

Pathways  
to work:

Helping people into employment





# Pathways to work: Helping people into employment

Presented to Parliament by  
the Secretary of State for Work and Pensions  
by Command of Her Majesty  
November 2002

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I believe that everyone who wants to work has the right to do so and that is why *Pathways to work* is right at the heart of our welfare reforms. In 1997 we inherited a system where, all too often, people were written off to a lifetime of benefits and which let down those who needed help the most. I am determined to put this right, and this paper sets out the next stage in our approach to help those with health problems or a disability, giving everyone the chance to turn their potential into reality.

At the heart of our Welfare to Work strategy are the New Deals, Jobcentre Plus and tax credits, and it is on their success that we intend to build. This 'work-first' approach has always been central to the Government's strategy and has been a success for most groups.

However, we still need to do more to support those with health problems or disabilities who have not yet had a chance to share in this success. Our objective is clear – helping those with the potential to get back to work to fulfil their aspirations and to avoid missed opportunities. Those who could work must be given the chance to gain employment and to become, and remain, independent.

This document sets out the more coherent way of supporting people moving onto incapacity benefits we intend to trial. It is based around increasing financial incentives to return to work, a better support and referral framework via Jobcentre Plus, groundbreaking rehabilitation programmes to help people manage their conditions, and more support for people who have to move from an incapacity benefit to Jobseeker's Allowance. These all combine to create a wide ranging Choices Package for those on an incapacity benefit.

But this is not, and never will be, about pressurising sick people back to work against their will. We recognise that for those with the most severe conditions work is often unlikely to be an option. For this group we need to ensure that incapacity benefits continue to provide vital support.

For others it is about providing support and changing attitudes – both their own and others. We know that the majority of those who claim an incapacity benefit expect to work again but are often frustrated by a range of obstacles such as low confidence, poor skills and the belief that they should not work with the health condition they have. We want to ensure that these people get the support they need to make the right decision – getting back to work, in many cases, will actually improve recovery and well-being.

This must be a collective effort and we all have a part to play. Government, employers, trade unions and health professionals need to work together. We all need to change our perspective on people moving on to an incapacity benefit. We must view them not as people at the end of their working life but as people with a working future. This must include changing the name of the benefit when we have the legislative opportunity to do so. 'Incapacity' benefit is too negative. It is a by-product of a system that has focused too much on what people can't do rather than what they can. Those claiming incapacity benefits will, I believe, respond to such a focus.

Of course, we always recognise that there is a continual need for improvement and we would welcome your responses on these reforms to help us refine and shape our proposals.

A handwritten signature in black ink that reads "Andrew Smith". The signature is written in a cursive, flowing style.

**Rt Hon Andrew Smith**  
**Secretary of State for Work and Pensions**  
**November 2002**



## *Pathways to work – helping people into employment*

### Background

Work is an integral part of most adult lives. The ability to participate in productive activity contributes significantly to both physical and psychological well being. The range of potential negative consequences from being out of work extends well beyond the loss of financial rewards. It often includes loss of a role, social contact, daily routine, feelings of participation, and self-esteem and self worth.

But currently in the UK there are 2.7 million people of working age receiving an incapacity benefit; and well over three-quarters of a million of these would like to work. Almost all of the 700,000 people moving onto the benefit each year expect to return to work in due course. For most, there is nothing about their health condition that makes this aspiration unrealistic.

Nonetheless, significant numbers will end up receiving an incapacity benefit for a very long time. We therefore need to do more to help people moving onto incapacity benefits with the potential for getting back to work. Failing to do so will have long-term consequences for the individual and their family, but also to the economy through the loss of skills, talent and opportunity and the public resources to pay people to be inactive.

Some unique opportunities are emerging to help address this problem:

- greater awareness of the real barriers to work;
- moves towards greater inclusion of people with illness or disability – for example disability discrimination legislation;
- creation of Jobcentre Plus as a single agency for handling work and benefit issues;
- emerging understanding of what needs to change and renewed focus on improving health services and benefit gateways; and
- the favourable state of the UK economy.

We therefore need to push forward and find out more about the most effective ways of ensuring we offer the right help to the right people at the right time. This is what *Pathways to work* is about.

### Content of the document

This consultation document sets out the Government's proposals for supporting people claiming an incapacity benefit. We would welcome comments from interested individuals and organisations (including welfare rights groups, organisations of and for people with a health problem or disability, those representing healthcare professionals or employers, and the wider research community) on our suggested way forward. The paper is set out as follows:

#### Part 1 – The case for change

**Chapter 1** sets out the **basis of the Government's welfare to work strategy** and explains how people on incapacity benefits have not yet fully shared in its success. It explores the reasons for the substantial increase in the numbers on the benefit and compares trends in this country with those of other developed countries.

**Chapter 2** sets out the **rationale for further change**. It looks at the main health conditions reported by people on these benefits and at people's expectations of getting back to work at the start of their claim. It explores how feasible a return to work should be for people coming onto this

benefit and identifies the key obstacles this group faces. In particular, it looks at the importance of non-health-related obstacles to work and how the process of inactivity worsens health and makes a return to work much less likely. It establishes some key principles around which any effective system must be designed and makes clear the range of stakeholders involved in effecting real change in this area.

## Part 2 – Giving people choices

**Chapter 3** looks at the **progress made since 1997** in extending more employment help to incapacity benefits claimants and in improving financial support for those with severe disabilities. It assesses the impact such measures have had so far in improving the proportion leaving benefits for work and identifies the key areas where the current systems of support can be further improved.

**Chapter 4** sets out **key features of the new system we wish to trial**, in particular:

- more skilled adviser support and help to return to work combined with action planning during the early stages of a claim; and
- easier access to the existing range of specialist employment programmes plus new work-focused rehabilitation programmes, offered jointly by Jobcentre Plus and local NHS providers.

These changes will enhance the opportunities available to people on incapacity benefits and create a 'Choices Package'.

**Chapter 5** describes how the new system will improve the **financial incentives for incapacity benefits recipients** both to seek work and to move into some form of employment. These changes will complement moves to build more of a work focus into the benefit. We propose to extend access to the Adviser Discretion Fund

and to establish a new return to work payment for those moving from an incapacity benefit to work. These changes will provide strong encouragement to make the transition into employment and to ensure the gains from working are much more visible than at present.

**Chapter 6** sets out how the new system will provide **early, tailored support for those having to move off incapacity benefits onto Jobseeker's Allowance (JSA)**. These measures will ensure specialist advice is available in drawing up reasonable return-to-work plans and that personalised help through the relevant JSA New Deal is immediately available.

**Chapter 7** explains the **important role General Practitioners and other healthcare professionals, employers, trade unions and the insurance industry have** in working together to keep people with health problems attached to the labour market. The clear aim must be to focus on each individual's long-term interests and improve the quality of support provided so that as many people as possible with the potential for getting back to work are actively managed to do so. We will disseminate to employers best practice on managing health at work and improve the accessibility of training and advice to healthcare professionals on fitness for work.

## Part 3 – Shaping change

**Chapter 8** explains how **interested readers/organisations can get involved** and contains a number of specific questions on which we would welcome views.

PART 1:  
The case for change





# 1 – The welfare to work agenda and people on incapacity benefits

## Chapter summary

- Our welfare to work strategy is proving to be a success for most groups but people claiming incapacity benefits have not shared in that success.
- Numbers on Incapacity Benefit have increased significantly over the last 20 years. Nearly half of those on it have been receiving it for at least 5 years.
- Reasons for the increase are complex, but dislocation from the labour market because of industrial re-structuring and recession is an important contributory factor.
- Most of the developed world has faced similar trends over the same period.
- Our commitment to creating a fairer, more inclusive society means we must do more to help this group participate in the labour market wherever that is possible.

## Opportunity to work

This Government has committed itself to the historic goal of full employment. We have put work at the very heart of our welfare reforms, yet also remained true to the principles of social justice which mean that a modern, civilised society must protect the most vulnerable within it. In short, work for those who can, security for those who can't.

At the heart of our welfare to work strategy have been the New Deals, Jobcentre Plus – providing a single work-focused point of access to benefits and return to work support – and tax credits to ensure that work pays.

Alongside a strong and stable economy, these reforms have delivered impressive results:

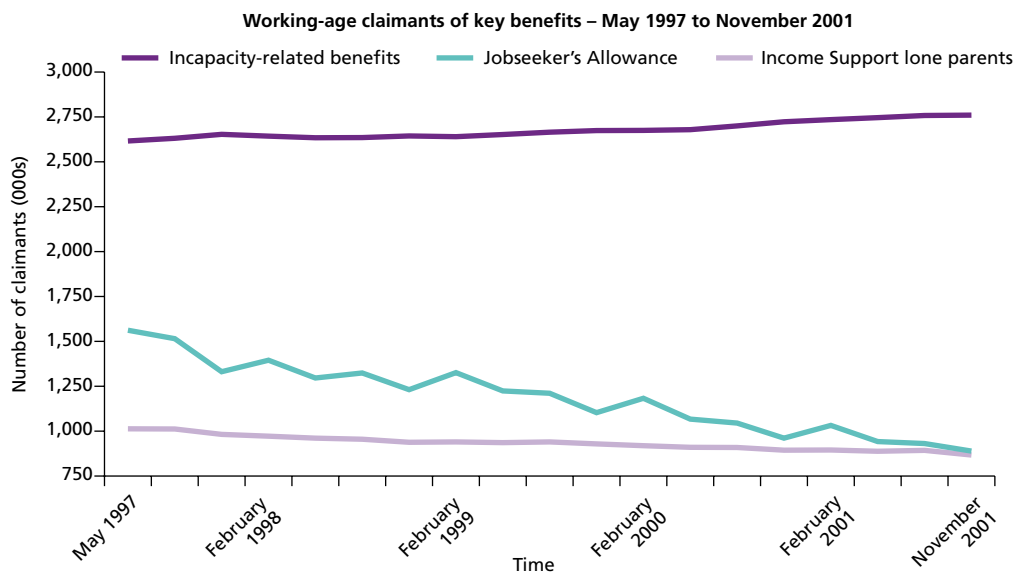
- a sustained fall in overall unemployment – well over a million more people in Britain are working today than five years ago; and the claimant unemployment count is at its lowest level since 1975;
- both long-term unemployment and long-term youth unemployment have fallen by 75 per cent since 1997. There are now just 5,500 young people who have been out of work and on benefit for 12 months or more; and

- there are nearly 900,000 lone parents in work, up nearly 200,000 since 1997. There are now 500,000 fewer children living in low income households.

But we need to do more. The creation of a single Department (the Department for Work and Pensions) covering all benefit claimants, gives us the framework to do that. Our significant progress in reducing both unemployment (numbers on Jobseeker's Allowance have fallen 45 per cent since 1997) and the number of lone parents on Income Support (15 per cent fewer) has not been matched by people with a health problem or disability. Figure 1 (overleaf) illustrates this.

The number of working-age people claiming incapacity benefits is now over 2.7 million. That is greater than the combined total of lone parents and unemployed people on benefit. About 7.5 per cent of the working-age population now receive these benefits. These numbers have more than trebled since the 1970s.

Figure 1: Trends in the numbers on key benefits since 1997

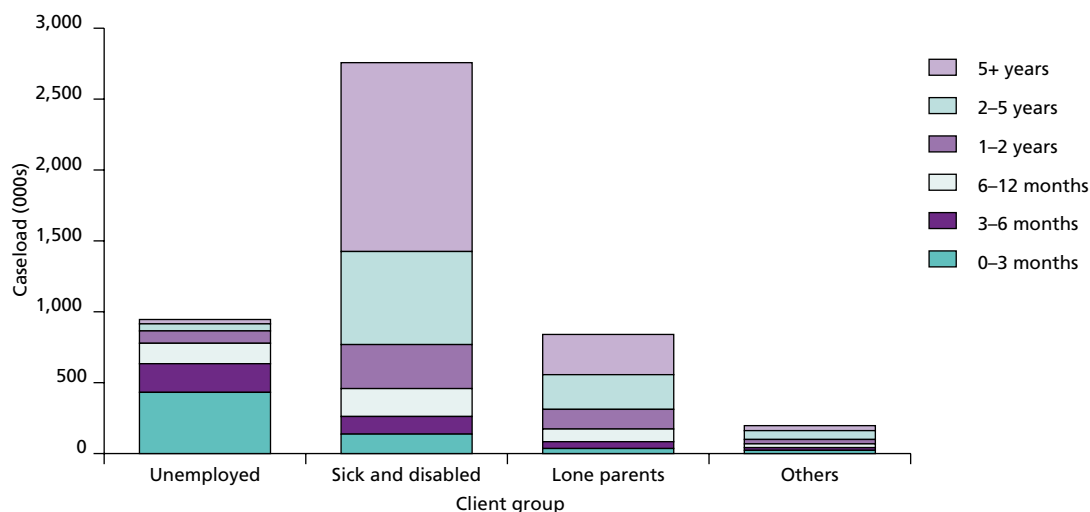


### What are incapacity benefits?

Incapacity benefits are benefits that give working-age people a replacement income when they become sick or disabled and stop working or looking for work as a result. There are two key benefits – depending on the level of National Insurance contributions paid, people may either be entitled to contributory *Incapacity Benefit* or income-related *Income Support*. Most people in employment receive Statutory Sick Pay for the first 28 weeks of incapacity and only then claim one of these benefits. Others can receive them immediately. The key difference between these benefits and Jobseeker's Allowance (the benefit for the unemployed) is that if the relevant medical test has been satisfied then there is no requirement to look for work in return for benefit. See *Annex A* for more details.

People on incapacity benefits are more likely to have been on benefit for a very long time compared to people on other benefits (Figure 2 opposite). Less than 5 per cent of the unemployed and 35 per cent of lone parents have been receiving benefit for over five years compared to nearly 50 per cent of those on an incapacity benefit. Just under half of the people on the benefit are aged 50 or over. In addition, outflow from benefit is very low – once a person has been on an incapacity benefits for 12 months, the average duration of their claim will be eight years.

Figure 2: Comparison of numbers claiming key benefits in different client groups with duration of claim



Source: Department for Work and Pensions Client Group Analysis – February 2002

### Why have the numbers of people on incapacity benefits increased?

In 1979, 690,000 people received Invalidity Benefit and Invalidity Pension (the forerunners to the current incapacity benefits). By February 2002 this number had more than trebled to 2.7 million. About 90 per cent of this increase occurred before the mid-1990s.

There has been no worsening of the health of the UK population to lead to such an increase. Most objective measures of health (such as life expectancy and morbidity rates) have shown notable improvements over this time. The modest increase in the numbers of people who say they have a limiting long-standing illness or disability (from around 15 per cent to 19 per cent of the working-age population<sup>1</sup>) reflects the greater social acceptability of acknowledging a health problem<sup>2</sup>. It is not enough to explain the large increases in the numbers on benefit.

The reasons for the increase in the numbers are complex. The balance between individual factors is far from clear and varies across different parts of the country.

Nonetheless all the following have contributed to the rise:

- **Economic trends** – in particular industrial re-structuring and the cycle of boom and bust in the UK economy led to many people losing all contact with the labour market, especially older workers and those with lower skills;
- **Benefit administration** – cuts in administrative expenditure during the '80s and '90s meant a decline in the amount of contact and support a person on incapacity benefits would receive. For those on Unemployment Benefit the opposite applied, with increasing levels of contact and active help to get back to work. For some unemployed people with health conditions this made incapacity benefits a more attractive alternative; and
- **Demographic changes** – an ageing population means higher numbers in their 50s and 60s. Older people are more likely to have health problems and claim incapacity benefits.

There are two key impacts of this process that are particularly worth noting. First, the significant number of older people on an

incapacity benefit. Around 75 per cent of those between 50 and state pension age on benefit are on an incapacity benefit. Many will have first claimed the benefit in their 50s, others will have claimed before that point but still be receiving the benefit several years later. Without support, much of this group will effectively have moved into early retirement, leaving themselves at much greater risk of ongoing financial insecurity. The Government's *Winning the Generation Game*<sup>3</sup> Report in April 2000 estimated the total cost to the economy of the drop in work rates for the over-50s since 1979 at around £16 billion each year.

Another highly visible impact has been the growth of a number of communities with a particularly high reliance on these benefits. These areas share similar attributes. For example, they were affected by the impact of the re-structuring of industry in the '80s and '90s. Although most workers made redundant through this process initially looked for work, many were in job blackspots. In addition, the help received did not stop many of them losing touch with the labour market and drifting onto incapacity benefits as a result. This has led

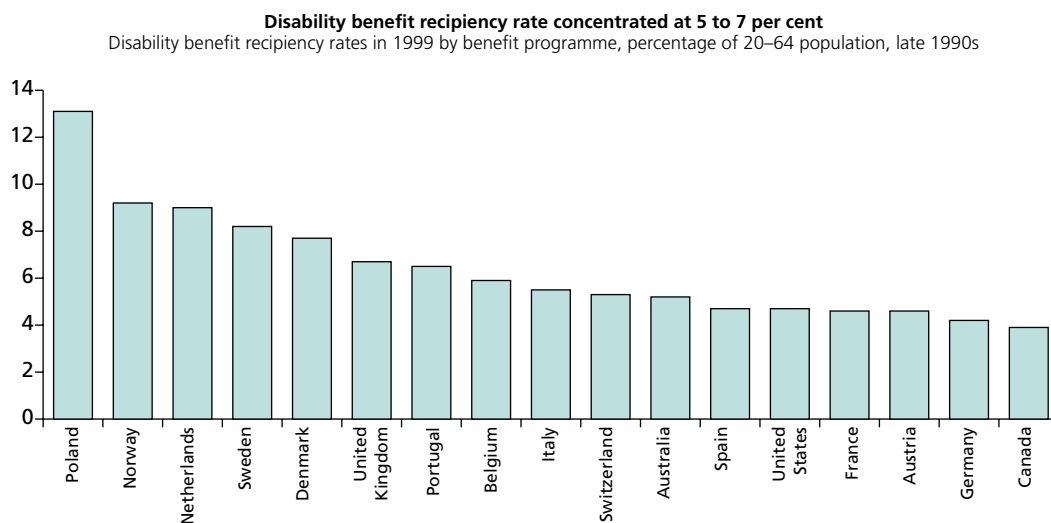
to a few specific areas within different parts of the country where, despite economic improvements, there remain high and sustained levels of recipients (for example parts of the North West and South Wales). In the 10 local authorities with the highest concentrations, 15 per cent of the working-age population are on these benefits.

The proportion of the 2.7 million people on these benefits who live in these areas is quite small – less than 9 per cent of the total number. Nonetheless such areas do cause considerable concern, as there appears to be a cross-generational impact with much higher than expected levels of younger workers making a claim to an incapacity benefit in these areas as well.

### How does this compare with other developed countries?

This increase in the number of people on incapacity-type benefits has also been in evidence across Europe and beyond (see Figure 3). The UK is close to the Organisation for Economic Co-operation and Development (OECD) average with Northern European countries having slightly higher and other OECD countries (US, Australia)

Figure 3: Disability benefit receipt across the OECD<sup>4</sup>



Note: The rate is corrected for persons receiving both contributory and non-contributory benefits (except for Canada [unknown])

Source: OECD database on programmes for disabled persons, see Annex Table A1.2.

slightly lower proportions on benefit. In most countries, a higher proportion of the population are now out of work claiming these benefits than claiming unemployment benefits. The numbers leaving these benefits for work is very low in all countries.

## Conclusion

There has been a significant growth in the numbers of people on incapacity benefits in the UK and across most of the developed world. Numbers continue to increase and outflow rates from the benefits are very low, despite the generally favourable economic situation. Having such a significant proportion of the population firmly detached from the labour market is a worrying trend. We therefore need to look closely at what further steps are required to change this situation. Such action is likely to offer significant benefits to many of the individuals themselves, their families, the local community and the wider economy.



## 2 – The obstacles to work faced by people on incapacity benefits

### Chapter summary

- We need to do more to help those people on incapacity benefits with the potential for getting back to work.
- A person who gets an incapacity benefit is not necessarily incapable of working. Nearly all those moving onto the benefit expect to get back to work at some point.
- Most people on an incapacity benefit do not have the most severe health conditions or disabilities. The outlook for a return to work for this group should be good and work will also improve their physical and mental health.
- Despite their expectations, huge numbers do not manage to make the transition back. Most face a range of health- and non-health-related barriers to getting a job.
- This is not about forcing people into jobs or cutting benefit – but re-shaping and creating new partnerships across society to ensure people get the right help at the right time to get back to work

### Can anybody on incapacity benefits realistically do any work?

There is a common misapprehension that a person must be incapable of doing any work to get an incapacity benefit. However, to claim incapacity benefits and satisfy the Personal Capability Assessment (PCA, the main medical test underpinning the benefit – see Annex A) a person needs to show certain clear limitations in their personal capacities as a result of their condition (for example ability to walk, speak or interact with others).

The PCA therefore sets a level of incapacity at which it is felt unreasonable to **require** a person to seek work in return for benefit. It is not a level at which work is impossible. Indeed, trying to draw a reasonable and objective dividing line between people who cannot work at all and those who can work, is impossible. This is because capacity for work is a continuum and the demands of individual jobs varies widely. This means there is no fixed point that distinguishes those who can work from those who cannot. To reflect this we have developed the PCA further in some areas to incorporate a Capability Report (see Annex A) to provide information on the health-related capabilities a person still has to help

understand the broad areas of work they may still be capable of.

Many people currently claiming incapacity benefits are therefore capable of doing some form of work. In addition, there are currently over 3 million people in work with a long-term disability that substantially limits the kind or amount of work they can do. Some will have the same functional limitations reported by people on the benefit that would allow them to get an incapacity benefit if they weren't working.

### Most people moving onto incapacity benefits expect to get back to work

We also know that doing more to support potential returns to work fits with the expectations of most people in the early stages of a claim to an incapacity benefit. At this point, 90 per cent of people expect to get back to a job in due course<sup>5</sup>. But in practice, over 40 per cent of those claiming the benefit will not make that transition and will still be receiving it 12 months later. And once a person has been on benefit for a year their prospects for getting back to work are likely to be very poor, whatever health condition they report. **Once a person has been on an incapacity**

benefit for a year, they only have a one in five chance of returning to work within five years.

### Most people moving onto incapacity benefits do not report severe health conditions

The positive expectations of the clear majority of people when they first claim reflects the fact that most have relatively manageable health conditions with a good prospect of a return to work. For a small number, the benefit acts as a short-term sickness benefit payable because of, for example, mild infections, muscle sprains or strains, or a fractured wrist. Such people will be unable to work for only a short time, after which they are very likely to return to work or jobseeking. At the other extreme, a small proportion of new incapacity benefits recipients have very severe conditions such as paralysis (including, for example, tetraplegia), severe neurological conditions and advanced arthritis. People with these conditions who want to work will face very significant obstacles to doing so that are directly related to their health condition or disability.

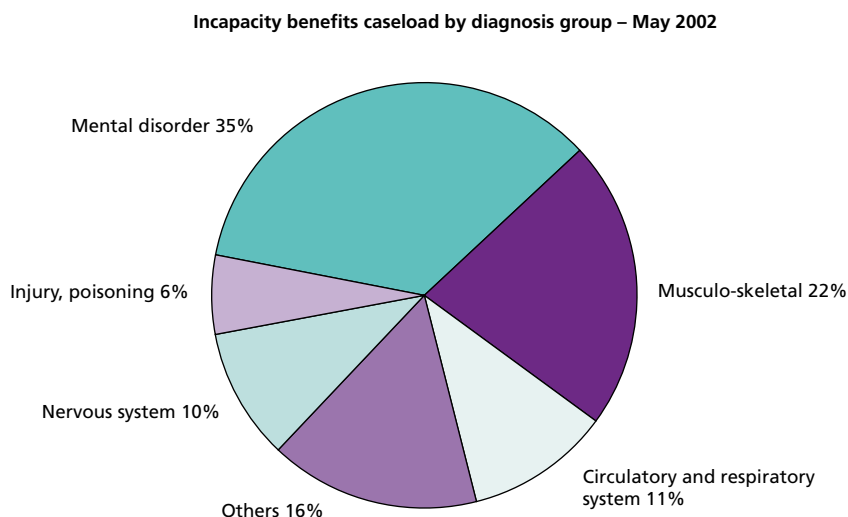
However, looking at people who have been on benefit for less than two years, the large

majority (around three-quarters), do not have severe conditions<sup>6</sup>. For many in this group the prospects of an eventual return to some form of employment, with the right forms of support, should be good. Figure 4 sets out the main conditions reported by clients.

Nearly two-thirds of incapacity benefits recipients receive benefits due to three main conditions:

- 35 per cent receive the benefit due to **mental/behavioural disorders**. The large majority of this group have depression, anxiety or other neuroses, with only a small number having conditions such as schizophrenia or severe learning disabilities;
- a further 22 per cent are affected by **musculo-skeletal disorders** – with the large majority having back/neck pain, rather than conditions such as severe arthritis; and
- 11 per cent have a **disorder of the heart or a circulatory or respiratory disorder** such as complications of high blood pressure, angina or chronic bronchitis, with only a small number having heart or lung disease that is severely and permanently limiting.

Figure 4: The reported conditions of incapacity benefits claimants<sup>7</sup>



By illustration, amongst the most severe conditions, 0.7 per cent of recipients have had a stroke, 0.2 per cent have tetraplegia, and 0.9 per cent have multiple sclerosis.

### **For most the outlook for a return to work should be good**

Very long-term benefit receipt and deterioration into chronic disability are not the inevitable consequences of the main health conditions reported by people on these benefits. Effective support and proper management at an early point would help people avoid these conditions becoming significant disabilities. For example<sup>8</sup>:

- the best clinical management for back pain is to continue an active life rather than waiting until the pain disappears completely. This will mean faster recovery and fewer long-term problems;
- an early return to work is now considered a major objective of cardiac rehabilitation for most people of working age and supportive of long-term recovery; and
- with appropriate treatment people with mental health problems can return to work – working will aid confidence, motivation and future health and is likely to be a key aim for individuals.

But significant numbers do stay on benefit for years and many do become more chronically disabled over time<sup>9</sup>.

This is not to belittle the difficulties that many people with less severe health problems experience in retaining or gaining employment. Some will end up on the benefit precisely because they and their employer were unable to arrange a return to work. There is evidence<sup>10</sup> that even minor health-related conditions can be an obstacle to successfully moving people back into work. It is also clear that for many people with health problems and disabilities employer attitudes remain an issue.

A breakdown of the main reported conditions shows, however, that significantly greater numbers who claim benefit may be able to get back to work. Far smaller numbers go back. This strongly suggests that there needs to be a fuller debate on what the obstacles faced by this group are and how better to address them. In particular we need clients, employers and healthcare professionals to help us understand the best ways of making a return to work a realistic expectation for this group.

### **Most people moving onto these benefits face a range of obstacles to getting back to work**

Incapacity benefits recipients perceive a range of obstacles to getting a job. These obstacles are often complex and varied as Figure 5 (overleaf) shows. This sets out the perceived obstacles faced by a sample of incapacity benefits recipients shortly after they first claimed (it excludes the 10 per cent who already think they will never get back to work)<sup>11</sup>. Although health problems are, not surprisingly, the most commonly mentioned obstacle, around 40 per cent did not mention health as an obstacle to them getting a job. This is backed up by other research<sup>12</sup>. What most individuals do report is a broad range of obstacles, including health difficulties, which are looked at in more detail in the next section and give us important pointers to the way the process of claiming incapacity benefits must be re-designed.

### **Obstacles to work – the longer a person is out of work the more their physical and mental health declines**

Although the outlook for a return to work should be good for significant numbers claiming benefit, many end up staying on for very long periods of time. For many, being inactive will worsen health and

*Figure 5: Percentage of incapacity benefits recipients mentioning particular obstacles to work*

Obstacles to work identified by incapacity benefits recipients	Looking for work	Would like to work – but not looking
<b>Health factors</b>		
I'm unlikely to get a job because of my health problems	34	59
<b>Finding work – availability of jobs</b>		
There aren't enough job opportunities locally for people like me	50	26
It's difficult to find the kind of work that would suit me	37	21
<b>Finding work – confidence and skills</b>		
My confidence about working is low	49	41
I haven't got enough qualifications and experience to find the right work	17	20
<b>Financial considerations</b>		
I have worries about managing financially until the first pay day	28	16
I have worries about managing financially while in work	18	13
I have worries about paying the rent or mortgage while in work	11	11
I think I would be worse off financially if I started work	13	10
I have worries about leaving benefit	15	11
<b>Discrimination</b>		
Other people's prejudices make it difficult for me to work	3	9
<b>Others</b>		
I couldn't afford the cost of transport to get to work	7	11
Travelling to work would be difficult	8	16
None of these	8	14
<b>Unweighted base</b>	<b>72</b>	<b>222</b>

Source: *Short-term effects of Voluntary Participation in ONE*, Department for Work and Pensions Research Report 126.

actually diminish the prospect of returning to work. The effects of inactivity on physical and mental health are well documented<sup>13</sup>. The Acheson Report<sup>14</sup> cited being out of work as a potentially major risk to health for the working-age population and their families. For the majority, being away from work has a significant adverse effect on both physical and mental health through:

- isolation, social exclusion and stigma;
- changing health-related behaviour;
- disruption to future work career; and
- trapping people on lower incomes than available through work.

People who are inactive because of poor health face similar risks. For many conditions, such as back pain and cardiac problems, inactivity will often make a health problem much worse over time<sup>15</sup>. Also, unless effective support to remain active is given in the early stages of depression,

people frequently accept the idea of being unemployable and become much harder to help<sup>16</sup>. For many older people on benefit these processes effectively lead to an acceptance of early retirement.

Best clinical practice therefore increasingly rejects both inactivity and prolonged rest as acceptable forms of treatment for the most common conditions reported on incapacity benefits (see page 13).

The NHS has a role to play in helping to keep people in work or helping them to return to work. However, although this clearly fits into best evidence-based practice<sup>17</sup>, it is still frequently not reflected in the clinical approach provided. This will leave many with understandable doubts about their abilities and a lack of necessary advice and guidance to help manage their condition. Where a person has been in this situation for a number of years the process

of declining health can make a return to work much more difficult.

**This means:**

- any system aiming to provide high-quality support needs to offer people early encouragement to avoid more chronic ill-health developing. At this point, a return to employment will be much more difficult;
- many people will need help and support to understand how their condition will impact on their ability to work and to recognise the positive effects work will have on their health; and
- healthcare professionals have an important role to play in supporting vocational goals as a key element of effective healthcare.

**Obstacles to work – people perceive no jobs are available or lack the confidence and skills to get them**

Many people making a claim to incapacity benefits are already at least partly detached from the labour market. This suggests that the process of moving across to an incapacity benefit may be influenced as much by declining confidence and

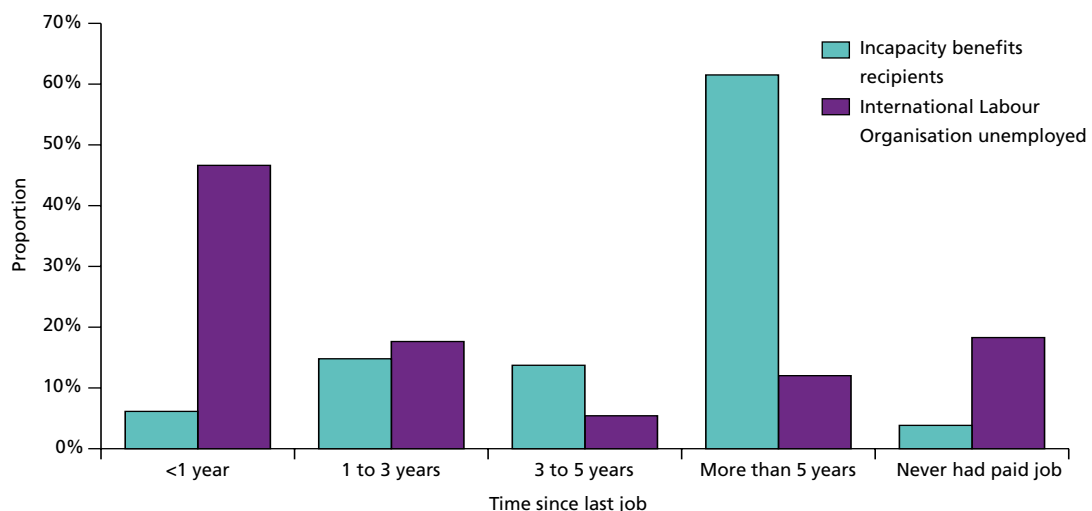
motivation as poor health. In the two years immediately before they claimed incapacity benefits<sup>18</sup> **a third of clients had not worked at all**. Looking at the caseload as a whole around 60 per cent of those on the benefit have not worked for more than 5 years (see Figure 6).

In addition, other processes reinforce that sense of detachment. For example, many incapacity benefits recipients fear they are too old to get a job. In addition, around 40 per cent of people on Incapacity Benefit have no formal qualifications (compared to 22 per cent of the unemployed), and around 15 per cent have basic literacy and numeracy problems. People with no educational qualifications find it harder to find and retain work. This puts them at a disadvantage, compared both to the population as a whole and to disabled people in work.

This combination of obstacles means that despite the fact that there are new and diverse jobs coming up all the time (over 2.5 million advertised each year in Jobcentres alone) across **all** parts of the country, many people claiming these benefits are:

- lacking in confidence about their employability and so less well motivated to seek work;

*Figure 6: Length of time since last job*



- unaware of the range of jobs that is available in most areas;
- suffering from a deterioration in skills which are often poor at the outset; and
- less attractive to employers because of their poor work history and health problems.

#### This means:

- many people flowing onto incapacity benefits face significant obstacles at least partly unconnected to their health, such as poor skills and low confidence and expectations. An effective system needs to do more to encourage take-up of the help that is already available rather than write people off as too ill to work

### Obstacles to work – financial incentives can be poor and the transition into work can be daunting

For those who want to find work, worries about the financial consequences of getting a job can be particularly heavy. We do already provide a range of financial incentives to incapacity benefits recipients to encourage a move. For example, for those eligible, the Disabled Person's Tax Credit (DPTC) combined with the National Minimum Wage guarantees

an income of £167 a week for a single person working 30 hours and £127 a week for part-time work of 16 hours.

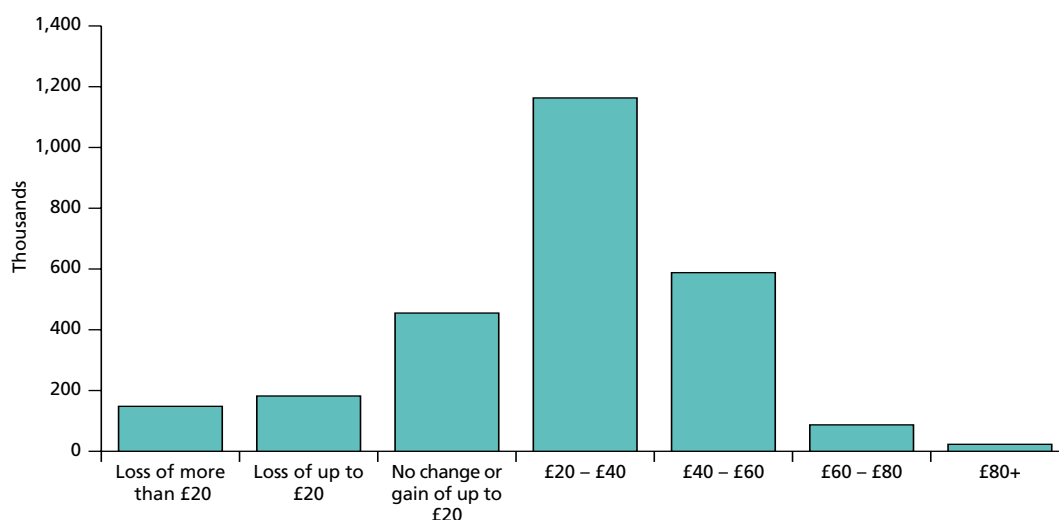
But although most incapacity benefits recipients would be better off financially from entering work, significant numbers would gain only a small amount, or in a small number of cases could even end up with less income by taking a job (see Figure 7).

What this means is that, at present, only about 25 per cent of people on an incapacity benefit would be at least £40 a week better off if they moved from incapacity benefits into work of 30 hours a week paid at the National Minimum Wage (although the introduction of the Working Tax Credit will improve this – see **Chapter 3**).

In addition, research shows us that people don't know what their actual in-work income might be because they don't know about the help already on offer<sup>19</sup>. Claimants also fear making the transition into work for other reasons, notably:

- fears that even looking for a job will put their benefit in doubt;

*Figure 7: Gains to be realised by incapacity benefits recipients moving into work of 30 hours a week at the National Minimum Wage*



- uncertainty over their ability to hold down any job and fears about giving up a reliable income stream;
- worries around whether they would be able to cope financially until they get their first pay; and
- lack of awareness that some benefits – such as Housing Benefit and Disability Living Allowance – remain payable in work<sup>20</sup>.

**This means:**

- there is scope to further improve the financial incentives available for people on incapacity benefits – particularly to support the transition back into work. The key is to maximise the visibility and simplicity of the incentives available and to reduce the uncertainty associated with a return to work.

### **Obstacles to work – reluctance by some employers to hire people with disabilities and older workers**

Many people with health problems and disabilities still face discrimination. By the end of 2000, over 200 disabled people had won discrimination cases at employment tribunals with many more agreeing settlements before the hearing. There is other evidence<sup>21</sup> to suggest that employers, particularly smaller ones without any occupational health provision, remain reluctant to employ or retain people with health problems or disabilities. This situation is particularly acute for people with any mental health difficulties<sup>22</sup>.

However, discriminatory treatment by employers is often due to a basic lack of understanding or the result of misconceptions about the cost of employing disabled people. Research carried out by the Disability Rights Commission<sup>23</sup> shows:

- only a third of firms which have made adjustments to help disabled people incurred any direct financial costs at all; and
- the most common adjustments relate to changes in working patterns or hours, and the organisation of work.

Many employers understand this now and are seeking to take advantage of the wealth of experience and knowledge that disabled employees can contribute.

Employer discrimination also works against people aged over 50 (many of whom have health conditions). This group constitutes nearly half of incapacity benefits recipients. Some employers still wrongly discriminate against recruiting, training and retaining older people, not least because of incorrect assumptions about the impact of ageing on sickness levels and commitment to a job.

**This means:**

- an important element to improve employment opportunities for people on incapacity benefits will be to raise awareness amongst employers of the advantages of employing those with the right skills who wish to get a job. This needs to be backed up with further enforceable rights for people with disabilities and new rights for older workers to address workplace discrimination.

### **Obstacles to work – the benefits system still does not do enough to encourage activity**

People who qualify for incapacity benefits do not have to look actively for work in return for those benefits. But many clients misunderstand this point believing that they must therefore do nothing to suggest they might be able to work. Also, some staff are unaware that a person who satisfies the medical assessment process may still be

capable of work<sup>24</sup>, reinforcing their detachment from the labour market. The very name of **incapacity** benefit and some of the terms used to describe different processes within it (such as the need to satisfy a 'test of incapacity for work') have reinforced this perception.

In addition, until recently, the benefits system had actively discouraged claimants from trying out work and, for many years, provided little or no help to incapacity benefits recipients who wished to find work. Claimants had very little contact with Jobcentres, and employment programmes were targeted on the unemployed rather than people on incapacity benefits or lone parents.

### This means:

- an effective benefits system must be based around the key premise that all people on benefit should be encouraged to stay focused on their expectations and helped back to work where that is possible.

### Conclusion: why we must take action

For most people moving on to an incapacity benefit, the prospects of a return to work should be good. But huge numbers do not get back to work and many will remain on benefit for significant periods of time.

For many older people the move across to these benefits will effectively signal the end of a working life. The current systems are therefore failing to help people realise their own expectations.

We therefore need to do more to help more people fulfil their aspirations. This is not about forcing people with health problems to take jobs or undervaluing the household or leisure activities a person may undertake. Rather it is about recognising that, for

many, work will be a positive and health-promoting outcome and a realistic possibility.

Given the obstacles to work faced by people moving onto the benefit there needs to be:

- **Early, ongoing support** to help people remain focused on capabilities and expectations before more chronic health problems develop;
- **Direct access to a comprehensive range of provision** that can address key health- and non-health-related obstacles; and
- **Decent, clear financial incentives** for more clients, particularly focused on supporting the initial steps back to work.

All within a context of improved employer attitudes and **comprehensive civil rights legislation for disabled people**.

We have already made significant moves in this direction (see Chapter 3) but there is more to do. This is a deep-rooted problem and will take time as well as sustained commitment and investment. It will also require a partnership across all sectors of society. The creation of the Department for Work and Pensions and Jobcentre Plus give us a clear opportunity to move this agenda forward. But we are not the only players – employers and healthcare professionals similarly need to make progress on allowing those with health problems and disabilities to remain in or return to work.

Part 2 of this document sets out our new approach. We invite readers and interested groups to comment on our suggested way forward, and we welcome input to the development of our strategy.

## PART 2: Giving people choices





## Chapter summary

- Since 1997 the Government has extended more employment help to people on incapacity benefits and greater financial support to those with the most significant disabilities.
- All the changes are essential building blocks in creating a more effective process for helping people back to work – however, the overall impact of the measures so far has been small.
- We now need to make further changes. The 2002 Spending Review has given the Department for Work and Pensions the funds to do this.

## Re-defining incapacity benefits

We want a much better deal for people on incapacity benefits with a new system that helps more of those who expect to get back to work realise their goal. As **Chapter 2** set out, some of the key elements of a good system are: early, ongoing support; direct access to a comprehensive range of provision; and decent, clear financial incentives.

## Where have we got to so far?

Since 1997, the Government has taken numerous steps to extend employment opportunities to the economically inactive. Before that time incapacity benefits recipients who wished to find work were offered virtually no help to get jobs. The changes that have been made since 1997 are essential building blocks that have enabled us to understand much more about people on these benefits and the obstacles they face to getting work. They will also allow us to take the next step forward. The key reforms are:

**Early ongoing support** – The roll-out of **Jobcentre Plus** (completion date March 2006) has merged the Employment Service and the working age parts of the Benefits Agency and will start to provide a work-focused service to all people making a claim to benefit. The practical implications of this change are that any person wanting to make a claim to an incapacity benefit is **required** to attend a one-off meeting with a personal adviser (known as a 'work-focused

interview'). The intention is to bring the clients into a jobs-focused environment and encourage job-seeking activity or take-up of training and to let people know about the financial support available. Any action beyond attending the interview is entirely voluntary although there will be mandatory follow-up interviews at least every three years thereafter.

**Direct access to a range of provision – New Deal for Disabled People** rolled out nationally from July 2001. It is the main employment programme available to people on incapacity benefits and is voluntary. People who are keen to seek work can access a network of job brokers from the public, private or voluntary sectors who aim to help them find and retain suitable employment and are paid according to their results. There are normally a number of competing job brokers in each area, and Jobcentre Plus personal advisers cannot at present directly refer interested clients to brokers. Consequently most people on the programme have to self-refer. Since July 2001 around 28,000 people have joined the programme (a very small proportion of the incapacity benefits caseload) and just over 6,000 have found a job. The **New Deal 50 plus** offers a range of practical back-to-work help to the over 50s, in addition to help from a personal adviser. There is an Employment Credit (EC) providing financial support for people moving into full- or part-time work, payable for up to a year. Successful claimants of the EC are also

eligible for a training grant of up to £1,500. Over 80,000 people have claimed the EC, and around 5,600 of these have moved into work from an incapacity benefit.

### **Jobcentre Plus employment programmes**

– people claiming incapacity benefits can also access a range of disability and mainstream employment programmes. Typically this is via a specialist Disability Employment Adviser. Such programmes offer help to people to address a range of obstacles, to put them in a much better situation to secure employment. However, the take-up amongst incapacity benefits recipients is very low, as few are aware of such programmes or are sufficiently encouraged to access them. The most relevant ones are:

- **basic skills** – Jobcentre Plus has a national model in place for helping clients address their basic skills needs. Clients found to have poor basic skills can be referred to appropriate full-time or part-time training provision under Jobcentre Plus or the Learning and Skills Council<sup>25</sup> to help improve their skills and acquire new qualifications;
- **wider workskill development** – through Work Based Learning for Adults; and
- **developing capability and confidence** – to overcome obstacles, combined with an exploration of alternative employment through short-term workplace trials, brought together under the Work Preparation banner.

**Better in-work financial support** – Disabled Person's Tax Credit (DPTC) was introduced in 1999 alongside Working Families' Tax Credit to ensure work paid for more people with disabilities on low incomes. In April 2002 just over 34,000 people were receiving it. From April 2003 there will be one tax credit for all people, the Working Tax Credit, which will provide additional help to support people moving into work with a disability that puts them at a disadvantage in getting a job. The minimum income for a single disabled person

working 30 hours a week will rise at this point from £167 to £189 a week, and for part-time work of 16 hours a week from £127 to £135 a week. These changes will further improve work incentives for people on incapacity benefits to move into work, increasing the proportion who would be more than £40 a week better off from around 25 per cent to over 50 per cent. In addition, Access to Work provides financial help to employers and individuals to meet the cost of adjustments or special aids resulting from a person's disability.

### **Measures to reduce age and disability discrimination**

– age discrimination is being tackled by actively promoting the standards in the Code of Practice on Age Diversity in Employment. Legislation will be introduced in due course to combat age discrimination in the workplace. The response from employers has already been positive. The number of employers using age criteria in recruitment has halved to 13 per cent since the Code of Practice was introduced.

### **Major achievements in taking forward rights for disabled people**

- Establishing the Disability Rights Commission in 2000.
- Beginning to implement the Special Educational Needs and Disability Act 2001.
- Bringing into force the Rail Vehicle Accessibility Regulations, improving access for disabled people on all new rail vehicles brought into service since January 1999.
- Bringing into force the Disability Discrimination Act's duties on service providers to make reasonable adjustments to their policies, practices and procedures in 1999 and legislating to implement the final duties in 2004 to help overcome physical barriers to accessing services.

- Bringing into force a new duty on licensed taxi drivers in England and Wales to carry guide, hearing and other prescribed assistance dogs without charge.

We are also committed to extending basic rights and opportunities for disabled people, as indicated in *Towards Inclusion* our response to the civil rights recommendations of the Disability Rights Task Force.

We have already taken significant steps, such as protecting disabled students and pupils. We will also legislate to ensure that small employers are covered by the DDA in 2004. At the same time we will end the current exemption of excluded occupations such as the police and barristers. This will bring well over a million small businesses and many millions more jobs under the scope of the DDA's employment provisions, ensuring access to a wider range of employment opportunities for disabled people. We are currently consulting separately on these and related changes to the DDA's employment provisions in the document *Equality and Diversity – The Way Ahead* and plan to lay draft regulations before Parliament in spring 2003.

There are other improvements to civil rights that we will make as soon as there is legislative time. For example, we will be introducing a duty on public bodies to promote equality of opportunity for disabled people and widening the scope of the DDA so it covers most functions of public bodies, not just those currently covered as services. We will also be issuing a consultation document on our proposals to extend the DDA's rights of access to transport and will make other transport improvements aimed at helping disabled people. These changes will assist people with mobility problems who find the lack of accessible transport is an obstacle to seeking employment.

We will start an awareness campaign next year to prepare small employers for the employment changes to the DDA in 2004. We will be emphasising that the duty to make reasonable adjustments often costs employers little or nothing but helps them ensure the most suitable person is in a job.

### Security for those who cannot work

Since 1997 the Government has also recognised the importance of doing more to deliver greater security for those with the most significant health-related obstacles to returning to work or those with severely disabled children. We have, therefore, improved provision for this group, especially where the household was already poor and will continue to look for opportunities to extend this help further.

#### Providing greater security

The Government has:

- introduced the Disability Income Guarantee – this helps nearly 130,000 of the poorest severely disabled people under 60 who are not working. It provides an income of at least £144 a week for an individual and £190 a week for a couple;
- improved the income of young people disabled before the age of 20 who have not had the opportunity to work and build up National Insurance contributions by, from April 2002, giving them up to £28.10 a week extra from Incapacity Benefit;
- extended the higher-rate mobility component of Disability Living Allowance to severely disabled 3- and 4-year-olds, providing extra help of nearly £40 a week for some 6,000 children and their families; and

- substantially increased the Disabled Child Premium in the last two Budgets, to £35.50 a week, benefiting around 80,000 children.

### What impact have these changes had on the number of people in receipt of incapacity benefits?

Many people on incapacity benefits have been able to get a job directly as a result of the help and financial support mentioned above. There have been improvements in the overall employment rate<sup>26</sup> of disabled people and the over 50s in recent years and a reduction in the numbers making a claim to incapacity benefits since the mid-1990s (in part because of greater economic stability). However, there is little evidence so far that the proportions flowing off incapacity benefits have increased or that the overall numbers receiving benefit have fallen as a result of these measures. This may be because a number of aspects of current arrangements need further development:

- an appropriate framework to fully engage with clients from the outset of their claim – one compulsory interview at the very start of a claim and no follow-up after up to three years may not be enough in many cases;
- personal adviser skills – to support this client group most effectively advisers may need a broader range of skills;
- referral arrangements between personal advisers and programmes – very little referral activity goes on and even where provision may be suitable, referrals may not be made. Often, only the most motivated end up with ongoing help;

- little coherence in the numerous overlapping programmes on offer – many appear to offer similar support and few are on the scale required to make a difference to the numbers on these benefits;
- significant gaps in provision – there is virtually no provision to support people to understand and manage their condition better; and
- despite the financial incentives available many people are uncertain whether they would be better off in work.

### Conclusion

To provide sufficient help to people on incapacity benefits who are capable of getting back to work we need to encourage and support more than just the most motivated. Most of the interventions and programmes we currently offer will be crucial in enabling us to move forward. However, we need to re-shape this support to give much greater focus to offering the right support at the right time. The Spending Review 2002 announced additional funds to test out new approaches.

# 4 – Making change – better pathways to work

## Chapter summary

- The proposed changes will be focused on six pilot areas. The key changes will:
  - create an entirely new framework of work-focused interviews within Jobcentre Plus for new claimants;
  - improve referral routes between these interviews and pre-existing employment support; and
  - establish new work-focused rehabilitation programmes in conjunction with the NHS.
- This will enable us to give people on benefit access to a much wider range of opportunities. It will create a Choices Package for incapacity benefits recipients in pilot areas as we have already done for lone parents.
- Existing benefit recipients will be able to access this provision – on a voluntary basis. In due course some recipients may also be required to attend work-focused interviews as well to ensure as many clients as possible are aware of the opportunities available.

To improve provision, we believe the best approach is to test out further significant changes. From around October 2003 we will pilot, in selected areas, improved pathways to work for people on incapacity benefits. We will aim to ensure that at least one of the pilot areas covers a region with particularly high concentrations of benefit recipients. Some of the new system builds on existing provision or arranges it in a different way to encourage take-up. Some elements are entirely new. But in its totality, this set of proposals offers people on incapacity benefits a much better, and more coherent, package of support and more choices than they have had in the past. We will need to understand the effectiveness of the measures and, where appropriate, roll them out across the country.

### Change 1 – a better framework for support in the first phase of a claim

#### A new work-focused interview regime

- Move the interview away from the initial point of claim.
- Increase the frequency of personal adviser support.
- Clients and advisers draw up mandatory action plans together.

- Co-ordinate the work-focused interview and personal capability assessments more closely.
- Create new teams of specialist advisers to work with people on incapacity benefits.

There may be some limitations to the current work-focused interview regime (such as infrequent interviews, lack of coverage of return to work issues<sup>27</sup>). However, the clear majority of new incapacity benefits claimants welcomed speaking to an adviser and many customers wanted more information about benefits, jobs and training. The new pilots will, therefore, include a more developed form of work-focused interviews. We will make **five major changes in pilot areas** focusing primarily on people making a new claim to benefit after the pilots start.

**First, we will shift the timing of the first interview.** For people who claim an incapacity benefit from the start of their illness we want to test whether waiting until about eight weeks after they make their claim would be more appropriate than having it when they first claim. This will:

- avoid an unnecessary interview for those people who get better quickly and get back to work or jobsearch;

- allow the claim to benefit to be fully processed before the interview so that the client is better able to focus on work; and
- provide a chance for a client's health to stabilise, making it easier to focus on possible work options.

For those who claim following a spell of Statutory Sick Pay, we will consider whether it is better to provide support more quickly, as the person will already have been out of work for up to six months. But we still want to get benefit up and running first to remove the worry of that initial transition onto an incapacity benefit.

### **Second, we want to increase the frequency of work-focused interviews**

to enable claimants to receive more on-going support. We know that without early, sustained contact the prospects of a person eventually getting back to work are much reduced and that chronic ill-health is more likely to develop. So we are proposing to require most new incapacity benefits claimants to have a series of four or five further interviews with a personal adviser, spaced over the early stage of the claim. As now, a benefit reduction will need to be applied where a person fails to show up for interviews without good cause. In setting the level of any reduction we will look closely at the levels that apply under existing work-focused interview legislation. After this sequence of interviews the current Jobcentre Plus regime of occasional mandatory follow-up interviews would apply.

We believe there are good reasons why these interviews should be mandatory rather than voluntary:

- people on an incapacity benefit very often lack knowledge and confidence to find out about the local labour market and the employment and financial support available. Sustained contact with personal advisers can be informative and stimulate confidence;
- many clients are understandably risk averse in light of concerns that considering work will throw their benefit entitlement into doubt – closer working with personal advisers can again address these concerns; and
- sustained support from a personal adviser makes clearer that we retain a belief that a person on an incapacity benefit can be supported back to work.

We therefore believe that further interviews would provide the best balance. We are not alone in this. The House of Commons Work and Pensions Select Committee recently recommended that all incapacity benefits claimants receive a further interview several weeks after the first<sup>28</sup>.

### **Content of work-focused interviews**

- Help people understand the nature of the benefit and the medical tests that underpin it.
- Explore options for work-focused activity, including: help with clarifying job goals, developing jobseeking and job retention skills; and encouraging transitions back to work through the new permitted work rules, or voluntary work.
- Encourage ongoing access to appropriate services, for example New Deal for Disabled People, New Deal 50 plus, other existing programmes, or new provision (see page 29).
- Identify where basic skills may be an issue and encourage take-up of screening and support.
- Explain the range of financial support available to help people move back to work.
- Encourage self-confidence and the maintenance of a positive stance towards work, reinforce the message that most individuals may well be able to return to some form of work.
- Facilitate and negotiate returns to work with a previous employer where possible.

- Give people who cannot initially prepare for a return to work greater opportunity to access help as their circumstances change.

We are looking to offer information and support to everyone flowing on to incapacity benefits. That said, we certainly do not expect every single client to need the ongoing sequence of work-focused interviews. **Those clients with the most severe disabilities** and those only likely to be on benefit for a short period **will not be required to attend the ongoing interviews** (although this help will still be available on a voluntary basis)<sup>29</sup>. We need to look at whether we need to develop further tools, to enable the right decisions to be made about who would benefit from the additional requirements. In addition advisers will retain the power to waive and postpone interviews where that is appropriate.

We think that the best way of determining whether a person has a severe disability may be whether they meet one of the Personal Capability Assessment (PCA) exempt criteria. The exempt criteria identify people with a health condition or disability that severely reduces their capabilities. As a result, such people do not need to undertake a PCA. The full exempt criteria are set out in the References<sup>30</sup>. However, they include:

- people with tetraplegia/paraplegia;
- people registered blind;
- people with a severe neurological/ muscle-wasting disease;
- people with a severe mental illness;
- people with a severe learning disability; and
- people with a terminal illness.

Such people would be automatically excluded from the ongoing interview requirement.

**Third, new clients and advisers will be expected to draw up an action plan together.** Such plans can be an important part of the process of establishing long-term goals. This plan will set out the steps the client feels able and willing to take to prepare for work or training, or stay in contact with the labour market. Completion of these agreements will be required as a part of participation in the interviews, but the detailed content will be decided jointly by the client and their adviser.

Despite these changes the basic approach for people claiming incapacity benefits remains the same. **No further action, beyond participation in the series of interviews and drawing up an action plan, will be obligatory.**

**Fourth,** we want to improve the framework of support in pilot areas **by co-ordinating the work-focused interviews and the PCA.** Until a decision has been made on whether a person is going to remain on an incapacity benefit or have their benefit terminated (depending on the outcome of the PCA) then many clients are unlikely to be able to focus much on preparing for a return to work. This medical test will often not be completed until over six months after a claim starts. We will therefore be working closely with Schlumberger Sema (who provide the medical advice that underpins the PCA) to ensure the process is undertaken on a timescale that directly supports our return to work activity. In particular we will be looking to access:

- earlier information on whether a person has a severe condition that exempts them from having to undertake the test at all;
- much quicker PCAs to resolve the ongoing benefit position of clients attending additional interviews. This will allow them to focus on longer-term options rather than, understandably, asserting their incapacities; and

- early advice on the remaining health-related capabilities a client has (through a capability report) and advice on who would benefit from the new rehabilitation programmes.

This framework of support will allow advisers to expect and encourage new clients to take some action to support their own return to work. Of course, many of those on benefit will not be able to do so or will choose not to, and will need to be supported over the long term. But we need to empower individuals and encourage those who may be capable of working to make a fully informed decision on this point. We will review the outcome of the Capability Report pilots under the PCA and develop this approach further to ensure the medical assessment process enables as clear a focus as possible on what a person can still do.

**Fifth**, Jobcentre Plus personal advisers already receive training to help them support incapacity benefits recipients. But if we want advisers to work closely with clients over a lengthy period we need to equip them with a broader mix of skills than is currently the case. So **we will be developing a new team of specialist advisers with existing expert Disability Employment Advisers at their core to work with people on these benefits.** In particular we will draw on both the training and management of:

- Disability Employment Advisers, expert in helping motivated disabled people find work and understanding the impact of an incapacity on work;
- Benefit Advisers, dealing regularly with incapacity benefits claimants and familiar with the processes within the benefits and the concerns raised by recipients; and
- New Deal Advisers, especially those dealing with the hardest-to-help unemployed groups and those

experienced in re-motivating those disconnected from the labour market.

We aim to take the knowledge and experience of these different groups of staff and develop a cadre of personal advisers who can provide much of the specialist support required and can work intensively with local employers to develop opportunities for their clients. We will involve outside experts and other organisations with experience of working with people like incapacity benefits recipients.

### Change 2 – improving referrals to disability employment programmes

We need to ensure that improvements to the way that Jobcentre Plus engages with people on incapacity benefits are accompanied by more specialised programmes of help that enable each individual to overcome the particular obstacles that stand in the way of their employment. **Annex B** sets out the range of employment programmes offered by Jobcentre Plus and the job broker support currently available through the New Deal for Disabled People.

Although in many cases these arrangements have worked well (see case study opposite), we believe they can be improved over time. At present the programmes lack easy referral arrangements, often have different eligibility requirements, and are not always easy to understand. Also, they are generally directed at people with disabilities whichever benefit they are on. We know that significant proportions of those on incapacity benefits do not perceive themselves as ‘disabled’<sup>31</sup> and are therefore unlikely to see disability programmes as relevant to their needs. As a result, only a very small minority of recipients consider using these programmes.

Through these pilots we will start to understand more about what a suitable range of intensive programmes might look like. Our aim will be to provide a simple coherent regime, administered by Jobcentre Plus, that both clients and employers can understand. We see the personal advisers handling the work-focused interviews as being at the centre of this regime. Their aim will be to encourage and point clients towards the differing elements of specialist and mainstream provision where that is appropriate. We will also look to ensure there is much wider identification of basic skills problems through screening and referral to appropriate support.

Our view is that the job broking currently available through the New Deal for Disabled People should be one of the central elements to integrate within this future regime. We need to look at ways of significantly improving the current referral arrangements to ensure a much clearer link between Jobcentre Plus advisers and those providing job broker services. However, in doing so we want to continue to harness the innovation and stimulus from successful private, voluntary and public sector organisations currently providing services and to encourage others currently operating with success under different welfare-to-work initiatives.

Other welfare-to-work programmes currently focused on the long-term unemployed, such as Employment Zones, may also provide useful evidence on alternative funding models and other methods for assisting those with more significant obstacles to working. We will ensure that lessons are learnt from these initiatives as well, as we move towards fresh contracts under a new regime.

#### **Case study: New Deal for Disabled People – delivering success**

After 37 years as a milkman, the idea of doing a different job seemed unthinkable to Mr B. Bronchitis had left him with long-term breathing problems which meant his daily milk round was out of the question. He was uncertain whether he would ever be able to work again.

Following a visit to a New Deal for Disabled People job broker, Mr B was able to consider the personal and employment skills that he could transfer into other work. He was also coached in interview skills and re-assured on some financial issues.

After his first interview he was offered a job as a security guard and was immediately £150 a week better off. Since then he has been promoted and earned further significant pay rises. Mr B says: “The New Deal for Disabled People team has turned my life around and my family are so proud of me.”

### **Change 3 – new employment programmes: rehabilitation support to help people manage their conditions**

One area where there is already a clear gap in programme support is around rehabilitation. Where high quality rehabilitation services are available they are understandably focused on supporting those with the most serious health problems or disabilities to live independently. In pilot areas we want to ensure support is also available to those with less serious conditions where the main focus needs to be on helping clients understand and assess the impact of their condition. To be most effective, such support needs to be available near the start of their period of incapacity

given that the chance of returning to activity and some form of work is much greater at this stage.

We therefore aim to establish a number of short-term programmes, delivering:

- work-focused support delivered by Jobcentre Plus; combined with
- health-focused rehabilitation delivered by, and building on best practice within, the NHS.

Such provision will be voluntary and can help those who want to get back to work but assume they are unable to do so as a result of their condition. In particular the programmes will offer:

- intensive support to understand their condition;
- help to understand its impact on their normal activities; and
- help to regain confidence, and support a return to some form of employment or training and as normal a life as possible.

We believe these programmes could well determine whether an individual is able to move back into some form of employment or drifts into inactivity and long-term benefit dependency.

Such an approach reflects current best clinical practice as mentioned in **Chapter 2**. For many people with back pain, mental health problems and cardio-vascular conditions, avoiding inactivity and planning for a return to normal life, including work, is seen as a key element of clinical management.

The programmes we establish in pilot areas will not replicate normal NHS clinical support for people on incapacity benefits. Rather these programmes would be new, with a clear focus on work and would be complementary to any clinical care already being provided by primary care and community services in pilot areas. The primary access route will be through Jobcentre Plus advisers.

The most effective UK (see case study on page 31) and international examples of such programmes have multi-disciplinary teams:

- behavioural interventions (provided by psychologists);
- coping with a health condition/disability (provided by counsellors, occupational therapists, physiotherapists); and
- jobs/employability training (provided by Disability Employment Advisers).

Taking work forward on these programmes will be done in liaison with relevant experts and local NHS providers, but would focus heavily on personal support rather than clinical intervention. For example, back pain programmes will probably need to focus on areas such as pain management, and a good sleeping guide, supported by one-to-one counselling and active job preparation. For cardio-vascular rehabilitation much of the content would be similar – counselling and job support for example – but might also cover areas such as lifestyle and diet advice, and exercise sessions.

These programmes will therefore be delivered jointly between Jobcentre Plus and local NHS providers (who will provide all the key input into the process from healthcare professionals). This will therefore require much closer working relationships between Jobcentre Plus and the NHS in pilot areas. It will also require close communication between those NHS staff delivering key elements of the programmes and participants' general practitioners. The programmes will build on the relationships that have been established through, for example, Health Action Zones and Joint Investment Plans in England and through Local Health Alliances in Wales.

The clear aim will be to establish programmes that cover at least the three main conditions reported by incapacity benefits claimants – non-severe mental health, cardiovascular and musculo-skeletal conditions.

### The 'Back to Work Programme' – a work-focused rehabilitation programme

Jobcentre Plus, in partnership with the NHS, has tested small-scale work-focused rehabilitation programmes in Salford and Bristol<sup>32</sup>. The programmes provided integrated support to enable people with chronic back pain to return to work. Group-based programmes (of between 8 to 12 people at a time) designed to overcome physical, psychological and vocational barriers to work were delivered in Salford and Bristol in partnership with the Salford Royal Hospital Trust.

The programmes utilised a multi-disciplinary team made up of employment advisers, psychologists and physiotherapists. The initial assessment process excluded those with more serious conditions (less than 2 per cent). The programmes then lasted 4–6 weeks and focused on areas such as pain management, exercise and a good sleeping guide, supported by one-to-one counselling and active job preparation.

The trial programme finished in 2001. Access was via Disability Employment Adviser referrals. Many of the participants (who were primarily incapacity benefits recipients) found work as a result of participation despite the fact that many had lost their job because of back pain.

The programme also demonstrated significant changes in other barriers to employment. In addition to the employment outcomes, clients were less depressed, less anxious and more able to undertake other daily activities. Plans are now well advanced to extend these programmes to two new locations in Scotland and Wales.

### Case study – focusing on abilities

Mr C had been a high specification welder until an injury at work prevented him from continuing in that trade. He had been out of work for seven months, although he had not worked for a year before he lost his job, and was in receipt of Incapacity Benefit. He had been very fearful of moving his back, believing that it would cause further damage. Through education, exercise and confronting his fear of activity through a progressive activity regime, he was confident that he could perform occupations that involved lifting, provided that it was not in an enclosed space or involved twisting. He applied for a job as a printing machine operator, was successful and now works full-time.

### Combining the changes – creating a Choices Package for people on incapacity benefits

In pilot areas we will, therefore, create much more coherent pathways of support for clients. Personal Advisers will be able to provide effective links from the initial claim onwards, through the mandatory Jobcentre Plus interviews back through to re-employment. Some clients may be supported back to work directly by their adviser, others may need more specialised support and will be referred to New Deal for Disabled People job brokers, existing Jobcentre Plus programmes, or the new rehabilitation provision we will be establishing. And substantial numbers will be able to take advantage of the new incentives described in **Chapter 5**. But in all cases advisers will be able to offer clients a wide range of opportunities to match their particular needs. In pilot areas we will therefore create a Choices Package –

offering a mixture of clearly signposted options for those who want to get back to work. Following evaluation of the pilots, we will look to roll out successful elements nationally to those incapacity benefits claimants who may benefit from more work-focused support, including rehabilitation programmes where they are considered appropriate.

### Combining the changes – a new approach – a new name

As **Chapter 2** made clear, being entitled to an incapacity benefit does not mean that a person is unable to do any sort of work. Changes the Government has made since 1997 reflect this. However, the legal name of the benefit, **Incapacity Benefit**, and some of the terms within it (such as the need to satisfy an **incapacity for work test**) carry connotations that can be misleading and unhelpful to the whole thrust of our efforts. The name has re-inforced a view amongst many claimants (and their family and friends) that they are, in fact, incapable of working. Too often personal advisers<sup>33</sup> and healthcare professionals have shared this view as well.

On a longer time scale, we therefore think a small, but important, part of the process of making change will be to remove the current name through legislation and replace it with a more accurate and less negative name, perhaps something like 'Capability Assessment Allowance'.

### What about existing incapacity benefits recipients?

This strategy focuses on people from the point they move onto incapacity benefits. But the majority of cases have been on the benefit for a long time. This group is already able to access, on a voluntary basis, help through the New Deal for Disabled People and other employment or training provision.

In addition, in the pilot areas, existing clients will, from the outset, be able to access the new work-focused rehabilitation programmes we are looking to put in place. They will also be able to take advantage of the existing and new financial incentives.

In due course, the Government will consider whether it would be sensible and feasible to extend a requirement to attend work-focused interviews to some existing recipients of incapacity benefits in pilot areas as well. But we want to have a clearer idea of whether the new arrangements are effective before we take any steps forward. We will also analyse further the evidence we have from the New Deal for Disabled People and other work to establish which existing claimants are most likely to be able to benefit.

### Conclusion

Different Organisation for Economic Co-operation and Development (OECD) nations have different systems of support for people with health conditions/disabilities and the balance between voluntary and mandatory provision varies (see box opposite). Nonetheless all nations are looking to improve their benefit systems to focus more clearly on a people's remaining capabilities and to provide appropriate services to facilitate a return to employment. The changes outlined throughout Part 2 of this document will encourage a clearer focus. It will also ensure we provide a clearer system of mutual obligations and early intervention to help reduce the numbers flowing unnecessarily into long-term benefit dependency. This will enable us to challenge the assumption that a life on state benefits is the best we can offer to people who have experienced illness or disability.

## Balance of provision in selected OECD countries

### Australia

Disability Support Pension can only be claimed after two years of sickness. The threshold for receiving the benefit is generally less stringent than the UK (although there are proposals for tightening in 2003). To receive this benefit claimants have to agree a 'Preparing for Work Agreement' including a requirement for them to undertake steps that will improve their capacity to work. These can include: employment assistance; basic skills; and personal support programmes. Centrelink, the Government's key employment centre, refers potential clients to providers. Services are delivered and access determined by the Commonwealth Rehabilitation provider.

### Denmark

The first 52 weeks of sickness or disability are covered by a sickness benefit. Whilst on this benefit clients can access appropriate support to allow a return to work such as work experience, job training, wage subsidies and supported employment. Individual employment plans are drawn up in co-operation with the client. After 52 weeks an Anticipatory Pension becomes payable. From 2003 this benefit will not be paid unless the employment plan has been implemented.

### Germany

People are eligible to receive Invalidity Pension if they are considered 50 per cent disabled. Rehabilitative interventions are open to all people with health problems/disabilities and are voluntary. Services cover: job preparation and placing services; training measures; temporary financial support in work; and psychological support.



# 5 – Making change – clearer incentives to try work

## Chapter summary

- Incapacity benefits recipients are concerned about security of income when they are considering making the transition back to work. The key is clear, easily understood incentives.
- We already have a range of incentives to help them move back to work. Many people are not aware of this help or may not be eligible.
- We want to make two further changes for this group in pilot areas:
  - first, more support to enable people moving on to incapacity benefits to compete effectively in the jobs market – allowing advisers to make an award of up to £300 to support return to work activities through the Adviser Discretion Fund; and
  - second, clearer returns from working through a new Return to Work Credit payable at £40 a week for 52 weeks to all those whose personal income would be below £15,000 a year to ensure a firm transition back to employment.

A key element in any improved package is clear, easily understood financial support. This allows a person to judge whether they would be able to cope financially and whether they would be better off moving into work. We must make sure that people see clear advantages to working.

Incapacity benefits claimants, like many others, are often concerned about maintaining security of income when making the transition into work/back to work. As part of the series of interviews, the personal adviser will clarify and explain the available existing incentive measures.

## Existing incentives

- Linking rules that help ensure that people with ongoing health conditions who move into work can return to benefit at the same rate should they find they are unable to continue working.
- Permitted Work rules that allow people on incapacity benefits to test out work of less than 16 hours a week for a fixed period whilst remaining on benefit.
- The Job Grant, providing a one-off cash payment of £100 to help incapacity benefits recipients who have been on the benefit for 12 months at the point they move into work.
- Transition benefits, such as the Housing Benefit and Mortgage Interest run-ons, to ease the shift from benefits to work.
- Disabled Person's Tax Credit (DPTC) and its replacement Working Tax Credit.

Changes since 1997 ensure the current system offers significantly more.

As mentioned in **Chapter 3** the creation of the Working Tax Credit from April 2003 means the minimum income for a single disabled person working 30 hours will be £189 a week. This will substantially improve financial incentives for this group. Nonetheless to further ease the transition back to work we propose making two additional changes in pilot areas.

### Extending the Adviser Discretion Fund

The Adviser Discretion Fund was introduced in July 2001 and gives personal advisers working as part of any of the New Deals, direct access to small sums of money. Advisers can access up to £300 to spend on anything that will help their client obtain a job or, if offered a job, to accept that offer. In the first year of operation, over 55,000 people who had received help have found work. The average payment made was just under £70.

Such payments build heavily on other initiatives such as the Jobseeker's Grant, Action Teams for Jobs and Employment Zones, all of which have shown how active and flexible use of small sums can make a real difference to helping people get jobs. Such sums might be used for:

- buying clothes for an interview;
- first month's travel costs; and
- work equipment (for example tools, overalls).

We want to ensure that the advantages of this approach are open to all clients claiming incapacity benefits rather than just those registered with a New Deal for Disabled People job broker. We will therefore **widen access to the Adviser Discretion Fund in pilot areas to allow Jobcentre Plus advisers handling this client group early access to funds of up to £300, subject to discretion, to support return to work activity.**

### Creating a new return to work credit

Under the New Deal 50 plus (a Jobcentre Plus programme helping people on benefit aged 50 and over find employment) clients entering work can receive a top-up payment, an 'Employment Credit', to help support and incentivise the transition back to work. This is paid for 52 weeks if their total personal income does not exceed £15,000 a year. This payment (which will form part of the Working Tax Credit structure from April 2003) has clearly improved the financial incentives for this group to return to work. The New Deal 50 plus has helped many people into work and over 75,000 have claimed the Employment Credit on making the move. Research<sup>34</sup> into the credit showed that:

- nearly 90 per cent of clients had found the payment very useful;
- 33 per cent said they would not have been able to afford to move into work without it; and
- the payment encouraged some people to take a job more quickly than would otherwise be the case and to stay in that job for longer.

We will now take direct steps to improve work incentives for all people moving back to work from incapacity benefits. In our pilot areas, **we propose a new return to work credit available to anyone leaving an incapacity benefit for paid work of at least 16 hours a week.** We believe it would be appropriate to set the payment at a rate of **£40 a week and make it payable for the first 52 weeks after a move from benefit into work.** As with the New Deal 50 plus credit we are likely to restrict the payment to those whose total personal income does not exceed £15,000 per year.

This credit would be available to anyone moving back into work after at least three

months on an incapacity benefit although for those who claim following 28 weeks of Statutory Sick Pay the credit will be available immediately.

Such a payment will be made through Jobcentre Plus offices rather than the tax credit system in pilot areas. Our advisers will ensure that all clients are made aware of this additional support so they can plan accordingly. In addition, given clients concerns about coping until their first pay packet we will ensure the credit is put into payment very quickly.

Such payments will not only be highly visible but will also make a significant difference to the financial incentives for this group to return to work. During the pilots it is likely they will be paid in addition to any sums payable through the Working Tax Credit.

This measure increases the numbers who would be at least £40 a week better off from work (30 hours plus) to over 90 per cent during the crucial first 12 months of work (see Figure 8). This, combined with the Working Tax Credit, will provide more in-work support than ever before for people moving back to work from an incapacity benefit.

### Conclusion

These changes will firmly complement our other welfare-to-work measures. Stronger pathways to work combined with clearer and more generous return-to-work payments should provide real assistance to many people. They are likely to be particularly welcomed by those who want to get back to work but fear the financial consequences of doing so.

*Figure 8: Gains to be realised by those moving into work from an incapacity benefit whilst the return-to-work credit is payable*

Gains from entering work for incapacity benefits caseload		Loss	Gain of up to £40	Gain over £40
Without credit	16 hours	49%	49%	3%
	30 hours	5%	40%	55%
With credit	16 hours	9%	44%	47%
	30 hours	2%	5%	92%



# 6 – Making change – helping those moving from incapacity benefits to Jobseeker’s Allowance

## Chapter summary

- To complement changes to support people moving onto incapacity benefits we need to provide more support for people who have to move off incapacity benefits onto Jobseeker’s Allowance (JSA) because of the Personal Capability Assessment (PCA).
- Many face residual health problems and other obstacles to work. Significant proportions become long-term unemployed or float back onto incapacity benefits. Few take up or are offered the specialist help available within JSA to move back to work.
- In our pilot areas we want to improve support and avoid the drift into long-term inactivity on JSA by making a number of changes:
  - first, ensuring all those who have to move across to JSA from incapacity benefits see an adviser with specialist skills in drawing up appropriate jobseeking goals;
  - second, ensuring all those who have to move across are automatically referred to the tailored help available through the relevant JSA New Deal without having to wait up to 18 months; and
  - third, removing the anomaly whereby some people end up without work-focused support on reduced rate Income Support rather than getting proper support on full rate JSA whilst awaiting an appeal against a PCA decision. We will also look to ensure presenting officers attend appeal hearings involving PCA issues.

## Better support for those moving off incapacity benefits onto JSA

Many clients who do not meet the PCA threshold (and whose claim to an incapacity benefit is then disallowed) move across to claim JSA. Around 35,000 people each year make this move.

We know that there is scope to provide more effective help for those ending up on JSA. Recent research<sup>35</sup> showed that many continue to have a health problem (albeit below the PCA threshold). Their condition also has some impact on the amount or type of work they could do as a result. Typically they also have less recent work experience, are older, have lower skills and suffer from negative employer perceptions. We also know that of those moving across to JSA:

- only 23 per cent will be in work 12–18 months later compared to about 95 per cent of the overall inflow into JSA;
- far fewer will have got a job than any other main group flowing onto JSA; and

- over 35 per cent will be back on incapacity benefits.

In addition, we know from **Chapter 2** that the health and confidence of those who remain on benefit will decline further the longer they are out of work. This makes them significantly harder to help.

JSA remains the appropriate benefit for this group, but it needs to be administered in a more effective way. There are skilled Disability Employment Advisers within Jobcentre Plus who are well placed to provide support. Despite this only about 20 per cent of those who move from incapacity benefits to JSA receive any specialist advice at present<sup>36</sup>. There is also scope within JSA to take account of a person’s health problems when determining what jobseeking requirements they need to fulfil.

In addition, the New Deal for Young People and the New Deal 25+ are targeted at those on JSA who are most in need of tailored help. Clients are referred onto these after either 6 or 18 months on JSA. They focus

on giving people the skills and confidence and motivation to find work. They have proved effective for people with health problems (with around a quarter of those placed into work reporting a health condition). People can access:

- skilled Disability Employment Advisers;
- work placements that take account of any health-based restrictions; and
- funds to ensure clients can participate fully in any programme activity.

Those disallowed incapacity benefits who move across to JSA are given access on a **voluntary** basis without a 6–18-month wait. However, very few exercise this right.

We therefore believe that the way JSA is administered can be improved. This will take two forms:

- people disallowed an incapacity benefit should **automatically see a Disability Employment Adviser or a specially trained Jobcentre Plus adviser to handle their claim to JSA, and draw up a Jobseeker's Agreement that reflects any health issues;** and
- they will be **automatically referred to the personal help available through the relevant JSA New Deal, without the normal wait of up to 18 months.**

We will also look beyond this group and ensure all Jobcentre Plus staff handling clients on JSA are fully aware of the existing flexibilities within JSA and the New Deals to ensure those with health problems are offered appropriate support to reduce the risk of a drift towards long-term incapacity.

### Appealing against PCA decisions

We hope that by providing personal, joined up support across benefits, we will lessen the anxiety that people feel at the prospect of leaving an incapacity benefit. We know that a small number of those who appeal against an incapacity benefit disallowance

decision (as a result of a PCA) claim reduced rate Income Support until their appeal is heard. Others move across to JSA in the interim. Claiming reduced rate Income Support means individuals end up on a lower benefit income than would be the case on JSA (about £10 a week less).

However, in pilot areas, it also means this group will be deprived for long periods of skilled, tailored help to re-establish themselves in work. This right to claim Income Support whilst awaiting the outcome of an appeal hearing is an unhelpful anomaly in the benefit system and, once we have the better provision in place, an unnecessary one.

We are therefore **minded to remove this anomaly in pilot areas where a more skilled and personalised service within JSA will be made available.** This would mean people would generally have to look to JSA rather than Income Support whilst their appeal was heard. On JSA they will be required to be available for, and actively seeking, work but may well be able to place some restrictions on their availability for work in line with their capabilities. As with those who currently choose this route rather than claiming reduced rate Income Support, claiming JSA in the meantime will not prejudice the outcome of any appeal. The appeal will be heard by a tribunal that is wholly independent of the Department for Work and Pensions.

To support this change we also want to do more to assist the tribunal. These are often amongst the most complicated cases for tribunals to decide. Therefore, if there are appeals against any decisions to withdraw incapacity benefits following a PCA in pilot areas, **Jobcentre Plus will aim to ensure that, unlike now, a presenting officer is available to attend the appeal hearing** in every appropriate case. This will help ensure that the tribunal receive a more thorough justification of the original PCA

decision than is currently the case and will ensure all relevant information is brought to the tribunal's attention.

## **Conclusion**

Other changes are needed to complement the changes outlined in earlier chapters. We need to avoid moving people with health problems from one benefit to another without being given the right help they need to find work. A more effective policy towards those who have to move to JSA from an incapacity benefit will help in this respect. This group continue to need a clear and strong focus on getting a job but also need more tailored advice in light of a clearer understanding of the real obstacles they continue to face.



# 7 – Building pathways to work – how other stakeholders can help

## Chapter summary

- Employers, trade unions, insurers and general practitioners (GPs) also have a key role to play in working together to keep people with health problems within the labour market. Our proposed changes will not succeed without them. We will ask the newly established Disability Employment Advisory Committee (DEAC) to advise on how to engage these key stakeholders in supporting the recruitment and retention of people with health problems and disabilities.
- The clear direction of change is to create an environment where as many employers as possible are actively managing health at work, effective occupational health support is accessible and staff are appropriately supported and encouraged to stay in, and to return to work, when health problems develop. This needs to be seen as good business sense. To support this process the Department for Work and Pensions will:
  - collate and disseminate a best practice guide to employers on effective management of health at work and rehabilitation of employees with health problems; and
  - create a simple aid for use by small- and medium-sized employers to facilitate the collection of sickness absence data and highlight where action to prevent work-related ill health may be required.
- Improving the quality of advice and fitness for work provided by GPs and others must be seen as an ongoing process. To support further change the Department for Work and Pensions will:
  - establish a website from early 2003 to provide online training and advice for all GPs; and
  - undertake research into the feasibility of extending responsibility for issuing sick certificates to other healthcare professionals (such as occupational therapists and community psychiatric nurses) to help ensure assessment of fitness for work is undertaken at all relevant stages.

Poor health and disability do not begin at the point where somebody claims an incapacity benefit. The changes Jobcentre Plus intends to make to incapacity benefits will not be effective unless other key stakeholders recognise the crucial role they have to play in this process. For example about a third of the people who end up on these benefits will already have been on Statutory Sick Pay and had their sickness absence managed through their employer for up to six months before Jobcentre Plus first gets involved. So:

- employers must deal effectively with the person's absence from work; and

- GPs must be enabled to co-ordinate and provide effective clinical management of the person's condition from the outset.

In addition, others such as trade unions, insurers and solicitors, and disability organisations themselves have an important role to play in supporting this approach. Like Jobcentre Plus, all parties should promote a focus on supporting people to return to work wherever that is possible. Like Jobcentre Plus many of the same broad solutions are likely to apply to these organisations – early active intervention, structured support and specialist input including, where necessary, rehabilitation.

Only when there is active management by employers, Jobcentre Plus and GPs combined with an effective anti-discrimination culture are we likely to achieve fundamental improvements in the recruitment and retention of people with health problems and disabilities.

We will be asking the newly established Disability Employment Advisory Committee (an independent advisory board offering guidance to Ministers on improving employment rates for disabled people) to report to us by around the middle of next year on the most effective way to engage employers and other key stakeholders in our agenda.

### **The challenge for employers – active management of health at work**

Larger employees are already under a duty not to discriminate against disabled job applicants and employees and to make reasonable adjustments to overcome workplace difficulties. We are strengthening and widening these duties as explained in **Chapter 3**. But employers also have a wider responsibility to proactively manage employees who become ill or disabled whilst in their employment. We already have a strong legal framework that imposes a duty on employers to assess the risks to employees' health and safety and take steps to reduce them. The Health and Safety Commission and its Executive ensure compliance (responsibility for these transferred across to the Department for Work and Pensions in summer 2002).

**But we also want to encourage more employers to move beyond this minimum. We seek an environment where health at work is actively managed, effective occupational health support is provided and staff are appropriately supported and**

### **encouraged to stay in, and to return to work, when health problems arise.**

This is a crucial staffing and productivity issue for employers themselves. In 2001 the Confederation of British Industry (CBI) estimated that the cost of sickness absence on businesses was £10.7 billion a year<sup>37</sup>. The *Self-reported Work-related Illness in 1995* survey estimated that as a result of work-related injuries and ill-health 24 million working days were lost and over 27,000 people were forced to give up work. As with incapacity benefits recipients, a large proportion (c.40 per cent) of the total number of days lost are accounted for by long-term absence (with the key conditions being musculo-skeletal disorders, and depression and stress). Where people leave work for an incapacity benefit, the business also incurs the often substantial costs of staff turnover. There is a marked difference in sickness rates between different sectors in the economy and different types of activity and there is also a significant difference between the best and worst performing companies in each sector. All of this strongly suggests that best practice does exist and focusing actively on managing and retaining staff who fall ill will benefit employers in a number of ways.

Recent research by the Association of British Insurers and the Trades Union Congress<sup>38</sup> looked at managing health at work and the provision of occupational health services. The key to success was seen as:

- the need for employers and staff to work together to develop health at work policies that respond to needs;
- union members raising awareness of the long-term benefits to individuals of managing a return to work; and
- a breaking down of the traditional view that managing sickness is just about forcing ill employees back to work.

The research also showed a clear link between businesses successfully managing sickness and:

- making returns to work and rehabilitation an active policy goal and supporting returns to work through adjustments in the workplace; and
- providing access to good quality occupational health facilities and workplace health initiatives.

Yet the research also showed that the provision of such support is at best patchy across different business sectors. Larger employers, in particular health, the utilities and public administration, emerged with the highest levels of good practice. Manufacturing, communications and finance sectors occupied the middle ground, with good practice being least common amongst smaller employers and, in particular, the construction sector.

Developing the level of occupational health provision across all businesses in the UK is crucial if we want to stop people unnecessarily leaving the workplace. This view is shared across business organisations and insurers as well. However, there is also a shared understanding that raising standards must be seen as a long-term objective.

#### **Best practice sickness management: Rolls-Royce**

Rolls-Royce plc is a global company; a key priority is keeping its skilled workforce 'happy, healthy and here'.

From 1999 to 2001 one site with about 5,000 employees achieved a drop in doctor-certificated sickness absence from 6.7 to 5.1 annual days per employee (almost 24 per cent) due to adopting an integrated approach to occupational health and promoting early rehabilitative interventions. Strong senior management commitment enabled development of the standard factory data management system to offer line managers the tools and information necessary to proactively manage health at work, such as by identifying frequent short absences and absences of greater than four weeks duration.

The Occupational Health Service also monitors the health of the workforce and individuals as well as support to management through independent access to the same data system. The learning cycle is completed through using the data to identify future training needs of managers, whose training programmes may be provided by the Occupational Health Service.

To take this long-term agenda forward the Deputy Prime Minister launched *Revitalising Health and Safety* in 2000. This was a strategic appraisal of health and safety setting challenging targets for reducing the level of work-related injury and ill health and reducing the number of days lost through illness and injury at work. Subsequent to this the Health and Safety Commission signalled its commitment to occupational health through:

- *Securing Health Together*, a long-term occupational health strategy for Great Britain;
- its Advisory Committee's report *Improving access to occupational health support*, which recommends ways of improving the availability of occupational health support especially to small- and medium-sized employers; and
- running the *Healthy Workplace Initiative* in conjunction with the Department of Health. This developed and supported a network of 30,000 businesses interested in improving their employees' health at work.

### Best practice sickness management: London Transport

Local ownership of the problem of irregular attendance helped to manage health at work for London Underground.

A new multidisciplinary team identified not only common, but also less obvious problems, such as maternity-related sickness and injuries resulting from assaults while on duty. In addition, remediable weaknesses were spotted, such as poor data collection on attendance patterns, lack of collaboration by occupational health, human resources and operational managers, and poor education of line managers on managing health at work.

By deriving solutions on the ground, the team built local ownership and support for remedies and gained the support of staff and workplace representatives, recognising that it is colleagues who often bear the brunt of the consequences of sickness absence.

Two important initiatives being undertaken are the Job Retention and Rehabilitation Pilots and NHS Plus. The Job Retention and

Rehabilitation Pilots will aim to establish the key elements of effective occupational health provision. They will operate from April 2003 and be run by both public and private sector providers. They will offer support to people who have just fallen ill, are still on Statutory Sick Pay but are at most risk of losing their job because of ill health. They will test a range of workplace-based tools to support employees to retain jobs. NHS Plus (launched in November 2001) allows the NHS to sell high quality occupational health services to small- and medium-sized employers. It is entrepreneurial in delivering such support (helplines, internet, peripatetic services) at no extra cost to the taxpayer and is available in well over 100 locations across the country.

### Best practice – the Rehabilitation Code of Best Practice for solicitors and insurers

The Bodily Injury Claims Management Group has compiled the Rehabilitation Code of Best Practice for personal injury claims. This recognises that solicitors should look to do more than simply obtain financial compensation on behalf of an injured client. This is on the basis that the client's long-term quality of life may be substantially improved if rehabilitation can also be undertaken, and as early as possible. Under the code a claimant's **solicitor** has a duty to consider whether immediate medical treatment may improve their present or future physical and mental well-being. The **insurer** is under a similar duty to make an early award if early intervention or rehabilitation would support long-term recovery. There are clear benefits to both the individual and the insurer under this approach as early intervention is likely to reduce the likelihood of long-term disability.

Our aim is to achieve long-term improvements in the availability and standard of occupational health support provided by employers in Great Britain. To develop this agenda coherently we need to spread best practice on which occupational health services are currently available and appear to be effective. We will therefore work closely with employers, the insurance industry and healthcare professionals to raise standards. To take this forward the Health and Safety Executive will:

- in conjunction with the Institute of Occupational Medicine, create a **straightforward aid for use by employers especially small- and medium-sized enterprises** which will **facilitate the collection of sickness absence data and help highlight areas where they may need to act to prevent work-related ill health and injury**; and
- in conjunction with Middlesex University Business School, **collate and disseminate a best practice guide to employers on the key known elements that will support effective management of health at work** and rehabilitation of employees with health problems. This should support employers, in partnership with their employees, in improving worker retention and reducing the costs of absence.

### Improving GPs' awareness of fitness for work

The other key party with a vital role to play in managing the flow onto these benefits is GPs. GPs provide advice to patients on fitness for work, recorded on statements such as Form Med 3. These statements may be passed by patients to an employer as evidence to support a claim to Statutory Sick Pay or used by Jobcentre Plus in managing initial access to incapacity benefits. Through

their clinical management of patients of working age and through their advice on fitness for work GPs play a key role in supporting the recovery and rehabilitation of people who fall ill or are injured.

We know that many GPs provide or initiate excellent clinical support and advice. But we also know that there is some way to go before all patients of working age receive treatment which encompasses the crucial outcome of job retention (this is particularly the case for conditions such as low back pain and mental health problems). Recent research<sup>39</sup> has shown that current areas for improvement include:

- GPs are not occupational health specialists, but few have sufficient knowledge of the basic issues around fitness for work and occupational health;
- when offering advice on fitness for work, and managing patients' expectations, GPs may not always encourage work retention and rehabilitation when this is appropriate, with significant long-term consequences; and
- offering quality advice on whether the individual is fit enough to return to work is made more complex by the need for GPs to maintain a positive relationship with their patient.

In addition, even where GPs have looked to ensure appropriate help is available they have been held back by either the absence of suitable NHS provision or the lengthy delays before it becomes available. This makes an eventual return to work much less likely even where appropriate clinical procedures already exist.

GPs are not the only healthcare professionals who might be involved in advising patients about fitness for work following illness or injury. Occupational health professionals have a particularly important role to play in developing best practice. Additionally, there

is a need to raise awareness amongst all healthcare professionals about the importance of work retention or resumption, where this is a possibility, as part of the holistic management of the patient.

We are already committed to helping improve understanding and professional practice in this area by:

- improving training for doctors and other healthcare professionals in the basics of assessing fitness for work and occupational medicine;
- working with the appropriate professional bodies to ensure that GP Registrars are assessed on their knowledge of fitness for work and medical certification before they become qualified GPs; and
- providing better and more easily accessible information to healthcare professionals on evidence-based recovery times to ensure certification does not continue unnecessarily.

In addition, we think it is appropriate to make two further changes to support progress in this area. **First**, to further improve the quality and accessibility of available information the **Department for Work and Pensions will establish a website from early 2003 for all GPs to provide online training and advice on sickness certification and fitness for work issues**. The website will offer interactive training materials that will allow GPs to show evidence on ongoing knowledge in this area for re-validation purposes.

**Second**, the Department for Work and Pensions has already committed to taking forward research to assess the impact of allowing practice nurses rather than just GPs to undertake certification<sup>40</sup>. We think it is appropriate to widen the scope of this research **to look at the feasibility of extending responsibility for issuing sick**

**certificates to other healthcare professionals such as community psychiatric nurses, occupational therapists and physiotherapists.**

This reflects the increasing role played by other healthcare professionals in clinical management of patients and could help ensure assessment of fitness for work is undertaken at all relevant stages.

In addition the substantial increase in NHS funding should allow for earlier referral to higher quality provision, helping to ensure clinical treatment is available at the right stage. The increased funding should mean much prompter treatment. In England this means that, by 2005:

- the maximum waiting time for an outpatient appointment will be three months; and
- the maximum waiting time for a hospital operation will be six months, falling to a maximum of three months by 2008.

# PART 3: Shaping change





This consultation paper describes a concerted new approach with a range of measures:

- taking active steps to keep people working where appropriate;
- ensuring that the process of claiming benefit does not encourage an assumption of complete or permanent incapacity;
- helping people focus more directly on taking steps to return to work;
- introducing wider pathways to work, providing advice, support and opportunity; and
- working with NHS service providers, employers and others.

We believe this approach will begin to help many more future and existing recipients of incapacity benefits to realise their aspirations and get back into work. But we must make sure. That is why we want to start pilots in some areas from around October 2003 (with further pilots starting in April 2004). Depending on decisions taken in the light of responses to this Green Paper, we would aim to bring forward any necessary changes to secondary legislation (on work-focused interviews primarily) sometime in summer 2003.

It is important to evaluate the proposed pilots robustly. We want to know which aspects of it work best, for whom, and how we can make it as effective as possible. Evidence from the pilots will be gathered before making decisions on any national extension.

### How can readers get involved?

We believe this is a coherent strategy that will help many more people find or retain some form of employment. But we want your views. For example:

- What is the best pattern of work-focused interviews?
- Does our definition of 'severely disabled' provide a sensible approach towards

excluding some people from the ongoing sequence of mandatory work-focused interviews?

- What key elements should the adviser training cover?
- How best can we encourage voluntary take-up of the programmes we already have available?
- Are there any parts of the Choices Package that are missing?
- How best can we ensure the new work-focused rehabilitation programmes provide effective support?
- If we wanted to rename Incapacity Benefit, what might a more suitable name be?

We welcome comments on these proposals. Please send any comments to:

Pathways to Work Team  
6th Floor Adelphi  
1–11 John Adam Street  
London WC2N 6HT

You can also respond using the following e-mail address:

[pathwaystowork@dwp.gsi.gov.uk](mailto:pathwaystowork@dwp.gsi.gov.uk)

We will need your comments by **10 February 2003**. If your response is on behalf of an organisation we would be grateful if you could make clear whom you represent. Responses will normally be available to the general public unless you specifically ask us to keep your views confidential.

This consultation exercise follows the Cabinet Office criteria on consultations. A full list of these criteria is at **Annex C**. If you have any comments, suggestions or complaints about the way in which this consultation exercise has been conducted please contact the Departmental Consultation Co-ordinator, Geoff Ashton, at:

5th Floor South  
Trevelyan Square  
Leeds LS1 6EB

e-mail: [geoff.ashton@dwp.gsi.gov.uk](mailto:geoff.ashton@dwp.gsi.gov.uk)





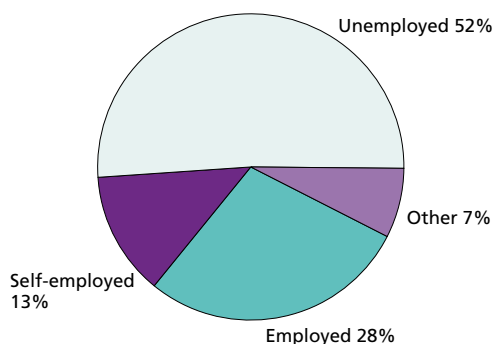


## What are the incapacity benefits?

Incapacity benefits is a generic term covering contributory Incapacity Benefit, Income Support (on the grounds of incapacity) and Severe Disablement Allowance.

All the benefits provide a replacement income to people below state pension age who have to stop working or looking for work as a result of sickness or disability. The key routes on are as follows:

*Figure 9: Routes onto incapacity benefits by previous employment status*



## How do you gain entitlement to an incapacity benefit?

People gain entitlement to one of the incapacity benefits depending on whether they have:

### a. paid enough National Insurance contributions on their earnings

If a person has paid or been credited with a minimum level of National Insurance contributions (NICs) and they satisfy the relevant medical test (see below) they will be entitled to contributory **Incapacity Benefit (IB)**.

If a person has not paid enough NICs but satisfies the relevant medical test, they can get National Insurance credits. If they have a low income, then they can claim **Income**

**Support (IS)** on the grounds of incapacity. People may also be able to get IS to top-up their IB where they have no other income.

If a person has not paid enough NICs, but has been treated as incapable of work for at least 196 days and that period of time began before the age of 20 (25 for those in education or training before age 20) they are now able to claim IB. Before April 2001 they would have claimed **Severe Disablement Allowance (SDA)** as would others who satisfy the 196-day test and were classified as 80 per cent disabled. SDA was abolished from April 2001 for new cases but existing recipients continue to receive it.

The 2.7 million recipients of all the incapacity benefits can be broken down as follows:

Incapacity Benefit only	1,195,000
Incapacity Benefit and Income Support	310,000
National Insurance credits only	115,000
National Insurance credits and Income Support	710,000
Severe Disablement Allowance	315,000
Income Support for disabled people	110,000

### b. and satisfied the relevant medical test

There are two different tests of incapacity that apply in different circumstances: the **Own Occupation Test** and the **Personal Capability Assessment**.

People who have been working recently need to satisfy the **Own Occupation Test**. This is a test that looks at whether ill health or disability stops a person from doing their **normal job** (with adjustments where necessary). A certificate from a medical practitioner, usually the person's GP, is normally sufficient to satisfy this test.

Employees need to satisfy an Own Occupation Test to get Statutory Sick Pay (SSP). SSP is paid for up to 28 weeks. However, there are some who have been in employment who are able to claim IB straightaway because they cannot get SSP. This group is made up of the self-employed, employed earners getting less than £75 per week, and people who have only recently become unemployed or whose contracts ended while they were sick. This group need to satisfy the Own Occupation Test for their first 28 weeks on benefit.

After 28 weeks on an incapacity benefit the groups affected by the Own Occupation Test are required to satisfy a different test, the **Personal Capability Assessment** (PCA). All other clients are required to satisfy the PCA from the outset of their claim. This includes those who have been unemployed or otherwise out of work and those moving across after 28 weeks on SSP.

The PCA (previously known as the 'All Work Test') is the medical test which is used to decide entitlement to longer-term state incapacity benefits. In contrast to the own occupation test, it looks beyond ability to perform the normal occupation to look at the extent to which a person's condition affects their ability to do a range of everyday work-related activities covering:

- physical functions such as walking, bending and kneeling, sitting in a chair;
- sensory functions such as ability to speak, hear or see; and
- mental functions such as interacting with others and coping with pressure.

Approved doctors working on behalf of the Department for Work and Pensions assess the extent to which a person's health condition impairs their ability to perform any of these key activities. A person satisfies the PCA if their ability to perform any **individual** activity is seriously curtailed (for example they cannot walk more than 50

metres without stopping, they cannot turn the pages of a book). Alternatively the PCA can be satisfied if there is a lesser degree of impairment **across a number of activities** (for example a person cannot stand up without holding onto something and cannot see well enough to recognise someone at 15 metres). It can also take account of the combined effect of mental and physical health problems.

Importantly, the PCA is not a test that distinguishes between people who can and cannot work. Rather it draws a line between people who should not be expected to seek work in return for benefit (those satisfying the PCA who stay on IB) and those who can be expected to do so (who need to move back to work or claim Jobseeker's Allowance).

Around 20–25 per cent of people on IB have very severe medical problems and are completely exempt from the PCA process. This group includes, for example, those who are already in receipt of Disability Living Allowance (DLA) highest rate care, those with terminal illnesses, and those with severe conditions like tetraplegia, chronic degenerative disease and schizophrenia.

The PCA process requires the collection of evidence to inform the decision-making process and will involve some or all of:

- a request for information from the doctor issuing sickness certificates;
- in most cases, the completion of a detailed questionnaire by the customer about the impact of their condition on the work-related activities;
- consideration of the paper evidence by an approved doctor to decide whether the customer's self-assessment is supported by the medical evidence (paper scrutiny); and
- in about a third of cases, where further evidence is required, a face-to-face medical examination with an approved doctor.

In certain parts of the country, approved doctors completing face-to-face medical examinations also complete a Capability Report. This Report contains additional information unrelated to PCA entitlement issues; it identifies the remaining work-related capabilities an individual has and provides advice on possible workplace adjustments. This Report is sent to the person's personal adviser and is used to focus discussions about returning to work.

Approved doctors provide medical advice in relation to the PCA to a Jobcentre Plus decision-maker who makes the final decision on benefit entitlement. Because of the need to collect sufficient evidence, the entire PCA process can take some time to complete. In the meantime, incapacity benefits can be put into payment supported by evidence from the patient's own doctor.

Where a person does satisfy the test, a date will be set for a further PCA to identify whether a person's condition has improved. Usually this is at an interval of between 3 and 18 months, depending when a change might be expected. Even where significant change is unlikely, cases need to be checked periodically. Procedures were standardised in May 2001 so that all cases going through the PCA are scheduled for consideration of a further test at least after 3 or 5 years – except for a small number of people with severe conditions where this would clearly be inappropriate.

### Rates of payment

There are three rates of IB which vary depending on how long the person has spent on the benefit, adding in any time spent on SSP:

- for the first 28 weeks – £53.50 a week (this is called IB short-term lower rate);
- from weeks 29–52 – £63.25 a week (this is called short-term higher rate and is the same amount as SSP); and

- from week 52 onwards – £70.95 a week (this is called the long-term rate).

In addition amounts can be payable where the person claiming has an adult dependant (that is a partner caring for the person's child or a spouse aged 60 or over). This amounts to £33.10 a week (more once a person is on long-term IB). Further amounts are payable for dependent children. However, these will be abolished for new customers from April 2003 when the Working Tax Credit and Child Tax Credit are introduced.

Where people receive IS rather than IB, the standard amount for a single person is £53.95 a week. A disability premium of £23.00 a week is added after 52 weeks of incapacity (or before that in some cases). Further amounts can be payable where the person claiming has other adults or children living in the same household. Both IB and IS remain payable until a decision is made that a person no longer satisfies any of the key entitlement conditions.

In addition other benefits can be paid alongside incapacity benefits such as DLA. Some 570,000 people on an incapacity benefit also get DLA. DLA makes a contribution towards the extra costs incurred by disabled people under the age of 65. It has a care component payable at three different rates and a mobility component payable at two different rates. In addition other benefits such as Industrial Injuries Disablement Benefit can be payable.

### Total expenditure

Expenditure on these benefits has increased significantly over the last 20 years. In 1979/80 expenditure on Invalidity Benefit was £3 billion in 2002/03 prices. The current expenditure on the modern day equivalents, IB short-term higher rate and IB long-term rate is £6.5 billion. Overall expenditure on incapacity benefits (including, for example,

Income Support on the grounds of incapacity) is currently over £16 billion year. Current figures for expenditure on lone parents is £8 billion and £4 billion for the unemployed.

## Work-focused help for sick and disabled clients

### a) Advice and support

**Jobcentre Plus:** Jobcentre Plus is a service for all people of working age who are looking for work or claiming benefits. All clients will need to have a work-focused interview with a personal adviser in order to get entitlement to benefit. It will give people the help and support they need to find work and become independent. Jobcentre Plus will provide a high quality service to employers, helping them find the right people to fill their jobs, quickly and successfully. Jobcentre Plus brings together the Employment Service, which ran Jobcentres, and those parts of the Benefits Agency that provided services for people of working age.

Within Jobcentre Plus, there are two main types of adviser providing support:

- **Personal Advisers:** Most people claiming an incapacity benefit in Jobcentre Plus are assisted by Jobcentre Plus advisers. If the disability or health condition isn't causing any particular difficulties in finding or keeping employment, the Jobcentre Plus adviser will be able to give the client appropriate advice and guidance; and
- **Disability Employment Advisers (DEAs):** DEAs provide support to disabled people who are having difficulty in getting a job because of their disability, and also to employed people who are concerned about losing their job because of a disability.

Within Jobcentre Plus there are a number of employment programmes open to people on incapacity benefits:

- **New Deal for Disabled People (NDDP):** An initiative to help people with incapacity, illness or a disability return to work. NDDP job brokers will

provide help with looking for a job and any support or training that is needed. Help is completely free and the programme is voluntary. NDDP also aims to help people to keep jobs they may be at risk of losing as a result of a disability or long-term illness;

- **New Deal 50 plus:** A voluntary scheme in which a personal adviser offers help and support in finding a job and may offer training to help increase ability to find a job. If the client goes into full-time work, expected to last a minimum of five weeks, a £60 a week tax free employment credit is payable (£40 a week for part-time work) for up to 52 weeks. An in-work training grant, of up to £750, is available once work has started. Available if the client is aged 50 and over and has been receiving, and is in receipt of, any of the main benefits including an incapacity benefit;
- **Work Based Learning for Adults (WBLA) (Training for Work in Scotland):** This is a voluntary training programme open to jobless people aged 25 and over on Jobseeker's Allowance (JSA) and a range of other benefits, including an incapacity benefit. Main eligibility is six months or more out of work, but a number of groups, including people with disabilities, can enter the programme earlier. Some 18–24-year-olds are eligible, including participants in NDDP in receipt of an incapacity benefit. WBLA is delivered by Jobcentre Plus in England, Education and Learning Wales (ELWa) in Wales and Local Enterprise Companies in Scotland;
- **Work Preparation (Employment Rehabilitation):** An individually tailored programme designed to help disabled people, or those with health conditions, return to work following a long period of sickness or unemployment;

- **Job Introduction Scheme:** A grant paid to an employer for the first few weeks in a job, helping to pay towards wages or other employment costs;
  - **WORKSTEP:** WORKSTEP provides supported job opportunities for disabled people facing more complex employment barriers;
  - **Access to Work:** Advice that can help disabled people and their employers overcome work-related obstacles resulting from disability. It can include an assessment of the clients' needs and whether Access to Work is appropriate for them. It can provide details of grants that may be available (through Jobcentre Plus) towards any extra employment costs that result from disability;
  - **Basic Skills & English:** Pre-vocational training available for people who need extra help before they start job-related training. Also available for individuals where English is not their first language; and
  - **Action Teams for Jobs:** Initiative where additional help is targeted at 40 of the most deprived areas in the country, those suffering low levels of employment and high claimant rates. Personal advisers work with disadvantaged clients, due to neighbourhood or ethnic reasons, to encourage and support the motivation and skills that may be required for them to obtain work. 25 teams are Jobcentre Plus-led and 15 sited in Employment Zone areas. The Teams are able to help all jobless people of working age regardless of what, if any, benefit they may be claiming. Initiative extended to October 2004 with more areas to be included. Participation is voluntary.
- b) Benefit flexibilities/work incentives**
- **52-Week Linking Rule:** Available for clients who leave an incapacity benefit to move into work or training for work and who reclaim the benefit within a 52-week period. The client will re-qualify for the same level of benefit without having to serve a fresh qualifying period.
  - **104-Week Linking Rule:** Available for clients who leave an incapacity benefit to move into work or training for work and who reclaim the benefit within a 104-week period. The client will re-qualify for the same level of benefit without having to serve a fresh qualifying period. The client must also be entitled to Disabled Person's Tax Credit to qualify for the 104-week linking rule.
  - **Job Grant:** One off tax-free payment of £100. Available to people claiming JSA, Income Support (IS), Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) who have continuously received benefit for 52 weeks and directly move into full-time work which is expected to last at least 5 weeks.
  - **52-week linking for mortgage interest:** Extended linking period to enable people to re-qualify for immediate help with mortgage interest payments after periods in work. Available for claimants on IS who have served the housing costs qualifying period and who take up work in an Employment Zone or New Deal waged option.
  - **Housing Benefit Extended Payment/Council Tax Benefit Extended Payment:** Help with rent and council tax for an extra four weeks, after an individual starts work and benefits stops. The job must last five weeks or longer and the client have been out of work for over six months and in receipt of income-based JSA or IS. Partner's receipts of IS/JSA also count towards qualifying period.

- **Mortgage interest run-on (MIRO):**  
Provides help with eligible housing costs for an extra 4 weeks after benefit ends. Available for clients who have been entitled to help with housing costs and have been on IS or income-based JSA for 6 months.
- **Disabled Person's Tax Credit (DPTC):**  
DPTC helps some people with health problems or a disability to start or return to work, or remain in their existing job. Claimants must be working for 16 hours or more a week and either be receiving or have been receiving a qualifying benefit for one of the days in the six months prior to the claim. DPTC is awarded for 26 weeks at a time and is not normally affected by a change in circumstances.
- **Voluntary work:** Benefit claimants are allowed to undertake voluntary work for individuals, organisations, in the community or for charities. Volunteers cannot be paid but they can receive reasonable expenses. IS, IB and SDA clients can do as much voluntary work as they like. JSA claimants must still be actively seeking and available for work.
- **Permitted work:** This replaced therapeutic work from April 2002. Under this measure any claimant is able to undertake work of less than 16 hours a week whilst on IB/IS/SDA as long as it does not call into question the specific grounds on which they were deemed incapable of work. This provision lasts for 26 weeks but can be extended to 52 weeks with the agreement of a personal adviser, job broker or DEA. There are special arrangements for people who receive support in work from a disability organisation or care worker. In addition people in receipt of an incapacity benefit can earn up to £20 a week at any time.

### **Code of Advice on Written Consultation: Consultation Criteria**

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned and so that sufficient time is left for it at each stage.
2. It should be clear who is being consulted, about what questions, in what timescale and for what purpose.
3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main issues it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.
4. Documents should be made widely available, with the fullest use of electronic means (though not to the exclusion of others) and effectively drawn to the attention of all interested groups and individuals.
5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.
6. Responses should be carefully and open-mindedly analysed and the results made widely available, with an account of the views expressed and reasons for decisions finally taken.
7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated.

- 1 General Household Survey 1998
- 2 Labour Force Survey Technical Report June 1998
- 3 Cabinet Office Performance and Innovations Unit Report, April 2000
- 4 Forthcoming OECD Report *Transforming Disability into Ability – Policies to promote work and income security for disabled people*, Paris
- 5 Department for Work and Pensions Research Report 156: *Short-Term Effects of Compulsory Participation in ONE*
- 6 Approximately 24 per cent of people on an incapacity benefit for less than two years are either exempt from the Personal Capability Assessment and/or are in receipt of highest rate Disability Living Allowance care or higher rate Disability Living Allowance mobility
- 7 The 'others' category is made up of the other 13 International Classification of Diseases diagnosis groups including (by order of size): diseases of the digestive system; endocrine, nutritional and metabolic diseases; neoplasms; certain infectious and parasitic diseases; and diseases of the genito-urinary system
- 8 For example see Waddell G and Burton AK (2000), *Occupational Health Guidelines for the Management of Low Back Pain – Evidence Review*, Faculty of Occupational Medicine, London; Jones D and West R (1995), *Cardiac Rehabilitation*, BMJ Publishing Group; Duckworth S (2001), *Disabled Person's Perspective 2001*
- 9 For example see Waddell G and Burton AK (2000), *Occupational Health Guidelines for the Management of Low Back Pain – Evidence Review*, Faculty of Occupational Medicine, London; Jones D and West R (1995), *Cardiac Rehabilitation*, BMJ Publishing Group; Duckworth S (2001), *Disabled Person's Perspective 2001*
- 10 For example see Waddell and Burton (2000), *Occupational Health Guidelines 2000*; Waddell (2002), *Models of Disability 2002*, RSM Press; Department of Social Security Research Report No. 54 (1996), *Disability, Benefits and Employment*
- 11 Department for Work and Pensions Research Report 126: *First Effects of ONE*
- 12 Department for Work and Pensions Research Report 156: *Short-Term Effects of Compulsory Participation in ONE*
- 13 Lawless P, Martin R, Hardy S, *Unemployment and Social Exclusion: landscapes of labour inequality* Jessica Kingsley Publishers; Nickell S, Bell B, *The collapse in demand for the unskilled and unemployment across the OECD*, Oxford Review of economic policy; *Unemployment 1995*, 11:40–62; European Commission (2001), *Unemployment and Public Health*
- 14 Acheson D (Chair) (1998), *Independent Inquiry into Inequalities in Health Report*, London, The Stationery Office
- 15 For example see Waddell G and Burton AK (2000), *Occupational Health Guidelines for the Management of Low Back Pain – Evidence Review*, Faculty of Occupational Medicine, London; Jones D and West R (1995), *Cardiac Rehabilitation*, BMJ Publishing Group; Duckworth S (2001), *Disabled Person's Perspective 2001*
- 16 Duckworth S (2001), *Disabled Person's Perspective 2001*
- 17 Department of Health, *National Service Framework for Mental Health Conditions* (1999); *National Service Framework for Coronary Heart Disease* (2000). All the National Service Frameworks can be accessed at: [www.doh.gov.uk/nsf/index.htm](http://www.doh.gov.uk/nsf/index.htm)

- 18 Department for Work and Pensions Research Report 156: *Short-Term Effects of Compulsory Participation in ONE*
- 19 Department for Work and Pensions Research Report 156: *Short-Term Effects of Compulsory Participation in ONE*
- 20 Department for Work and Pensions Research Report 126: *First Effects of ONE*
- 21 Department for Work and Pensions Research Report 139: *Recruiting Benefit Claimants: A survey of employers in ONE pilot areas*
- 22 Blackwell T, Burns P and Hardy S, *Attitudes on mental health in the workplace, with proposals for change*. Research report for Working Minds, London The Industrial Society; Department for Work and Pensions Research Report 139: *Recruiting Benefit Claimants: A survey of employers in ONE pilot areas*
- 23 Meager N et al. (2001), *Impact on Small Business of Lowering the DDA Part II Threshold*
- 24 Department for Work and Pensions Research Report 162: *Evaluation of the Capability Report: Identifying the Work-Related Capabilities of incapacity benefit claimants*
- 25 Or the National Council for Education and Training in Wales, and Scottish Enterprise/Highlands and Islands Enterprise in Scotland
- 26 Between spring 1998 and 2002 the employment rate for older people improved from 65.7 per cent to 68.1 per cent; for disabled people it improved from 43.5 per cent to 48 per cent.
- 27 Department for Work and Pensions Research Report 167: *Delivering a work-focused service*; Department for Work and Pensions Research Report 149: *Moving towards work: the short-term impact of ONE*
- 28 'One' Pilots: *Lessons for Jobcentre Plus*, Work and Pensions Select Committee, 2002
- 29 Although, as now, the current Jobcentre Plus regime of mandatory follow-up interviews would continue to apply.
- 30 Full list of exempt conditions is: tetraplegia; persistent vegetative state; dementia; paraplegia (or uncontrollable involuntary movements or ataxia which effectively renders the sufferer functionally paraplegic); a severe learning disability; a severe and progressive neurological or muscle-wasting disease; an active and progressive form of inflammatory polyarthritis; a progressive impairment of cardio-respiratory function which severely and persistently limits effort tolerance; dense paralysis of the upper limb, trunk and lower limb on one side of the body; multiple effects of impairment of function of the brain or nervous system causing severe and irreversible motor, sensory and intellectual deficits; severe and progressive immune deficiency states characterised by the occurrence of severe constitutional disease or opportunistic infections or tumour formation (disorders such as AIDS); severe mental illness. In addition, people who are: registered blind; terminally ill; receiving the highest rate care component of Disability Living Allowance, or certain other allowances, are also exempt.
- 31 Department for Work and Pensions Research Report 173: *Disabled for Life? Attitudes towards, and experiences of, disability in Britain* found 52 per cent of people with a disability in Great Britain did not see themselves as 'disabled'
- 32 Watson P, *From back pain to work – A collaborative initiative between the NDDI and the Department of Behavioural Medicine*, Salford Royal Hospitals Trust, Final Report to the Department for Work and Pensions
- 33 Department for Work and Pensions Research Report 162: *Evaluation of the Capability Report: Identifying the Work-Related Capabilities of incapacity benefit claimants*

- 34 Atkinson J, Dewson S, *Evaluation of the New Deal 50 plus – Research with Individuals Wave 1*. ESR91, September 2001
- 35 Department for Work and Pensions Research Report 145: *Well enough to work?*
- 36 Department for Work and Pensions Research Report 145: *Well enough to work?*
- 37 CBI Absence and Labour Turnover Survey 2001
- 38 Labour Research Department – Rehabilitation – The Workplace View 2002
- 39 Department for Work and Pensions Research Report 148: *The Role of GPs in Sickness Certification*
- 40 Report from the Cabinet Office Public Sector Team, *Making a Difference: Reducing General Practitioners Paperwork*.



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