Transforming employment support for individuals with health conditions?: 3Cs to the aid of the Work, Health and Disability Green Paper

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Abstract

The UK's recent Improving Lives Green Paper, and the new joint Work and Health Unit that penned it, offers a genuine window of opportunity for much-needed transformative change in service user experiences and system performance around health-related unemployment. Its analysis of the current system problems and its articulation of the UK's need for a better integrated future work-health system are well-considered. Its proposed reforms to bridge the gap are however inadequate. Focusing on this conversion gap, the article highlights the central but neglected role of three Cs (capacity, conditionality, connectivity) urgently needed to come to the aid of the Green Paper vision if it is to realise its potential.

Keywords

Health-related unemployment; Work and Health Unit; work and health; Improving Lives; local integration; welfare-to-work; employment support

Introduction

Work and health are intimately related in individuals' lives but are frequently fragmented in terms of services and support in welfare systems across advanced economies. 'Good work' (note, importantly, not any work) is known to provide individuals with both financial and non-financial gains (confidence, self-valuation, sense of purpose, etc) (van Stolk et al. 2014;

Oguz 2013; Waddell and Burton 2006; Dolan et al. 2008). That idea of 'good work' needs to be self-defined by individuals themselves so that job roles are tailored to their specific needs (both health and wider) and interests, alongside a set of employment characteristics that are shared more generally across all individuals (e.g. contractual and income security, income adequacy, choice and agency, interest, safety, respect, opportunities for development) (Ritter and Anker, 2002; Warhurst et al., 2012; Jones et al., 2017).

In a comparative perspective the 'disability employment gap' – the percentage point difference in the employment rate of working age adults with a disability or health condition compared to those without – is always negative, typically large and has proven stubbornly difficult to reduce (WPSC 2017). At one end of the international spectrum Luxembourg stands alone at only a 2% point disability employment gap whilst countries like Sweden, France and Turkey have relatively small disability employment gaps of around 10% points. At the other extreme the Netherlands and Hungary show disability employment gaps closer to 40% points (WPSC 2017: 6). Though not the worst performer comparatively, the UK fares relatively poorly internationally with a disability employment gap of 32% points: 49% of working age adults with health conditions and disabilities in paid employment compared to 81% of working age adults without paid work (WPSC 2017: 6; DWP-DH, 2016a: 8). Whilst vast therefore, the scale and stubbornness of the UK's policy challenge around health-related unemployment is one that is to differing extents shared by virtually all advanced economies.

In response, the UK Government took the ambitious step in 2015 of committing itself to halving the disability employment gap. As part of its strategy towards this commitment central government formed the innovative cross-departmental joint Work and Heath Unit (WHU) between Department for Health (DH) and Department for Work and Pensions (DWP)

to seek to better connect the UK's fragmented health and employment systems at both the strategic and operational levels.

Whilst the ambition and commitment is certainly to be welcomed the scale of the UK work-health challenge is enormous. Around 70% of the UK's working age population who are unemployed and in receipt of key out-of-work benefits have a health condition or disability, with mental health and musculoskeletal conditions by far the most prevalent issues. The number of claimants in receipt of the UK's key health-related out-of-work benefit (now Employment and Support Allowance (ESA)) has remained at between 2-3 million for the past twenty years and now makes up around two-thirds of the total out-of-work benefits population (DH-DWP 2016c: Table 4a). This is a diverse as well as a large group and hence generalisations are inherently dangerous. In general, however, two main groups can be identified: a group of older males who have become long-term unemployed since deindustrialisation and the decline of manufacturing and a second more diverse grouping of individual suffering mental and behavioural disorders related to stress, anxiety and low mood within a modern economy and society felt to be increasingly competitive and insecure (Macnicol, 2013).

Similarly, the reasons driving the growth in these groups is complex and multi-faceted (Macnicol, 2013). It involves a combination of economic factors (e.g. deindustrialisation and worklessness, greater competition for vacancies, increased intensification, insecurity and routinisation of employment for those in work), employer behaviours (e.g. concerns, inexperience and/or challenges over hiring and retaining disabled workers (Burke et al., 2013; Chan et al., 2010), hiring discrimination (Ameri et al., 2018)) and the negative scarring effects of sustained unemployment of both work and health prospects. Also relevant are social factors

(e.g. growing feelings of precarity, risk, relative failure, competitiveness) and demographic factors (e.g. increased prevalence of health conditions amongst the working age population (Emmerson et al., 2017)). Finally, key policy decisions have played important roles (e.g. the shift of caseloads from unemployment benefits to health-related benefits in the 1980s, the lack of meaningful employment support for long periods for many unemployed individuals with health conditions).

Within the welfare system two key inter-related issues have been the role of the Work Capability Assessment (WCA) and the impact of severe resource constraints and resultant rationing of support (both access to support as well as the intensity of any support received) in the UK's mainstream Jobcentre Plus public employment service. In the UK system WCA determines whether an individual is considered eligible for Employment and Support Allowance (ESA) social security benefits on the grounds of ill health. Alongside persistent concerns about its accuracy and implementation (NAO, 2016) a further issue is the dual function of WCA in the UK system in effect determining eligibility for mainstream public employment support as well as eligibility for social security benefits on the grounds of ill-health. For individuals deemed by the WCA to be eligible for social security benefits on the grounds of ill-health in the present system as a consequence receive no (ESA Support Group) or virtually no (ESA Work Related Activity Group) employment support at all, despite being the majority share of the total out-of-work benefit claimant population (DWP-DH 2016b: 7). The shift to Universal Credit dissolves these previous benefit categorisations but the lack of capacity and meaningful employment support for these types of claimants with health issues remains in Universal Credit.

In response to this context, the past twenty years of UK employment policy are littered with attempts from DWP to lift the employment rates of disabled people. None of these programmes have been able to make a significant dent in health-related benefit caseloads. The commitment has been made and the recognition of the need for change is clear. This is the context in which the joint Work and Health Unit was formed and to which its Improving Lives Green Paper speaks.

The Work and Health Unit and Improving Lives Green Paper: transformational intent, progressive potential

The arrival of the joint Work and Health Unit (WHU) in 2016 and its Improving Lives: Work, Health and Disability Green Paper and consultation in 2016/2017 offer the UK a genuine window of opportunity for a much-needed transformation around employment support for individual with health issues. WHU is an innovative cross-departmental central government initiative between Department of Health (DH) and Department for Work and Pensions (DWP) in governmental recognition of "the need to bring work and health agendas together to break down the silos of the welfare agenda and employment on one side and then health, social care and carers on the other" (BSC, 2016).

Published in October 2016 and consulted on through 2017, Improving Lives presents a thoughtful and well-evidenced critical analysis of many of the key weaknesses, needs and future priorities facing the UK's disconnected work and health systems. As with any Green Paper it is wide ranging in its scope. The focus of this article is primarily on its core theme around supporting unemployed individuals with health issues into work. More specifically, our focus is on what we term the Green Paper's significant conversion gap between its well-

considered analysis of problems and solutions as contrasted with its inadequate and mis-specified articulation of the mechanisms to bridge the gap between the two. It is this conversion gap that poses a fatal risk to the progressive potential of the Green Paper and hence that warrants our scholarly attention.

The Green Paper's stated ambition is to consider what it would take to deliver a transformative step-change the employment support experiences and outcomes of individuals with health conditions and disabilities, not to tinker at the margins (DH-DWP 2016b: 3). The Green Paper rightly diagnoses that the heart of the problem is the long-standing and myriad disconnections between the work and health systems and what this means for the type of patchy and disjointed support that individuals receive and that commissioners and frontline practitioners are forced to operate within (DH-DWP, 2016b: 6). In doing so it recognises our shared need to work "beyond artificial system boundaries" in order to build the type of "integrated network of health and employment support" required to deliver "more holistic patient care" (DH-DWP 2016b: 25, 65, 17). This is rightly recognised to be about changes in cultures and practices as much as funding, commissioning and data flows (DH-DWP 2016b: 17, 65-67). It is also rightly recognised to require greater attention to evidence of what works and to the need for stronger collaborative partnership working across a range of key stakeholders nationally, regionally and locally to better integrate employment, health and wider policy systems (e.g. skills, housing) to enable "a more joined-up approach to health and work" (DH-DWP 2016b: 16). As such, Improving Lives can be seen to offer a well-considered and well-evidenced diagnosis of many of the key problems at the heart of the UK's disconnected employment and health systems alongside a considered and ambitious articulation of the desired progressive vision to build its future integrated alternative work-health system.

As with all green papers Improving Lives is forced to tread a difficult line between its multiple purposes and, in this case, its multiple cross-departmental authors: the genuine desire for an open and positive discussion about challenges and change; the political necessity to at least partly defend the government's record; and a reluctance to open the debate to politically or fiscally undesirable or undeliverable demands given known parameters within which future reforms will likely have to fit. As a consequence, the proposed ways forwards set out in the Green Paper to bring the gap between the well-articulated current problems and desired integrated future work-health system lacks both the ambition and evidence-based realism seen elsewhere in the document.

Rather, Improving Lives seeks both to defend the government's work-health reform record to date as well as to control and narrow down the invited areas to comment and considered in scope for reform. Striking is the extent to which the Green Paper narrows down on the Jobcentre Plus public employment service as the key to delivering its transformative vision. Specifically, Improving Lives sets out a desire for Jobcentre Plus frontline employment advisors – Work Coaches – to have more flexibility in how they personalise support for claimants, to intervene earlier and to signpost claimants to other local provision. It also sets out a desire to better engage that large majority of unemployed individuals in the UK who, as outlined above, are in receipt of ESA (or Universal Support equivalent) health-related benefits and who as a result receive little to no employment support in the present UK system.

A new Personal Support Package containing multiple disparate elements is announced with some emphasis. A first element focuses on staffing. There is an emphasis here on upskilling Work Coaches to be disability trained and accredited and additional specialist staff: an extra

300 Disability Employment Advisors (who have no caseload themselves but instead oversee Work Coaches to deliver improved support to claimants with health issues) and 200 new Community Partners to signpost to relevant local provision beyond Jobcentre Plus. Secondly, all ESA claimants (or Universal Credit equivalents) will be offered a new a Health and Work Conversation three months into their benefit claim to assess needs and draw up a suitable action plan. For new claimants of ESA WRAG (or Universal Credit equivalents) a range of other items are included: the new contracted Work and Health Programme; the Specialist Employability Support programme; peer-led Job Clubs; and work experience places for young people (DH-DWP 2016b: 26-27).

Taken together, Improving Lives argues that as a result of these reforms "[W]hatever a person's needs, this new package of support offered through Jobcentre Plus will ensure more personalised, integrated and targeted approaches" (DH-DWP 2016b: p35).

Bridging the gap: 3Cs to the aid of Green Paper obscurity

It is far from clear however that the reality will live up to the Green Paper's rhetoric confidence to deliver a transformative change inn work-health performance (where 'performance' is understood to mean the combination of service user experiences, employment and health outcomes, and financial costs and savings). At the heart of these concerns is we argue a combination of conceptual under-specification, plain delusion and deliberate obfuscation within Improving Lives in three key areas for reform: capacity; conditionality; and connectivity. These we argue will need to be at the heart of any credible work-health system reform strategy that has the potential to deliver transformative change to the performance of the UK work-health system but are unduly side-lined within the Green

Paper. The following sections discuss each of these three items in turn and the limitations of their treatment within the reform strategy outlined in the Green Paper.

Capacity: reform rhetoric, highly constrained reality

Delivering a transformation in the performance of any employment system inevitably requires resourcing. As outlined above, some limited new investment around staffing and interventions is set out in the Green Paper. However, in the context of the significant and sustained budgets cuts seen since 2010 the UK employment system remains far from the level of capacity needed to deliver the type of intensive, personalised and integrated support that unemployment claimants with health (and other more complex and/or severe) issues require.

The Work and Pensions Select Committee, the cross-party government committee that scrutinises government policy around employment support, recently conducted an enquiry into the future role of Jobcentre Plus (WPSC 2016). Whilst welcoming some aspects of DWP's proposed reforms the select committee had significant concerns over Jobcentre Plus's ability to deliver against the increased policy asks being made of it: "we have grave concerns that shifting a raft of new, specialised demands and requirements onto Jobcentre Plus, without significant training and preparation and with greatly reduced resources, is simply front-loading this brave new world for failure" (Public Finance 2016).

In 2010, the latest data for which UK comparative data are available, the UK spent around 0.4% of GDP on employment support activities (excluding social security cash benefits) (Eurostat 2017). In comparative perspective this is low: the UK figure is similar to Italy,

around half that of the EU28 average, around one third that of France, Sweden and the Netherlands, and around a quarter that of the highest spender Denmark. Moreover, since that time the UK has experienced a period of sustained and significant cuts to central and local public sector budgets: between 2009/10 and 2019/20 the DWP operational budget for core staff and programmes will be reduced by 45% (Resolution Foundation 2015; House of Commons Scrutiny Unit, 2015). Cuts have inevitably been made in UK employment support provision from that already comparatively weakly resourced 2010 position. DWP have closed around 20% of their Jobcentre Plus offices and the number of frontline Work Coaches – the major part of DWP's cost base – has had to be cut severely: between 2011/12 and 2015/16 the number of Work Coaches fell by 35% from 17,750 to 11,453 (WPSC 2016: 33). DWP in 2017 discussed plans to hire 2,500 new Work Coaches (Hansard 2017) but this will take time, may well not fully take place, and even in its totality would replace just 40% of that staffing reduction. Moreover, the contracted employment support offer has seen an 80% reduction in its budget and size in the current Work and Health Programme compared to its predecessor contracted programmes.

As a result, an already comparatively lean Jobcentre Plus employment regime in 2010 has had to become considerably leaner. On the other side of the equation this occurs at a time of escalating demand and ambition with the system: millions more – and more complex – new claimants will be flowing through Jobcentre Plus doors for support due to the expanded reach of Universal Credit and the government has committed itself to halving the disability employment gap.

It is helpful to consider the figures involved on the frontline to get a sense of the true scale of the capacity gap within the current UK employment system. Jobcentre Plus Work Coaches

currently have on average a caseload of 100 claimants (WPSC 2016: 33) and spend an average of 10 minutes per fortnight with each claimant across days of back-to-back appointments (WPSC 2016: 12). Before employment support needs can be considered in these fortnightly 10 minute appointments Work Coaches must confirm job search activity and satisfaction of conditionality requirements and then highlight new vacancies listed that the claimant might apply for before the next meeting. Time for meaningful personalised employment support is scarce. Moreover, as noted earlier this typically excludes ESA Support Group and ESA WRAG claimants (or Universal Credit equivalents) who clearly have health issues but who receive little to no employment support offer.

It is illuminating to reflect on the expectations placed on the new Personal Support Package outlined in the Green Paper in the context of these capacity constraints. Improving Lives suggests that its "range of new measures and interventions" (DH-DWP 2016b: 26) introduced will deliver a "comprehensive menu of support" (DH-DWP 2016b: 43) and a "step change" (DH-DWP 2016b: p36) in the level and effectiveness of support for individuals with health conditions. The reality of the reach, depth and ambition of these reforms is in practice considerably more modest however. The core Personal Support Package available to all claimants with health issues is exceedingly light. There is a welcome Health and Work Conversation to identify needs and action plan but no additional capacity, resource or referral options to respond meaningfully to needs identified. Additional frontline staff are to be welcomed but the numbers discussed are trivial in the context of the system's demands and aspirations. They would not be expected to make any noticeable impact on system performance (whether experiences, outcomes or savings), particularly given that they arrive in a context of previous far larger staffing cuts.

Additionally, the 'enhanced offer' set out in the Green Paper is severely limited in both its reach and in its depth. In terms of reach, only new ESA WRAG claimants (and UC equivalents) are eligible to receive it, yet this is a tiny minority of the total cohort in need of more effective work-health support. The far larger volumes of unemployed claimants with health issues are existing claimants who have often been without any meaningful employment support for several years. These claimants are not eligible for this enhanced offer. There is in addition a sizeable minority (around 20-25%) of Jobseekers' Allowance claimants who self-identify with health issues who are also ineligible. In terms of its depth, peer-delivered Job Clubs, work experience places for young people only, unspecified additional places on an extremely small Specialist Employability Support programme, and 80% cuts to the budget and size of DWP's Work and Health Programme compared to its predecessor programmes offer slim pickings for Work Coaches to make referrals for meaningfully intensive and personalised employment support.

Taken together the rationing of the enhanced offer is acute and the on-going severe capacity constraints of the UK employment system present weak foundations on which to build any desire for transformative performance change.

Conditionality: alarmingly suggestive and counter-productive

A second dimension of mismatch between strategic vision and operational delivery within the Green Paper relates to its unclear overtures around the future approach to conditionality for unemployed claimants with health issues. Improving Lives is a fascinating place to examine this for it is by nature forced to bring together the pens of two culturally disparate government departments on this issue – the significantly enhanced role of conditionality, sanctions and

individualised behaviouralism within the employment system from recent Department for Work and Pensions administrations as compared to the principles of duty of care, no harm and patient choice and well-being within the Department of Health.

It is not an easy tightrope to walk and the tensions regards its handling of conditionality are visible throughout the Green Paper. Improving Lives has at heart a sensible position that all unemployed claimants should have opportunity to access employment support. It contrasts this position to what it argues is an inappropriate "one-size-fits-all" (DH-DWP 2016b: 26, 41) current policy approach whereby ESA Support Group claimants – who make up around 60% of all ESA recipients – are "parked on financial support alone" (DH-DWP 2016b: 16) and not generally given the option of employment support, despite half of this group saying that they do want to work (DWP 2013). In response, the Green Paper suggests separating out the two current distinct functions of current WCA assessment procedures that it argues are unhelpfully conflated: eligibility for financial support and access to appropriately designed employment support.

The principles behind this suggestion are sound. Implementing that principle satisfactorily is a separate key issue however. The Green Paper's proposal to grant frontline Work Coaches full discretion to determine what employment support activities and conditionality requirements should apply to each individual claimant is highly problematic. This the Green Paper argues would enable Work Coaches to decide flexibly which claimants would be able to benefit from employment support and to then tailor that support to the individuals' needs. In systems where frontline staff are able to accurately make these decisions around claimant segmentation then such an approach may be viable. But UK evidence shows that Work Coaches are on average no better than random at segmenting claimants (DWP 2006: 49; DWP

2015). In this context the Green Paper's suggestion for full Work Coach discretion over conditionality towards all claimants with health issues leaves claimants unacceptably exposed to variable and inappropriate frontline discretion. Whilst it is on the one hand highly problematic that this group at present are significantly outside of any meaningful employment support offer, this current exclusion does on the other hand spare this cohort having to engage with the UK's minimal support 'stick and sanction' current model of employment support. Foreseeing concerned responses about DWP's record on conditionality and sanctions, Improving Lives assures that DWP would "of course put safeguards in place" (DH-DWP 2016b: 43) to ensure that Work Coach requirements were at all times appropriate and reasonable. The lack of detail around these ideas in the Green Paper however raises concerns that its intention may be more to extend the current behaviouralistic, minimal and threat-based 'low road' (Fletcher and Wright, 2017) employment regime to individuals with health conditions rather than to seek genuine progressive performance transformation.

More broadly, also of key concern in terms of the UK's prospects for delivering transformative positive change for service users, frontline practitioners and policy makers, this proposed approach to conditionality within the Green Paper undercuts its own recognised need to develop a better integrated work-heath system and support offer. Instead, the suggestion of a DWP owned model of Work Coach discretion over conditionality and employment support for this health cohort displays an inability and/or unwillingness by DWP to reflect and engage seriously on the need for effective partnership working with wider local partners – health partners, local authorities and combined authorities chiefly. For any effective integrated work-health system of the sort that the Green Paper rightly recognises to be required will need willing engagement from those key local partners in a range of ways if it is to be effective and sustainable – referrals, health support, co-location, co-case management,

aligned aims and cultures, pooled financial contributions, and so on. To achieve this model of a well-functioning integrated work-health system, however, those local stakeholders will need to be treated as valuable partners of equal standing with central government being prepared to listen and take seriously valid concerns that those local stakeholders may have around system design, patient wellbeing, medical ethics and ways of working.

More narrowly, it is simply not viable for the Green Paper to seek to gloss over local stakeholders' valid concerns around engaging with DWP's current employment regime as it relates to claimants with health issues, chiefly Work Capability Assessments, conditionality and sanctions and contracted employment programmes. To take briefly the issues raised by each in order to illustrate some of the concerns of necessary key partners, DWP's Work Capability Assessments frequently find patients 'fit for work' when the clinician's medical expertise says otherwise (McVeigh 2016; Butler and Pring 2016). Secondly, key local stakeholders continue to express and ongoing concern around the application and level of sanctions that local residents and patients are experiencing within Jobcentre Plus. Of concern are the associations of those sanctions with hardship, mental and physical harm, foodbanks and even suicide and evidence that it is the already more disadvantaged – including those with health conditions – who are disproportionately affected by sanctions (Oakley 2014; Loopstra et al. 2015; Butler and Pring 2016; Webster 2016). Thirdly, amongst major contracted programmes such as Work Programme individuals with health issues have not only experienced low employment success (DWP 2017) but have also been at particularly high risk of being 'parked' (i.e. deliberately neglected in either absolute or relative terms) by providers (Newton 2012; Meagher et al. 2013). The replacement Work and Health Programme is 80% smaller in size and whilst it modifies some of Work Programme's more problematic design features it shares much of its core DNA as a Prime provider model across large contract areas

and disengaged through its design and mobilisation from the key local partners and services that the programme will inevitably need to rely on if it is to succeed. In this context it is of concern that as Improving Lives implores local health partners to engage their services and their patients with the employment system it seeks almost to blame those partners for their current reluctance to do so and chooses not to engage seriously with their valid reasons for concern and their needs to feel able to engage and collaborate.

However, well-evidenced alternative models of effective voluntary and collaborative model of employment support are available to draw upon. Individual and Placement Support (IPS), emerging city-region devolutionary models, and DWP's own national Work Choice are all voluntary employment approaches and all significantly outperform the performance of mandatory support approaches such a Work Programme and Jobcentre Plus. Conditionality is not the only reason for these performance differences but it is an important part of the reason. The Work and Pensions Select Committee – and the range of independent expert witnesses and specialist disability provider organisations that provided it with evidence – clearly recognise why voluntary employment support is appropriate for this cohort to help engage and build the types of positive collaborative relationships required both between claimants and advisors as well as between the employment advisor and the range of local partner actors and organisations required for effective whole-person support (health, housing, financial advice, etc) (WPSC 2016: 28). For at the heart of transformative change in work-health support and outcomes is connectivity, the final critical cause of the Improving Lives conversion gap between its well-considered system vision and its proposed approach to getting there.

Connectivity: Building locally integrated work-*health 'ecosystems'* – inadequate consideration of partners, governance, scale

The Green Paper rightly recognises the need for better integration of work-health services to offer co-ordinated support for individuals' holistic support needs, holding up an integrated public service hub as an exemplar of what is needed (DH-DWP 2016b: 75). At the same time, however, the Green Paper does not engage seriously and critically with the key questions of what a locally integrated employment system means and entails or of the necessary partners, mechanisms and geographical scales that will be required to deliver it effectively.

Stepping back to the comparative perspective, the UK is an international outlier in two key and interrelated dimensions – its comparatively low spend (noted above) and its high degree of centralization within the responsible central government DWP. Taken together, this renders DWP's operational Jobcentre Plus operational arm – and the claimants who flow through it – significantly short of resources and time for meaningfully intensive and personalised employment support at the same time as being unhelpfully disconnected from a range of key local stakeholders, services and resources beyond JCP. It is a quantitative (weak resourcing of core employment support) and qualitative (narrow, disconnected) double whammy of a counter-productive employment model if one wishes to transform the performance of the employment system for individuals with health conditions.

To better understand the Green Paper's neglected connectivity need it is helpful to step out briefly to analytical consideration of the five different governance approaches through which employment support programmes can be managed to seek to drive desirable outcomes: procedural (standardized rules and processes); market (financial risks and rewards); corporate (targets); network (relationships and trust); and democratic (political accountability and/or service user influence) (Jantz et al 2015; Author, 2017). The UK employment support model

is built around negative versions of procedural (within the public sector JCP model) and market (within the UK's contracted programmes) accountability levers. In contrast, the Green Paper's vision of an effectively integrated employment support system for claimants with health conditions is instead rooted in the need for what has been described as positively networked accountability (Author, 2017). The Green Paper naturally does not use the same analytical terminology but of real concern is that neither does it show critical awareness – and/or willingness – to engage seriously with the conceptual and practical realities of what such an integrated approach is and requires. Three factors are especially important but neglected in the Green Paper: stakeholders; governance; and the essential role of localities.

Firstly, effectively integrated employment approaches require the partnership working of a range of stakeholders across alternative organisations and service teams in order to provide the type of holistic, whole-person wraparound support that employment support for individuals with health issues often requires – mental and physical health needs, housing, debt and finances, family issues, skills, transport, and so on. Importantly, these support needs cut across organisational boundaries – local authorities, city regions, employers, health commissioners and providers, Jobcentre Plus, colleges, third sector organisations, and so on. Central government are critical in either enabling or disabling opportunities for integration but it is only through the effective integration of organisations and services locally that integrated approaches can become reality.

Improving Lives recognises these integration needs but in response offers merely greater signposting from Work Coaches to local services. However, this is neither ambitious nor credible as a means to seek a step-change in performance. Alongside deep cuts to Jobcentre Plus's own budget since 2010 as outlined above those wider services have themselves

experienced sustained budget cuts. Between 2010 and 2020 local authorities will on average experienced budget cuts of 37% in real terms (LGA 2015:11) and it has been estimated that health partners are required to deliver £22bn in savings by 2020/21 within their recent Sustainability and Transformation Plans (STPs)(BMA 2016). More fully, for the successful collaborative development of an effective integrated work-health system DWP engagement with these wider stakeholders must be based on a partnership of trust, respect, and collaborative recognition of the need for shared voice, powers, risk and reward. However, by framing the discussion unidirectionally as Work Coaches connecting into "local, integrated support available through Jobcentre Plus" (DH-DWP 2016b: 26) the suggestion is given instead that DWP are seeking to simply access and self-brand those external resources at a time of deep cuts in its own budgets without any attempt to build the necessary genuine partnership working required.

Secondly, bringing these various central and local organisations and service teams together to deliver in new integrated ways requires new forms of formalised multi-system governance. These sorts of cross-cutting governance arrangements are critical at the senior level to provide legitimacy, accountability and strategic cross-silo decision making. They are essential at the operational level to enable co-case management, support sequencing and support unblocking across the range of wraparound support services involved. Multi-stakeholder local governance arrangements are varied and evolving in the UK context. Health and Wellbeing Boards and city-regional Local Integration Boards for example are continually emerging and evolving as areas seek locally to drive better integrated approaches to public service delivery. Any successful model of employment support for individuals with health issues will need to develop and utilise such cross-silo integration governance arrangements and it is of concern that these needs are not discussed at all within the Green Paper.

Thirdly, and related, the Green Paper overlooks the important spatial dimension to this policy debate. For although effective integration requires collaboration across all tiers of government it is only at local scales that the necessary key cross-silo relationships, cultures, strategic and operational changes and governance arrangements can be anchored. Given the centrality of localities it is of significant concern therefore that Improving Lives fails to engage meaningfully with questions around the appropriate roles and responsibilities of alternative local, city-regional and central partners respectively. Indeed, at a time when directly elected city-region Mayors are in place across key Mayoral Combined Authorities with growing devolutionary powers it is astonishing that the Green Paper offers just eight lines of its eighty-five pages to discuss the increasing roles and opportunities that devolved city-regions afford in this policy space. The word 'local' – or occasional variants of it – appear 126 times in the document but in the context of general sentiments around the importance of local partners and contexts. Most tangible is a somewhat confused discussion of local commissioning options (DH-DWP 2016b: 73). What the Green Paper fails to grasp entirely is the need for, and the potential of, the 'local' – once properly conceptually understood and mobilised – to qualitatively transform the employment model as required into a positively networked integrated work-health system of the type that the Green Paper itself rhetorically envisions.

Delivering a credible movement for change: Improving Lives beyond Green Paper rhetoric

As the Green Paper rightly notes the current moment is through the joint Work and Health Unit a significant window of opportunity to deliver transformative progressive change in the multi-faceted performance of the UK employment system for individuals with health

conditions and disabilities. Improving Lives in many ways makes an impressively articulate, considered and well-evidenced progressive foray into this terrain. It makes a welcome and much-needed attempt to stimulate a conversation around positive system transformation in UK employment support policy. Yet although its analysis of the 'problems' and 'solutions' are sound, for the three key reasons that we have outlined above it is itself unable to put forwards the credible "movement for change" (DWP-DH 2016b: p81) that it calls for from others.

In this final section we suggest instead that a priority next phase of activity flowing from the discursive momentum that the Green Paper and its consultation have stimulated is not a specific raft of interventions but, rather, ought to be a period of collaborative conversation between policy makers at all tiers of government underpinned by a shared commitment to seeking the type of integrated work-health system and transformation that the Green Paper outlines. Genuine collaborative working across these partners of the sort that the future system change requires is unusual in the UK context and will be challenging. Critical to enabling this process this will be the shared commitment of policy stakeholders centrally, regionally and locally to four key principles of partnership working: equality of partners and their voices; partnerships of positivity (meaning trust, openness, honesty and willingness); constructive challenge, a willingness to listen and flexibility to change positions and compromise; and transparency and accountability.

A proposed way forwards to achieve this would be an Integration Commission comprising a series of stakeholder review sessions bringing together key partners of relevance to building an effective work-health system locally (local authorities, Clinical Commissioning Groups, NHS Trusts, GPs, employer organisations, third sector organisations), regionally (combined

authorities, Integrated Care Systems) and centrally (Department for Work and Pensions and Department of Health most critically but also of relevance to reform are the Ministry for Housing, Communities and Local Government as well as the Treasury). At the local level it is critical that employers are fully engaged and able to contribute, both large employers but also the vast array of SME and micros that dominate the employer base in all areas. As Improving Lives recognises, these demand-side considerations are equally important as the supply-side activation considerations, despite the tendency of the latter to dominate the work-health debate and policy activity. For in many cases the ability of individuals with health conditions to sustain paid work depends in significant part on the nature and adaptations of roles and working environments as well as the flexible and supportive line management of employers (Selvanera and Whippy, 2015).

Such an Integration Commission should be underpinned by the principles outlined above and partners should commit at the outset to working together to agree of a set of short, medium and long-term system reforms to move the UK towards that Green Paper vision of an effectively integrated work-health system. It may be that central government and selected local areas satisfying readiness conditions could sign up to a fuller role of piloting innovative reforms falling out of this collaborative process on a test and learn basis.

Building on the work of the Green Paper, this collaborative process could sensibly comprise several key elements. A necessary first step is to understand the current system performance from a triangulated perspective of different types of service users, frontline practitioners and commissioners within the current system. This might usefully involve a map of the current (inevitably complex) system for patient pathways/customer journeys alongside analysis of the strengths, weaknesses, gaps, blockages and disconnects of different parts of the system.

It is also necessary to develop collectively a shared vision. The Green Paper vision of a locally integrated work-health system is a sensible starting point but it is important that this visioning work is re-opened such that all key stakeholders are able to feed in their views and flag possible tensions with competing priorities or activities. In this way all key partners across all tiers of government should feel able to sign-up up to the resulting collectively agreed system vision and to any wider implications that it introductions for existing processes and practices.

A key operational need will then be to establish collectively the range of operational needs in order to progress towards that vision. This will need to encompass a wide range of elements, including: options around roles, responsibilities and ways of working of different national local and national stakeholders; blockages and dependencies on the fulfilment of those roles; conditions under which partners would and would not be prepared to progress together; what would governance need to look like; and how might commissioning and funding be more effectively used across partners.

Clear system change milestones would help to focus attention on realising tangible change and monitoring progress. Compiling suitable metrics (both quantitative and qualitative) play an important role in understanding and comparing performance and progress across time and space. There are significant differences and gaps currently in the collection, comparability and sharing of data across areas and parts of the employment and health system in the UK context. This limits significantly the extent to which services and service users can be effectively connected within the present system and, related, inevitably therefore limits the extent to which we can compare performance, learn lessons and share best practice. Streamlining and

standardising data collection and data sharing is an essential but formidable task – technically, legally, ethically, culturally. It is however necessary to make progress in these areas if a fully integrated work-health system and set of cross-silo practices are to be enabled. There are simple but meaningful steps that can be taken more easily with shared willingness. The agreement of a core set of standard work and health metrics across national and local programmes would help, as would greater access to suitably anonymised central government administrative data to enable powerful, simple, comparable metrics. The calculation of agreed deadweight figures for different cohorts would enable comparable assessments of impact. And to ensure that data, evidence, learning and best practice are shared across a fragmented and time-poor national patchwork of stakeholders, and that decisions are helped to be made on n the basis of a strong evidence base, the creation of a What Works evidence centre in this policy space would be a considerable support for central, regional and local commisisoners and providers.

As Improving Lives recognises, the UK work-health challenge to which it responds is both significant and enormously complex. The Green Paper is a much-needed and long overdue attempt to stimulate a productive and progressive debate around transforming system performance for service users, front line practitioners and policy makers across all tiers of government. The type of collaborative Integration Commission urged here is novel and would be challenging. It would be enormously productive for taking forwards in a meaningful way the significant potential that lies within Improving Lives but that is without such a process at significant risk currently of being lost given the key limits to the Green Paper that have been outlined above.

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