Why Work Doesn't Work For Me

Qualitative research into the experiences of economically inactive Londoners

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BIG IDEAS

Contents

Executive Summary

This piece of qualitative research investigates the experiences of working-age economically inactive Londoners accessing support services.

It aims to capture insights into their experiences of accessing services related to employment, education, health and wraparound support. The findings will inform the design and improvement of services aimed at better supporting economically inactive individuals.

The research highlights the complex interplay of long-term health conditions, caring responsibilities, and personal circumstances that keep people out of work, but also their strong desire to return to meaningful employment. Participants consistently emphasised that what matters most is having consistent, trusted, and relationship-based support, rather than impersonal or fragmented services. Embedding this principle across employment, health, and community services is the key recommendation arising from this study.

Key Findings

1. Complex Health Needs Create Unpredictable Barriers

Many participants live with multiple long-term physical and mental health conditions, most commonly musculoskeletal (MSK) pain and depression. Chronic fatigue and fluctuating symptoms create unpredictability from one day to the next that undermines efforts to engage with back to work services.

> “It takes me about two hours in the morning to be mobile... my back is killing me.”

2. Workplace Culture Often Fails to Accommodate

Participants reported that while some employers provided flexibility, many workplaces were unempathetic, rigid, or discriminatory, especially when health conditions were invisible or poorly understood. Participants taking legal action against their employer and job loss due to inflexible sickness policies and prejudice were not uncommon.

> “They [the employer] want somebody who doesn’t take time off work at all, which I thought was quite weird.”

3. The Strain of Competing Responsibilities

Balancing work with managing longer term health conditions or caring responsibilities places constant pressure on time, energy, and emotional reserves. Women described having to make the choice to step back from employment to care for others.

“Each day, the most challenging thing is managing their appointments [from caring responsibilities] and my own energy levels.”

4. Mental Health and the Cycle of Inactivity

Poor mental health, often a consequence of unemployment, was widespread. Participants spoke of isolation, loss of identity, and declining self-worth as time away from work stretched on. A desire for purpose and routine remained strong, but many felt forgotten by services and ill-equipped to re-enter the labour market.

“So I don’t earn anything. I’m worthless. And that’s what it feels like.”

5. Support Services Often Miss the Mark

Participants shared frustration with inconsistent and impersonal employment and health support services. Participants felt that programmes were described as box-ticking exercises, often not tailored to real-world barriers like fluctuating health, language needs, housing instability, or immigration status.

“They [support services] just leave you be... They don’t really listen.”

6. Practical Barriers Are Deep and Overlapping

Even beyond health, structural challenges such as insecure housing, childcare costs, poor-quality job opportunities, lack of English proficiency, and benefit system rigidity played a defining role in keeping people out of the labour market.

“I don’t know tomorrow where I’ll be living.”

7. The Desire to Work Remains Strong

Despite significant adversity, all participants expressed a desire to work. For many, employment symbolised more than financial independence - it represented identity, purpose, and a path to recovery.

“It’s not financial. It’s just the thought of getting up and having something to do.”

Methodology

Big Ideas researchers spoke to 16 economically inactive working-age people living in London.

Economic Inactivity was defined by the Get Britain Working White Paper as ‘those who are not in employment, have not sought work in the last four weeks, and/or are not available to start work in the next two weeks’.

We took a purposive sampling approach to recruit participants from different areas of London and as a cohort, diversity was considered across characteristics such as age, gender, ethnicity and barriers to employment. Purposive sampling sought to be as reflective as possible of the priority groups of the trailblazers across the subregions. This approach also ensured representation from groups recording the highest economic inactivity in the sub-regions including individuals with disabilities and long-term health conditions, specifically Musculosketal (MSK) conditions, those over age 50, those in social housing, people with caring responsibilities, women, those from an ethnic minority and those with no/low qualifications.

Participants were recruited face-to-face in community settings such as community centres, food banks and via support services. It was ensured that each participant understood the research and voluntarily agreed to participate through a process of informed consent. Each participant received clear and concise information about the study, how their data would be used and storied and the researcher ensured all participants understood this to allow them to make a free decision about participation. Each participant received a £40 shopping voucher to thank them for their time.

The 16 participants were interviewed face-to-face by Big Ideas researchers, an exception to this face to face approach was made for two carers who could only participate if interviews were conducted online. Interviews lasted up to one hour and took place in a location of the participants’ choosing. Privacy was prioritised for those who requested it. Safeguarding of all parties involved was prioritised. Interviewees were often accompanied by young children. In one case, two women were interviewed together with one acting as a translator for her sister-in-law who had no English. Interviews were recorded on a digital voice recorder, a transcript was then produced and the data anonymised.

The interviews covered the following themes:

1. Challenges and barriers to looking for a job
2. Life context and background
3. Awareness and perception of support services
4. Experience of support services and accessibility
5. Thoughts and reflections on support and services needed

Where appropriate, participants were also led through a visual service mapping exercise to record their experiences in an accessible way using post-it notes and emoji stickers to express their feelings about the support received.

Following completion of the interviews, we took a grounded approach to analysis starting with open coding of the transcript data in order to identify themes. A thematic analysis was then undertaken in order to produce this report.

The findings and recommendations contained in this report are a contribution to assist in humanising the data around this topic by offering real-life, genuine insights into barriers into work and to engaging with support. Each of the 16 participants was willing to share their story in the hope that it may contribute to changing the way services are delivered.

Researcher reflections

This group of participants are some of the most isolated from the mainstream and therefore the hardest to reach. Recruitment of this cohort was extremely challenging and required meeting face to face in places where they felt comfortable and safe. We noticed that working with trusted community partners, such as community food banks run from churches or community centres, would still require a couple of visits. It was rare to recruit someone off the back of one conversation. Reluctance to participate was influenced by a number of factors. The nature of the qualitative data we wanted to collect was personal health data and we needed to spend time going through the Participant Information Sheet and Privacy Policy to answer questions about how their data would be used and stored. High levels of worry exists within this cohort around the fragility of benefit support they currently receive, and they wanted reassurance that participation would not jeopardise this. This research relied on being able to quickly establish trust and personal connection with participants. It was very striking the level of fear, mistrust and sense of persecution that were prevalent amongst participants.

Participant Overview

This report is based on the qualitative insights provided by 16 working age participants from across London.

Location

The participants come from a range of London boroughs, with the highest representation in Bromley and Hounslow (three individuals each). Other areas include Islington, Ealing, Croydon, and Newham (two each), with individual cases from Merton and Lambeth.

Gender

The group is predominantly female, with 11 women compared to 5 men.

Ethnicity

The most common backgrounds include British Italian and White British (three each), followed by Black British (two). Other individual backgrounds include British Syrian, British Somalian, British Indian, British Afghan, Afghan, British Bulgarian, British Pakistani, and Nigerian.

Housing

Most participants live in social housing (six people), followed by shared accommodation (three), and a small number who are homeowners (two) or living with parents (two). One participant lives in Home Office accommodation, one is experiencing homelessness, and one lives in a shared ownership property.

Work History

Work histories reveal long-term disengagement from employment, primarily due to health or caring responsibilities. The most common pattern was being out of work for four years, while others stopped working due to injury or illness (e.g. 3.5 years ago), or have been unemployed for five years but actively seeking support. A few participants had unclear or disrupted work histories, connected to homelessness or migration.

Medical Conditions

The most common health issues include musculoskeletal (MSK) conditions combined with mental health challenges, followed by people living with MSK-related pain with mobility issues. Other conditions include general long-term health conditions and multiple complex conditions. Many participants reported overlapping physical and mental health needs.

Qualitative Findings

When health gets complicated: Struggling to stay or return to work

Many participants lived with the intersection of multiple long-term physical conditions and suffered from poor mental health, particularly depression and anxiety, creating a complex and often debilitating reality that shaped every aspect of their daily lives. A commonly reported barrier to employment was persistent and extreme fatigue - not simply tiredness, but chronic lethargy and an inability to complete even the smallest of everyday tasks.

> “In terms of day to day, even sometimes getting out of bed could be quite hard.”

For participants with musculoskeletal (MSK) conditions, chronic pain and reduced mobility were dominant and recurring challenges.

> “Normally, every morning when I wake up, it takes me about 2 hours to be able to walk about, to be mobile. My back is killing me. I have to take medication.”

These symptoms often fluctuated significantly from day to day and, crucially, lacked any clear cause or pattern. One participant described his condition as having “a mind of its own,” reflecting a deep sense of frustration and loss of control. This unpredictability made it difficult to plan, attend appointments, or commit to a consistent work schedule. Living with such conditions also took a significant emotional toll.

> “Sometimes if you see me, I’m fit. I don’t have anything to show externally, but the energy levels - very, very low. It can vary all of a sudden. I can be really unwell.”

> “The most frustrating thing about the issues that I have is there’s no rhyme or reason to it. There’s no pattern to it.”

Many participants reported that delays in diagnosis or treatment had left them in prolonged periods of uncertainty, unable to plan for recovery or make informed decisions about their future. One participant described living with severe back pain for seven years before receiving a correct diagnosis. By then, further physical damage had occurred. He had also been seeking eye surgery for over a decade - an operation that could dramatically improve his chances of returning to work. However, the procedure is not available through the NHS, and private treatment is unaffordable. Another participant echoed this struggle, noting that essential therapies like physiotherapy or chiropractic care remained out of reach due to cost.

Impact of COVID-19 on Access to Care and Support

The COVID-19 pandemic severely disrupted access to healthcare and employment support services for a number of the participants. Several described delays to treatment and a lack of follow-up care all of which intensified their existing health challenges.

A 57-year-old man from Islington, who experienced a major health crisis in 2020, reflected:

> "A lot of things should have been dealt with that weren't.
> The NHS is still catching up."

A 55-year-old woman in Merton, already managing arthritis, was hospitalised with COVID-19. When she returned home, she faced worsening health and increased domestic abuse during lockdown, eventually being forced to leave her home:

> "So I'm just trying to get myself back on my feet, getting my health sorted."

The pandemic not only interrupted the delivery of health services it exacerbated existing health conditions and compounded social vulnerabilities for a number of participants.

Workplace Culture and Employer Attitudes

Participants consistently highlighted how the attitudes and culture within workplaces shaped their ability to manage health conditions and remain employed. While there were examples of employers making helpful accommodations, such as offering remote work or adjusting hours, many did not.

> "The real issue is the companies themselves that don't really help
> support people with illnesses. That's the truth."

One participant, a 63-year-old woman from Bromley, described how a lack of reasonable adjustments severely impacted her health. Following a serious back injury, she developed significant mobility issues and could no longer manage stairs. An occupational health assessment recommendation that she should be moved to an office close to her home was ignored. She continued working for a year until the lift broke down and she was unable to safely access her workspace. She was forced into medical retirement and is now pursuing legal action.

Others described rigid sickness policies, poor communication, and a lack of trust, particularly when their conditions were invisible. A few felt disbelieved or penalised for needing time off.

> "They [the employer] think young people, they're not telling the truth, being
> honest, but I did give them proof. But they said, 'We want somebody who
> doesn't take time off work at all' which I thought was quite weird."

One participant described a pattern of being pushed out and forced to start over:

> "I'll be in one branch for two or three months. Because of taking time off work, they'll [the employer] tell me to leave. Then after a couple of months, I'll apply to a different branch and get there."

A number of participants reflected on the challenges for employers to manage fluctuating health and empathised with the logistical problems it can cause. However, most wanted a greater degree of flexibility and trust from employers.

One woman spoke of feeling uncomfortable discussing her health condition with male managers, especially when the issues were seen as personal and gender-specific. There was an assumption that they would be met with a lack of understanding.

> "The condition is something that is quite personal... You can discuss it with your employer, but it depends, it's a woman issue. Discussing it if your manager's a man, he's not really going to understand."

Another avoided asking for help altogether, choosing not to access the support offered rather than having to disclose personal information.

Discrimination and the Emotional Toll of Legal Action

A small number of participants talked about how they had been discriminated against in the workplace due to their disabilities. A woman from Bromley was forced to leave her job when her health deteriorated and she became a wheelchair user.

> "And then basically, he [the employer] didn't want me back. He said, 'I can't have you back because we can't get a wheelchair in.' So that was my last time working."

A small number of participants pursued legal action following workplace discrimination. In one case, an employer was found guilty of both disability and gender discrimination. However, the process of taking employers to an Employment Tribunal was described as "hell" by one participant and negatively impacted their health. They reflected:

> "I would never put my health through that again."

Several shared how the stress of legal proceedings, combined with the trauma of being forced out of work, worsened their mental health and eroded their confidence in returning to employment.

> "If I was an able-bodied person, I would get snapped up like that."

For most participants, leaving the labour market was not a single event but the result of a slow and painful process shaped by physical symptoms, emotional strain and poor workplace culture, and systemic failure. Despite these challenges, many expressed a clear and ongoing desire to work.

What mattered, they emphasised, was the ability to work with their health conditions not in spite of them.

> “Because there are some illnesses that you absolutely cannot work. But there are some illnesses that you can work around your illnesses, which is like mine.”

This message underscores the need for timely treatment, supportive employers, and responsive systems. With these in place many believed they could still be contributing through work. As one person summed it up:

> “If the system was right, I’d still be working.”

Researcher reflections

One of my observations is that many of these people’s perceptions and beliefs around employer attitudes have been shaped by previous negative experiences and trauma. One participant disclosed a violent sexual assault in the workplace and described the continued impact on them, but did not connect this with their relationship to work and the workplace. Often participants did not articulate how much previous experience has shaped their attitudes to opportunities and limited their own expectations of what they can achieve in life.

Because of the strong correlation between physical and mental health, I observed that the majority of participants suffered from extremely low self esteem and sense of self worth. Sometimes the hopelessness they expressed around their own situation and health was a product of this. This highlights the necessity of mental health support to improve every aspect of these people’s lives.

It was also striking the levels of loneliness and isolation within this cohort. The act of sitting down with someone new who was interested in their story and circumstances led to a number of disclosures. This group felt disenfranchised and unheard so participation in this project unlocked strong personal responses.

When Work Doesn’t Fit: The Challenge of Competing Priorities

For many individuals, balancing paid work with the demands of caring or managing chronic health conditions creates relentless time pressure. Participants spoke of having to make the choices between attending medical appointments, managing symptoms, supporting loved ones, or engaging with back to work services or employment.

Rigid job schedules were frequently at odds with the unpredictable realities of being a carer. Caring for children, partners, or elderly relatives meant dealing with needs that could arise suddenly and consume significant time and energy.

A 47-year-old mother of three from Croydon, reflected on how her responsibilities changed over time. One of her children, now 19, has autism, hypermobility, and fibromyalgia.

"Primary school was fine. I worked in the same school. So if there was a problem, I was just a few doors away."

But as her child's needs grew more complex and he transitioned to secondary school, she made the difficult decision to stop working as a Teaching Assistant.

"I took the decision to step back and do the full-time care. I couldn't commit to my role, and that wasn't fair on the children I was supporting."

Even now, with her child attending university, she still provides regular support:

"I never know if I'm going to have to jump in a car, on a coach, or on a train to Plymouth to deal with an issue. You can't do that when you're working. You can't just leave mid-shift, it's not fair on everyone else."

A 51-year-old woman from Bromley experienced job loss after a change in her working hours conflicted with her caring responsibilities. She had to leave work when her hours were suddenly extended and she couldn't find the childcare required. After leaving, she pursued a case for constructive dismissal and was successful.

Health and Work: A Delicate Balance

People managing chronic or fluctuating health conditions described how their own wellbeing often had to take priority. This wasn't about lacking ambition or drive, it was about the amount of time they need to spend managing their health leaving little time or certainty for employment.

"I can have two or three medical appointments a month. That would impact any job I take anyway."

A 63-year-old woman from Bromley hoped to work from home so she could better manage the physiotherapy and personal training sessions needed for her recovery but this proposal was turned down by her employer. A 56-year-old man from Islington shared how much time and energy went into researching his condition and seeking clinical trials and spoke of managing his health almost like an occupation in itself:

> “Alongside my health, I really want to work as well.”

Yet the admin alone can be overwhelming:

> “Sometimes you’re trying to do all these things and they get lost - an email disappears, a letter gets buried under a pile.”

A 43-year-old-man from Ealing has to carefully manage his mornings due to pain, stiffness, and digestion issues. He wants to work, but only if he can start in the afternoon, after going through his essential morning routine of stretches and medication.

The Need for Flexibility

Across the board, participants emphasised a clear and urgent need for more flexible employment and support systems. Those with caring responsibilities especially found it difficult to locate work that accommodated their unpredictable schedules.

A 35-year-old single mother of two from Ealing, asked:

> “Where is the work for people who need to work within school hours?”

Sometimes the opposite was true, a woman with retail experience described how the sector felt inaccessible to her now she has caring responsibilities due to irregular shift patterns. She needed a more rigid schedule to plan care:

> “Trying to find a job where you’re on a consistent schedule so you can arrange for somebody to be in your place. It’s impossible.”

People caring for adults with learning disabilities or elderly relatives with complex needs described the influence of the quality and consistency of statutory care being provided impacting their ability to engage with back to work support or employment.

> “When you’ve got children or adults with autism, consistency is key. That regular person or people, it makes a massive difference because the person being cared for also gets to know the carers.”

Language barriers and poorly trained care workers made this even harder.

> “When I was working, social care came to help, but they couldn’t speak English. Communication was so limited, and it caused so many problems.”

One woman in Newham, supporting multiple elderly relatives while living with her own long-term health condition, summed it up:

> "Each day, the hardest thing is managing all their [the person they're caring for] appointments. They have so many, and I also have to think about my own energy level."

Participants also spoke about the need for support services, like appointments or training sessions, to be flexible and accessible from home. The cost of childcare was repeatedly cited as a barrier to pursuing education, training, or work.

A 28-year-old woman with young children shared her desire for remote, part-time work:

> "I need something I can do from home. I don't have access to affordable childcare."

In contrast, a positive example came from a 31-year-old Nigerian mother who was able to study at Westminster College thanks to a bursary that covered childcare costs.

Excluded by health and care

A number of participants described being "fit for work" on paper, but unable to participate in employment because of the constant juggling of responsibilities.especially found it difficult to locate work that accommodated their unpredictable schedules.

> "I'm fit for work. It's not that a doctor said I'm not. It's just the juggling between everything. I never asked to become a carer, to be quite honest."

The demands of unpaid caring roles means that many, particularly women, are excluded from the labour market. This is also true of people with complex health conditions that require day to day management where it makes engaging with back to work services or employment difficult to plan to fit in. Not because they don't want to work, but because work, in its current rigid form, simply doesn't fit into their lives.

> "There's so many challenges. Number one is my health. Second is my in-laws' health, the caring responsibility falls to me.

Researcher reflections

Poor mental health here again impacted people's perceptions of their abilities as well as their actual capabilities to juggle competing priorities. Although many were acutely self aware that their mental health would improve if they were able to access work, they did not appear to connect this thought to how they managed their time.

Trust in care provision was also a barrier for this group with many defaulting to the perspective that care from a family member is always superior. The sense of duty to care for family was also stronger within certain ethnic minority groups.I also experienced a strong feeling around how different care roles were or weren't valued and this led to different justifications around some participants' choice to care. Carers for adults with special needs in particular felt that they fell outside the usual bounds of what is considered necessary caring.

It also was apparent that perceptions of rigidity of employers were connected to people's fear and lack of confidence.

When Not Working Makes It Harder to Work: The Mental Health Loop

> "My mental health is not good at the moment at all, so I don't really go out too much. I'm very isolated."

Many participants reported experiencing poor mental health, with anxiety and depression commonly diagnosed. For most, these mental health challenges developed or worsened after leaving the labour market, creating a vicious cycle that made returning to work increasingly difficult.

A 49-year-old woman in Lambeth, described how her partner's mental health deteriorated after he was forced to medically retire due to ill health. The sudden loss of work led him into depression, which in turn had a significant impact on her own wellbeing:

> "Health-wise, I started putting on a lot of weight because of his [partner's] depression. It affected me too."

For several participants, poor mental health was closely linked to traumatic experiences in the workplace or the emotional fallout of having to leave work due to injury or illness.

A woman in Bromley developed chronic anxiety following a workplace injury that also caused ongoing physical pain. Eventually she was forced to take ill-health retirement. She described the emotional trigger of returning to the scene of the incident:

> "As I looked up, all I could see was the spot where I was first injured, and I had the worst panic attack."

Extended periods out of work, often driven by untreated or unsupported mental health conditions, had a profound impact not only on practical skills but also on participants' confidence and sense of self-worth. Many described feelings of hopelessness about their futures, shame at being unable to provide for themselves or their families, and a deep loss of autonomy and independence.

> "So I don't earn anything. I'm worthless. And that's what it feels like to me, that I am worthless because I don't earn a single penny."

One participant reflected on the damaging impact of public narratives that portray people with mental health conditions as unwilling to work. She expressed frustration at being overlooked despite having valuable skills to offer, and highlighted the hidden financial and emotional costs of living with a disability:

> "I've got this skill. I would like to give it to other people. But no one wants me."

A 35-year-old single mother from Ealing spoke about how both her own mental health and that of her children had been negatively affected by poor housing conditions and her ongoing inability to find work. The emotional weight of these circumstances made daily life feel overwhelming:

> "It is so difficult to go to any place when I feel so bad inside."

A 43-year-old man from Ealing who takes antipsychotic medication, explained how the effects of his treatment shape his ability to function day to day. He often has to wait for the medication to take effect before he can leave the house:

> "Because if they haven't kicked in, then it'll be difficult to go outside, to be honest. My life's not the same anymore."

For others, peer support and community activities provided vital relief and connection. One woman, referred by a friend, joined a singing group with Avanti CIC a mental health support organisation in Mitcham. The experience of being around others facing similar health challenges helped ease her sense of isolation:

> "I think just meeting other women helps me. They have different, different challenging health issues or things that they are going through."

The importance of family and a support network was crucial to supporting people's mental health. A 61-year-old man in Islington who has been unable to work for the past decade due to MSK condition caused by a car accident was very clear about the importance of his wife and children to his wellbeing:

“Without that, I don’t know what I would do now but it wouldn’t be with the emotional support, the daily support, the knowledge that if I fail at something or I’m feeling down, that there’s no one there for me.”

“There’s always been somewhere there for me, someone to fall back on, a family.”

A few of the participants in this research lived alone without support networks. The men in this situation, in particular, were unable to find strategies to improve their mental health.

This lack of a support network further diminished people’s belief in their ability to find or sustain employment. As time away from work stretched on, participants struggled to maintain structure in their daily lives, often describing themselves as feeling useless or directionless. This growing anxiety about their capability reinforced withdrawal and isolation, deepening the sense of despair and making the prospect of returning to work feel increasingly unreachable.

“My mindset has been, I’ve forgotten about working because it’s not something that’s within reach.”

Some participants reflected on how deeply tied their sense of self had been to working life. One man, who identified as Black British and has lived in Islington all his life, reflected on cultural and generational shifts:

“I’m from a generation that work was a very major part of our identity. Today, it’s not the same for young people, from my perspective. But for us, work meant everything. If I didn’t have work, you were less of whatever you were, less of a man thing. I know it sounds like old hat, but that’s how we were raised. Not just Black people, white people especially. Work was very much part of our British identity. Not so much today.”

Despite the challenges, many participants recognised that being in work would be beneficial for their health, not just financially, but emotionally and physically. Several reflected on previous jobs and the positive effect work had on their overall wellbeing.

“My general health and my mental wellbeing improved because I was happy. I was doing something I enjoyed, working with people I like. I had responsibility.”

Most participants felt that the mental health support they received was insufficient, untimely, or poorly tailored. One man from Ealing expressed his frustration that medication was offered as the default solution, when what he really wanted was access to more holistic or therapeutic support.

Several women described how volunteering helped improve their mental health by giving them a reason to leave the house and feel useful again. There was also hope expressed that volunteering could lead to paid employment. For example one participant manages her mental health by keeping active and engaged. She volunteers at a centre where she teaches English to asylum seekers, a role she discovered through a friend. Another spoke about the benefit to her of volunteering at a community food bank:

> "This is why I come here. It gets me out of the house. It gives me something different to do."

In contrast, men were generally less likely to engage in any form of social prescribing, often preferring to deal with things independently.

> "I haven't really tried to reach out. I've tried to do my own thing."

> "I tend not to like to depend on other people."

Across the group, participants emphasised the importance of work in restoring routine, identity, and motivation. Without that sense of purpose, mental health often continued to decline, reinforcing a self-perpetuating loop of isolation and inactivity.

Researcher reflections

I observed that the strength of feeling around work as being an important part of identity was more prevalent in people over 50 and particularly acute with men, who may subscribe to traditional values of the man being the sole provider. There were also strong feelings of shame around poor mental health, again more prevalent among this older age group.

With this group I could clearly see the signs of unresolved trauma impacting people's ability to think clearly or make good decisions about their life. Where people had been victims of direct discrimination, domestic or workplace violence or had been through the trauma of losing homes, jobs and whole families, these experiences continue to have a huge influence on how they interact with support or on their belief that they deserve support at all.

Beyond Health: The Practical Challenges That Block Employment

While health conditions were a central barrier for many, participants also identified a range of practical challenges that significantly limited their ability to enter or re-enter the labour market. These included fears about benefit loss, unresolved immigration status, housing insecurity, low-quality job options, and limited English proficiency.

A common concern was the risk of losing vital benefit support. For people managing long-term or fluctuating health conditions, the prospect of starting work, only to lose financial security if the job failed, created deep reluctance. The lack of a clear or safe route to trial employment left many feeling stuck.

“Why don’t I just stay at home and collect some benefits and be fine?”

A 49-year-old woman in Lambeth with complex health conditions described a wish to explore work “without obligation” and without risking her existing benefits:

“It would be good if people could be paid to try jobs, but without the obligation of having to take them.”

A couple of participants awaiting settlement status or work permits described feeling stuck in limbo, unable to work legally, but also unable to move forward. A 31-year-old Nigerian woman waiting for a Home Office decision spoke about the toll of this prolonged uncertainty:

“I feel ashamed. I feel neglected.”

The quality of available work was another concern. Participants were clear that low-paid, insecure, or physically demanding roles were not sustainable, particularly for those managing health conditions or caring responsibilities. A 35-year-old woman in Ealing, who previously worked as a travel agent, reflected on how her past work was low-skilled and unlikely to meet her needs now. Others expressed frustration that their skills and aspirations were undervalued.

“I’ve got this skill. I would like to give it to other people. But no one wants me.”

This frustration also existed when it came to the link between training and well paid work:

“After so much effort, commitment you put in for many months and then come out and get a little pay, you won’t be satisfied with it.”

Housing insecurity emerged as one of the most frequently cited barriers and had a negative impact on people’s wellbeing.

A 43-year-old man in Ealing who became homeless following redundancy, now lives in shared accommodation and described how the instability worsened both his physical and mental health:

“It just went completely wrong from there.”

“In the beginning, when I first came out the tent, it was so hard to even make eye contact with people. Even now. This is still something I’m having to teach myself.”

Living in shared accommodation, temporary housing, or overcrowded spaces made it nearly impossible to focus on employment or complete training. For a 55-year-old domestic abuse survivor, the lack of a private, quiet space meant that even online learning was a challenge:

“You don’t have privacy. Even if I do my online course or training, I have to try and keep quiet because another lady is working from home.”

She also explained how her housing situation was preventing her from accessing needed surgery:

“I live on the top floor and share facilities. That makes it harder to recover or even get the surgery in the first place.”

Participants highlighted how this instability not only harmed their mental health, but also made practical engagement with employment support nearly impossible. A 35-year-old single mother in Ealing raising two young children in a shared house with another family, connected her poor health directly to her housing:

“With people, with anybody, who has a house, then normally their health is good. Everything is good.”

Limited or no prior work experience posed a major challenge for some, particularly women who had spent years out of the workforce or who had never worked. A 28-year-old woman who got married as soon as she left education explained:

“Because I haven’t worked before, it’s going to be really hard for me to start.”

Her sister-in-law, recently arrived from Afghanistan, faced additional barriers due to cultural expectations and gender roles in her home country, where she had never been allowed to work.

Language barriers added another layer of difficulty. Limited English restricted access to jobs and support services and led to feelings of isolation. One participant shared a preference for telephone-based support to reduce pressure, another struggled with formal therapy even when translators were provided.

“I don’t want to share my problem with anyone.”

Others, like the 28-year-old from Afghanistan referred by her JobCentre Work Coach to a free ESOL course, was about to embark on her first step toward employability through language classes.

These practical barriers, especially when combined, created an environment in which re-entering work felt overwhelmingly out of reach. Participants made it clear that health alone was not the only obstacle; the surrounding conditions of daily life, housing, immigration, finances, and a lack of flexible work, played a defining role in shaping their economic inactivity.

Researcher reflections

When talking about wider life circumstances I observed so many instances of fear, lack of trust and low confidence that is dominating many of these participants' day to day experiences. Living in insecure housing and the risk of homelessness presents a near existential threat to a number of these participants particularly where past trauma exists or where they are responsible for the safety and welfare of their children. Many of this group seemed overwhelmed by the number of obstacles and challenges they face on their journey to financial stability and safety, in a number of cases this led to extreme anger and frustration at the systems they were battling against and sense of injustice over their treatment. For others, this exhibited as powerlessness and gave me the impression that they had given up hope.

Mixed experiences of service provision

Across employment services, health care, education, training, and community support, participants described consistent challenges: difficulty navigating complex systems, poor continuity of care, inflexible delivery models, and a lack of truly person-centred approaches. When services worked, it was due to trust, sustained support, and a holistic understanding of people's needs.

Navigation and referral

Many participants found it hard to know where to go for help, particularly after a health crisis or change in circumstances. People often turned to friends, family, or trusted professionals for guidance.

> "Who do you contact? Where are these people? Who are these charities?"

> "There isn't a directory of: now you're disabled, you're allowed to do this."

Referrals worked best when they came from trusted individuals, such as friends, family members, or familiar professionals like Work Coaches in JobCentres. These referrals often acted as a bridge to support that felt otherwise out of reach.

A really significant proportion of the participants expressed reluctance to accept help or engage with new services without it coming from a family member or trusted friend

> "I'll only accept help from someone that I know."

A friend encouraged a 57-year-old woman from Bromley to apply for PIP, but at first she didn't see herself as disabled. It was through this conversation that she came to recognise her long-term health condition and realised she was eligible for support. A newly arrived 28-year-old woman from Afghanistan talked about how she is only willing to seek help from family and friends due to language barriers.

Trust often developed outside formal services. A 61-year-old man from Islington, for example, was initially reluctant to access community support until a long-time acquaintance encouraged him:

> "Originally, I didn't want to go there because of my ego and stuff. But a local guy I've known for many years recommended it."

Barriers to access: location, money, delays

The location of services for this group, many with low mobility and access needs, is a key consideration that informs access. Several participants faced barriers due to the physical location of services. A 63-year-old woman from Bromley had to drop out of retraining when the provider moved and parking became an issue.

Another participant with poor mobility and chronic pain could only attend training in areas served by familiar bus routes. Another woman was only willing to travel to access support if she knew that it would be "worth it."

Financial barriers also limited access. A wheelchair user in Bromley noted that while the gym would help with her mental health and pain, she couldn't afford it. A Bromley man found a job driving children with special educational needs and disabilities to school. It provided him with the flexibility and support he needed to support management of chronic pain caused by a serious MSK condition. Unfortunately, he had to give up the job due to an eye condition that could be corrected with private surgery, which he couldn't afford.

Across the board, participants described long waits and systemic barriers to accessing appropriate healthcare. One man experienced an 18-month delay for talking therapy due to an administrative error. A significant number of participants also spoke about their struggle to secure referrals to health specialists. Pain management, mental health support, physiotherapy were mentioned as inaccessible or inadequate.

> "It's me having to push things and request things."

> "I don't feel I am getting the help. I feel like I'm just being pumped with drugs."

Consistent throughout the participants' experiences of accessing services was the fundamental importance of initial referral from their GP.

On the other hand, where people received free access to timely services, this could be transformative. For example, a 61-year-old man in Islington with a serious MSK condition had joined a council scheme where he gets access to free swimming and spoke of the benefits he was starting to see to his health from regular swimming. Another woman was accessing lots of free training online.

Another example is a bursary providing access to childcare for her two year old so that she, a 31-year-old single mother, could complete a qualification in social care at Westminster College.

Service quality and the importance of continuity

Participants' experiences with employment services, particularly the JobCentre, were highly variable and often dependent on individual staff members. Some described receiving excellent, personalised support from Work Coaches in JobCentres who took the time to understand their situation, offer relevant referrals, and build trust over time.

> "I've had good support from my Work Coach specifically… he's actually listening to my situation."

However, these positive experiences were not echoed by everyone, particularly those whose engagement with JobCentres had been in the past. Some described early contact with JobCentres as dismissive, rigid, and stressful, particularly when dealing with health-related barriers to work. Several reported being made to feel worthless or penalised for not fitting narrow eligibility boxes.

> "These jobs are on offer. You either take them or you don't. And if you don't, you get sanctioned."

> "Everything there is tick boxes. You fit this criteria or that criteria—you can't do a bit of both."

Trust across this participant group was very low and this reinforced the importance for many of them of having consistent contact with the same person and how this improved the support they received.

> "If you see the same person, they've got an understanding of where you are and how far down the line you are with something."

People with depression and other mental health conditions are particularly vulnerable to having to retell their circumstances each time they access help. A 54-year-old man in Bromley with a history of self-harm and suicidal feelings articulated this:

> "The last thing you want to do in that position is have to go through and explain everything every time to see someone."

When a consistent relationship is established, it makes a huge difference to how people feel about the value of the support they are receiving. For example, a single mother with limited English in Ealing described one trusted staff member at the JobCentre as "my angel," someone who understood her despite language barriers.

Another aspect of service provision that these participants flagged as of high value to them was following up on the help given and offering additional support. A disabled woman in Lambeth expressed this sentiment succinctly:

> "They [support services] didn't say what else can we help you with? Did you go somewhere with the advice we gave you? There was no follow-on. This is important."

Applying for support while in work and after leaving was frequently described as difficult, slow, and sometimes demoralising. A woman in Bromley successfully accessed an adapted car through Access to Work, which enabled her to continue working for a time. In contrast, an application for a support worker by an autistic woman in Newham suffering from a series of complex health conditions was denied after a 10-month process.

> "It was just the system is not tailored to really listen."

A man living with serious spinal injury and depression found the process of applying and reapplying for PIP particularly distressing:

> "It's such a horrible process for people to go through."

Back to work programmes were not always targeted at the right person or at the right time. For example, a man in Islington was mandated by his JobCentre Work Coach onto an eight-week course provided by Ingeus that did not meet his needs at the time. However, a subsequent programme by the same provider that he chose to access to support him with his CV and LinkedIn was received positively.

The same man a few years on feels more optimistic about his future employment prospects by a recent referral to a health-led programmes by Nuffield Health and Shaw Trust as he feels these will better address his health needs in the context of back to work support. This demonstrates a consistent theme expressed by participants that how people felt about the relevance of the support they received impacted how high quality they believed it to be.

Participants wanted services that adapted to them, not the other way around. Many felt treated as problems to be solved or boxes to be ticked. There was a clear call for support that is flexible, responsive, and focused on individual potential.

> "These are your needs, this is how we [support services] can adapt to fit you." "They shouldn't pressurise people. People have a lot of pressure as it is. They should say: we're here to listen to your needs."

Benefits: The end of the road?

A key insight from this participant group was around the correlation between benefits and support. Most participants were motivated to work or study but a number of them felt they were no longer offered support to access work once qualifying for certain benefits. They felt there was no longer an expectation that they would be able to access work and that they would no longer be supported in their efforts to find employment that supports their health or caring needs.

A 27-year-old woman in Newham described how, after receiving an additional Universal Credit element, the JobCentre's involvement dwindled:

> "Once you get that element, they [the JobCentre] don't help you find work, which I think they should because they just leave you be."

Similarly, a 54-year-old man from Croydon shared his perception of withdrawal of support once he no longer needed to attend the JobCentre weekly:

> "Once I wasn't having to go there every week, then they [the JobCentre] were not interested in supporting me any further, or that was what came across to me."

Digital vs In-Person

When it came to employment services there was a strong preference among participants for face to face support. One person mentioned that online platforms, especially webchat, were seen as slow and impersonal.

> "You wait five minutes for an answer because they're [employment services] dealing with five people at once."

A 55-year-old woman in Merton found Zoom-based support helpful when travel was difficult, but stressed she would prefer in-person if closer to home.

> "I'm open to both. But it's all the way in East London, it's a bit of a challenge."

Participants had specific requirements around the support they needed to start thinking about looking for work and many were unsure about whether it existed. Most participants expressed that having their health needs met was the priority, though many recognised that being back at work could improve health, specifically their mental health.

Where English language proficiency was a barrier there was a mixed response to how these people would like to receive support. Some needed that face to face interaction in order to feel understood and to communicate effectively. However, one woman with no English and suffering from depression and anxiety found the idea of in person support overwhelming and was much more willing to engage with support over the phone.

When it came to engagement with education and training there was a mix of preferences to access either online or face to face. A significant number of participants were happy to access training and educational opportunities online. An Islington man valued the interaction and collaboration of in-person learning environments:

"Collaborating with people and being in a proper learning environment, not just on your own."

Because of the high level of need among this participant cohort, people wanted sustained support over time so the length of support was also important.

Culture of service impacts outcome

Many participants described services as inflexible and bureaucratic. A woman in Croydon, for example, avoided the JobCentre due to past experiences. One woman described being dismissed by housing caseworkers. A man struggling with a serious mental health condition who missed GP appointments expressed frustration that the system had no flexibility to rebook.

On the other hand one man's mental health nurse "finds a way to make me talk" and another man talked about the community matron coordinating support across multiple services in a moment of crisis. One woman expressed how she would like services to be more adaptable:

"Don't say, 'I can't help you because you don't fit this box.' Say, 'These are your needs - this is how we can adapt to fit you."

Participants who had built relationships with community organisations (e.g. BromleyWell, Elizabeth House, Stay Safe East) reported better outcomes. These services were seen as more approachable, less bureaucratic, and easier to navigate. Trust, warmth, and consistency were repeatedly cited as critical.

"That personal touch means the world."

"They are somebody to ask, how are you?"

A woman in Lambeth was clear on how important listening is to meeting people's needs:

"They [support services] shouldn't pressurise people. People have a lot of pressure as it is. They should say: we're here to listen to your needs."

Researcher reflections

This group was generally far away from the employment market and extremely underserved. Very few had been offered or engaged in substantial back to work schemes run by local or national providers in London. The lack of engagement here underscored for me the hidden nature of this community of people and the challenges in supporting them. For some, rejoining or entering the workplace just may not be possible but access to other support would make a big difference to their quality of life and have wider benefits to those around them.

Work as recovery: Key motivators for returning to work

Despite the significant challenges they face, all participants expressed a desire to work. They spoke clearly about the personal and practical benefits that employment could bring to their lives.

For most, financial stability was a primary drive, particularly for those living in insecure housing. There was a shared understanding that current forms of support were insufficient. Earning money was seen not just as a means of survival, but also as a way to better support dependents and regain autonomy.

> "You're the one who gets your financial autonomy. Not depending on someone else. It's just I have always been working since 19, I was free."

However, participants consistently emphasised that their motivation to return to work extended well beyond financial need. Employment was associated with structure, purpose, identity, and emotional wellbeing.

> "It's not financial. It's just the thought of being able to get up in the morning and have something to do. Have the routine back in my life and get up in the morning."

> "The weekend only feels like the weekend once you work the whole week. I miss that weekend feeling, I really really do."

While many voiced a sense of hopelessness about their current prospects, they still held onto a vision of the kind of work that might be viable for them, whether that meant accommodating physical limitations, seeking flexible hours, or exploring remote opportunities.

> "I can still see myself being able to work. My back also, like I said, there's ways around it. I can find evening work or even online work."

Overall, the idea of returning to work was viewed not simply as a financial solution, but as an essential part of recovery, a step toward reclaiming agency, routine, and a meaningful place in society.

Researcher reflections

Despite the majority living in extreme poverty and suffering disadvantage on multiple fronts, they were thinking beyond the financial benefits of work and what it would mean to them. Even with me, they were exploring ways they could make it work if certain health, flexibility requirements were met. I was struck by their ingenuity and willingness to visualise a different future for themselves despite the significant challenges they faced. A large number of the participants were recruited at community food banks where they were accessing crisis support, including debt and housing advice services simultaneously. The universal assertion by this group that they would still like to work if possible was really striking.

Conclusion

This research exposes the layered realities of Londoners across the capital with long-term health conditions, caring responsibilities, and other compounding challenges as they attempt to navigate support services on their journeys back to the workplace

Their daily experiences of living with often overlapping and complex long term health conditions paint a picture of lives dominated by chronic pain, fatigue, and depression. Their paths to access support are rarely straightforward.

Throughout this research, participants consistently described services that are difficult to navigate, often rigid, and ill-suited to the complex, fluctuating needs of their lives. Services were most effective when trust was built over time, when people were seen as individuals and support was tailored to their specific needs. Empathy and understanding were qualities craved by this cohort as they attempted to rebuild or improve their lives.

For many, the desire to work remains strong, motivated not only by financial need but by a deeper yearning for identity, purpose, and routine. Yet this drive is often undermined by poor service experiences, unstable housing, a lack of flexibility, and deteriorating mental health. Experiences varied. For some, being out of work was a sudden traumatic event, for others a slow descent into worklessness due to compounding factors, untreated health issues and work environments that at best lacked flexibility and at worst were discriminatory. When the right support is in place however, participants showed hope, motivation and ingenuity in imagining a better future.

At its core, this research reveals a group of people who are often unseen and underserved. It was striking that even within this small sample there were extremes of experience which are present in the narrative. Their stories powerfully advocate for increased support and a reimagining of services that are rooted in empathy, flexibility, and person-centred design.

What Works

The quotes below highlight how participants defined “good work” — not just as paid employment, but as purposeful, flexible, health-conscious, and emotionally supportive – as well as what participants would like to see.

Flexible, Accessible Work

“I can still see myself being able to work. My back also, like I said, there’s ways around it. I can find evening work or even online work.”

“Trying to find a job where you’re on a consistent schedule so you can arrange for somebody to be in your place. It’s impossible.”

"I need something I can do from home. I don't have access to affordable childcare."

"Where is the work for people who need to work within school hours?"

"Because there are some illnesses that you absolutely cannot work. But there are some illnesses that you can work around your illnesses, which is like mine."

Supportive Employers and Inclusive Workplaces

"If the system was right, I'd still be working."

"The real issue is the companies themselves that don't really help support people with illnesses. That's the truth."

"You can discuss it with your employer, but it depends, it's a woman issue. Discussing it if your manager's a man, he's not really going to understand."

Enabling and Practical Support, Trusted Relationships

"A bursary provided access to childcare... so I could complete a qualification."

"I've had good support from my Work Coach... he's actually listening to my situation."

"Trust often developed outside formal services... a local guy I've known for years recommended it."

Safe Pathways Back to Work (Without Risking Benefits)

"It would be good if people could be paid to try jobs, but without the obligation of having to take them."

"Once you get that element, they [the JobCentre] don't help you find work, which I think they should because they just leave you be."

“Once I wasn’t having to go there every week, then they were not interested in supporting me any further.”

Trust-Based, Empathetic, Person-Centred Services

“They shouldn’t pressurise people. People have a lot of pressure as it is. They should say: we’re here to listen to your needs.”

“These are your needs, this is how we [support services] can adapt to fit you.”

“If you see the same person, they’ve got an understanding of where you are and how far down the line you are with something.”

“They didn’t say what else can we help you with? Did you go somewhere with the advice we gave you? There was no follow-on. This is important.”

Recommendations

1. **Build consistent support through integrated case management** – Current services often engage with people sporadically and inconsistently, which erodes trust. Trailblazers should model long-term, relationship-based approaches across employment, health, and wraparound support, reducing duplication and ensuring individuals aren't passed from service to service.
2. **Embed empathy and flexibility into frontline delivery** – Many existing services feel transactional and "box-ticking." Trailblazers can set a new standard by requiring providers to demonstrate relationship-based practice- empathy, flexibility, and continuity- across boroughs, ensuring more consistent quality of engagement.
3. **Strengthen specialist pathways for acute needs** – Some groups face extreme crises (e.g. severe mental health episodes, survivors of violence) but fall through gaps because mainstream services are ill-equipped. Trailblazers should coordinate specialist provision and ensure clear referral routes across boroughs, avoiding postcode lotteries in access.
4. **Support employers to offer genuinely inclusive work** – Employer engagement remains fragmented, with little consistency in how flexibility is offered. Trailblazers can play a convening role, supporting employers to adapt roles to fluctuating health/caring needs and promoting consistent, joined-up employer engagement strategies across the city.
5. **Rebuild trust between employers and jobseekers** – At present, employer-employee relationships are undermined by misunderstanding and stigma. Trailblazers could broker structured opportunities for dialogue (e.g. co-designed pathways, local employer forums), strengthening understanding on both sides and ensuring good practice is shared regionally rather than staying siloed.
6. **Clarify safe pathways through the benefits system** – Fear of benefit loss remains a major deterrent. This is compounded by inconsistent communication across providers. Trailblazers should work with DWP and local providers to develop standardised messaging and guidance, ensuring people receive the same clear reassurance no matter where they engage.
7. **Improve navigation through trusted community partnerships** – Currently, referrals between statutory and community services are patchy and heavily dependent on local relationships. Trailblazers could formalise networks of trusted community ambassadors and build referral protocols, reducing variation between boroughs and strengthening community-to-service pathways.
8. **Expand integrated mental health support beyond medication** – Mental health services are siloed from employment support, and default heavily to medication. Trailblazers should embed therapeutic and peer-support models into employment pathways, ensuring consistency across boroughs and addressing both wellbeing and employability together.
9. **Join up fragmented services into coherent pathways** – People are currently "falling through the cracks" due to siloed commissioning between health, employment, housing, and immigration services. Trailblazers should explicitly design integrated service models that prevent fragmentation, coordinating provision across boroughs to avoid duplication and gaps.
10. **Investigate gendered inequalities in economic inactivity** – Variation in outcomes for women, particularly linked to caring, health, and gender-based violence, is poorly understood. Trailblazers should commission research to strengthen the evidence base and ensure system-wide responses address these gendered barriers consistently, rather than leaving them to ad-hoc local practice.

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