.
Flexible assessments so disabled applicants can demonstrate they can do the job.	Ditto	Disabled employees are entitled to reasonable adjustments as and when needed.	Reasonable adjustments, it's the law!
Make reasonable adjustments as required.	Ditto	Disabled employees are entitled to reasonable adjustments as and when needed.	This is the law of the land, not some optional extra deserving praise and the reward of a logo.
Encourage suppliers and partner firms to be Disability Confident.	New		This is new and actually quite good – if Disability Confident meant anything.
Ensure employees have disability equality awareness.	Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination against a disabled employee and they fail to address it.	Teach equality, or face the consequences.
Take at least one of the activities below:	Most implied by: Interview all disabled applicants who meet the minimum criteria.		See Comment 2 for several general points. Remember a single one of these would be a pass.
<ul style="list-style-type: none"> Provide work experience 	Ditto		Work experience placements by schoolkids apparently not excluded.

<ul style="list-style-type: none"> Provide work trials “to see potential recruits in action”. 	Ditto	Applicants cannot be excluded on the basis of disability alone.	See Comment 3
<ul style="list-style-type: none"> Provide paid employment (permanent or fixed term). 	Ditto	Applicants cannot be excluded on the basis of disability alone.	Could be passed by employing a disabled contractor for a single day.
<ul style="list-style-type: none"> Provide apprenticeships. 	Ditto		Just have to exist
<ul style="list-style-type: none"> Provide traineeships (sub-apprentice level). 	Ditto		Just have to exist
<ul style="list-style-type: none"> Provide paid or supported internships. 	Ditto		Just have to exist. See Comment 4
<ul style="list-style-type: none"> Advertise vacancies in disability media. 	New		Assumes disabled people read them. Most won't. I've never heard of several of the proposed venues!
<ul style="list-style-type: none"> Engage with JCP, Work Choice providers or DPULOs for support. 	New		Just saying to your local JCP “I was wondering about employing disabled people” appears to be a pass.
<ul style="list-style-type: none"> Provide an accessible environment for staff and customers. 	Meet with disabled employees to ensure needs are met , at least once a year	There is a presumptive duty on all organisations to provide accessible services; waiting until someone is forced to demand a reasonable adjustment fails to meet this. Disabled staff and customers remain entitled to reasonable adjustments as and when needed.	‘Can I get in the door’ shouldn't be a criterion, but so often is. Putting this in the options mean it is possible to be awarded Disability Confident with an inaccessible workplace.
<ul style="list-style-type: none"> Otherwise encourage disabled people to apply. 	New, but so, so woolly.		“We put a job ad for disabled people in a locked filing cabinet in the cellar behind a door saying ‘beware of the panther’”.

Comment 2:

- The intention is obviously that these should be applied in relation to disabled recruits, but the wording in most of the cases doesn't actually say that. Given the known history of abuse of the Two Ticks criteria and the switch to self-assessment, this is either incredibly naïve, or utterly intentional.
- Most of these options collapse to a general 'be willing to employ a disabled person', which is already required by the "Actively look to attract and recruit disabled people".
- Most of these options relate to entry level positions. There is little to no focus on employing disabled people in professional/managerial positions.
- The "one or more of" structure creates an either/or potential between being willing to employ disabled people, and having an accessible building. Disabled people, of course, require both.

Comment 3: "to see potential recruits in action" is a disturbing re-interpretation of the intent of a work trial, which is normally understood as an opportunity for a disabled candidate to confirm to themselves that they can manage the job without health consequences. This can be read as a disabled recruit facing an additional pass/fail test compared to a non-disabled recruit, which would be direct disability discrimination counter to EA2010.

Comment 4: "Supported internships do require time and commitment to set up, so might be most appropriate for a larger employer". Is this trying to talk people into providing them, or out of providing them? Additionally, it creates a presumption that disabled people who require support workers are not employable by small or medium sized enterprises (SMEs).

Theme 2: Retention and Development

Disability Confident L2	Two Ticks	EA2010	Commentary
Promote a culture of being Disability Confident.	Ensure employee disability awareness.		Disability Confident's cultural dependence on inspiration porn is not going to help.
Support employees to manage their disabilities or health conditions.	Meet with disabled employees to ensure needs are met , at least once a year.	Disabled employees are entitled to reasonable adjustments as and when needed.	Unfortunate wording implies managers may involve themselves in how the employee deals with disability. See Comment 5.
Ensuring there are no barriers to the development and progression of disabled staff.	Meet with disabled employees to ensure needs are met , at least once a year.	Allowing such a barrier to exist would be disability discrimination.	Credit given for not breaking the law. See Comments 6 and 7
Ensure managers are aware of how they can support staff who are sick or absent from work.	Meet with disabled employees to ensure needs are met , at least once a year.	Disabled employees are entitled to reasonable adjustments as and when needed.	Not actually disability specific.
Listen to feedback from disabled staff.	Meet with disabled employees to ensure needs are met , at least once a year.	Staff raising disability related issues are specifically protected from retaliation.	See Comment 5

Continual self-assessment.	Review the five commitments annually.		Established as good practise in all business areas.
Take at least one of the activities below:			
<ul style="list-style-type: none"> Provide mentoring and support networks. 	Meet with disabled employees to ensure needs are met , at least once a year.		
<ul style="list-style-type: none"> Disability awareness training. 	Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination	Why is this an option? How can you be Disability Confident with untrained staff?
<ul style="list-style-type: none"> Keep staff informed on mental health issues. 	Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination.	See Comment 8
<ul style="list-style-type: none"> Provide occupational health services. 	Meet with disabled employees to ensure needs are met , at least once a year.	Disabled employees are entitled to reasonable adjustments as and when needed.	Employees and managers require OH advice to provide appropriate support. Impossible to be Disability Confident without professional support.
<ul style="list-style-type: none"> Identify and share good practice with business partners. 	New.		New and good, but not an excuse to not provide the other options.
Provide HR staff and recruiters with Disability Confident training.	Ensure employee disability awareness.	Employers are liable for the actions of their employees if these result in discrimination.	See Comment 9

Comment 5: There is a long history of disabled people being penalised for admitting disability, up to and including summary dismissal. Similar persecution has also followed calls for disability related improvements, or just adherence to equality law. Disabled people are well aware of this and there is a considerable body of advice urging disabled job applicants not to acknowledge disability unless absolutely necessary. These are points where Disability Confident is absolutely required to address the history of workplace disability discrimination in order to allow the employer to understand the reluctance to engage they are likely to encounter. It does not, for what can only be presumed to be its ongoing politically-motivated insistence that workplace disability discrimination does not exist.

Comment 6: "This could include: encouraging disabled staff to be ambitious and seek progression in the workplace, **including increasing hours**". Further evidence of a profound disconnect in Disability Confident's understanding of disability. Many disabled people have limited energy and may struggle to complete even part-time hours. Linking advancement to increased hours creates a presumption that actively links ability and promotion to endurance/energy, even though

this would be constitute discrimination under EA2010 if not actively required by the position. "Including increasing hours" therefore makes no sense from a disability perspective. However, it makes complete sense as an ideologically driven inclusion related to DWP's initiative to force people in receipt of Universal Credit to increase their hours if not in full time working. As far as Disability Confident is concerned, it appears ideology trumps legality.

Comment 7: "monitoring, whether formally or informally, progression rates for disabled staff and ensuring they are in line with general progression rates". This is actually a good suggestion, though of course it should be done for every minority group.

Comment 8: "guiding staff to information on mental health and well-being in the work place can help them identify the symptoms and know how to support their team members and colleagues" This is frankly disturbing in its call for staff, and particular supervisors, to engage in amateur psychological diagnosis and/or treatment.

Comment 9: Poor layout means the status of the requirement to train HR staff is unclear. Layout and format appear to imply it is meant as a separate activity equivalent in level to the "Take at least one of the below", but this is far from clear and is contradicted by an initial instruction that only one activity from the optional lists in each theme need be completed.

To illustrate just how badly the Disability Confident criteria are written, you can be awarded Disability Confident at Level 2, and therefore also at Level 3, with no disabled employees and an inaccessible workplace. You just have to claim to be willing to take on a disabled employee (even if you aren't), while workplace accessibility falls under 'one or more of these 10 options'.

Over and beyond my normal criticism of Disability Confident; writing process documents is something where I have extensive professional experience. The Disability Confident requirements defining how to reach each of Levels 1, 2 and 3 are dreadful. They are unclear, inconsistent, and utterly riddled with loopholes. They make Two Ticks look like a model of good practise.

So What is Actually New in Disability Confident?

There are elements of Disability Confident that are new in comparison to Two Ticks, however they are largely peripheral. The principal change is one of focus, from simply prescriptive to an attempt to educate. Unfortunately this isn't actually particularly good, or founded on any deep understanding of the issues disabled people will encounter in the workplace. Worse, it attempts to both prescribe and educate in the same sentence, with the result that the requirements are obfuscated, or defined so loosely as to be useless. The three level documents should have been divided into separate "You must do" and "This is how" sections.

Beyond that, the new elements consist primarily of trying to tie the Two Ticks element of Disability Confident into the wider Disability Confident programme. Being a model of good practise is valuable, but should not have the potential to free an employer from, for instance, providing disability awareness training, which the current requirements allow.

Tallying Disability Confident against Two Ticks, we see that even at Level 2 (and therefore Level 3 also, as the only difference is external assessment), requirements have been loosened, rather than the promised tightening. Many elements that were required under Two Ticks, for instance Disability Awareness Training, are now optional under Disability Confident, but the poor layout makes this almost impossible to realise with anything less than a systematic point by point comparison.

Not So Disability Confident Conclusions

We were promised a stronger scheme with increased external supervision. We have been delivered a weaker scheme with no external supervision.

The replacement for Two Ticks turns out to be worse in almost every respect. It is trivially easy to look at the way that Two Ticks was abused and see that Disability Confident further enables that abuse rather than preventing it. DWP civil servants may have problematic views of disability,

but they are by no means stupid, and they are past masters of using the letter of a process to justify either action or inaction, whichever is most politically expedient at the time. If Disability Confident is trivially easy to abuse, then perhaps that was in fact its primary design constraint. There was a telling comment from one of the architects of the scheme in the DNS article on the launch: 'if we had asked them to do anything more they wouldn't have signed up', but when the commitments are so loose as to be worthless, why bother having the scheme at all?

There is a cynical answer to that question. That the point of the exercise is not to make things better for disabled people, but to be seen to be doing something by non-disabled people. Cynical, perhaps, but all too believable.

Conclusion

This report is a response to the Green Paper. It is not as comprehensive as Spartacus Network would have liked. The Green Paper is a complex and misleading document, and we believe it is deliberately so.

It is clear that this legislation – the seventh attack on payments to people who are sick and/or disabled in as many years¹⁸⁹ – will leave people without the support system the Government promised would mitigate the scrapping of the ESA WRA component, as this starts in April yet the Government is still seeking, trialling and testing the systems it claims will mitigate the effects of this cut.

Throughout the Green Paper the Government introduces various hypotheses, such as ‘work as a cure’, and then carries this hypothesis forward as fact. Many of the ideological statements given can be disproved; for example, Waddell and Burton pointed out clearly in their oft quoted report that work can be bad for a person.¹⁹⁰ It is this conversion from hypothesis to fact that has allowed the Government to distort the truth and suggest ‘solutions’ for problems created singularly by them from falsehoods. Additional to this is the use of weak evidence – e.g. the evidence of 5 couples and then extrapolating across all of society, or selecting a low deprivation index to suggest a false correlation.

Another example is the ‘disability employment gap’, for which there are numerous figures available, dependant on how employment and disability are measured. Yet the Green Paper makes numerous fundamental errors – this is not just in calculating the gap, but also in failing to recognise that people often recover, and hence when they return to work they are no longer counted as a ‘disabled person in work’. Hardly surprising then that the level of disability employment is fairly constant – if recovery is a pre-cursor to work then recovery also removes the person from the criteria of being ‘disabled’ under EA2010.

A third error is the government’s repeated referral to chronic illness as ‘health conditions’, which it covertly defines by the examples it uses as obesity, back pain, smoking, problematic drinking, depression and anxiety. Having created this definition, the government carries it forward under the assumption that no other illnesses or disabilities (bar learning disabilities) exist. Not only that, it assumes that all people who experience these public health conditions experience them in a mild-moderate form, and only one at a time. Thus the government is able to talk about low-level, isolated medical care as a viable support mechanism for this group.

Such low-level care is not viable. Where people are on ESA because of these ‘public health’ conditions, it is because of experiencing multiple conditions in such a severe form as to make work incompatible with their current capacity for activity. What is needed is not isolated low-level interventions, but contemporaneous high-level support. For people with chronic illness not coming under the ‘public health’ banner, good quality, ongoing healthcare is also necessary. The government must also acknowledge that, unlike public health conditions, it is often not possible to

¹⁸⁹ (Time limit for those in the WRAG) Announced Autumn Statement 2010, updated Budget 2012 - (Abolish NI youth concession) Announced Budget 2011 - (Apply a 7-day waiting period) Announced Budget 2014 - (Additional healthcare professionals) Announced Autumn Statement 2014, updated Budget 2015 - (Restricting repeat claims) Announced Autumn Statement 2014, updated Budget 2015 - (Align WRAG rate with JSA) Announced Summer Budget 2015, updated Budget 2016

¹⁹⁰ Waddell and Burton, 2006.

achieve an improvement in health that permits a return to work, only a management of health that – coupled with decent social security – can allow a person to maintain a decent quality of life and good wellbeing.

The Green Paper, as mitigation for cutting the ESA WRA Component, has suggested a series of new Work Programmes, with embedded health treatments. It suggests further Payment by Results, using Prime Contractors,¹⁹¹ who in turn will use Local Authorities, charities and voluntary organisations for the actual provision of the ‘treatments’. The Green Paper openly admits that it is not yet ready for these Work Programmes to be rolled out, even though the cut to ESA starts in April. Funding for various aspects of the creation and testing of the systems to support or be part of the Work Programmes has been identified – however one funding stream is Social Investment Bonds. The Green Paper doesn’t elaborate how the bond success will be measured.

So whilst the government does appear to be aware of the need to support people with chronic illnesses, it does so by focusing solely on people with public health conditions, and assumes incorrectly that these people can be supported with low-level intervention and next to no commitment from the government itself.

The Government is not so open to the idea of helping those on ESA who are healthy (but disabled), which is perplexing. Nowhere does the Green Paper address the needs of those who don’t suffer ill health to obtain work – those whose needs in the workplace can be addressed, and whose journey to work does not involve any sort of health intervention, but may have on-going costs of Access to Work and Adult Social Care. One would assume that those who are healthiest, and therefore most employable from an employer’s view-point, would be helped first. But the government only says that it may make people with learning disabilities or autism work without pay for private employers.

It’s quite clear from this Green Paper why the Government is not addressing the issue of healthy disabled people, and we believe it is two-fold: those with no health issues but with functional disabilities – such as sensory impairment or limb loss – may have both up-front and on-going costs. Those with health issues which the Government thinks may be ‘cured’ by Work Programme-embedded treatments have very low one-off costs. The financial implications are obvious – albeit wrong, because the government does not understand either chronic illness or severe, multiple public health conditions.

There are serious concerns about data sharing and disclosure. Current Employment Advisors in Job Centres will be re-cast as Work Coaches who are able to diagnose and signpost people to ‘treatment’ – often via a new Work Programme. The Health and Work Conversation is to be used as both a triage and diagnostic service, ignoring the advice of the claimant’s GP. It should be noted that the Green Paper also disparages the ability of GPs to diagnose mental health conditions, and yet is quite happy to allow Work Coaches to signpost and refer people to what is effectively compulsory health treatment. The idea of mandating GPs to discuss work with their chronically ill patients is particularly disturbing, given that there is a real risk of driving the patient away from getting help and of undermining the patient’s trust in the GP’s understanding of their illness.

The Green Paper suggests further Work Programmes, offered as support for those in the Support group, increasing fears that the Government has not considered that people in the Support group have very low functionality, and that claimants are placed in Support only after rigorous testing by the DWP itself.

¹⁹¹ DWP's Umbrella Agreement for Employment and Health Related Services

What is perhaps the most sinister is what is tagged onto the end of the Green Paper: plans for the future include systems that should already be in place –

- launching the Work and Health Programme in autumn 2017 – which contradicts the idea of early intervention for people joining ESA in April on reduced financial support;
- researching and trialling help for the Support group – but no dedicated services to help those with good health;
- health led employment trials; exploring the ‘Fit note’, medical verification and judgments of fitness for work involving many non-medically trained people;
- embedding work as a health outcome;
- involving NICE in ‘employment outcomes’ of people who are ill; and
- examining if musculoskeletal conditions can also be treated in a one-stop compulsory treatment scenario.
- Finally there is additional reform of the WCA –with expectations of criteria being tightened up further.

In conclusion we find that the government fails to understand the severity of illness experienced by people on ESA, and fails to comprehend the impact of poverty, as opposed to its proxy ‘worklessness’, on further illness. Whilst the government waxes lyrical about people ‘being all they want to be’, the reality is that these new Work Programmes provide only for the Primes: there is no individual personalisation; there is no recognition of sustainability of employment, of funding or of care; there are no job brokers; there is no comprehension of chronic illness. Sickness is being commodified and the role of GPs as medical experts is being undermined, whilst treatment is being made compulsory for eligibility for financial assistance.

This Green Paper is a smokescreen, and in our response we feel we have scarcely touched on much more than the basic issues.