

**Building Capacity for Work:  
A UK Framework for Vocational Rehabilitation**



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# Introduction

Since 1997 real progress has been made in the shared ambition to help people who encounter health conditions, impairments or injuries to access, remain in, or return to work. Effective Vocational Rehabilitation (VR) is one approach that has the potential to make a difference to people's employment chances. The Framework for Vocational Rehabilitation published in October sets out Government's ambitions in this area.

For ease of presentation we have produced this Framework Annex which contains:

- an overview of responses to the VR Discussion Paper - Developing a Framework for Vocational Rehabilitation - that was published in May 2004 (**Appendix A**);
- a selection of current strategies, initiatives and projects that contain VR. The first section gives some insight into what is happening in VR for business and the workplace. The following section provides insight into VR from the insurance industry perspective and includes some examples of legal initiatives. The next section highlights ongoing work in Government that contributes to the VR agenda, including a brief outline of the Disability Discrimination Act. In the final section, brief details of some of the other initiatives, mainly aimed at helping those who have been out of work for some time, that contain VR, are presented (**Appendix B**); and
- a selection of VR case studies (**Appendix C**).

These Appendices should be seen as part of the Framework, and serve as a useful insight into stakeholders' views on VR and the broad range of current strategies, initiatives and projects that contain VR and help people to fulfil their employment potential.

In the Framework Document, Government highlights that the term VR can mean different things to different stakeholders. In producing the Framework the Government listened to all stakeholders' views on what VR means to them and then produced a working description of VR which can be used as we work together to develop a new approach to VR. As well as the working description of VR, another way to improve understanding of the term is to describe those projects that contain VR. It is hoped that the examples contained in Appendix B will serve as a practical demonstration of what we mean when we are talking about VR.

The appendices have benefited from the efforts and contributions of stakeholders. Government is grateful to all stakeholders who have contributed to this work.

It is important to note that although there would seem to be a lot of good work on VR, Government is not yet in a position to comment on the relative effectiveness of the interventions highlighted in the appendices.

# APPENDIX A

## Overview of the responses to the discussion paper on Developing a Framework for Vocational Rehabilitation

In May, the Department for Work and Pensions (DWP) distributed a Discussion Paper to a wide range of stakeholders including:

- Health Services and health organisations;
- National and Local Government/Public Services including Emergency Services;
- Industry and employers' organisations;
- Charity/Disability Organisation;
- Insurance and related services;
- Self Help/User Groups;
- Higher education/Training colleges;
- Self Help/User Groups; and
- Legal and related services.

This has formed a part of the wider discussion: we have spoken at several events and shared thinking with a number of discussion groups with an interest in VR in the last six months. We have also worked closely with stakeholders in the devolved administrations and other Government Departments to ensure a coherent and consistent approach.

This appendix summarises the diversity of replies to the DWP Discussion Paper "Developing a Framework for Vocational Rehabilitation" to give you a flavour of the types of responses we received. This exercise was not designed to be a representative survey of views so responses to each of the questions are presented on a thematic basis.

**Question One: *Does the description of Vocational Rehabilitation we are using correspond to your understanding and/or practice of vocational rehabilitation?***

***If not, what do you suggest we might include or exclude from the description?***

Overall, most of the responses agreed with the description of Vocational Rehabilitation we are using. Quite a few responses, however, referred to the term VR not being particularly meaningful and alternatives were suggested.

### Ideas for changes to the term

- Return to work;
- Employment Rehabilitation;
- Helping employees back to work and/or helping employees continue working;
- Restoring Fitness to Work; and
- Return to employment or other useful occupation, including voluntary work, caring for someone else.

There were also quite a lot of suggestions for additions to the description such as “occupational” perhaps being a better term than “vocational” so that it also embraced those not engaged in paid employment. The point was also made that it would be useful to make it clear that VR applied to disabilities and illnesses that sometimes tend to be forgotten, especially mental health problems.

### Suggestions for additions to the definition of VR

- Helping to identify what people can do;
- Greater recognition of the “Social Model” of rehabilitation;
- Make reference to the different professionals who may be involved or the different activities that are involved - employers, all clinicians (not just VR specialists);
- Sustained support before and after return to work;
- Empower people to return to work and note the rehabilitative benefits of work, and to include people starting work for the first time;
- Promote social inclusion and recovery;
- Include mention of environmental issues such as areas of high unemployment, since they may be the appropriate focus for action;
- Ability to advance in (as well as enter) suitable employment; and
- Address quality of life more generally.

### **Question Two: *Have you come across health or disability related barriers to work?***

***(If yes) Please describe the health or disability related barriers you have come across and to whom these were applicable (e.g. employer or person with a disability).***

A number of the responses we received stated that they had encountered health or disability related barriers. In addition to illness or disability in itself a major barrier, other barriers that respondents cited included financial matters. Some respondents gave examples as to how the benefit system can serve to hinder a return to work. Others pointed out how expensive it is for employers to provide VR.

### Financial matters

- Social Security rules present a 'minefield' of uncertainty for someone considering a return to work;
- The £20 earnings "disregard" for people on income related benefits, in effect, limits people to four hours a week work (because of the National Minimum wage) - unless people are able to switch to a full time job;
- The "Permitted Work" rules (ability to earn around £70 a week for 6 months and receive non-income related benefits) are very useful, if not generous, in encouraging a return to part-time work but are not effective in encouraging people to earn more and work longer if they are able;
- The extent to which eligibility for Disability Living Allowance is challenged when people (especially for those with less obvious disabilities like mental illness) enter work is most unhelpful;
- The Housing Benefit system seems to be very slow when dealing with changes in employment status;
- Fear of Losing Benefits/return to work seen as financially risky;
- Low pay (and status) from the sort of jobs people get after long illness (etc) compared with (better/adequate) income from IB, Housing Benefit, insurance pay outs etc;
- Employers cannot afford VR, or expensive adaptations - cannot do it in-house - especially smaller firms; and
- Cost of Insurance to Employer.

Leading on from concerns about the prohibitive cost for some employers of providing VR, some respondents recognised that effective VR invariably involves an employer playing a constructive role. There were anxieties about this in terms of employers accessing and/or providing services, facilities and suitable types of work.

### Access to services, facilities and suitable types of work

- Difficult for employer to find 'light duties', reduced hours, less stressful redeployment opportunities or intrusive adjustments;
- Lack of knowledge of and/or information about what is available and to whom to turn to help an employee with a health problem or disability;
- Difficult to make adjustments to the workplace - especially to older buildings and complex machinery;
- Safety concerns (rightly or wrongly) applied in workplace and preoccupation with safety and liability issues;
- Long NHS waiting lists for treatment, delays in referrals (e.g. to specialists) and slow communication between different stakeholders;
- Lack of access to Occupational Therapists, employee support, health and safety expertise, and vocational expertise; and
- Services (e.g. Jobcentres) for job retention are minimal compared with those for people who are unemployed.

Respondents also pointed out that in addition to direct health impacts, people with a disability, injury or illness can also experience indirect impacts such as lower self-confidence, self-esteem and motivation. Others mentioned how spending time out of work because of an illness or disability can have an affect on an employee's social skills as well as the currency of their training and educational skills.

### Effects of disability on individuals

- Stigma of disability - assume employers won't be interested, negative self-image;
- Out of Work for a long time, become resigned to it, give up trying;
- Apprehension about entering/returning and dealing with work colleagues, poor working relationships (especially hidden disabilities);
- Possibility and fear of possibility, that work will make condition worse;
- Difficulty in disclosing details of condition(s), even to Occupational Health Professionals and GPs;
- Complex multi-disability and "hidden" disabilities, affects of disability that are hard to explain to supervisors and others;
- Effects of medication and desire to avoid treatment that will interfere with ability to work once in a job;
- Variable medical condition (e.g. M.S., mental illness); can work sometimes but might have further bouts of illness;
- Lack of skill or qualifications; literacy and numeracy; qualifications out of date;
- Problems with recruitment processes, CVs (gaps), interviews (hidden disabilities, easy for employer to decide someone else is a better candidate);
- Unrealistic job goals, unwilling to consider different duties;
- Lack of opportunities for working from home;
- Emotional support not available in the workplace; and
- Old work friends may have moved on – no support left.

We received comments about ignorance of what could be achieved and negative perceptions of disability.

### Attitudes and perceptions towards people with health conditions, injuries and disabilities

- Peoples' attitudes, perceptions and preconceptions that injury and disability mean incapacity;
- Lack of disability awareness and awareness of options available among managers and employers;

- Lack of support in the workplace, co-workers unsympathetic to, or ignorant of, certain disabilities and illnesses;
- Lack of awareness of special services available (e.g. ergonomic assessments and occupational psychology services);
- Social Workers promote claiming and reliance on benefits rather than on people going back to work;
- Health professionals can be over-protective and can discourage individuals moving on;
- GPs seem too willing to sign sick notes, not skilled in understanding workplace demands; and
- Ill health retirement seen as the solution to health problems.

**Question 3: *From your experiences of vocational rehabilitation, which approaches work best and which work less well and for whom?***

We received examples of a number of approaches that were said to have worked well for different organisations and people. There were many comments about the effectiveness of seeing VR as a process, which might go through several stages, starting with early identification and intervention in sickness absence, continuing right through to monitoring progress after return to work. Other respondents referred to other approaches being necessary when trying to help people who had either never worked or who had already been out of work for several years. Some people thought that it was better to get someone into work and then help them to sort out their problems. On the other hand some thought it was preferable to go through a series of stages sorting out problems before attempting getting someone into a job. Among individuals who responded about their own experience of getting back to work, several despaired of the complex rehabilitation industry and said that they had to rely on 'self-help'.

- Joined-up services – multidisciplinary approach;
- Return to work as a phased planned process or trial return to work/build confidence/regular contact during absence;
- Easy access to (and involvement of) occupational health relevant practitioner, therapists and advisers;
- Link job knowledge with health knowledge;
- Focus on the individual; planned services tailored to individual and their skills, individual ownership of the activities;
- Continuing contact and support in the work place after return to work, monitor and deal with new problems that arise;
- Early intervention and referral;

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- Comprehensive assessment of individual and their needs before attempting a return to work;
- Employer positively motivated and involved at early stage; employer aware of benefits to company of staff retention and rehabilitation;
- Supported work placements, voluntary work and related methods of using a phased step between working and not working;
- Holistic approach focused on outcomes, not processes, but encouraging discovery of capability;
- Manage expectations, accept that complete rehabilitation is not always possible and that there will sometimes be set backs; and
- Absence Management Policies/Pro-active management of absence through ill-health.

Things that have not worked so well include:

- Inflexible targets: only recognise job entry or 'bums on seats', encourage selecting 'easy' cases or unsuitable participants respectively;
- Late referrals - allowing things to drift when problems become well established and employee loses motivation;
- Lack of consultation with employee;
- Stigmatising policies and 'tokenism' – (e.g. supporting disabled people in jobs they are unable to do competently);
- Lack of active management;
- Lack of disability training – especially mental health;
- Inflexible laws;
- Need for verifying paperwork and evidence; and
- Over regulation.

**Question 4: *What are your longer-term objectives for vocational rehabilitation, and what can Government do to help you deliver your objectives?***

### Long Term Objectives

Again, we received a wide variety of thoughts reflecting the wide variety of types of organisations and individuals who offered comments.

- Develop and improve VR and related training;
- Develop partnerships with stakeholders;

- Prompt intervention, get people back to work quickly, where possible through job retention approaches, encourage early referrals;
- Increase disability awareness training and support for employers and managers;
- Encourage employers to access occupational health and health and safety in the workplace;
- Be flexible where possible (e.g. allow working from home as a start to return to work);
- Promote good practice through guides and information;
- Build a specialist VR centre;
- Promote awareness of VR specialist support to front-line practitioners (in the health services);
- Stress deduction (leading to healthier workforce);
- Offer VR to all who need it;
- Create training places, work placements and jobs for long-term unemployed;
- Unified programme - to bring together a range of services, which collectively create VR;
- Make return to work a routinely measured criterion for assessing effectiveness of treatment; and
- Evaluate effectiveness of what we are doing.

### **What should Government do?**

- Clear strategy for VR including guidance and guidelines for VR;
- Set National standards of VR;
- Provide VR courses/training;
- Improve co-ordination of services;
- Facilitate joined up agency approach (e.g. local forums for exchanging information about local services and local availability of specialist help);
- National database to allow searches for relevant services/providers in their area;
- NHS to provide VR and/or greater awareness of employment issues in way services are delivered;
- Employ more occupational therapists;
- Raise public awareness of issues and options for successfully reducing problems;
- Raise awareness of good, safe, healthy working practices, publish good practice guidance or examples - focus on employers;
- Have VR separate from benefits system;
- Make benefit system more flexible: encourage people to earn what they can, when they can;

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- Examine sick pay rules;
- Better training for Jobcentre Plus staff and publicity for services available for people who have disabilities;
- Financial Incentives for VR/greater Investment in VR;
- Exempt private health rehabilitation treatment and fast track access to therapeutic treatment from tax;
- Award contracts for integrated VR services rather than piece-meal;
- Financial penalties for people not engaging in VR in a reasonable way;
- Provide more part-time jobs; and
- Employers to sign up to flexible work practices.

#### ***Question 5: If you do not feel that vocational rehabilitation is an appropriate approach for your organisation, why not?***

The sorts of responses received to this question were:

- We do not employ people;
- VR is not suitable for everyone;
- Lack of money;
- Lack of time; and
- Organisation too small.

## APPENDIX B

# A selection of current strategies, initiatives and projects that contain vocational rehabilitation

### **BUSINESS AND THE WORKPLACE**

#### **CONFEDERATION OF BRITISH INDUSTRY**

The Confederation of British Industry (CBI) members recognise the importance of vocational rehabilitation and view Vocational Rehabilitation from two key perspectives - sickness absence management and in the context of ELCI and compensation. There are many CBI initiatives that make a contribution to vocational rehabilitation. The drivers for business are managing employment costs and ensuring employee contribution and performance for business sustainability and competitiveness.

The CBI is primarily a lobby organisation and their policy and commercial activities support that role. The CBI produces information on developments and shares information on best practice. Members provide services such as training, medical and other support services. The CBI also provides information and policy development on skills needs and innovation, recognising the changing world of work, the identification of management skills to encourage and build capacity and making reasonable adjustments to working arrangements in adapting equipment, access and workspace.

The CBI carries out an annual absence survey where they signpost the activities of member companies in absence management - this ranges from flexible working arrangements of all types, part time, job sharing, flexitime, career breaks and tele-working to accommodate people's work capabilities and needs.

#### **EEF MANUFACTURES ORGANISATION**

The EEF - the Manufacturers Organisation (EEF), has a membership of 6,000 manufacturing, engineering and technology-based businesses and represents the interests

of manufacturing at all levels of government. Comprising 11 regional associations, EEF is one of the UK's leading providers of business services in employment relations and employment law, health, safety and environment, manufacturing performance, education and skills, and information and research.

EEF has published a practical guide to help firms maximise staff attendance, keep a lid on litigation and better manage a healthy return to work for staff on sick leave for more than four weeks - **“Fit for work – a complete guide to managing sickness absence and rehabilitation.”**

On vocational rehabilitation, a 2003 survey undertaken by EEF, with IRS research, indicated that one in three manufacturers said long term sickness absence is on the rise, accounting for 80 per cent of the total time lost from work. However, it was clear from discussions that managers feel ill equipped to deal with the growing challenges of helping sick staff get back to work. Written by legal and occupational health experts, ‘Fit for Work’ outlines six simple steps that companies should use to develop a culture of good attendance, effective rehabilitation and improved health and safety (see Infobox 1). These steps can be tailored to meet the needs of firms of any size.

#### **INFOBOX 1 – FIT FOR WORK STEPS**

1. Defines roles for senior, line and HR managers;
2. Identifies priorities for action by absence measurement and risk assessment;
3. Involves and informs the workforce of company policies and new drives to maximise attendance;
4. Establishes appropriate access to occupational health support, the benefits and where to find it;
5. Focuses on rehabilitation, avoiding dismissal and ensuring a healthy return to work; and
6. Tackles frequent short term absence, through return to work interviews, enforcing procedures and training line managers.

Particular emphasis was placed on providing guidance on frequently asked questions and everyday problems in the “real World” such as;

- Wouldn't rehabilitation just increase pressure on colleagues?
- Wouldn't contacting the sick employee be seen as harassment?
- Typical rehabilitation measures;
- Should a business pay for treatment or medical investigations?

- How do we ensure the company receives good quality medical information?
- Monitoring the employee's progress and preventing relapses; and
- Overcoming barriers to rehabilitation (for example, reluctant managers and vague medical certificates).

Dr Sayeed Khan, EEF Chief Medical Adviser, and co-author of the EEF Guide said:

*"Maximising staff attendance has become a key performance indicator but, for small firms in particular, practical support for dealing with sickness absence is not often easy to obtain.*

*"Fit for Work' cuts through the complexity of the law, makes sense of the medical issues, and provides a complete solution to managing sickness absence."*

For details on how to obtain a copy of "Fit for Work – the complete guide to managing sickness absence and rehabilitation" contact the local EEF Association or visit the website [www.eef.org.uk](http://www.eef.org.uk). See also the health and safety pages of the EEF website: <http://www.eef.org.uk/UK/whatwedo/healthandsafety/default.htm>

## **THE HEALTH AND SAFETY COMMISSION AND THE HEALTH AND SAFETY EXECUTIVE**

When an individual is in employment it is an employer's legal duty to ensure, as far as reasonably practicable, that risks to health and safety at work are controlled. Doing all that can be done to prevent work-related ill health and injury and thereby reducing the need for vocational rehabilitation is an important starting point when considering an individual's needs. The Health and Safety Commission (HSC) is the strategic body that leads on this important issue in Great Britain. The Health and Safety Executive (HSE) and local authorities are responsible for enforcing health and safety at work legislation in workplaces.

HSC's strategy for workplace health and safety in Great Britain sees sensible health and safety as a cornerstone of a civilised society

**(<http://www.hse.gov.uk/aboutus/hsc/strategy.htm>)**

A commitment in the strategy is for HSE to work with DWP and others to strengthen the role of health and safety in getting people back to work through a much greater emphasis on rehabilitation. This vision naturally arises from the Revitalising Health and Safety (**<http://www.hse.gov.uk/revitalising/index.htm>**) and Securing Health Together strategies (**[www.ohstrategy.com](http://www.ohstrategy.com)**). These two strategies, both launched in 2000, wisely foresaw the important role that managing sickness absence and return to work would make to improve health at work. HSC's commitment contributes to the wider government employment agenda by stemming the flow onto benefits. HSE's work to prevent work-related accidents and ill health, along with DWP, to help people who have been ill to

return to work, complements the Department of Health's aim to take action to safeguard health and prevent illness and disease, promoting healthier and longer lives.

One important area of HSE's work is the Occupational Health, Safety and Rehabilitation Support Pilots. HSE has put in place the Better Health at Work Partnership Programme, which will major on working with partners in a voluntary way to improve access to occupational health, safety and rehabilitation support, especially for small firms.

HSE's support model is based on a tailored problem-solving approach, which is active in preventing ill health, promoting rehabilitation and getting people back to work more quickly when they have been ill. HSE is developing innovative partnerships, in the public and private sector, to provide occupational health, safety and rehabilitation support regionally, locally or by sector to test the model (see Infobox 2).

The pilots will be fully evaluated to test what works, why it works and how we can use this knowledge to develop future services to deliver what employers really want and need.

#### **INFOBOX 2: CURRENT OCCUPATIONAL HEALTH, SAFETY AND REHABILITATION SUPPORT PROJECTS**

- **Constructing Better Health**, a not-for-profit company limited by guarantee and representing construction employers and employees, is taking the occupational health pilot forward. Due to launch in October 2004, this pilot will provide health risks education and training, awareness raising and health screening for construction workers, assistance for construction companies on management solutions for health risks, including free advice on workplace risk assessment. In addition the pilot will provide active case management support to increase job retention and rehabilitation;
- **Kirklees Metropolitan Borough Council, along with three local Primary Care Trusts and Jobcentre Plus** are working in partnership to develop an integrated occupational health, safety and rehabilitation support service to improve the health status of people within the Kirklees region. This pilot will provide advice, information and support to employers to enable them to prevent work related ill health and to help people suffering ill health to remain and return to the work force. It also aims to reduce the number of people who need to claim sickness and incapacity benefits; and
- NHS Scotland's **Safe and Healthy Working**, a Scottish national occupational health and safety support service run with the support of a wide range of health and work stakeholders, was launched in May 2003. The service aims to improve small and medium sized enterprises' (SMEs) knowledge, understanding and proactivity towards occupational health and safety, and, through partnership working, improve Scotland's health, enterprise and economy. ([www.safeandhealthyworking.com](http://www.safeandhealthyworking.com)).

HSC envisages a time when it is normal everyday practice for all employers, in partnership with their employees, to help those at risk of long-term sickness absence and job loss to return to their jobs, and for all employees to trust the process. This responds to current challenges around managing longer-term sickness absence and maintaining a healthy and productive workforce.

Smaller organisations often lack an appropriate level of human resource management expertise and infrastructure to address the issues and support managers with suitable training or basic information. Focus groups of small businesses, conducted for HSE, have shown that whilst their managers practice some of the elements of best practice in return to work these tend not to be consistently and systematically applied. Managers are not confident in their actions.

HSE has therefore concentrated its efforts into drawing together a best practice approach to “Managing Sickness Absence and Return to Work”. This advocates a partnership approach between employers and employees and their representatives, and combines helping the individual with appropriate organisational interventions, including prevention. It also aims to both affirm good practice in exemplar organisations, whether large or small, private or public, and, through a series of tailored products, provide the means for others to get started or improve their current practice.

HSE’s approach to “Managing Sickness Absence and Return to Work” is drawn from academic and scientific reviews and extensive consultations with experts and practitioners. The approach is based on employers taking various steps, and, as appropriate, an organisational policy. These include:

- Recording, monitoring and analysing sickness absence;
- Keeping in contact with the off-sick employee;
- Planning workplace control measures and adjustments;
- Making use of professional, other advice or treatment; and
- Agreeing and reviewing a return to work plan which addresses barriers to return to work in the following areas;
  - I. Health conditions;
  - II. Personal or psychological issues;
  - III. Organisational and work issues; and
  - IV. Coordinating the return to work process.

Additionally, HSE asked the Institute of Occupational Medicine to produce a prototype sickness absence recording and management software tool. This is aimed primarily at small and medium sized enterprises to help them record and analyse sickness absence

information. Using linked web pages it will also help them identify what individual and organisational interventions should be put in place to both return longer term sick employees to work and better control workplace health and safety risks. This tool is available for trial use by organisations but will be subject to further evaluation before more active marketing is undertaken.

### **FEDERATION OF SMALL BUSINESSES**

There are numerous trade associations and other bodies who also provide support to employers. Some of these are particularly focused at small firms. The Federation of Small Businesses (FSB) is the UK's largest lobby organisation representing the self-employed and owners of small businesses. Founded in 1974, it now has over 185,000 members across all industries, trades and services. The FSB website (<http://www.fsb.org.uk>) is used to provide information and guidance to small firms. Generally, the FSB supports the principle behind rehabilitation, the FSB's main concern is how effective it would be for small businesses.

### **SCOTLAND'S HEALTH AT WORK (SHAW)**

Scotland's Health at Work is a national award scheme (Bronze, Silver and Gold Awards) which rewards employers who demonstrate commitment to improving the health and ultimately the performance of their workforce. The Award scheme was set up in 1996 to address Scotland's poor health record and boost Scotland's image as an international business location. The scheme brings benefits to employers as well as employees by helping create a healthier, more motivated workforce and reducing sickness absence.

There are now as at 31 March 2003, 972 participating workplaces, 657 of which are SMEs (employing over 638,000 people). This equates to 26% of the Scottish workforce.

In 2003/04 SHAW will move in to the next phase of its development as it aims to work with 40% of the Scottish workforce by 2006. The new team of SHAW advisers will focus on:

- Increasing awareness of the scheme through promoting its benefits to business and individuals;
- Increased participation of SMEs, through network development and mentoring;
- Maximising opportunities for working in partnership with the HSE, NHS Health Scotland, Occupational Health providers and others;
- Providing dedicated support for the members of the Community Planning Partnerships; and
- Addressing the findings of the Evaluation and Structural review reports.

The following link provides further information on Scotland's Health at Work ([www.shaw.uk.com](http://www.shaw.uk.com)).

## **WORKING FOR HEALTH - A LONG-TERM WORKPLACE HEALTH STRATEGY FOR NORTHERN IRELAND**

Working for Health has been developed to tackle the problem of work-related ill health in a concerted and co-ordinated way. It embodies a vision that aims to achieve “a work culture that protects, promotes and supports health and wellbeing” and provides for the delivery of a holistic, innovative and practical approach to tackling health issues and health inequalities in the priority setting of the workplace.

The implementation of *Working for Health* is being taken forward by the Workplace Health Strategy Implementation Group and five Programme Action Teams, which are formal partnerships, involving representatives from Government Departments, District Councils, health professionals, employer organisations, trade unions, HSENI and other key stakeholder organisations.

The Workplace Health Strategy Implementation Group oversees the implementation of the strategy and coordinates the efforts under the five key elements of the strategy, namely Support, Awareness, Compliance, Rehabilitation and Intelligence. Working for Health launched its Action Plan covering 2004 – 2007 and this sets out how each of the five key elements of the strategy, Support, Awareness, Compliance, Rehabilitation and Intelligence can be effectively pursued over the next three years.

## **WALES - CORPORATE HEALTH STANDARD**

The Corporate Standard is a national mark of quality in health promotion in the workplace and was launched in 1996. The National Assembly for Wales awards the Standard to those workplaces that have demonstrated a commitment to improving the health of their workforce. It is endorsed by the HSE, the CBI in Wales and TUC Wales. The Corporate Standard is a continuous journey of best practice and improvement. To date 61 organisations have achieved the award including 14 NHS Trusts, 19 Local Authorities and 7 Local Health Boards (LHBs).

The Corporate Health Standard is not simply an award for good practice, it is a tool that develops workplace health throughout Wales by providing free advice and support to all organisations and disseminating good practice via its network. This advice and support is available to all organisations and employers throughout Wales.

The programme addresses the link between a healthy workforce and economic activity. The process targets specific occupational health issues and encourages good practice and contributes to the Assembly's strategic health and economic improvement programme.

Currently the programme is targeting all LHB's. The Assembly has set a target date of March 2005 for all LHB's to achieve the award.

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The programme is currently under review and its redevelopment will include exploring the most effective means of encouraging good practice in Occupational Health to improve staff retention and will also include key elements that encourage good practice to rehabilitate people who become ill or injured whilst in employment.

### **JOB RETENTION and REHABILITATION PILOT (JRRP)**

The Job Retention Rehabilitation Pilot is a joint initiative between the Department for Work and Pensions and the Department of Health.

The pilot is designed to test the net impact of a person-centred case management approach to delivery of services that both eases and boosts individual access to:

- Healthcare services;
- Occupational/workplace focused help; and
- Combined healthcare and workplace services.

The pilot is open to employed and self-employed volunteers who have been off work for at least six weeks, but no longer than 26 weeks. People are encouraged to get in touch with a national contact centre for further information.

The pilot is a randomised control trial and individuals who volunteer to take part are assigned into one of the three intervention groups listed above or a control group. All those who participate in the trial, including the control group, continue to have access to existing services, whether from the health services or their place of work.

The pilot operates in the six areas below; and is delivered by external providers.

#### **Pilot Locations:**

Greater Glasgow;	Teesside;
Sheffield;	Birmingham;
West Kent;	Tyneside.

The pilot will run for two years from Spring 2003. An evaluation report will be delivered at the end of the project. The findings will help shape future policy decisions.

### **THE RELIEF SERIES**

The Relief Series offers on-line multimedia programmes and solutions to employers wanting to meet their duty of care to employees in a practical way, delivering benefits to both. The programmes provide tools to identify, educate, motivate and support people suffering from anxiety, depression, stress and insomnia, conditions which now cause the greatest number of days lost in the workplace.

Available confidentially and securely online, anytime, anywhere, this user-friendly suite of programs provides confidential access for employees from either work or home.

Based on the successful mental health therapy, Cognitive Behavioural Therapy, the suite allows users interactively to identify problems and set and manage personal goals to address those issues and prevent their repetition. The Relief Series gives best practice advice using multimedia distance learning techniques

Inspired by Ultrasis' clinically proven solutions for anxiety, depression and stress related health issues, the Relief Series uses these techniques to address four key areas using validated assessment tools and multimedia personal programs:

- Stress Relief teaches relaxation and visualisation techniques for prevention and treatment of stress;
- Depression Relief uses Cognitive Behavioural Therapy techniques to support employees by letting them recognise and address their depressive problems;
- Anxiety Relief uses Cognitive Behavioural Therapy techniques to relieve anxiety; and
- Insomnia Relief delivers sleep hygiene and stimulus control techniques to relieve sleeplessness.

According to the Royal College of Psychiatrists in any year three out of ten employees will suffer mental health problems. The Relief Series offers immediate access to self-help solutions for common mental health problems and can also improve conventional healthcare delivery.

**Benefits include:**

- Increased efficiency;
- Decreased absenteeism; and
- Lessened healthcare costs.

**TRAFFORD HEALTHCARE NHS TRUST – OCCUPATIONAL HEALTH EXERCISE REFERRAL SCHEME**

The Occupational Health Service of Trafford Healthcare NHS Trust is currently piloting an Exercise Referral Scheme in partnership with the George Carnall Local Authority Leisure Centre. Referral onto the scheme is for employees with a broad range of health conditions. The scheme is designed both to support staff remaining in work, and aid rehabilitation for staff absent from work by virtue of long term health conditions; evaluation will determine the long term benefits. The project believes that this is a first in the field of Occupational Health.

### Details of Exercise Referral Scheme

Occupational Health provision encompasses the need to protect and promote the health of employees, and to aid their rehabilitation to work following illness or injury.

As part of an overall plan to improve the activity levels and well-being of the workforce, a partnership approach was set up between the Trust and Trafford Local Authority leisure services staff. A strategy was devised in consultation with the potential users of the service, taking account of “Exercise Referral Systems: A National Quality Assurance Framework”.

The Consultant in Occupational Medicine has received training in motivational interviewing in line with the above document, to support him in referring employees onto the scheme, and is shortly to cascade this training to the Occupational Health Nurses to increase referral numbers. Key leisure services staff have received specialist training to enable them to understand a wide range of medical conditions, the effects of medication and the psychology of exercise and illness. This enables them to design tailored activity programmes that meet the individual's activity need whilst avoiding any harm related to their health condition.

Funding for the pilot scheme from the Salford and Trafford Health Action Zone will support up to 50 referrals. The evaluation of the pilot will be used to support a business case for long term funding of this scheme. A robust evaluation framework is key to this process and has been designed to measure changes in both objective and subjective health status, and includes any employees who decline to accept a referral as a semi-control group.

The anticipated benefits to the Trust are at both individual and organisational level. It is anticipated that employees referred onto the scheme will have a speedier recovery from illness, with associated reduction in absence from work. The referral will support sick employees to move from ‘illness’ to ‘wellness’ behaviour, and it is hoped that this structured approach will support them in increasing their activity on a long-term basis. Early analysis shows a significant improvement in subjective health status.

The existence of this scheme sends a positive message to the workforce and helps demonstrate both the positive role of the Occupational Health Service and the way in which the Trust supports the rehabilitation of its employees.

### HEALTH@WORK IN LIVERPOOL

Health@Work in Liverpool offers free independent occupational health advice to patients in GP surgeries; individuals can self refer or be referred by clinical staff. Health@Work also offers employers occupational health and safety advice - targeting SMEs, some of which are referred by the HSE and Environmental Health departments as companies at risk of prosecution.

The SME advisor is based at Liverpool Chamber of Commerce and the patient advisor is based in surgeries and an NHS Walk in Centre. H@W feel it is vitally important to deliver these services in two different settings that are relevant to the client, this ensures independence and impartial advice can be given.

Both advisors however, meet weekly to ensure that they are co coordinating the work effectively.

H@W have a unique partnership in place and this is reflected on their Board of Trustees, which includes environmental health, PCTs, trade unions, Chamber of Commerce, representatives from voluntary and community sector, and an independent OH consultant physician.

The partnership arrangement is essential for the services to be effective and relevant to the client group and this has been developed over several years.

### **Liverpool Business Partnership Group**

An example of effective partnership working is the Liverpool Business Partnership Group, which is facilitated and administered through H@W. The purpose of this group is to work with the local authority, Chamber of Commerce, and representatives and service providers for the business community on OH and safety issues, which incorporate support on HR issues. It addresses as a minimum the basic legal requirements that a business has to comply with, and supports the enforcement agencies in giving advice, support, guidance and training to SMEs.

Having an independent organisation such as H@W facilitate this process is key to the Group's increasing success.

### **Workers Safety Advisory Fund**

This work is to focus on the hospitality and retail sectors in the city and raise awareness of health and safety amongst both employers and employees.

For more information Contact Charlie Kavanagh at [charlie@healthatworkcentre.org.uk](mailto:charlie@healthatworkcentre.org.uk)

### **WORK LIFE PARTNERSHIP**

Work Life Partnership (WLP) is a new kind of Public Private Partnership (ppp) which was defined by King's College London research as a 'Strategic Partnership' rather than solely the old type of Private Financial Initiative.

Designed and developed by a private sector consortium and 30 NHS Trusts, Work Life Partnerships empowers employers and GPs to deal with stress, the mild to moderate end of mental health issues, work life balance and psych-social risk.

## Building Capacity for Work: A UK Framework for Vocational Rehabilitation

### The Framework Annex

Employers are required to deal with their obligations under the HSE requirements for stress risk assessments and the DDA (Disability Discrimination Act). Many employers, particularly SMEs, struggle to know how to comply with these regulations at an affordable cost.

To this end, WLP has developed an entry level product to be distributed by insurance companies, their brokers, affinity groups, trade unions and Independent Financial Advisors. This product may be regarded as the gateway to an embryonic National Vocational Rehabilitation Service (NVRS) which now offers to Government and Employers a unique solution to manage a far reaching problem, manifested in unsatisfactory IB costs and poor health consequences and outcomes for the people of the UK. LifeCare Vouchers will be launched in the UK in December 2004.

This entry level product - 'LifeCare Vouchers' – is to be distributed to employees via employers and GPs. The projected cost at less than 10 pounds per person per annum make them affordable to the SME market, which is particularly ill served by Occupational Health services. LifeCare Vouchers deliver a health risk assessment to encourage early intervention, a high quality helpline with counselling and advice and, most importantly, access to Vocational Rehabilitation Services, Life Coaching, Mediation and Conciliation and the other related services needed by employers to enable them to deal with their obligations under existing legislation.

Work Life Partnerships work uses a business model and technology developed by Cisco Systems. The 'eco-system' - otherwise accurately defined as an 'Intelligent Network' - is underpinned by a web based internet portal to ensure employers, employees and GPs have access to best in class providers of Vocational Rehabilitation and other services as noted above. The quality of service provision is to be monitored by an Independent Advisory Board with representation from Government Departments (DWP/DOH), Trade Unions, the NHS, employers and other relevant interest groups.

WLP is committed to a rigorous evaluation of outcomes, costs and benefits through randomised control trials (RCTs).

### **ABSENCIA**

Absencia, from Employ-Mend, offer sickness absence and disability management services and software aimed at not only monitoring but also managing each and every sickness absence. The approach aims to integrate corporate policies (sickness absence, accident/incident reporting etc.), services (occupational health, health & safety), benefits (group income protection, private medical insurance) and State support (disability employment advisers, SSP1/Incapacity Benefit).

Absencia is fully configurable so that organisations do not have to change current practice or suppliers/benefits providers as the system introduces the right intervention at the right

time thereby optimising such expenditure. For example, group income protection providers like to have claim forms completed as early as possible so that they can do all that they can to prevent an employee from becoming a claimant. This could include the payment of medical treatment costs, disability counselling and case management. Too often claim forms for this benefit are completed late but the Absencia service ensures that the form is sent to the line manager for completion at whatever stage the employer and insurer agree.

The timely co-ordination of such an array of services significantly improves the level of vocational rehabilitation support. Many employers are unaware that some Group Income Protection and Employers' Liability insurers often provide vocational rehabilitation free. Links to Occupational Health services can also be provided as part of the Absencia service, with a free help-line to an OH nurse. This is followed by a 'pay as you go' approach to assessments by an OH Physician, and vocational rehabilitation by trained OH nurses experienced in work reintegration.

One of the key messages from the DWP is the need for early intervention, as this is critical for successful vocational rehabilitation. Many organisations are still using paper based monitoring systems or HR IT systems which merely monitor and do not manage absence, with the result that sick or disabled employees are often not proactively supported back into the workplace. With Absencia in place, introducing the potential for day one case management, proactive management and ownership of the case (by all stakeholders), and the timely optimisation of current healthcare expenditure, available resources are co-ordinated to support an effective work re-integration process.

Employ-Mend Ltd, The Drive House, Manor Farm, Kenn Moor Road, Kenn, Near Clevedon, North Somerset BS21 6TZ (tel: 01934 875930; fax: 01934 875915; e-mail: [employmend@drivehouse.co.uk](mailto:employmend@drivehouse.co.uk)).

## **TRADE UNIONS AND THE TRADES UNION CONGRESS (TUC)**

The TUC considers itself one of the main drivers for interest in rehabilitation. Rehabilitation is seen as vital for those people who fall through the health and safety net and can make a contribution of its own to improving health and safety standards, especially where people return to work after injury. Rehabilitation is cheaper than the alternative and the TUC believes that stakeholders will quickly see that the question is not how much to spend on rehabilitation, but how much can be saved by it.

The TUC supports the concept of the "injury cycle" in which a person-centred approach to rehabilitation, rather than looking at the injury itself, is taken and which seeks to intervene at the appropriate time with the appropriate intervention to ensure a proper return to work. The earlier the rehabilitation kicks in the better the results are likely to be.

## Building Capacity for Work: A UK Framework for Vocational Rehabilitation The Framework Annex

To this end the TUC has suggested the development of a rehabilitation policy framework in the workplace. Unions are being encouraged to build rehabilitation approaches into their work on health and safety and ensure their members take an active role in their own rehabilitation. A number of individual unions, such as Unison, Transport Salaried Staffs' Association, and the Transport and General Workers' Union, are following this advice and, recognising the benefits of rehabilitation, are recommending that local branches encourage employers to establish formal rehabilitation and retention policies.

The TUC's role involves:

- Conducting research;
- Sponsoring events;
- Providing training and online surveys;
- Producing reports, Guides and factsheets;
- E-mail bulletins on H&S; and
- Consulting and advising stakeholders (including Government) on important issues.

### **Papers produced**

*Restoring to health, returning to work* 9 July 2001;  
*Rehabilitation and retention: what matters is what works* July 2002;  
*Rehabilitation and retention: the view from the workplace* July 2002;  
*Rehabilitation and retention: the case studies* July 2002; and  
*A paper on the TUC approach to rehabilitation* 7 April 2004.

### **Guides and Factsheets**

The TUC website ([www.tuc.org.uk](http://www.tuc.org.uk)) contains a number of guides and factsheets on things like Asbestos, Stress, H&S issues for Women, Dust, Noise etc.

The TUC site links to relevant sites including the magazine Hazards' site.

### **THE INSURANCE INDUSTRY**

In recent years, there has been considerable and growing interest in the concept of rehabilitation within the insurance industry. Most recently, the ELCI Review has focused attention on the benefits of workplace rehabilitation and 'return to work' programmes. However, the scope of insurers' interests extend to other 'third party' insurance products like public liability and motor insurance. In addition, income protection and private medical insurers also have a direct stake in the rehabilitation of sick or injured policyholders.

The Association of British Insurers (ABI) has initiated research to estimate some of the aggregate gains for vocational rehabilitation. This work (Costing of a No Fault Compensation Scheme, Greenstreet Berman, June 2003) highlighted that 10-40% savings in the cost of workplace accident and disease compensation arising from lower damages could be achieved.

Insurers feel that, in addition, improving the medical condition of injured or ill people enables them to return to work earlier. Not only does this reduce the need for benefits and other social care, but retains experience in the workplace and can have a positive effect on the employer-employee relationship, with fewer incidents resulting in claims. In Victoria, Australia, reform of the workplace compensation system in 1992 to include better rehabilitation resulted in a 40% fall in claims over the subsequent 4-5 years (Costs and Benefits of Return to Work and Vocational Rehabilitation (Greenstreet Berman, April 2004)).

ABI figures suggest in 2002, around 10% of EL claimants and just 3% of motor claimants that might have benefited from rehabilitation actually got it (Rehabilitation - The Way Forward (ABI, October 2003)), indicating huge scope for improvement.

In autumn 2003, the ABI called for co-ordinated action to develop a national action plan to ensure that rehabilitation becomes commonplace in the UK (Rehabilitation - The Way Forward (ABI, October 2003)). The insurance industry have demonstrated their support to vocational rehabilitation by actively taking part in the debate and looking at further establishing rehabilitation as part of the claims process.

Insurers feel that cost effectiveness is also a critical element of rehabilitation and suggest that it may not always be desirable to achieve a return to work regardless of cost, and so see one of the purposes of rehabilitation as being to maximise quality of life, reduce the need for ongoing care and so reduce the cost of claims.

Vocational rehabilitation could be part of the compensation package across a range of product areas, such as motor and public liability. It can also be part of the income protection and medical insurance offering. In any environment where there are potential incentives for an insurer to facilitate an early return to work, there is potential for vocational rehabilitation to be offered.

Ultimately, though rehabilitation works best when all the interested parties have a joint commitment, rehabilitation should not be seen as a conspiracy to reduce compensation without putting something in its place.

Some insurers provide rehabilitation in the workplace on a no-fault basis. This does not limit provision to accidents and illnesses incurred in the workplace, but overcomes the problem of delays in offering rehabilitation due to the claims process. No-fault

rehabilitation is a more risky strategy, since insurers need to have confidence that it will have sufficient impact on claims behaviour (frequency and size) to offset the cost of providing rehabilitation to a wider audience. Ideally, partnerships with employers would help share the cost, and insurance could provide the pooling mechanism to allow small and medium sized businesses to access occupational health services.

Insurers want to capture potential savings through making more appropriate offers of rehabilitation. A 10% saving on compensation within the fault-based Employers' Liability system is equivalent to £200m. Liability insurers are also keen to promote a different perspective on what compensation is for, embracing rehabilitation as a normal part of restitution for an injured party.

## REHABILITATION OFFERED BY INSURERS

The ABI recently conducted a survey of rehabilitation offerings. Many insurers now offer rehabilitation services, but the scope (cases covered, services offered, etc) can vary widely. Insurers wish to preserve this diversity of offering, and it could be developed as a competitive dimension within a national framework. However, it is also clear from the survey that insurers do not have a consistent view on the costs and benefits of rehabilitation.

Six Motor Insurers companies responded to the ABI survey, representing around 125,000 personal injury claims. All provided rehabilitation services either directly or through other service providers. The proportion of those who would potentially benefit from rehabilitation who actually received an offer ranged from 0.7% to 15%. Offers are usually the outcome of an assessment by occupational therapists or case managers.

Almost all offers of rehabilitation identified by the survey were part of a fault-based settlement, but there was recognition of the benefits of rehabilitation to achieve a return to work. One insurer also considered the impact on quality of life and integration into society. Although one of the respondents felt that rehabilitation had no benefits, 3 were able to demonstrate savings of between £1.90 and £3.75 for every £1 spent on rehabilitation.

Only one Employers' Liability (EL) Insurer responded to the survey, stating that 21% of claimants could have benefited from rehabilitation, though only 2.5% received it. Offers are not made on a no-fault basis and claims are usually settled following rehabilitation so a full assessment of post-rehabilitation recovery can be made.

Other insurers do offer rehabilitation, but products are not consistent. One major insurer provides 'no fault' rehabilitation within the EL package (i.e. for no extra cost to the employer), finding that the cost of rehabilitation is offset by changed claims behaviour

(fewer, cheaper claims). Another has tried to structure a rehabilitation product by charging an additional fee in the first year for a rehabilitation programme and guaranteeing future premium cuts if there is a change in claims behaviour as a result.

On the provision of rehabilitation services in the UK, the ABI have also commissioned Greenstreet Berman to do a research study into the "Availability of rehabilitation services in the UK".

### **ZURICH FINANCIAL SERVICES – REHABILITATION**

Within Zurich, rehabilitation is delivered in three main areas, driven by the nature of the injury and adopting the most optimal approach. The manner in which rehabilitation is delivered is subject to the view that we are delivering the optimum service to the injured party.

#### **Soft Tissue Injuries.**

This type of injury is more likely to occur as a result of a road traffic accident, (RTA) but will also be utilised for non-RTA matters, where appropriate.

The treatment will initially be offered as soon as the insurer is made aware of the claim being notified. This will trigger an offer to the claimant direct, or via his legal representative, for physiotherapy treatment, provided by an external provider such as BUPA. The treatment will be provided in the claimant's locality and takes the form of an initial assessment to agree/determine the treatment, followed by a number of physiotherapy treatments. If, after initial assessment, some other form of treatment is identified this will be agreed with the claimant and his legal representative/medical advisors before implementation. If the injury requires the input of a consultant orthopaedic surgeon then this will be provided under the scheme. However, the bulk of these cases are treated by means of physiotherapy.

#### **Employers' Liability Injury Management**

Zurich provide rehabilitation, irrespective of liability, for work related injuries to major customers.

There will be a nominated contact, generally within the employer's occupational health department, who will notify appropriate cases to Zurich for inclusion. An assessment is carried out, in conjunction with other health care professionals such as the work's doctor or claimant's GP. A rehabilitation plan is set up, and agreed with the employee and his health care professional. Zurich will then source the provider and implement the programme. The rehabilitation process is monitored throughout by Zurich's Nursing team until the return to work is complete.

The types of injury that are most frequently referred are:

- Neck;
- Back;
- Fractures;
- Hernias; and
- Amputations.

Of all employers' liability accidents, 75% are as a result of slips, trips, falls, machinery accidents or struck by moving objects.

### **Catastrophic Personal Injury**

For cases of the utmost severity Zurich will tailor the rehabilitation process on a case by case basis depending on the nature and extent of the injury. They aim to work in partnership with the claimant's legal team, to agree the most appropriate treatment. In these cases rehabilitation may take the form of supplying equipment such as a wheel chair, or in one case supplying a washing machine, to enable soiled clothing to be washed separately from the normal family wash.

Zurich are now in a position to provide a portacabin style pod that can be attached to a family home, as a temporary measure, to facilitate early discharge from hospital, for spinally injured claimants. This enables them to return to their family homes and integrate back into the community after a lengthy period in hospital.

### **JUSTICE SYSTEM**

Greenstreet Berman found that the take up of rehabilitation remains vulnerable to the attitude of personal injury lawyers, insurers and claims handlers and that there is scope for the judiciary to increase their awareness of, for example, the Rehabilitation Code. ('Costs and Benefits of Return to Work and Vocational Rehabilitation' (Greenstreet Berman, April 2004)).

Proposed amendments to the Pre-Action Protocol for Personal Injury Claims (relevant to England and Wales) include additional measures that deal with the need to consider rehabilitation. These provide that promoting the provision of medical or rehabilitation treatment will become one of the aims of pre-action protocols; a new section "Rehabilitation" will require parties to consider the need for rehabilitation treatment or other measures as early as possible and how that need can be addressed; and a copy of the Rehabilitation Code will be annexed to the protocol. Agreement to the amended protocol will be sought from the Master of the Rolls, who as Head of Civil Justice is responsible for approving pre-action protocols.

There is general support for rehabilitation from those involved in the justice system. The Civil Justice Council (CJC) held a Forum on Rehabilitation earlier this year which was attended by a wide range of stakeholders. To consider further how to make rehabilitation play a more central role in the UK compensation system the CJC has also set up a Working Party, which is considering ways in which the civil justice system can more effectively promote practical rehabilitation. However its members consider that the real improvements needed to bring rehabilitation centre stage require a clear and co-ordinated lead by Government and a joined-up approach by all stakeholders.

Although the Rehabilitation Code of Practice is a step forward, the system for awarding personal injury compensation still inhibits early intervention. Poor information flows and waiting times mean that rehabilitation is often inappropriate simply because it is too late to be effective. Employers' Liability insurers in particular can sometimes wait many months before they are informed about a potential claim and can then further delay intervention themselves while fault is established.

The fact that insurers do not routinely offer, and claimant lawyers do not routinely seek, rehabilitation is a result of the adversarial system and the resultant focus on the financial consequences of settlement. Insurers are not confident that the claimant's settlement will reflect the 'whole package' aspect of a lump-sum incorporating rehabilitation. Claimant lawyers are not confident that rehabilitation is not simply a cost cutting measure that will leave claimants with a smaller lump-sum and an inferior rehabilitation package.

In addition, organisations like the Association of Personal Injury Lawyers' (APIL) are also working on rehabilitation initiatives. For example, APIL's new best practice guide on rehabilitation will be distributed free of charge to all 5,000 APIL members.

The guide addresses the key practical issues of combining effective rehabilitation with full and prompt compensation, including:

- How litigation and rehabilitation work together;
- Dealing with client expectations;
- Different types of rehabilitation;
- Payment for rehabilitation; and
- Immediate needs assessment.

The guide complements the distribution to APIL members of special publications dedicated to rehabilitation, and the development of the association's first directory of rehabilitation providers, which is due to be completed in November 2004. The Association of British Insurers and other insurance providers are being consulted prior to the guide's publication.

## GOVERNMENT SUPPORT

### THE DISABILITY DISCRIMINATION ACT 1995

#### Summary

The Act makes it unlawful for employers and those providing services to the public to discriminate against disabled people.

In employment, from the 1 October 2004, the duty not to discriminate applies to all employers, whatever their size.

Since 1996, anyone providing a service to the public (a public or private enterprise of whatever size) has had to take steps to ensure that they don't discriminate against disabled people. From 1 October, this duty extends to making reasonable physical changes to premises.

#### Employment

There are four forms of employment-related discrimination:

- Direct discrimination;
- Failure to comply with a duty to make reasonable adjustments;
- Disability-related discrimination; and
- Victimisation.

#### Direct discrimination

This involves less favourable treatment on the grounds of disability, when compared to how another person (without that disability, but whose relevant circumstances, including abilities, are the same or similar) would be treated.

Direct discrimination can never be justified. However, less favourable treatment that does not amount to direct discrimination can sometimes be justified. In deciding whether the treatment is justified, and therefore whether there has been disability-related discrimination, the question of reasonable adjustments has to be taken into account.

#### Failure to comply with a duty to make reasonable adjustments

Failure to comply with a duty to make reasonable adjustments amounts to discrimination in its own right (as well as being relevant to disability-related discrimination). This is a failure to change arrangements that place the disabled person at a disadvantage when compared to a non-disabled person.

Failure to comply with a duty to make reasonable adjustments can never be justified. The factors affecting “reasonableness” include the cost and disruption of making the adjustment and the resources of the employer. Most employment-related adjustments are low or no cost. Where there are costs, support may be available from the Access to Work scheme.

Where an employer has failed to make a reasonable adjustment, and where direct discrimination does not apply, disability-related discrimination may still apply.

### **Disability-related discrimination**

In the case of disability-related discrimination, the reason for less favourable treatment relates in some way to the person’s disability (but not directly the disability itself). In order that the less favourable treatment can be determined, a comparison is made with a person to whom the disability-related reason does not apply and the employer cannot show this treatment to be justified.

Disability-related discrimination occurs in circumstances where the discrimination does not amount to direct discrimination but is nevertheless unlawful.

Employers may be able to justify disability-related discrimination in limited circumstances. The Act says that justification is possible if, and only if, the reason for the treatment is both material (that there is a reasonably strong connection between the reason given for the treatment and the circumstances of that particular case) and substantial (in the context of justification, that the reason must carry real weight and be of substance).

However, this type of justification is not possible in circumstances where the employer is also under a duty to make a reasonable adjustment. In these circumstances, consideration must also be given to whether the treatment would still have been justified even if the employer had complied with the duty to make reasonable adjustments.

### **Victimisation**

Victimisation is illegal under the DDA where an employer treats someone (whether or not they are disabled) less favourably than others would be treated in the same circumstances because they have (or may in the future) provided evidence or information in connection with proceedings under the DDA or done anything else under or by reference to the Act or have alleged that someone has contravened the DDA (whether or not the allegation is later dropped).

Victimisation can never be justified. However, if the allegation was false and not made in good faith, it is not victimisation to treat the person concerned less favourably.

## Harassment

In addition, it is unlawful for an employer to subject a disabled person to harassment which relates to their disability by engaging in unwanted conduct that has the purpose or effect of violating the disabled person's dignity or by creating an intimidating, hostile, degrading, humiliating or offensive environment for them - whether or not the above behaviour has the intended effect on the disabled person.

## Instructions to Discriminate

It is also unlawful for an employer to instruct or put pressure on a person over whom they have influence or authority to act unlawfully. Only the Disability Rights Commission (DRC) can take action against employers for this type of unlawful practice.

The employment duties continue to apply after a disabled person's employment has come to an end, for example in relation to not giving an unfair reference or harassing someone who has taken a case in an employment tribunal. The Act does not prevent employers from treating disabled people more favourably than those who are not disabled or stop an employer from appointing the best person for the job.

The DRC has produced a statutory Code of Practice about these duties. This is a legal document that will be considered by the courts. Details are on the DRC website at [www.drc-gb.org](http://www.drc-gb.org)

## Providing Services to the Public

Anyone who provides a service to the public has duties not to discriminate against disabled people under the Disability Discrimination Act.

The duties have been introduced in three stages:

- Since 2 December 1996 it has been unlawful to treat disabled people less favourably for a reason related to their disability;
- Since 1 October 1999 service providers have had to make 'reasonable adjustments' for disabled people, such as providing extra help or making changes to the way they deliver services; and
- From 1 October 2004 service providers may have to make other 'reasonable adjustments' to the physical features of their premises to overcome barriers to access.

The DRC has produced a statutory Code of Practice about these duties. This is a legal document that will be considered by the courts. Details are on the DRC website at [www.drc-gb.org](http://www.drc-gb.org)

## **PATHWAYS TO WORK, CONDITION MANAGEMENT PROGRAMMES**

Based on best available clinical evidence, and delivered in conjunction with NHS Primary Care Trust providers, Condition Management programmes will, early in the Incapacity Benefit (IB) claim, provide additional specialist services to support IB customers' ability to consider employment. The programmes aim to transform the client's outlook, so that they are better able to manage their condition and refocus on work options. Delivered as one to one or group counselling, the programmes will help educate, support and advise customers on: how to manage their pain; improve their fitness levels or motivation; best use of medication; combating or prevent depression; increasing confidence in the ability to work or train; enhancing understanding of, and ability to cope with, fears and uncertainty about health conditions; and tackling social exclusion.

## **WORK PREPARATION**

Work Preparation is an individually tailored, work-focused programme, which enables disabled people to address barriers associated with their disability and prepare to access the labour market with the confidence necessary to achieve and sustain their job goal.

The client's individual needs are identified during an assessment organised through specialist Disability Employment Advisers (DEAs). Although each client has specific needs, the broad areas which are addressed during the Work Preparation programmes include the need to develop in one or more of the following areas:

- Occupational decision making;
- Job-finding behaviours; and
- Job-keeping behaviours.

Work Preparation is delivered through contracted providers from the private, voluntary and public sectors, some of whom also deliver WORKSTEP and other Jobcentre Plus programmes. They are paid by Jobcentre Plus to arrange individually tailored programmes, to achieve goals that have been agreed by DEAs and their clients. There are currently around 270 Work Preparation contracts, nationally.

## **NEW DEAL FOR DISABLED PEOPLE**

New Deal for Disabled People (NDDP) supports people in receipt of a disability or health-related benefit in finding and retaining paid employment. It is a voluntary programme delivered through a network of Job Brokers across England, Scotland and Wales who:

- Help customers understand and compete in the labour market;
- Agree with each customer the most appropriate route into employment for them;
- Support customers in finding and keeping paid employment;

## Building Capacity for Work: A UK Framework for Vocational Rehabilitation The Framework Annex

- Work closely with providers of training and other provision where a customer needs additional support;
- Work with local employers to identify their needs and match them with the skills of their customers; and
- Support customers during their first six months in employment.

Job Brokers are made up of organisations from the private, public and voluntary sector. Customers can choose which Job Broker to register with and, as each operates differently, are advised to contact the ones in their area before deciding.

Contact the NDDP Helpline on **0800 137 177** – or if you use a text phone, call **0800 435 550**; visit [www.jobbrokersearch.gov.uk](http://www.jobbrokersearch.gov.uk); or look on the New Deal website at [www.newdeal.gov.uk/nddp](http://www.newdeal.gov.uk/nddp)

### **SOCIAL EXCLUSION UNIT MENTAL HEALTH REPORT**

On 5 March 2003, the Prime Minister and the Deputy Prime Minister asked the Social Exclusion Unit (SEU) to consider what more could be done to reduce social exclusion among adults with mental health problems. The report, published on 14 June 2004, looks at what more can be done to enable adults with mental health problems to enter and retain work, and how to ensure that adults with mental health problems have the same opportunities for social participation and access to services as the general population. The report was developed in close partnership with the National Institute for Mental Health in England (NIMHE).

#### **What is the Problem?**

- Adults with mental health problems are one of the most excluded groups in society;
- Although many want to work, fewer than a quarter actually do, and so adults with mental health problems have among the lowest employment rate for any of the main groups of disabled people;
- Too often people do not have other activities to fill their days and spend their time alone;
- Social isolation is an important risk factor for deteriorating mental health and suicide. Two-thirds of men under the age of 35 who die by suicide are unemployed;
- Severe mental health problems, such as schizophrenia, are relatively rare, affecting around 1 in 200 adults each year;
- Depression, anxiety and phobias can affect up to one in six of the population at any one time. GPs spend a third of their time on mental health issues;
- Prescription costs for anti-depressant drugs have risen significantly in recent years, and there are significant variations in access to talking therapies;

- Over 900,000 adults in England claim sickness and disability benefits for mental health conditions, with particularly high claimant rates in the North. This group is now larger than the total number of unemployed people claiming Jobseekers' Allowance in England;
- Mental health problems can have a particularly strong impact on families both financially and emotionally; and
- Carers themselves are twice as likely to have mental health problems if they provide substantial care. An estimated 6,000 to 17,000 children and young people care for an adult with mental health problems.

The SEU conducted an extensive consultation exercise over summer 2003 to learn more about the problems faced by people with mental health problems, which included:

- A written consultation, to which over 900 responses were received from a variety of sectors;
- Seven consultation events across England held in partnership with the NIMHE, to seek the views of people with mental health problems and carers. Approximately 500 people attended these events;
- Around 50 visits to schemes, that were already tackling the problems highlighted in this report; and
- Four local area research studies were undertaken to provide an in-depth understanding of delivery issues.

The Social Exclusion Unit has also worked closely with Government departments and other organisations. This work has resulted in an action plan involving over 20 departments, agencies and organisations at national level that will ensure effective implementation of the report.

#### **PRIME MINISTER'S STRATEGY UNIT PROJECT ON IMPROVING LIFE CHANCES OF DISABLED PEOPLE**

This project is expected to complete in the Autumn with a final report before Christmas 2004. An analytical report has already been published. The project has been examining the life chances of disabled people from early years through transition to adulthood, independent living and employment. It is expected to recommend ways of ensuring that disability issues receive more prominent attention in coming years in both policy making and delivery of services, with an emphasis on the removal of barriers to the inclusion of disabled people and improved opportunities for them to live independently.

The project has observed that rehabilitation is seen on the one hand as crucial to independent living and quality of life, but is also seen on the other hand as playing a key role in retaining people in work when they fall sick or injured, as well as helping people to return to work from incapacity benefits. The report is expected to comment on rehabilitation insofar as it contributes to proposals in both of these two areas. It will recognise the lack of hard evidence about the impact of specific interventions, and the importance of carefully designed and evaluated pilots in establishing what works. At the same time, it will note the heavy costs to employers and taxpayers from failing to get rehabilitation right – costs which could be reduced if interventions and delivery systems were improved.

The report is likely to discuss issues such as:

- The importance of Government leadership in building a coherent strategy upon the Framework for Vocational Rehabilitation;
- The need for leadership from professional bodies, and open debate within the medical world towards a stronger focus upon work as a positive driver for good health;
- Options for a more coherent and visible structure for supporting disabled people into work, within which rehabilitation can have a recognised place; and
- Ways of establishing common terminology and agreement about the roles of different stakeholders.

## **TRAINING AND SKILLS**

### **Entry to Employment (E2E)**

Government Departments such as the Department for Education and Skills (DfES) contribute to the disability employment agenda, for example, on 1 August 2003 the Learning and Skills Council (LSC) introduced a new scheme Entry to Employment (E2E) to enable young people who are not yet ready or able, to directly enter Modern Apprenticeship programmes, further education or employment. E2E replaces Life Skills, Preparatory Training and NVQ Learning at Level 1 (for those aged 16-18). Young people, often those with learning difficulties, are helped to prepare for progression to employment, employment with training, Modern Apprenticeships and further education. The aim is for young people to develop their motivation and confidence, personal effectiveness, basic and/or key skills and acquire vocational knowledge, skills and understanding through sampling a range of work and learning contexts.

### **Skills Coaching**

Budget 04 announced a “New Deal for Skills” featuring “a one-stop skills service with access to personal skills advisers and training” co-located with Jobcentre Plus (JCP).

DfES and DWP are currently creating a new skills coaching service, co-located with JCP where possible, which will serve those on inactive benefits and the long-term unemployed for whom lack of skills is the primary barrier to returning to the labour market and securing sustained, productive employment.

Skills coaching will provide an intensive, unified service that takes people from skills assessment through choosing training, through to Workforce Development once in employment.

Access to the new service would be by direct approach from clients, or from signposting from JCP Personal Advisers, or from other routes such as Information and Advice services, including those in colleges.

People who are long-term benefit dependent, including some with health issues or disabilities, are more likely to have low or very low basic skills and/or lack other key skills for employability. The Campaign for Learning notes that it is particularly difficult for people living on benefits to plan their upskilling because they do not have a long term planning horizon. Inspiring such individuals to articulate personal goals and then to develop a learning and training plan is a complex, long term process.

Skills coaching would be for adults of working age for whom lack of skills (or inability to apply their skills successfully to the labour market) is the main barrier to sustained employment. In terms of JCP clients, those eligible would be:

- Inactive benefit claimants who intend to return to the labour market in the mid to longer term, but want to do something in the short term to improve future job prospects;
- Jobseekers for whom lack of skills is the barrier to employment; and
- Jobcentre Plus clients moving into employment under an Employer Training Pilot (ETP).

Skills coaching should be tailored to the needs of the individual client and be relevant to the needs of the labour market. It should provide support to the individual to develop employment related learning goals within a framework of improving the individual's chances of sustained employment. Skills coaching would add value and complement the programmes and services offered by Jobcentre Plus (including New Deal and BOND), LSC and the support available through employers and as part of ETP. Access to skills coaching would be through the integrated IAG service, following a referral or intelligent signposting from the Personal Adviser at Jobcentre Plus. Clients wishing to access skills coaching would request a work focused interview at Jobcentre Plus. Skills coaching would be delivered by competent advisers, through organisations accredited to the matrix Standard.

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DfES and DWP propose running up to six trial projects starting in 2005 exploring a range of delivery models, of which one would involve an ETP. The purpose of the trials would be to evaluate:

- costs of delivering the service – paying particular attention to cost differentials between the eligible client groups;
- the competences of skills coaching staff to deliver a high quality and effective service;
- capacity building needed to deliver a high quality service and to ensure equal opportunity access;
- levels of demand for the service and its impact on the local labour market;
- effectiveness of referral and communication systems – focusing on whether appropriate people are referred to the service, and whether links with related services/agencies are efficient and seamless from the client point of view; and
- effectiveness of the service – does it meet clients' needs? Does it avoid duplication with other support to this client group? Does it enhance the likelihood of a positive outcome for clients? What is the added value of skills coaching over information and advice, for these client groups?

The trials would be independently evaluated and will draw upon a range of quantitative and qualitative outcome measures to assess progress towards greater employability. As part of the evaluation, we will consider the use of control groups to measure the effectiveness and added value of the service.

Quantitative outcomes could include figures relating to: entry into employment; employment retention; entry into education/training; completion of education/training; progression from education/training; and wage rates on entry to employment.

DfES is sponsoring two projects providing guidance to people with learning difficulties and disabilities, and a further project offering guidance to women and people from ethnic minority communities living with HIV/AIDS. The purpose of these projects is to:

- Identify good practice in meeting the needs of people with sickness/disability for the IAG service as a whole;
- Deliver an accessible guidance service through voluntary sector bases and outreach visits to clients' homes, day centres and rehabilitation/specialist hospital bases; and
- Assist clients by easing their passage into the labour market through client centred guidance, work placements and training opportunities.

## DEPARTMENT OF HEALTH, NHS (England)

### Expert Patients Programme

The Expert Patients Programme (EPP) is a NHS-based training programme that provides opportunities to people who live with long-term chronic conditions to develop new skills to manage their condition better on a day-to-day basis. Set up in April 2002, it is based on research from the USA and UK over the last two decades which shows that people living with chronic illnesses are often in the best position to know what they need in managing their own condition. Provided with the necessary 'self-management' skills, they can make a tangible impact on their disease and quality of life more generally.

This vision for a new patient-centred NHS reflects the fact that the predominant pattern of disease in this country during the second half of the 20th Century and the beginning of the new century is of chronic rather than acute disease. Diseases such as cancer, heart disease, stroke and arthritis can and do kill - but more often they are a burden that people carry from the middle years of their lives into old age.

Plans for the establishment of an EPP were announced in the 1999 Health Strategy White Paper *Saving Lives - Our Healthier Nation* and later reaffirmed in the NHS Plan of July 2000.

An Expert Patients Task Force was set up in late 1999 under the Chairmanship of the Chief Medical Officer Professor Liam Donaldson, to recommend a new programme that would bring together the valuable work of patient and clinical organisations in developing self-management initiatives. Task Force members included representatives from the medical profession, non-governmental organisations, and experts in the fields of self-management training and research.

The Task Force's report - *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century* - was published in September 2001 and included a key recommendation for NHS-based self-management training programmes for patients.

### What is an Expert Patient?

An observation made frequently by doctors who take care of patients with long-term chronic illness is "my patients understand their condition better than I do". Many patients are indeed experts in their own right for they have gained the life skills to cope with a chronic condition, and there is increasing evidence that patients - with proper support - can take a lead in 'self-managing' their conditions. A review of the available UK and USA research on self-management conducted for the Expert Patients Task Force by Professor Julie Barlow of Coventry University showed that the benefits include reduced severity of

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symptoms, significant decrease in pain, improved life control and activity, resourcefulness and life satisfaction.

The concept of patient self-management was first developed in the 1960s and 1970s as a method of seeking better solutions to illness. Often this meant patients taking more control of their lives by ceasing involvement with organised health care systems.

Today the emphasis is very different. Self-management is seen as an integral, even central, part of the system of care provided to people with chronic diseases. Patient self-management or EEPs are not simply about educating patients about their condition or giving them relevant information - they are based on developing patients' confidence and motivation to use their own skills, information and professional services to take effective control over life with a chronic condition.

### **Features of the EPP training course**

The EPP course is based upon the Chronic Disease Self-Management Program (CDSMP) developed and researched over the past twenty years by a team led by Professor Kate Lorig at the Patient Education Research Centre, Stanford University, California.

The CDSMP recognises that people with all kinds of long-term conditions are dealing with similar issues on a daily basis. These include pain management, stress, low self-image and the development of coping skills. The programme has been used in Australasia, Europe, USA and by a number of patient bodies in the UK. The course is run over six consecutive weekly sessions of 2½ hours each week. Each week, two volunteer tutors lead 8-16 participants through structured course material delivered from a scripted manual covering topics such as relaxation, diet, exercise, fatigue, breaking the symptom cycle, managing pain and medication, and communication with health care professionals.

### **HEALTHY WORKING LIVES**

In comparison to other western European countries Scotland's health record is not good. In order to tackle this problem the Scottish Executive aims to initiate an improvement in Scotland's health. The Executive's strategy for doing this is set out in *Improving Health in Scotland - the Challenge*.

The Challenge identifies the workplace as one of four main areas to focus on to drive positive change and reduce health inequalities. Healthy Working Lives is the policy being developed to take forward this workplace strand of the Challenge, with the aim of promoting ways of life which "continuously provide working age people with the opportunity, ability, support and encouragement to work in ways and in an environment which allows them to sustain and improve their health and well-being".

In the past, health interventions in the workplace have primarily been aimed at preventing accidents and injuries. Healthy Working Lives looks to take a holistic approach to improving the health of working age people in Scotland, stretching beyond traditional views which focus on physical health and medical ailments and brings together workplace health, social justice and lifelong learning issues.

In addition, because of the well established links between health and work, Healthy Working Lives also considers ways of securing more and better employment opportunities and promoting job retention for people with mental or physical health difficulties or other disadvantages in the labour market.

The lessons learned from New Futures Fund will be extremely valuable as part of Healthy Working Lives and these lessons will be incorporated in future employability work and the process of mainstreaming the New Futures Fund.

Partnership working across the Scottish Executive, with UK government departments such as DWP and HSE and with other stakeholders such as NHS Scotland, enterprise networks, the voluntary sector, local authorities, employers and trade unions will be crucial in delivering the aims of Healthy Working Lives.

Contact: Colin McHardy (colin.mchardy@scotland.gsi.gov.uk) or  
Kevin Hanlon (kevin.hanlon@scotland.gsi.gov.uk)

## **HEALTH CHALLENGE WALES**

To support the objectives for Wales: a Better Country, the Welsh Assembly Government launched 'Health Challenge Wales'. This will provide a new inclusive national focus to secure ownership, commitment and action for better health, as part of a co-ordinated sustained effort to improve health in Wales. Health Challenge Wales is a challenge to government at all levels to create the conditions necessary for people to lead healthy lives and improve their health; to organisations and groups in the public, private and voluntary sectors to do as much as they are able to help customers, service users and their own employees to improve health; the media to communicate the 'better health' message more effectively and to individuals to improve their own health and that of their families.

Health at Work, The Corporate Standard contributes to the Welsh Assembly Government's strategic plan, Wales: a Better Country. The strategy recognises that to achieve a healthier and more prosperous country we must help more people into work and improve health. Workplace health and Occupational health play key roles in delivering this.

For further information please contact Matt.Downton@Wales.GSI.Gov.UK

## THE NATIONAL EMPLOYMENT AND HEALTH INNOVATIONS NETWORK

The National Employment and Health Innovations Network has been effective in facilitating the exchange of practice and ideas between a broad range of stakeholders including, among others, health practitioners, policy makers, employers' representatives and VR specialists from across the UK.

### Aims of the Network

- To provide opportunities to share good practice and innovation in promoting health and tackling ill-health in the workplace; and reducing health inequalities through creating employment opportunities;
- To support the implementation of innovative projects and programmes by designing learning opportunities around key themes linking their work to Government policy objectives in employment, public health, regeneration, reduction of health inequalities and social inclusion; and
- To support the dissemination of proven innovation and good practice and its integration into the mainstream modernisation agenda.

The network now supports several hundred members. In addition to having the opportunity to attend meetings, members receive regular bulletins on important developments on the health and work agenda.

For further information and instructions on how to join the forum please contact [www.healthaction.nhs.uk](http://www.healthaction.nhs.uk)

## ADDITIONAL HELP AND SUPPORT

### THE HOST REPORT

In July 2000, the National Vocational Rehabilitation Association (NVRA) and a range of other organisations made representation to Margaret Hodge, Minister with responsibility for Disabled People, to consider the need to develop qualifications for people with responsibility for providing employment support, information, advice and guidance for disabled people.

### Background

The project was tasked to make recommendations for reform and for further development work. Underpinning this, the research shows:

- A distinctive range of functions undertaken by practitioners and managers working to support disabled people into, and to progress in, employment;

- A gap analysis has indicated that, although about 50 per cent of these functions were covered to some extent by identified NOS, and 20-25 per cent by other specialist standards, further standards development work is required to enhance these, and to provide complete coverage;
- There is a need for competence-based, practice-led and professionally orientated qualifications. Current qualifications do not meet the needs of practitioners in the sector. They also cannot - unless substantially altered - be used to develop and recognise the competences of all practitioners as identified in the functional map; and
- Further standards and qualification development work is going to be needed if a suitable range of accredited qualifications is to be made available for the field.

On the basis of the research, HOST made the following recommendations:

**Recommendation 1:** Consideration is given as to how best to develop the necessary infrastructure to support world-class training and development provision for the vocational rehabilitation sector. This would require an assessment of:

- The need to create a central body with a similar remit and role as the new General Social Care Council, working across the fields of employment, training and health, to take responsibility for ongoing training and development in the sector, for specifying minimum standards, approving, encouraging and funding agreed training developments and provision;
- The need - in consultation with existing sector associations and professional bodies - to agree methods of accrediting managers and practitioners, of fostering and accrediting ongoing continuous professional development, and if necessary to create new and/or supra-organisational structures to facilitate and implement their development; and
- The need to identify training providers and to identify, develop and accredit assessors and trainers in advance of stimulating training and development activity, and to ensure adequate provision is available to deliver agreed forms and levels of training.

**Recommendation 2:** An urgent review is required of the options outlined in the research in regard to the varying levels of training and development intervention, including considering:

- The creation of a list of approved training providers via a central agency (as above) and the development, and delivery through them, of national training programmes in gap areas;

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- The development of a national foundation-training programme for all new entrants, regardless of previous training/qualifications. This foundation-level programme to be delivered by approved trainers/institutions, and reviewed by a central body;
- The development of a post-initial training certificate, based on a revised Certificate in Supported Employment (with appropriate title change) including appropriate NOS units from advice and guidance, learning and development and DEA/Adviser standards;
- The development of a Diploma programme to reflect national specialist training requirements, for example case management, and the extension or development of practice-orientated Masters programmes to enable ongoing learning development and progression opportunities; and
- The review of content within existing professional development pathways for example occupational therapy against the distinctive functions for the constituency as identified in this research, and appropriate reform to ensure that qualifying practitioners operate effectively in this functional framework.

### **Recommendation 3:** An early review of:

- Additional public funding required to develop provision for all/any of the above training developments, and on a sustained pump-priming basis, to develop a critical mass of qualified practitioners necessary to deliver policy priorities in this area;
- The contribution that evidence-based practice can make to the field, and how it can inform the development of effective training systems, including the possibility of the establishment of one or a number of centres of excellence - based on the US Research Rehabilitation Training Centre (RRTC) model;
- The role that demonstrator projects could have in developing current practices, and providing evidence of the impact and the cost benefits of more systematically developed practitioners; and
- The evaluation strategy to capture the economic and social benefits of the development of research and related training and development structures, and to seek evidence of cost-effectiveness, and impact on the client group.

**Recommendation 4:** an assessment is needed of how best to create ongoing and sustainable demand for training, including CPD, amongst managers and practitioners in this constituency, and what delivery methods and costing strategies might maximise participation.

### **Overview**

The HOST research provided a clear picture of the occupational competences that are required to assist disabled people into - and to progress within - employment, and to

identify key issues in charting the way forward in regard to skills and wider HR development issues in the field.

It suggested a failure to act will leave many practitioners ill-prepared to provide the quality of integrated support that clients need, and miss an opportunity through this for government to better help disabled people to break out of benefits dependency. However, the real casualties will be disabled people themselves. Inaction will mean many will see little change in the capacity and capability of practitioners who would continue to drive a rehabilitation and support system which lacked the quality of responsiveness they need to return to, or remain in, paid employment.

### **BARRIERS TO EMPLOYMENT PROJECT**

The Barriers to Employment project is a multi agency initiative set up to consider the barriers to employment facing Incapacity Benefit claimants in Doncaster. The first stage of the project will end in March 2005 at which point a document will be produced which will detail the barriers identified in the research and proposals on the strategies to be adopted to overcome these barriers.

A number of approaches are being used to obtain this information:

- Bibliographic research of the issues;
- A literature review of national and international good practise;
- Specific research with a representative sample of Incapacity Benefit claimants in Doncaster. This research will be conducted throughout August and September 2004 and a report on findings will be available late October; and
- Investigation of local, national and international initiatives and an examination of what works.

### **RICHMOND FELLOWSHIP EMPLOYMENT AND TRAINING QEST (RFET)**

RFET runs a range of services providing rehabilitation, training, work experience and support into employment, for people with mental health problems and other disabilities who have been excluded from the labour market as a result of poor mental health. RFET offers two main models of service that are integrated and provide a continuum of service where they are offered in the same area. The two models are:

#### **Supported employment**

These services offer supported work experience through in-house placement opportunities in a range of work skills, tailored to individual needs.

### **Support into employment: QESTs (Quest Employment Support Teams)**

QESTs help people with mental health problems to find suitable training or employment and to gain any help that may be needed in the workplace. People can refer themselves or be referred by their social or healthcare worker. Clients are linked with an Employment Advisor who works in partnership with them to achieve their goals of training or employment. Together RFET supported employment and QEST services provide:

- work experience in the local community;
- work and employment in commercial settings for people needing long-term support;
- vocational rehabilitation and training; and
- career guidance and support into open employment.

For further information contact [www.richmondfellowship.org.uk](http://www.richmondfellowship.org.uk)

### **TOMORROW'S PEOPLE, FROM SICKNESS TO WORK, THE RIGHT PRESCRIPTION**

There are 2.7 million people claiming incapacity benefits, costing the state billions of pounds a year. However, this burden of costs has the potential to be reduced, as employment charity Tomorrow's People have found.

The charity has helped hundreds of people with health barriers to work re-enter employment, education or training through a number of innovative projects.

In one initiative, patients at the James Wigg Practice, Kentish Town, North West London, are being offered a 'one-stop shop' for health and welfare advice in a bid to help people off the sickness register and back in to work.

Many people receiving Incapacity Benefit and Disability Allowance are willing and able to work but because of difficulties arising from their health problems, such as low self-esteem or outdated skills, they need extra help with navigating their way back into sustainable employment.

Tomorrow's People has answered this specialist need and placed an employment adviser at the James Wigg Practice one day a week to help patients suffering from a range of conditions, including depression, mild circulatory disorders, back pain and stress.

The idea was to help GPs stop signing long-term 'sick notes' for certain patients who may benefit from receiving advice and assistance from a welfare and employment expert. So far, nearly 200 patients have seen the adviser, and of those registered, 100% have returned to employment or are back in education or training. On average, 75% are still in work 12 months on.

The scheme has been a great success for both the patients and the 17 doctors at the James Wigg Practice. They estimate that Tomorrow's People's presence there has helped save an average of **five** GP consultations per patient, already saving the surgery thousands of pounds.

Dr Roy Macgregor, a partner at the practice, said: "Having an employment adviser on site working as part of the primary care team is a unique way of helping people re-gain their confidence and re-enter the work place. The project has not only saved us time and money, it has changed many patients' lives, freeing them up from being stuck in the cycle of doctors' consultations with no real direction."

For Further information Please contact Steve Swan  
National Business Development Manager, Tomorrow's People  
Tel: 023 8089 9915

## **REHAB WINDOW**

Rehabwindow ([www.rehabwindow.net](http://www.rehabwindow.net)) was set up in 2003 to fill the gap experienced by those wanting to source information about disability and rehabilitation. The website is built around a core Directory of service and product providers, who submit an entry online. The Directory may be searched in various ways. The site also carries information on relevant events, news and jobs. There are plans to expand it to offer newsletters to subscribers, a "feature of the week" and guest articles. Visitors to the site include insurers, employers, solicitors and many disabled people and their supporters.

For more information, contact Jean Brading on 0118 933 3366, or email [jean.brading@rehabwindow.net](mailto:jean.brading@rehabwindow.net).

## **TURNING POINT**

### **Current model**

Progress2Work is specifically designed to help people who have had or have a drug problem gain jobs or training. It supports people through treatment and into work, and offers drug misusers employment advice and full access to Jobcentre Plus programmes. Progress2Work LinkUP has been extended to include people with support needs relating to homelessness, offending and alcohol.

Turning Point runs Progress2work schemes in the following areas: Berkshire, Buckinghamshire and Oxfordshire, Cambridgeshire, Hertfordshire, Bath and North East Somerset, Sandwell and Dudley, West Lancashire, Worcester, Neath and Port Talbot, Cardiff and the Vale and Swansea. Turning Point is also runs Progress2Work and/or Progress2Work LinkUP schemes in: Lambeth, Southwark and Wandsworth, Berkshire, Leicestershire and Wakefield.

## Benefits

The possibility of relapse is acknowledged and periods of relapse are allowed for on the programme. In liaison with Jobcentre Plus, project workers have discretion to sign off a person from the programme with no loss of benefits.

Some grants and discretionary funding is available to support people to secure training and/or employment, which enables them to access a wide range of courses and opportunities.

## Concerns with the current programmes

Initial funding is only for 2-3 years, but subsequent funding will be dependent on these outcomes.

It is a new model, so partnerships between therapeutic and employment agencies are at early stages, which require consistent and committed levels of funding.

The outcomes are unrealistic and clients are not as job-ready as the referrals would indicate. Many have multiple needs requiring attention if they are to move on successfully, such as housing problems. In effect, Progress2Work providers have to fill the gap in after-care provision. Turning Point's view is that the caseload needs to be substantially reduced.

Although there is some welcome recognition that episodes of relapse can be part of a cycle of change towards stable employment, 2-3 years is too short a period to expect participants to make long-term change their lifestyle and sustain employment. The Government needs to take a longer-term view to evaluation and funding of these initiatives.

Taking these things into consideration the key features that contribute to the model's success are that:

- It recognises that to engage successfully with a person who has complex needs, it is essential to have specialist expertise and to have a central player who can act as a broker.
- It has dedicated funding and ring fences money specifically for the client group. It is focused and not spread across other groups. This enables the provider to build packages around the individual.

It offers employers the benefits of ongoing specialist support to employees including a phone line – so they can try and resolve any problems instead of automatically taking the option of terminating employment.

For more information please contact:

Caroline Hawkings on 020 7553 5262 Email: [caroline.hawkings@turning-point.co.uk](mailto:caroline.hawkings@turning-point.co.uk)

### **AVON AND WILTSHIRE MENTAL HEALTH CARE TRUST**

The Avon and Wiltshire Mental Health Care Trust (MHCT) has created comprehensive vocational services for people with mental health difficulties and provided training and consultation for over 60 Healthcare Trusts nationwide. Their service is named as “an excellent example of partnership working” in the National Service Framework Document for Mental Health and they have been awarded NHS Beacon status, have been commended in the Health & Social Care Awards 2001. In addition, the trust has recently won the NHS Modernisation Award in the Mental Health category in order to conduct research into Job Retention best practice internationally.

They have recently completed a successful Job Retention Pilot, supported by the Department for Work and Pensions and NHS Executive and are currently engaged in helping to create a national co-ordinated service for employers, linking NHS provision to private sector services. This will enable employers to receive a comprehensive service addressing all their psycho/social needs.

### **TRUCK BY TRUCK**

Truck by Truck is an employment and vocational development project which is contracted to provide opportunities for people with a learning disability to build confidence, self-esteem and skills in a supportive work-focused environment. Its business is to provide usherette-sized snack trays to customers’ officers across Kent. Service users are involved in all aspects of the service, including pricing the goods, preparing trays, checking stock and delivering the trays to customers.

They began with a work-focused rehabilitation project for people with a learning disability that aimed to develop a viable business, targets being mainly based on income levels and profit margins. A secondary target focused on training and the personal development of service users. The project received individual spot funding through the local social services, based on the number of individuals referred through disability care management. The people who attended were called project workers and were paid an attendance fee of £5.00 per day.

They now have a service, which offers a range of employment and vocational opportunities – including training and personal development, highly supportive employment placements and support, obtain open employment and education.

In particular the service:

- Is led by the needs of service users;
- Provides a range of training and employment opportunities for individuals;
- Ensures individuals have more money and are paid in line with minimum wage legislation and permitted work rules;

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- Is still financially viable;
- Actively promotes the employability of all; and
- Encourages people to move into open employment.

### ABILITY MATCH

#### Introduction

Employers everywhere say they would like to employ more disabled people and retain staff with a long-term health problem or disability. Corporate social responsibility, diversity strategies and a tight labour market drive this agenda.

Over the last ten years many initiatives have been tried but not much has changed. The employment rates of disabled people remain stubbornly low.

#### The Problem

This happens because managers do not know what to do when approached by a disabled applicant or if they have a member of staff absent with a long-term health problem. At one level there is an assumption of limitation. At another level managers can feel awkward or uncomfortable. Investing in Disability Awareness Training helps to a degree but more needs to be done to enable managers to match the individual employee with a specific job and make any reasonable adjustments.

#### The Solution

AbilityMatch is an innovative computer based tool, underpinned by ergonomic principles. It compares the abilities of disabled people with the requirements of the job. By doing so it determines the need and scope for any solutions that may be required to ensure the individual can perform tasks effectively. Following initial training, HR managers and Occupational Health professionals will be able to deliver fast and effective solutions in partnership with managers in an entirely objective way.

This product has been developed by AbilityMatch Ltd, bringing together the combined skills of Medical Experts, Vocational Case Managers, Occupational Psychologists, Ergonomists, Software Developers, Educationalists, Employers and over 250 people with disabilities or long term health problems. Initial findings suggest that this product has significant potential.

For further information please contact: [geraldine@disabilitymatters.com](mailto:geraldine@disabilitymatters.com)

## **THE MAKE IT WORK SCHEME**

The scheme has worked with over thirty people and had great success. Nine people have achieved an NVQ level 2 and five people have moved to paid employment. All the trainees feel they gain from the scheme and many continued their voluntary work or went on to train further.

The scheme is funded by The Learning Skills Council, and works in partnership with Tees and North East Yorkshire NHS Trust. The partnership was entered into a national award Parents At Work Employer of the Year Awards 2003 and got into the final five, out of three hundred applications for the Driving Diversity Award.

The award ceremony was held in London and Lisa Cole (Service Coordinator) and two trainees Peter Simpson and Catherine Haigh along with two people from TNEY NHS Trust flew to London to be involved. The partnership between TNEY NHS Trust and Mental Health Matters (MHM) received a runners up prize and received a certificate of high commendation awarded by Gerry Sutcliffe, Parliamentary Under Secretary of State for Employment Relations.

The partnership involves the Trust offering work placements and allows MHM to use their NVQ systems. As a result of this three trainees have gained full time employment within the Trust. The awards demonstrate how the scheme has helped create diversity in the work place and that employers can recruit people with disabilities. The scheme has been an educational process for staff within the Trust as they now feel that working with people who use mental health services has helped break down stereotypes and remove stigmas.

In April 2004 a new project began called Brighter Futures, funded by Northern Rock. This project will hopefully continue the partnership between MHM and TNEY NHS Trust and go on to have many more successes.

## **FORTH SECTOR**

Forth Sector is an Edinburgh-based mental health organisation with 15 years experience of providing 'vocational rehabilitation' support to people with severe and enduring mental health problems. The primary focus is vocational rehabilitation through creating social firms that are small semi-commercial businesses that provide supportive employment and training for people with a disability or disadvantage in the labour market. Additionally they develop transitional employment initiatives to provide employment and training support to enable people with severe and enduring mental health problems to retain or regain mainstream employment.

## WORKING LIFE PROJECT

The Mersey Neurological Trust in the Glaxo Centre launched a bridge to employment and training for people diagnosed with a neurological condition, the Working Life Service, with a grant from the National Lotteries Charities Board. The Service started in September 1995. The Working Life Service aims to help people who are in work or looking for a job, and have been diagnosed with a neurological disorder.

The project offers an individually tailored programme of support, which could include:

- Individual counselling;
- Help to stay in employment or find alternative work;
- Advice about training;
- Access to benefit advice;
- A chance to talk to the specialist organisations who know about the different neurological conditions; and
- Help to sort out problems with daily living.

Everyone has different problems and this is not an exhaustive list. Their aim is to adapt to whatever people need.

## WORK DIRECTIONS UK

WorkDirections UK is part of the Ingeus Group, supporting businesses with integrated human resource solutions, and providing governments with effective, accountable employment-focused welfare services. The group now employs around 850 people and delivers related services through subsidiaries in the UK and Australia. These include:

- Inergise provides pro-active, outcome-focused Corporate Health services, in particular: injury management, injury prevention, rehabilitation programmes, occupational health and safety and related training;
- Clements provides recruitment services in: labour hire, office and administration (permanent and temporary), technology, corporate and executive;
- Invisage provides management training, IT training, accredited vocational training and traineeships;
- WorkDirections Australia provides employment services, as part of the Job Network, and supports individuals on initiatives such as the Personal Support Programme and Transition to Work. In 2000 WorkDirections became Australia's fourth-largest provider of Intensive Assistance. In 2003 WorkDirections was awarded 31 new welfare-to-work contracts across Australia; and
- WorkDirections UK delivers innovative welfare-to-work services for people who are long-term unemployed on the Private Sector led New Deal in Central and West

London and the Employment Zone in Nottingham. New offices opened in 2004 for Employment Zone delivery in Birmingham, Brent, Haringey and Southwark. In April 2004 we also opened a service for clients in Birmingham on New Deal for Disabled People.

WorkDirections is committed to performance with integrity as a result of:

- Experience of service delivery, particularly for people excluded from employment over extended periods of time, enabling an informed service;
- A unique approach to staff, with a depth of professionalism that gives us the skills to deliver;
- A delivery model, and associated processes, bringing together best industry practice; and
- Premises and resources that empower their users and facilitate the move back to sustainable employment.

For more information please contact:

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Or visit [www.workdirections.co.uk](http://www.workdirections.co.uk)

## **POSITIVE FUTURES**

Positive Futures is a partnership of HIV charities, supporting people living with HIV and AIDS. Their aim is to improve the employment, education, skills and prospects of people living with HIV in the Greater London area. The partnership brings together the experience and knowledge of organizations, which have been providing services for, and campaigning on behalf of people living with HIV for many years. The Positive Futures' partners are: The Globe Centre, Oasis North London, Positively Women, Terrence Higgins Trust & Lighthouse (T.H.T.), U.K. Coalition of People Living with HIV and AIDS, and National AIDS Trust.

The Positive Futures Partnership (PFP) services include training, support and guidance to help people living with HIV achieve their full potential and also provide advice and training for employers on issues relating to HIV in the workplace. In addition to the services provided by each partner organisation, the specific services provided under the PFP are: Adult Guidance, including general guidance, black and ethnic minority guidance and gay and lesbian guidance, Careers Guidance and a Careers Library, IT Training and Development Opportunities including professional presentation skills and ESOL, Welfare Benefits and Rights Advice, Mentoring, Volunteering Opportunities and the Routes Into Work project.

For further information please see [www.positive-futures.org](http://www.positive-futures.org)

## NEW FUTURES FUND

The New Futures Fund (NFF) aims to reduce social exclusion and disadvantage amongst 16 to 34 year-olds in Scotland - funding a range of projects to help vulnerable young people who have problems getting a job.

People supported by NFF projects may have found mainstream support services unsuitable for their needs. With the help of the projects, they can get the skills and confidence they need to get into the labour market.

NFF aims to help people who have:

- Homeless difficulties;
- Drug and alcohol addiction problems;
- A background of offending and anti-social behaviours;
- “Chaotic” lives;
- Mental health problems;
- Disabilities; and
- Learning difficulties; and a number of other groups.

The following is an example of the type of project that the NFF Supports:

Situated near Ailsa Hospital in Ayrshire, Scotland, the Scottish Association for Mental Health (SAMH) Ailsa Training Centre provides horticultural training for the long-term unemployed and for people who have special needs or poor mental health. Assisting people who have experienced mental ill-health to acquire the skills and confidence to become independent is a cornerstone of SAMH's work.

The learning and training centres offer an opportunity to develop foundation skills and to progress towards employment and/or achievement of vocational qualifications for 25-59 year olds, New Deal placements for 18-24 year olds and Day Care services for those with health or related problems. Referrals are generally taken from Jobcentre Plus personnel, Social Work departments, NHS Trust staff, and Community Mental Health teams. Horticultural training to Scottish Vocational Qualification Level 1 in Commercial Horticulture and Level II in both Amenity Horticulture and Nursery Horticulture is currently available. A 60 acre site including bowling and putting greens and working nursery provides practical on-site training. These qualifications provide recognition of the varied skills required by today's horticultural employees.

**Activities include:**

- Garden Centre and Nursery Practice;
- Sports and Fine Turf Maintenance;
- Hard and Soft Landscaping;
- Plant Propagation and Care; and
- Home and Allotment Gardening.

**THE WORKING OUT PROGRAMME**

Working Out is a specialist brain injury vocational rehabilitation programme run by the Community Head Injury Service, Vale of Aylesbury Primary Care Trust. It was set up in 1993 for people with severe traumatic brain injury who are unable to establish or re-establish themselves in employment post-injury. The programme comprises four linked phases: vocational assessment; work preparation; voluntary work trials; and supported work placements. The programme is recognised as an example of good practice by the Department of Health, Jobcentre Plus and Social Services Inspectorate and was the South-East Regional Winner of the NHS Nye Bevan Modernisation Award 2000.

The original research and development project was funded originally by the Department of Health (1992-97) with additional funding from the Employment Service. The project included a detailed research evaluation. Clients have continued to be funded through the NHS and a series of specialist brain injury work preparation contracts with Jobcentre Plus. By June 2004 around 200 clients with brain injury had been seen for vocational assessment. Outcomes (as of June 2004) for those seen for vocational rehabilitation are as follows: returned to paid employment or vocational training – 67%; permitted work, voluntary work or adult education - 18%; referred for further brain injury or other intervention – 6%; no activity – 0%; dropped out of the programme prior to completion - 9%. In the original evaluation project outcomes were well maintained at two year follow-up.

**RESIDENTIAL TRAINING PROGRAMME**

The Residential Training Programme (RTP) is delivered nationally by the Residential Training Unit (RTU) located within Government Office North East on behalf of DWP/Jobcentre Plus. The RTU is expected to manage its budget to achieve maximum outcomes by contracting with appropriate providers, setting an appropriate fees structure and offering training programmes relevant to the needs of the labour market.

The RTU has corporate responsibility for ensuring the referral agents (Disability Employment Advisers) are made aware of RTP and kept up to date with developments. The RTU continues to develop its role as a funding body in line with the HM Inspection process, working with both OfSTED and ALI.

The Residential Training Programme (RTP) is a national programme to help unemployed adults with disabilities, particularly those at risk of exclusion from the job market, to secure and sustain employment, self-employment or enter into further education. This is achieved through an individually tailored combination of guidance, learning in the workplace, work experience, training, and approved qualifications carried out in a residential setting at one of 13 training providers located throughout England. Vocational training is backed up by: psychological support; specialised learning approaches; specialist medical facilities and expertise; therapeutic support; technical support; assessment and employment preparation; advice and guidance; enhanced staff expertise; and specially designed buildings and facilities.

### **PRISMA HEALTH LTD**

The Prisma Health group was incorporated in 1999 to help life insurers resolve complex disability claims. Since then the Prisma Programme has resolved more than 60% of the difficult long-term disability cases referred by UK insurers. These clients have successfully returned to work after sickness absence of at least 2 years and in many cases more than 5 to 10 years duration.

Prisma Health Ltd employs a team of Psychiatrists, Physicians, Rheumatologists, Psychotherapists, Psychologists and Physiotherapists in the comprehensive high quality interdisciplinary assessment and treatment of disability that arises through chronic illnesses such as chronic fatigue, pain and depression.

The Prisma Programme addresses all aspects of the client's difficulties including medical, social, physical, financial, work-related and psychological issues where appropriate, and takes place the client's home, each client being allocated a Field Consultant who coordinates all aspects of their programme.

In addition to the comprehensive Prisma Programme we also offer individual assessment and treatment packages tailor-made to clients' requirements including:

- Psychiatric, Medical, Physiotherapy and Cognitive Behavioural Psychotherapy Assessment;
- Dedicated Case Manager who co-ordinates all aspects and phases of rehabilitation;
- Physiotherapy and Cognitive Behavioural Therapy with specific vocational goals from the outset, for example:
  - Anxiety Management;
  - Depression Management;
  - Pain Management; and
  - Fatigue Management.

- Fitness For Work Assessment;
- Liaison with existing employers regarding adherence to the Disability Discrimination Act and Health and Safety at Work Act;
- Construction and Supervision of Graded Return to Work Programmes;
- Exploration of alternative careers options using the relevant software packages, matching transferable skills and interests;
- Identification of retraining needs;
- Facilitation of retraining; and
- Workplace management to ensure successful transition back to work.

Prisma Health has regional offices in London and the Northwest of England with staff placed over a wide geographical area (England, Scotland and Wales) enabling acceptance of referrals from throughout the UK (Website: [www.prismahealth.co.uk](http://www.prismahealth.co.uk)).

### **WORKING FUTURES – A DEVELOPMENT STRATEGY FOR PEOPLE WITH MENTAL HEALTH PROBLEMS IN POWYS**

Valued occupation had a low and peripheral profile in Powys until 2000. There was no data on the numbers and potential of people with mental health problems in relation to education, training, and work related aspirations so we submitted a bid for European Social Fund funding for a research programme. The bid, which aimed to gather base-line data and to map existing provision was successful.

Key to the success of the Project, which took 12 months to complete, was the active engagement of service users as members of the steering group, as researchers and as the focus of the research. The resulting “Working Futures Report “sets out nine clear objectives:

1. Supporting the user infrastructure;
2. Tackling discrimination & mental health promotion;
3. Maximising route-ways to valued occupation;
4. Maximising volunteering opportunities;
5. Access to education and training;
6. Creating supported work opportunities;
7. Job Creation;
8. Access to Open employment; and
9. Overcoming barriers.

A Steering Group was re-established and two part-time development workers were appointed. The following progress has been made over 16 months:

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- Printing and distribution of an information booklet on valued occupation opportunities (Stepping Stones);
- Development of a self-management tool (Taking Control) to be used with Care Programme Approach;
- Establishment of a specialist mental health one-to-one service to help people look at routes to valued occupation (60 referrals in first 6 months):

*Example 1 - Someone in employment but on shortened hours due to mental health difficulties experiencing problems with debts and finance. Thought he would have to give up job. Subsequently found he was entitled to Working Tax Credit, has undertaken assertiveness training, and is now dealing with debt problems and building towards full-time work;*

*Example 2 - Someone out of work for 13 years with poor self-confidence and low self-esteem who was completely reliant on family. Through support has taken some control and responsibility. He has been supported into voluntary work in the Court System, is more responsive in the home and socially and is growing in confidence. - planning to extend voluntary work into hospital system;*

- Establishment of 5 pilot groups (based in each of the main towns of Powys) to address local interests.
  - a) A job retention scheme with a GP Surgery (Newtown),
  - b) A possible training package for Jobcentre Plus staff on stigma (Welshpool),
  - c) Development of a partnership with local stakeholders (Brecon),
  - d) A user led initiative that will work with a local volunteer bureau and
  - e) An Equals bid to test different approaches to social inclusion (including mental health).

# APPENDIX C

## Vocational Rehabilitation Case Studies

The previous section demonstrated the relative usefulness of vocational rehabilitation strategies, initiatives and projects. However, it is also important to learn from stakeholders', including individuals', experiences.

This section complements the previous appendix and gives a flavour of some vocational rehabilitation approaches and interventions that stakeholders have implemented, and found useful.

We are grateful to those stakeholders who have supplied us with the following contributions. Please note that confidentiality is respected and some names have been changed.

### **Case Study 1: Insurance Company**

This Insurance Company has decided to operate its vocational rehabilitation return to work programme via independent occupational therapist Case Managers who are self employed.

The main focus of their programme is on job-risk injury claims – those cases where the injured person without some kind of help would be unlikely to return to work.

The Insurance Company can refer cases to the Case Manager at any time prior to settlement. Sometimes the process is held up by the need to obtain the agreement of the claimant and or their solicitor and sometimes because the Insurance Company had not been made aware of the claimant's circumstances. In some instances the return to work programme had been initiated some years after the original accident and sometimes it is commenced within 6-9 months of the accident.

The Insurance Company's rehabilitation programme takes a holistic approach to their clients. The Case Manager will visit the client to assess their circumstances and then agree and make recommendations as to the kind of interventions that would be appropriate. They will also meet or liaise with other parties involved in the case including the GP and other medical specialists, and the employer, other family members etc.

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The Case Manager seeks to work with the patient to develop and agree a return to work programme. In the short term Case Managers can authorise provision of equipment/modifications to the home such as level access showers. Other interventions included in the overall holistic and patient centred approach include:

- Counselling;
- Referrals to (private) physiotherapists/pain specialists;
- Funding of gym membership;
- Care assistance;
- Driving assessments/suitable vehicle provision;
- Liaison with Disability Employment Advisers, Access to Work Officers, Careers Service etc;
- Liaison with local education service;
- Liaison with employer to facilitate staged return to work, modifications in the workplace;
- Developing work hardening programmes;
- Assistance with benefits and financial matters; and
- Guidance on retraining options.

### Examples:

J, a fork lift truck driver had an accident at work that resulted in amputation of his toes on one foot. He was experiencing pain, and had problems standing and walking and was depressed.

J was referred to the occupational therapist fifteen months after the accident. As part of the holistic return to work programme the occupational therapist:

- Arranged for private physiotherapy and pain management from a specialist;
- Organised gym membership and a Weightwatchers subscription;
- Arranged for an assessment by a podiatrist and for an orthopaedic firm to provide special shoes;
- Liaised with John's GP;
- Provided and undertook a work place assessment; and
- Arranged a graduated return to work to a different job with the same employer.

J returned to work with his previous employer 27 months after the accident, initially working 4 hours a day and gradually returning to full time work.

K, a factory operative, had fractured his leg and injured his knee in an accident at work. Although he had returned to work one year after the accident he was referred to the occupational therapist 3 years later.

K had previously been through a rehabilitation programme which had funded retraining to a different type of employment which he had not pursued. He was experiencing pain and had difficulty standing all day at work.

The occupational therapist liaised with the employer who did not want to become involved, fearing that it might affect K's claim. She also made contact with K's solicitor who also did not want her to intervene as the compensation claim was on-going and the case was proceeding to trial.

After further liaison with the employer, the occupational therapist identified that K could manage to do his job if he could use a perching stool. The perching stool was purchased, but then could not be used on the grounds of health and safety on the shop floor.

The employer then agreed to support and fund K's retraining to do another job in the firm.

### **Case Study 2: Public Transport Operator**

The organisation is a large, mainly public sector employer with its own internal Occupational Health department.

The services provided by the department include medical advice, physiotherapy, a specialist counselling and trauma unit, drug and alcohol advice and treatment. It also runs a programme designed to help and encourage those off sick or injured to return to work if possible.

The department's role includes assessing staff's fitness to do their work, and advising managers on the medical aspects of people who are off sick and how quickly they can be got back to work.

In order to reduce levels of sickness absence the organisation is using the case management approach to allocate the kind of help and treatment that might be suitable to help individuals back into work. These initiatives are designed to be holistic and include:

- Physiotherapy;
- Cognitive Behaviour Therapy;
- Counselling sessions;
- Stress reduction;

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- Adjusted working hours;
- Agreed return to work programmes; and
- Modifications to workplace/duties undertaken.

A system had been set up whereby after 28 days off sick all cases were reviewed by their line manager, HR and Occupational Therapy to agree an approach to helping employees back to work.

#### Examples

L, a station assistant, was suffering from multi-functional visual impairment, which would normally compel him to take early retirement or give up working. In order to enable him to go on working the ticket office was adapted to suit the needs of someone with significant visual impairment. Usually Station Assistants working on platforms and ticket offices would be required to meet quite stringent vision requirements. Making an exception to allow this particular employee to work in one place represented a significant modification of established procedures.

M, an operational trainer, was suffering from the effects of chronic severe heart disease. In order to allow the employee to continue working, it was agreed that she should work at home on alternate days. Thus she would work 3 days a week at the training centre and 2 days a week working from home. Working at home meant that she did not have to undertake the journey to work and furthermore, she could spread the work throughout the day taking rest periods, allowing her to complete her work over a longer period of time. Arrangements were also made to minimise her journey when she did come into work.

The job is now arranged so that M does not need to take much exercise, and because she has to walk slowly and stop regularly to take her breath, sufficient time is allowed for her to walk from one location to another. The job has also been adapted from continually delivering training to marking papers and developing courses.

#### Case Study 3: Vocational Rehabilitation Provider

The organisation is an independent rehabilitation case management company providing medical, vocational and occupational health services to the legal/insurance industries and employers. A rehabilitation case manager directs the return to work and recovery process. The company adopts a holistic approach to rehabilitation, and the case manager works in conjunction with the injured person, their medical practitioner(s) and, if appropriate, their employer.

**Examples:**

N was a victim of serious crime while working. He was off work following this incident for nearly 9 months. He underwent post incident counselling via the Employer's Employer Assistance Programme, but when the course was over he was not offered further treatment. His GP prescribed anti-depressant medication and put him on a waiting list for counselling.

The rehabilitation programme for N involved sessions with a Cognitive Behaviour Therapist and regular reviews with a Consultant Psychiatrist. When N was considered 'fit', the Case Manager began to plan N's return to work on reduced hours/duties. The Case Manager liaised with N's employers to identify suitable hours and duties and advised the employers on what to expect and how best to manage N on his return.

Initially, N went back to work for 3 hours per day 3 days a week. After 12 weeks he was able to go back to his pre-incident work and hours.

O, a Care Assistant sustained an injury to her knee and was told at A&E that she had torn a tendon. Following surgery, O was able to return to work some three months after the injury. Four months later, while performing her duties, she sustained a soft tissue injury to her right thigh muscle. Although O returned to work, this injury was exacerbated in a further accident a few weeks later. After this incident, O met with her Manager and it was agreed that she would remain off work until her injuries were resolved. O has since undergone further surgery and more surgery is currently being considered. O has been advised by her Consultant Orthopaedic Surgeon to avoid work as a care assistant.

The case was referred for rehabilitation case management. Following an initial rehabilitation assessment, the case manager established that O's employers were willing to retrain O into a clerical position. O was referred to a vocational consultant to confirm she had the aptitude to perform clerical work within the same organisation. It was agreed with O's employers that basic computer training was required and a training programme was sourced. A graduated return to work programme was also developed to introduce O to her new position.

O has continued on the return to work programme and is continuing on the computer course. She has returned to her pre-accident working hours.

**Case Study 4: A Small Voluntary Organisation**

An individual in a small voluntary organisation was referred to the H@W patient OH advisor in surgery by the GP. Information was given to the individual on employment rights and health and safety information. There was also a general discussion around

issues in work. The individual (who was a project manager) was also referred to the advisor for small and medium sized businesses who carried out health and safety audit for the organisation. The result of this intervention was that both employer and employee benefited from advice, which enabled the organisation to implement policies and changes to the working environment, which ultimately resulted in the staff member returning to work.

### **Case Study 5: Routes into Work Project**

The Routes into Work project is a Positive Futures Partnership (PFP) pilot initiative targeted specifically at individuals who want to go into work but have significant barriers that they need to overcome in order to enter into paid employment. The project offers the following services: re-accreditation of overseas qualifications, work experience placements, additional skills training funded by the project, CV and job applications support, dealing with disclosure and the Disability Discrimination Act, job searching techniques, 1:1 support and start up financial support once in employment.

The following is an example of how the interventions of PFP Routes Into Work project have assisted someone. Our client was an African woman with a bachelor's degree in management and several years' work experience in her home country. She had applied for several jobs in the UK and had been unsuccessful on all her attempts. When she came to PFP she was unsure as to what else she could do in order to enter into paid employment. In the initial meetings we looked at the methods she had been using to apply for jobs, at what level, at the particular industry she was applying to as well as the requirements in the London labour market. Through several meetings we concluded that she lacked UK specific retail management knowledge as well as UK work experience.

Through Routes Into Work she was able to complete a part time management course and a short-term part time work experience to overcome these barriers and be competitive in the labour market. We met several times throughout her course and work experience placement to work one on one to continue to develop her job search and application techniques as well as support with issues related to her HIV status and employment. As a result she was able to get a job in management for a nationwide retail company at management level to support her and her two school aged children.

### **Case Study 6: Exercise Referral Scheme**

A is a 45 year old trained senior nurse who works full time in a very busy acute medical unit. She is married and has a 3 year old child, and therefore has to balance a number of conflicting demands in her life. She has had asthma for five years, for which she takes a variety of inhaled medication; recently this has not been well controlled and she has also suffered from recurrent chest infections, necessitating a number of short courses of systemic steroid medication and antibiotics.

A was referred onto the Exercise Referral Scheme in order to assist her with improved asthma control and minimise the likelihood of her having to take time off work. Prior to this her activity level involved walking 20 minutes per day. Self-assessment of her physical well being at referral was 5 (on a 1-10 scale - 10 being extremely well) and self-assessment of her psychological well being at referral was 5 (using the same scale).

At the 6 week review appointment, A had significantly increased her activity level. Self-assessment of both physical and psychological well being was 8, and she reported a considerable improvement in her ability to cope with the physical demands of her job in addition to feeling more energised. At 12 weeks she had been suffering from a long-term chest infection that had curtailed her activity, with some reduction in her self assessed health status. However A said "I plan to return to exercising next week as I found such a difference in my ability to do my work when I was more active". She went on to say "I am now looking seriously at my work in relation to my health and plan to apply for some flexible working to help with childcare and to support me in maintaining my activity and health." Her long-term health status will be assessed at a further follow up appointment.

### **Case Study 7: Exercise Referral Scheme**

C is 60 years old and works part time as a support services assistant, with responsibility for domestic work on one of the hospital wards. He was referred onto the Exercise Referral Scheme following suffering a heart attack some months previously. At referral he was very anxious regarding taking activity, and worried about the effect that exercise could have on him despite having attended a cardiac rehabilitation programme.

At referral he assessed his motivation to exercise as 6 (on 1-10 scale) and self assessed his confidence that he would exercise at 5. He responded well to the induction and tailored activity programme, gaining confidence in his ability to increase his activity level in preparation for return to work. At the 6 week review, his self-assessed motivation to exercise had increased to 8, and confidence to sustain his new activity programme increased to 7.

C said "I was really anxious regarding doing normal activities, but this programme has increased my confidence that I can return to work on a phased return to work programme." He is now planning to join the leisure centre to maintain his health and activity level.

### **Case Study 8: WorkDirections and Cognitive Behavioural Therapy**

The five year gap in R's CV, due to an escalating drugs and alcohol problem, became such a source of anxiety he couldn't even apply for a job without sweating and feeling nauseous. He considered himself unemployable and so did not show real willingness to find a job.

Once his WorkDirections Personal Advisor discovered these personal issues he immediately offered him the chance to speak to the company's in-house Cognitive Behavioural Therapy (CBT) Advisor who could bring their specialist skills to bear. Earning his trust quickly, the CBT Advisor worked with R to address his anxiety issues while maintaining a focus on work. The Advisor explained that R was suffering physical manifestations of stress and suggested ways he could alter his negative thought processes. Coupled with relaxation techniques and continuing interventions by his Personal Advisor, this transformed R's perceptions of himself and his employability, and thereby his ability to manage his stress.

R wants to be a landscaper so when a position in a company that services office plants was identified, it provided an ideal opportunity for him to move closer to this goal. The Employment Liaison Advisor secured R an interview. He was successful, undertook a work trial and is now a full-time employee. In fact, R has so impressed his new employers, they have since taken a further three WorkDirections clients into full-time employment.

R had the opportunity to work with three specialists, with both employment and health expertise, who provided him with an integrated service. As one of them said, "I believe that this is not only an example of how CBT can help, but also the incredible team work that goes on in a WorkDirections office."

### Case Study 9: Return to Work

Perkin Elmer Llantrisant is proud of its absenteeism level, currently running at 2.3%. The absence is controlled by return to work interviews and a rehabilitation programme to return employees to work who have been absent for an extended period.

When an employee is absent from work, for no matter how long a period, the employee has a return to work interview with their line manager. The absenteeism is recorded in a database where each absence is recorded and points are accrued. When the points reach a certain level it triggers an interview with the line manager; the next trigger is an interview with the line manager and the human resource leader and the final trigger is with the operations director and her leader. These interviews form part of the absenteeism programme which is very tightly controlled.

When an employee is absent from work for a long period due to sickness a rehabilitation programme is arranged where the employee is introduced back into the workplace gradually. They start back by having a couple of hours each day until they are ready to work more hours, there is no pressure on them to return to work full time. We also look at their work area to see if there are any alternations that we can do to ease the return to work.

A recent example of this is when an employee had a heart attack and was off work for six months. The doctor said that he was clear to return to work, however the employee was

anxious about coming back to work full time. So over a period of six weeks, we encouraged the employee to start work at 10 and finish at lunchtime then gradually over the six weeks he introduced more hours until he was ready to work full time. The feedback from the employee was fantastic; he appreciated what we had done for him.

### **Case Study 10: Disability Employment Advisers**

S from Hartlepool left school at 16 and became an apprentice fitter with ICI in Billingham. Upon completion of his apprenticeship he went on to also train as an Instrument Technician. Following a motorcycle accident in August 1999, S suffered serious leg injuries which, following an extensive stay in hospital and several years in physiotherapy, resulted in him having to use a wheelchair. It was while in physiotherapy that someone suggested to S that he contact his local Disability Employment Adviser (DEA). Following an interview with his DEA, S began a training programme at Finchale Training College in Durham.

Twelve months later having completed a range of technology courses, including PC maintenance, Networking and Web page design, S is about to embark on the next stage of his career. With his extensive and valuable experience as an Instrument Technician and the computing background he has developed at Finchale, S has been offered a place at Sunderland University on a Foundation Degree course in Computer Science.

### **Case Study 11: Tomorrow's People Project**

C thinks life is pretty good. She loves her job as a hairdresser's receptionist and at age 22 is looking forward to a bright and happy future. But just 12 months ago things did not look so positive for her. Having lost her full-time job and unable to find a new one she soon spiralled into a cycle of sleeping problems and depression.

Forced to abandon her dreams of a job in childcare she was claiming Incapacity Benefit and on medication, and it was only during a consultation with her doctor that she heard about the Tomorrow's People project based at her doctor's surgery.

C made an appointment and following a programme of advice and support is now happily working full time as a receptionist.

She said: "Making the appointment with Tomorrow's People was the best decision I have ever made. I would thoroughly recommend this kind of service being available at other surgeries. There must be thousands of other people out there like me. I had lost my way and Tomorrow's People helped me get my life back on track. My depression has completely gone now and I feel like a different person. I feel so lucky to be in this situation."

### **Case Study 12: Working Out Programme**

D was an aircraft technician in the RAF when he incurred a severe head injury in a road traffic accident. On return to light duties at 6 months he experienced difficulties with concentration, memory and slow speed of function. After returning to his former duties he failed to follow set procedures due to a memory lapse, resulting in a serious health and safety incident. He was referred for assessment of his head injury and then medically discharged from the RAF. Over the next five years he secured but could not maintain a series of jobs, struggling with poor organisation, poor memory, slow speed and back pain. He worked long hours to keep up and became increasingly fatigued, frustrated, irritable and, at times, aggressive. He consulted his DEA at 4 and 6 years, had an assessment and was referred first for employment advice and then to a local work preparation provider, but without this leading to sustainable employment.

He was referred to the Working Out Programme at 7 years post-injury. Having been advised to stop his latest job he was very despondent, had lost confidence and felt like giving up. Specialist assessment revealed mild physical and language difficulties, moderate cognitive impairment (attention, memory, speed of processing and executive skills), irritability, variable mood, emotional vulnerability and low self-confidence.

D found the feedback of the specialist assessment to be re-assuring in identifying and clarifying the underlying nature of the difficulties he had experienced at work. He then completed a period of specialist vocational rehabilitation including a work preparation group, community vocational rehabilitation activities, cognitive rehabilitation group, vocational counselling and psychological therapy. He responded very positively to the opportunity to learn about and develop strategies to manage the effects of his head injury. He then progressed to a part-time supported voluntary work trial in a carefully selected light engineering company. A similar paid position was then found and set up initially as a voluntary trial, progressing to full-time paid employment. His new role was closely monitored, reviewed and adjusted at 3 months, leading to sustainable paid employment.



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