

Health Inequalities National Support Team

Employment, Worklessness and Health

*Potential Key Actions for Reducing Inequality at Population Level
(Appendix 1)*

*Identifying strengths and effective practice and making tailored
recommendations on how to address gaps in service delivery*



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Description	This Employment, Worklessness and Health workbook was developed by the Health Inequalities National Support Teams (HINST) with 70 local authorities covering populations in England. Local areas could use this approach when analysing whether a population level improvements could be achieved from a set of best-practice and established interventions. This is offered as useful resource for commissioners: use is NOT mandatory.
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Foreword

National Support Teams (NSTs) were established by the Department of Health from 2006 to support local areas – including Local Authorities, Primary Care Trusts (PCTs) and their partners – to tackle complex public health issues more effectively, using the best available evidence. By undertaking intensive, ‘diagnostic’ visits to local areas, spending time with key leaders (commissioners and providers) including clinicians and front-line staff, the ten NSTs provided intelligence, support and challenge to local areas to assist in their achieving better public health outcomes. The programme finished in March 2011.

The ten subject specific teams (Sexual Health, Tobacco Control, Health Inequalities, Teenage Pregnancy, Childhood Obesity, Alcohol Harm Reduction, Infant Mortality, Response to Sexual Violence, Vaccination and Immunisation and Children and Young People’s Emotional Wellbeing and Mental Health) were commissioned and established with a focus on improving health and reducing health inequalities.

The ten teams undertook more than 450 visits to local partnerships during the course of the programme and their findings and successes have been documented in Knowledge Management and Evaluation reports. Each team also produced reports setting out and consolidating the learning from their work. A further report that captures best practice identified by each team is planned to enable local areas to continue using the expertise and lessons learnt from the NST model.

The NST process involved a desk review of key documentation and data-based intelligence, and interviews with key informants, often in combination with a series of workshops or focus groups. Collation and analysis of findings was immediate, and the findings, including strengths and recommendations, were fed back straight away and on site to the key local players and leadership. Recommendations were accompanied by offers of support, either at the time of reporting, or as part of follow-up activity.

The Department is publishing a number of reports which distil the learning from the programme, and exemplify the methodology employed.

Executive Summary

This workbook is one of a series developed by the Health Inequalities National Support Team (HINST), in its work with the 70 local authorities covering populations in England with the highest levels disadvantage and poorest health. These workbooks are a summary of local views on good practice. The suggested approaches are not mandatory, and reflect learnings from a snapshot in time. Where there is clear established evidence to support interventions, this has been signposted in the footnote. This is offered as useful resource for commissioners: use is NOT mandatory.

It is designed to prompt discussion amongst commissioners of health and employment services, local providers, employers and other relevant local partners on issues of health, employment and worklessness. These discussions should identify local strengths and opportunities, gaps in provision, and evidence-based interventions.

The topic of this workbook – Employment, Worklessness and Health - was selected for its proven impact¹ on health and wellbeing, and on mortality and life expectancy in the short, medium or long term. This is recognised in the Marmot Review of health inequalities², and the recent Public Health White Paper (Healthy Lives, Healthy People).

Work is generally good for people's health and wellbeing – including for people with health conditions. It can promote good mental and physical health, provide important social networks and routines, and contribute to recovery from health conditions.

Conversely, higher rates of unemployment cause more illness and premature death. Unemployment puts health at risk, and the risk is higher in regions where unemployment is widespread. Health effects of unemployment are linked to both its psychological consequences and the financial problems it brings – especially debt.

Health effects start when people first feel their jobs are threatened, even before they actually become unemployed. Prolonged job insecurity acts as a chronic stressor whose effects grow with the length of exposure. It increases sickness absence and health service use.

Unemployment is unequally distributed across society, with those in lower socioeconomic positions at higher risk. This contributes to the social gradient in health. Unemployed people incur a multiplicity of both short and long term elevated health risks. They have increased rates of limiting long-term illness, mental illness and cardiovascular disease. The experience of unemployment has also been consistently associated with an increase in overall mortality, and in particular with suicide. There are three core ways in which unemployment affects levels of morbidity and mortality²:

- Financial problems
- Distress, anxiety and depression

¹ Waddell and Burton – Is Work Good For Your Health and Wellbeing; The Stationary Office; 2006

² Fair Society, Healthy Lives, The Marmot Review; Strategic review of health inequalities in England post-2010; 11th February 2010

- Impacts on health behaviours (e.g. smoking and alcohol consumption and decreased physical exercise)

Unemployment and poor health impact on each other. Unemployment contributes to ill health and having a health condition increases the likelihood of unemployment. The two are mutually reinforcing. The longer a person is unemployed, the greater the risk of developing a health condition and facing increased challenges in returning to employment.

The HINST has developed a 4-point framework for employability and in-work support that includes the following elements of support to workless people, employees and employers (p18 - 19).

- Finding work: support to workless people and employers
- Transition to work: supporting workless people in their period of adjusting to being employed.
- Sustaining people in work / workplace health: supporting the health of employees, including supporting people not to leave employment as a result of health or social problems – through Fit for Work Services (FFWS).
- Support for employees facing retirement and redundancy

This workbook – which is recommended for use either to carry out a local stocktake or to run a facilitated workshop – provides advice on achieving best outcomes at **population level**, and for identifying and recommending changes that could be introduced locally. Recommended workshop invitees are listed on pages 4 - 5.

Central to the HINST approach is a diagnostic framework – Commissioning for Best Population Outcomes (see p10 - 11), which focuses on evidence-based interventions that produce the best possible outcomes. Part of the framework addresses delivery of **service** outcomes in the most effective and cost effective manner. This is balanced by considerations of how the population uses services, and is supported to do so, to aim for **optimal population level** outcomes that are fairly distributed.

The framework points to the following areas of intervention:

A CHALLENGE TO PROVIDERS

1. Known intervention efficacy
2. Local service effectiveness
3. Cost effectiveness
4. Accessibility
5. Engaging the public

B POPULATION FOCUS

6. Known population needs
7. Expressed demand
8. Equitable resourcing
9. Responsive services
10. Supported self
11. Adequate service volumes
12. Balanced service portfolio
13. Networks, leadership and coordination

This workbook is made up of sets of detailed questions against each of the above categories. They provide local groups of commissioners and providers with **a systematic approach to deciding what needs to be done in relation to employment, worklessness and health** to further improve population health and wellbeing, capitalising on evidence-based interventions. How these improvements will best be achieved in a given locality will be for local participants to decide. The workbook signposts good practice and guidance where this may be helpful.

Appendix 1 outlines high impact changes for successful interventions this area.

General reference - Health Development Agency, (Carl Mclean, Chris Carmona, Simon Francis, Clare Wohlgemuth and Caroline Mulvihill), *Worklessness and Health – what do we know about the causal relationship?* Evidence review 1st edition – March 2005.

Introduction

This is one of a series of diagnostic workbooks developed by the Health Inequalities National Support Team (HINST), while working with the 70 local authorities covering populations in England with the highest levels of deprivation and poorest health. The programme finished work in March 2011, but the Department of Health is publishing its key outputs for local commissioners and providers to use if they so wish. Each workbook topic was selected for the importance of its potential impact on health and wellbeing, and also on mortality and life expectancy in the short, medium or long term.

At the core of each workbook is a diagnostic framework – Commissioning Services to Achieve Best Population Level Outcomes' (see p10 - 11). The diagnostic focuses on factors that contribute to a process in which a group of evidence-based interventions produce the best possible outcomes at population level. Part of the structure addresses delivery of **service** outcomes in the most effective and cost effective manner. However this is balanced by considerations of how the population uses services, and is supported to do so, to help achieve **optimal population level** outcomes that are fairly distributed.

The framework is made up of a set of detailed, topic-based questions. These provide local groups of commissioners and providers with a **systematic approach to deciding what needs to be done** to further improve population health and wellbeing, capitalising on evidence-based interventions. **How** these improvements will best be achieved in a given locality will be for local participants to decide. The workbooks signpost good practice and guidance where this may be helpful.

The resource represented by this workbook can make a significant contribution during a period of transition for the NHS, as responsibility for commissioning of health and health related services transfers to the NHS Commissioning Board, GP Commissioning Consortia and work towards passing delivery to the Health and Wellbeing Boards. Changes are also in progress within local government, social care and the voluntary sector. Current policy in relation to public services highlights the centrality of engaging people – as individual service users and patients, and as whole communities, in their own health and wellbeing and that of the wider community.³ The workbook will support the newly emerging organisations and networks as an aid to understanding commissioning processes to help to achieve population level outcomes. Key processes that should significantly influence local commissioning priorities as part of the development of Joint Strategic Needs Assessment and Health and Wellbeing Strategies, will be highlighted through the use of the workbooks. The skills and knowledge embedded within the realigned local Public Health teams will be critical in development and coordination of these key processes.

The workbook is designed and tested to help areas identify which factors are important in the systematic and equitable delivery of health improvement. They should, therefore, provide a good framework for early identification of local solutions driven by the new perspectives being brought to bear.

The NHS also faces a challenging financial environment during the transition. Through the Spending Review, the government protected the NHS, with cash funding growth of

³ See for example NHS Constitution:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx> and Localism Bill: <http://services.parliament.uk/bills/2010-11/localism.html>

And NHS and Social Care Bill: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

£10.6bn (over 10%) by 2014/15. Nevertheless, by historical standards this remains extremely challenging and the NHS has been developing proposals to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge of efficiency savings of up to £20 bn by 2014/15 for re-investment. This means that considerations of the affordability, and evidence on the cost-effectiveness and cost-benefit of the interventions presented should be of central consideration. Where possible priority should be given to interventions which are likely to lead to cash-releasing savings that can be re-invested in other services, based on a sound evidence base. Some of the relevant evidence has been referenced through the workbook.

Local facilitators and participants will be aware of changes that may be outside the scope of this workbook and of any detail in the workbook that may have been superseded. These should be taken into account. To facilitate this, a generic workbook - *A Generic Diagnostic Framework for Addressing Inequalities in Outcome from Evidence-based Interventions* - has been produced that could be used to guide the diagnostic questions and discussion during the workshop, with this detailed workbook being used alongside the generic one for reference

How to Use this Workbook – a guide for facilitators

The objective of the workbook, used in a workshop setting, is to gain a picture of the local strengths and gaps in services in relation to the objective of achieving best outcomes at **population level**, and to identify and recommend changes that could be introduced.

The workbook is best used in a **facilitated** workshop setting for a **minimum of 8 and a maximum of 25 participants. Allow 4 hours for the workshop.** The participants in the workshop should include key individuals who are involved in planning, commissioning and delivering services and interventions in relation to the workbook topic through a partnership approach. The make-up of the group will vary according to local situations but a suggested attendee list for a workshop based on this workbook is set out below:

Health sector

1. *Director of Public Health*
2. *Commissioners –physical and mental health*
3. Multi-agency services /Social Inclusion lead from local NHS
4. *Mental Health Trust – employability specialist (e.g. an Occupational Therapist [OT])*
5. Health and Safety at Work (HASAWA) officer
6. GP /Practice Based Commissioning representative

Employment sector

7. *Job Centre Plus – district external relations teams*
8. *Connexions*
9. *Skills Funding Agency and/or Young People's Learning Agency (successor organisations to the Learning and Skills Council)*
10. Work Programme providers
11. Work Choice providers
12. Remploy
13. Regional Health, Work and Wellbeing co-ordinator

Apprenticeship schemes

14. *Lead for Modern Apprenticeships – (e.g. a local college representative)*

Advice sector

- 15. Prison Service Plus
- 16. Probation Advisors
- 17. *Welfare Rights Service (County and /or District Council), and/or Citizens Advice Bureau⁴*

Regulatory sector

- 18. *Health and Safety Executive (HSE) representative*
- 19. Department of Work and Pensions representative (Job Seekers Allowance)

Local strategic partnership

- 20. *Chair of Economic Partnership*

Local authority

- 21. *Head of Economic Development Department*
- 22. Employment and Social Inclusion Officer
- 23. Adult Social Care representative (County or Unitary Council)
- 24. Health and Safety at Work (HASAWA) officer

Human resources (for corporate citizenship, employment policies on alcohol and drugs, policies for employment of disabled people and people with enduring medical conditions, sickness absence policies)

- 25. *HR Officer –PCT*
- 26. HR Officer –Acute trust
- 27. HR Officer –Mental health trust
- 28. *HR Officer –local authority*

Employers

- 29. Chamber of Commerce representative
- 30. *Occupational Health representative*

Voluntary sector

- 31. *Voluntary and Community Sector (VCS) agency/agencies dealing with employment and social inclusion.*

Health and Safety Executive (HSE): contact HSE via their [online enquiry service⁵](#) or by telephone on 0845 345 0055. For details of HSE regional offices, see appendix 2.

Where there is more than one organisation (for example, hospital trust) providing local services, it is advisable to invite senior representatives from each.

Provide a copy of this workbook to each participant at the workshop. It is suggested that the participants do not see the workbook in advance, but are informed that the workshop will be an opportunity to explore their knowledge of approaches to the issue with others who will bring differing perspectives.

The facilitator should be familiar with the workbook questions and the model described below, which supports a population level perspective to be taken. It is suggested that facilitators introduce the participants to this model and approach. Following the

⁴ The registered office of national Citizens Advice Bureaux is: Citizens Advice, Myddelton House, 115-123 Pentonville Road, London, N1 9LZ. Tel. 020 7833 2181, Fax 020 7833 4371 (admin only)

⁵ <http://www.hse.gov.uk/contact/ask.htm>

introduction, it is useful to look at section 13 first as this gives an overview of the situation in the area for this topic and enables all participants to have an opportunity to contribute at the beginning. Finish by working through each sections 1-12 of the model.

Group discussions about all of the questions in each section allow strengths, best practice and gaps to be identified, and the group to begin to think about where improvements could be made. A separate publication contains a facilitator's recording book, which can be used during the workshop to record this discussion. This need not be copied for workshop participants.

Key actions and lead stakeholders to take these actions forward can be identified during the workshop. The greatest impact is likely to result if summaries of these key actions and of the recognised strengths and recommendations from the workshop are produced and circulated to attendees and key accountable stakeholders within the partnership, following the workshop.

There is a list of potential key actions summarised in Appendix 1. It is sensible to emphasise these questions during the workshop.

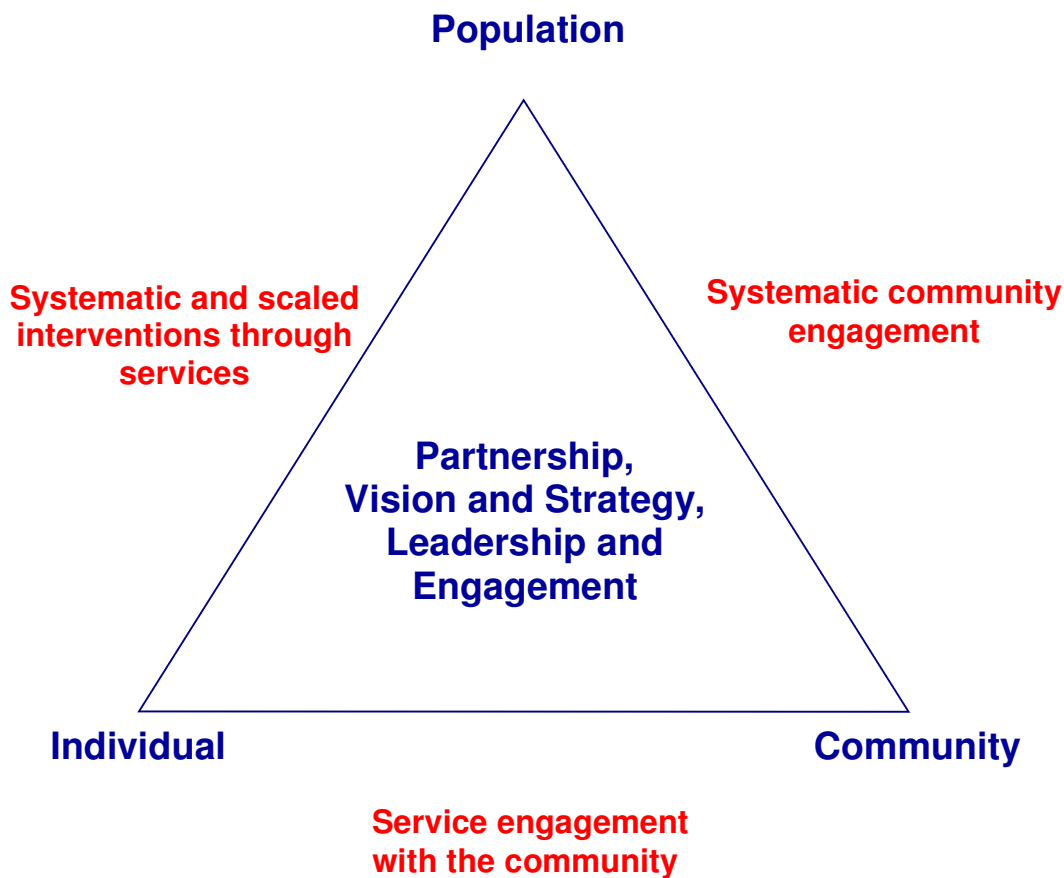
Background to Population Level Interventions

Challenging public health outcomes, such as achieving significant percentage change within a given population by a given date, will require systematic programmes of action to implement interventions that are known to be effective, and reaching as many people as possible who could benefit.

Programme characteristics will include being:

- **Evidence based** – concentrating on interventions where research findings and professional consensus are strongest
- **Outcomes orientated** – with measurements locally relevant and locally owned
- **Systematically applied** – not depending on exceptional circumstances and exceptional champions
- **Scaled up appropriately** – 'industrial scale' processes require different thinking to small scale projects or pilots ('bench experiments')
- **Appropriately resourced** – refocusing on core budgets and services rather than short bursts of project funding
- **Persistent** – continuing for the long haul, capitalising on, but not dependant on fads, fashion and changing policy priorities

Interventions can be delivered through three different approaches to drive change at population level, illustrated by the following diagram:



Producing Percentage Change at Population Level

C. Bentley 2007

Population Approaches

Direct population level interventions will include developing healthy public policy, legislation, regulation, taxation and public funding strategies. These elements should support making 'healthy choices easy choices' for individuals and communities.

The impacts of such population level interventions, however, will not automatically 'trickle down' to all, often in particular missing those who are socially excluded for various reasons. Strategies for targeted communication and education, service support and even enforcement will be required to achieve full impact.

Individual Approaches through Services

Some interventions taken up at individual level, such as support for environment and behaviour change, therapies, treatments and rehabilitation, can change individual risk significantly, in some cases by 30-40%. The challenge is to achieve so many of those individual successes that it adds up to percentage change at population level. This will be achieved only if services take into account issues of system and scale to enable this to happen, and work to address population level outcomes as well as those for individual service users.

Improvements in health and wellbeing will require some reorientation of health and other services to take a more holistic view of individual circumstances, with regard to any

personal characteristics/sub-population group status or socio-economic status and to focus on development of personal skills of staff and service users, so promoting healthy choices and actions.

Community Approaches

Individuals will only choose to use and benefit from certain behaviours and actions if those behaviours fit with the cultural and belief system of their own community. Communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith) and others (disability, sexual orientation). Community development is one way of facilitating communities' awareness of the factors and forces that affect their wellbeing, health and quality of life.

Community engagement is often patchy, favouring those communities that already have leadership, organisation and some resources. Instead, it needs to be systematic in bringing top-down and bottom-up priorities together into plans. This will strengthen community action to create more supportive environments and develop knowledge and skills of community members.

Service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and faith sector as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.

Commissioning for Population Level Outcomes

Substantial progress can be achieved in making an impact in the short, medium and long term in relation to inequalities in mortality and life expectancy through a focus on existing services. Because of this, extra attention is given here to extracting maximum benefit from delivery of interventions for which there is strong evidence of effectiveness. In addition there is a deliberate emphasis wherever possible, on improving access to services of a scale that will impact on bringing about a population level improvement in mortality and life expectancy within a two to three year period.

The detail is illustrated in the attached diagram on Page 10 with the title 'Commissioning for Best Population Level Outcomes', otherwise known as the 'Christmas Tree' diagnostic, with an accompanying description of its component principles. The framework balances two sets of factors that determine whether optimal outcome can be achieved at population level from a given set of personal health interventions.

The right hand side of the diagram (1 to 5) - a challenge to providers: links the factors that will influence health *service* outcomes, that is, how can we construct the most effective service.

However, optimal outcomes *at population level* will not be obtained without the following:

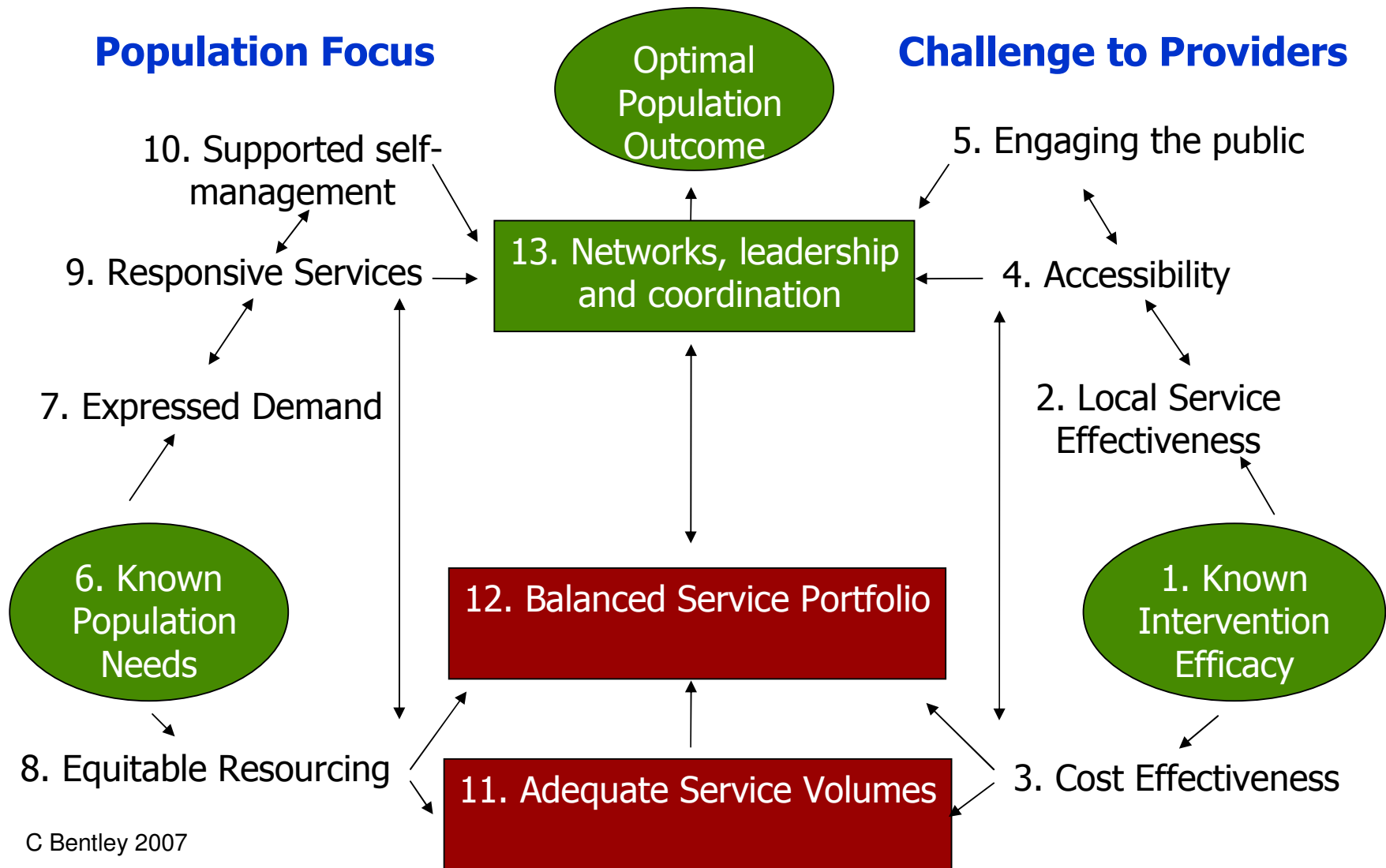
The left hand side of the diagram (6 to 10) - a population focus: identifies those factors that determine whether a community makes best use of the service provided – for example, whether the benefits of personalised improvements to services are having a systematic impact on reducing health inequalities at the population level.

The balance between the two sides of the diagram - the commissioning challenge:

Working towards equality of outcome, not just equality of access to service provision and support, is a significant and crucial challenge for commissioners. The 'Christmas Tree' diagnostic, is a tool to help achieve this. The right side of the diagram enables commissioners to identify the best services available for their population. The left side allows commissioners to consider whether services commissioned and delivered best meets the needs of all people in the local population. Attention to both sides of the diagram will help all services to be effective **and** engaged with and used by all of the diverse communities in the area they serve.

The central elements of the diagram are concerned with working towards the scenario where the most effective services/interventions are identified that are fully acceptable, accessible and effective in terms of take-up and compliance, there is adequate capacity to meet the need. Effective leadership and networks are needed to keep all these elements under review to aim for continuous improvement and equality of morbidity and mortality outcomes.

Commissioning for Best Population Level Outcomes



C Bentley 2007

Commissioning for Best Population Level Outcomes

A CHALLENGE TO PROVIDERS

1. **Known Intervention Efficacy:** Looks at life saving interventions, for which there is strong evidence, and that are implemented equitably and made available to as many people who could benefit as possible.
2. **Local Service Effectiveness:** Aim for service providers maintaining high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit
3. **Cost Effectiveness:** Aim for programme elements that are as affordable as possible at population level
4. **Accessibility:** Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of those service.
5. **Engaging the Public:** Working with service users and communities to aim for their needs and requirements to be at the centre of service provision, and for quality assurance systems to be in place that makes the services acceptable to service users
11. **Adequate Service Volumes:** Commissioning adequate service volumes to aim for acceptable access times.
12. **Balanced Service Portfolio:** Aim for balance of services within pathways to avoid bottlenecks and delays.
13. **Networks, Leadership and Co-ordination:** Designating leadership and co-ordination to aim for services that are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

B POPULATION FOCUS

6. **Known Population Needs:** Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.
7. **Expressed Demand:** Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population.
8. **Equitable Resourcing:** Aim for the distribution of finance and other resources to support equitable outcomes according to need.
9. **Responsive Services:** When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.
10. **Supported Self Management:** Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

Whilst the service design elements are an immediate concern to providers, all sections of the 'Christmas Tree' diagnostic are of direct relevance to commissioner

Equality

Equalities perspectives need to be built into all whole population approaches. The Equality Act 2010 set out the public sector equality duty:

(1) A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Act identifies a number of “protected” population groups/characteristics where specific elements of the legislation apply. These groups/characteristics are:

- *age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.*

Although socioeconomic inequalities are not specifically included in the Equality Act, there are a range of duties in relation to tackling inequalities included at different levels in new health and social care legislation, and for all key structures and partners involved in the commissioning and delivery of health and social care, in new health and social care legislation. The Health and Social Care Bill 2010 proposes new legal duties on health inequalities for the Secretary of State and the NHS. Subject to Parliamentary approval:

- The Secretary of State for Health must have regard to the need to reduce health inequalities relating to the NHS and public health.
- The NHS Commissioning Board and GP consortia must have regard to reducing inequalities in access to, and outcomes of, healthcare.

In order to carry out these duties effectively an emphasis on socioeconomic disadvantage will be essential as it is recognised as a major driver in relation to inequalities of access to, and outcomes of, health and wellbeing services.⁶

Useful Materials⁷

⁶ The Marmot Review (2010) *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England post 2010*

<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

⁷ Department of Health (2008) *Making the difference – The Pacesetters beginner’s guide to service improvement for equality and diversity in the NHS*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

The Workbook
Employment, Worklessness and Health

Why this Topic has been Chosen

This workbook discusses the relationship between employment, worklessness and health and helps identify what local changes might improve health outcomes at population level. It is considered from the perspectives of:

- The strength of partnership and strategic approaches to address worklessness – enabling people to enter and stay in local employment.
- The range of services and support that may exist in any given geographic area, and any assessment of quality, quantity and gaps in such services
- The specific linkages between employment, worklessness and health (e.g. occupational health)
- The role that commissioners and service providers can play in improving the prospects of employment for local workless people and supporting people who have health conditions to stay in or return to work

Employment, Worklessness and health

Work is generally good for people's health and wellbeing – including for people with health conditions. It can promote good mental and physical health, provide important social networks and routines, and contribute to recovery from health conditions.

Support to stay in work: It is important to support people who have health conditions to stay in or return to work. Early intervention when problems begin has been shown to have the best health and employment outcomes. The introduction of the Fit Note encourages employers and healthcare professionals to focus on what an employee can do rather than what they can't in the early stages of sickness absence. The national occupational health adviselines for small businesses also offer free, confidential advice on employee health issues to help people remain in work.

Job retention services are in line with evidence that suggests that work is generally good for health and that returning to work at the appropriate time is part of the recovery process. They provide support to employees who may be at risk spending long periods away from work with health problems. Services coordinate help with:

- health and treatment
- employability
- wider support services – for example debt, relationship or housing problems

Of course, work can sometimes also pose risks to people's health. Work-related stress and musculo-skeletal disorders are some of the most common examples of health problems caused or exacerbated by work. Working with employers and regulators to encourage healthy workplaces should be an important part of local approaches to stop people developing health conditions caused by work.

Health and safety: Under the law employers are responsible for health and safety management. It is an employer's duty to protect the health, safety and welfare of their employees, and other people who might be affected by their business. Employers must do whatever is reasonably practicable to achieve this. The Health and Safety Executive provide a range of advice and guidance to help employers meet these responsibilities – including on issues such as stress and musculo-skeletal disorders.

Unemployment is a key risk factor for health problems. Higher rates of unemployment cause more illness and premature death. Unemployment puts health at risk, and the risk is higher in regions where unemployment is widespread. Evidence from a number of countries shows that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death. The health effects of unemployment are linked to both its psychological consequences and the financial problems it brings – especially debt.⁸

The health effects start when people first feel their jobs are threatened, even before they actually become unemployed. Job insecurity has been shown to increase effects on mental health (particularly anxiety and depression), heart disease and risk factors for heart disease – these effects grow as the insecurity continues. Insecure or unhealthy jobs can be as harmful as unemployment, so merely having a job will not always protect health: job quality is also important.

Unemployed people incur a multiplicity of elevated health risks - including increased rates of limiting long-term illness, mental illness and cardiovascular disease. The experience of unemployment has also been consistently associated with an increase in overall mortality, and in particular with suicide. Unemployed people have much higher use of medication and much worse prognosis and recovery rates – and within each socioeconomic group, unemployed people have higher mortality rates than those who were employed.⁹

Unemployment is unequally distributed across society, with those in lower socioeconomic positions at higher risk. This contributes to the social gradient in health.

Unemployment has both short and long-term effects on health. Adverse effects on health are greatest among those who experience long-term unemployment. There are three core ways in which unemployment affects levels of morbidity and mortality:

- Financial problems as a consequence of unemployment can lead to direct reductions in living standards

⁸ **World Health Organization 2003** Social determinants of health: the solid facts. 2nd edition / edited by Richard Wilkinson and Michael Marmot.

⁹ See Marmot Review -footnote 4

- The loss of a core role which is linked with one's sense of identity, as well as the loss of rewards, social participation and support. Can lead to reduced social integration and lower self-esteem.
- Unemployment can trigger distress, anxiety and depression. These can also affect the wider families of unemployed people.
- Unemployment impacts on health behaviours, being associated with increased smoking and alcohol consumption and decreased physical exercise⁹.

Unemployment and health conditions are inter-related.¹⁰ Unemployment can contribute to health conditions, and having a health condition increases the likelihood of unemployment. Employment rates for people who have health conditions are lower than those of the general population, although these vary depending on the nature of the condition. The extent to which limiting illness and disability act as a barrier to work is highly dependent on educational qualifications.

- *Impact of being out of work or job searching:* Worklessness significantly impacts on people's ability to find work. The loss of self-esteem and self-confidence sometimes felt can demonstrate itself in:
 - reluctance to apply for work – unwillingness to expose oneself to further rebuttal or 'failure'
 - lack of confidence to make a convincing application, and the consequent 'failure' of not being offered and interview
 - lack of conviction in the interview situation – especially set against the ebullience shown by more confident (often still-employed) candidates
 - consolidation of sense of failure when not offered the job and increase in reluctance to 'risk' more applications.

People who are out of work often experience multiple disadvantages, over and above not having a job. These may include challenging personal circumstances such as a substance / alcohol abuse, at risk of health problems, being homeless or under threat of homelessness, being in acute debt; experiencing or having recently experienced family breakdown.

A referral system is required to help people to access the right support to address as many of these issues as possible. Most areas have a range of professional and voluntary organisations which can offer such support – it is crucial that support services are aware of other support available, and how people can access it. Properly co-ordinated relevant support services can achieve this.

- *The role of the health system:* The clear links between health and employment mean that it is important that there are effective joint working arrangements in place between health and employment services – and other relevant local partners.

¹⁰ Maier R, Egger A, Barth A, Winker R, Osterode W, Kundi M, Wolf C, Ruediger H (2006) Effects of short- and long-term unemployment on physical work capacity and on serum cortisol. *International Archives of Occupational and Environmental Health* 79(3): 193-8.

Health services can make a significant contribution by addressing two fundamental requirements:

- Aiming for health practitioners to be fully aware of the links between health and work *and* health and worklessness – including the fact that people do not have to be 100% ‘better’ to return to or move in to work.
- Building awareness of the range of local support to help people with health conditions to stay in or return to work - and crucially, how to access that help.

Services and support

- *Jobcentre Plus*: Jobcentre Plus (JCP) is the key organisation for helping people back to work. Its primary function is to help workless people get on track to enter or re-enter employment. JCP clients are eligible for two major benefits:
 - Jobseekers Allowance: is payable to people who are fit for work. They agree an action plan with a JCP Adviser from their first registration and are required to undertake action that will help them return to work.
 - Employment and Support Allowance: is paid to people who are assessed as not fit for work following a Work Capability Assessment.
- *The Work Programme*: The Government aims to have the new Work Programme in place nationally from the summer of 2011. Providers will be free to design support based on the needs of individuals and target the right support at the right time.
- The Department for Work and Pensions will offer providers higher rewards for supporting harder-to-help customers into employment to make it worthwhile for providers to help all customer groups.
- The providers the Department has selected represent the very best of organisations from both the private, public, and voluntary sectors. There is a good mix of existing suppliers and new entrants to the market. Work Programme providers will be key local partners in addressing employment and health issues.

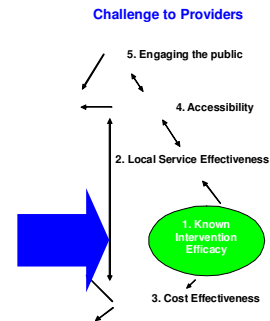
4- POINT FRAMEWORK FOR EMPLOYABILITY AND IN-WORK SUPPORT

This model was developed by HINST as a way of describing the support needed for job seekers, employees and employers in terms of entry into employment and sustaining employment.

	Finding work: support to workless people & employers	Transition to work	Sustaining people in work / workplace health	Support for existing employees facing retirement & redundancy
<p>People who are not in work (longer term and those more recently made redundant)</p> <p>and</p> <p>Employees</p>	<p>Employability support: Supporting progress to work for workless people. Delivering services (e.g. outreach; personal development; training; job application skills; job broking; in-work support).</p> <p>Employability Support to workless people needs to be aligned to the recruitment needs of local employers (see below)</p>	<p>Transition to work: Support can sometimes be helpful for employers and new entrants to employment to sustain the jobseeker in the employment. These may include:</p> <ul style="list-style-type: none"> • a grant to an employer / jobseeker, • training costs / 'vouchers', and • the support of mentors, 'buddies' or 'advocates' 	<p>Job retention services provide personalised and timely back-to-work support to people off sick from work, to enable them to make an early return to work. Support should coordinate health, employability and wider social support and case management.</p> <p>Workplace health: Legal protection includes Health and Safety, Long Hours and Low Pay. Larger employers are likely to have occupational health services. A range of workplace health initiatives can encourage physical activity and fitness, good diet and stress control.</p>	<p>Discuss retirement planning with manager and attend timely pre-retirement courses if available</p> <p>Redundancy: take up support in refreshing CV, job search, developing job application skills, interview practice and networking.</p>

	Finding work: support to workless people & employers	Transition to work	Sustaining people in work / workplace health	Support for existing employees facing retirement & redundancy
Employers	<p>Employer engagement for employing workless people: Engagement with local employers to assess their recruitment/skills needs, and align these with the employability support services on offer.</p> <p>Recruitment: Active work to encourage employers to give priority consideration to workless people in their recruitment processes.</p> <p>Job Broking: The process of acting as intermediary between the employer and the jobseekers (e.g. searching for vacancies / jobseekers, discussing candidates, gaining commitments from employers, arranging interviews, follow-up etc).</p>	See above	<p>Support for employers to sustain people in employment</p> <ul style="list-style-type: none"> • support to employers in respect of new job-seeker entrants, • employers supported in maintaining employees in work when they develop chronic and other health conditions, social difficulties and for those off sick to return to work. This can involve more flexible working arrangements, adjustments, and time off' <p>Provide workplace health (as above) and in-work support to include wider social support service elements (e.g. help with housing, debt, or becoming a carer) and health support – eg job retention services and local GPs.</p>	<p>Job design for older people –so that in the years running up to retirement, jobs make the most of the skills and attributes of older workers, instead of creating difficulties</p> <p>Redundancy and Retirement: Deliver appropriate courses and support as above. Involve local JCP offices.</p>

The following pages contain some key questions for workshop attendees to discuss. The conversations that they are intended to stimulate should help local decision-makers identify gaps in services, as well as local strengths and opportunities.



1 Known intervention efficacy

Looks at critical interventions for which there is strong evidence and that are made available to as many people to benefit as possible.

1. Worklessness and health

- What is the knowledge amongst providers of the models of employment support, and the extent to which different models can be used in different situations?

2. Recruitment

- To what extent do the local leaders of strategic partnerships promote positive policies on recruitment, especially with those employers who are part of the strategic body?
- What are the common recruitment practices in the locality? Examples at different levels¹¹ might include:
 - * There are no consistent messages going to employers about the positive aspects of recruiting workless people. Employers have not been influenced, and so their recruitment processes are not adapted to give priority to workless people.
 - ** Some employers have been influenced positively, possibly for a specific individual, but the effect may be short-term (e.g. because of a lack of a consistent flow of similarly suitable people or absence of success with vacancies for whom the support organisation had no suitable candidates).
 - *** Effective Local Employment Partnerships (LEP)¹² exist, through Jobcentre Plus's activity. Some of the national network companies (e.g. Asda, Tesco, McDonald's), and local major employers, including local authorities and NHS trusts, are engaged in giving priority consideration to workless people. Systematic adaptation of recruitment processes are introduced

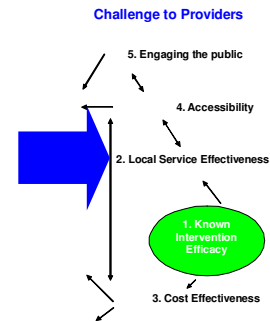
¹¹ Note: If local practice is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 3 and 4 asterisk practice.

¹² Note: A local employment partnership (LEP) was set up to encourage employers to form relationships with Jobcentre Plus. It provides a commitment that an employer will work with Jobcentre Plus to ensure that priority customers within local communities have access to employment opportunities..

(e.g. holding vacancies available for a number of days exclusively for workless people, simplified application forms for jobs, briefings for applicants prior to form filling / interview, guaranteed interviews for minimum attainment in tests, etc).

**** The Local Employment Partnerships and JCP's staff inputs are supplemented by the JCP's partner agencies playing a role in supplying their clients for the vacancies, enhancing the in-flow of suitable candidates. They are also able to add more customised services, to improve the candidates' chances, often allied to the funded programme they are delivering (e.g. providing training to candidates that has been adapted to be specific to that employer's needs; conducting psychometric and skills testing based on the employers specific worker-profile; supporting child care provision on an interim basis – or during pre-entry training activities).

- To what extent is there a recognised group of organisations that actively promote consistent positive policies for recruiting workless people?
 - Which organisations are involved?
 - How are they organised?
 - Is there a coordinating body, and how does it manage the activities to maximise effectiveness for employers and jobseekers?
- To what extent does the local vacancy management system enable the recruitment process that is being offered to employers? For example simplified application forms, coaching people on writing CVs.
 - Is it incorporated into the JCP database, or is it dedicated?
- To what extent do local NHS trusts engage in positive actions for recruitment of workless people?
 - How is this coordinated?
- To what extent are local trusts open to a wider inclusion / equalities agenda in this aspect?
 - Are there examples of trusts adapting their processes to improve the prospects for workless people?
 - How do the trusts encourage the good practices from the personnel department are followed by all managers who will make recruitment decisions?
 - How is this monitored and quality assured?
- What role do the NHS trusts and GPs play in supporting the statutory and other support organisations in enhancing recruitment practices across their localities: for example, input to employers (individual or groups) and/or to support organisations on the effect that illnesses may have on people's behaviour?



2 Local service effectiveness and value for money

Aim for service providers to maintain high standards of local effectiveness through education and training, driven by systems of professional and organisational governance and audit

1. Worklessness and health

Range of service options for worklessness

- What description¹³ best describes local provision?
 - * Piecemeal, based more on organisations' ability to source budgets, often focused on a narrow group of people and not geared to strategic need
 - ** A mix of provision covering some jobseekers' particular needs but not geared to employers specific local needs
 - *** A good range of provision meeting most jobseekers' needs, but not extensively based on known employers' needs
 - **** A flow of information from jobseekers and employers, used strategically to determine the nature and focus of provision, that is geared towards improving capability for employment, and delivering people with the right skill (or skill potential) to employers
 - ***** In-work support so that people are supported to maintain employment - for example through access to occupational training and qualifications¹⁴.

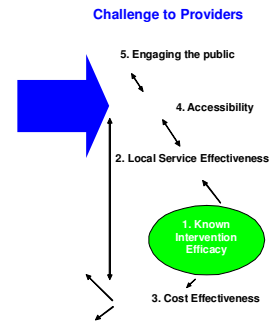
- In setting up provision is there cooperation between employability support agencies to maximise expertise (e.g. an IT specialist trainer gearing provision to meet the needs of people with learning difficulty; developing a generic numeracy programme so that it addresses the knowledge requirements of an occupational sector – retail, construction etc)?

- To what extent do providers form partnerships to bid for funding?
 - Is this strategically led, or in any way coordinated, or on an ad hoc basis?
 - Is such process used to maximise the benefits for jobseekers and employers?

¹³ Note: If local provision is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 5 asterisk provision.

¹⁴ There is a strong relationship between qualification and skill and ability to remain successful in getting and keeping work.

- To what extent do local providers network and move people from one source of development and learning to another?
- Have the cost benefits of local programmes which secure entry to gainful employment been calculated against the costs of maintaining people who are workless and on benefits over the short, medium and long term?



4 Accessibility

Aim for services to be designed with the minimum barriers to access, balancing a drive to bring services closer to the patient with the need for efficiency and effectiveness of those services

1. Worklessness and health

Worklessness outreach and engagement

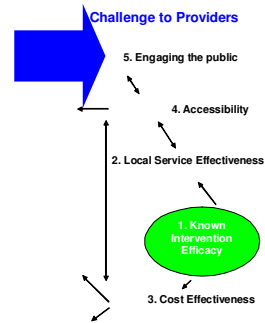
- To what extent does a structured network of outreach / engagement support¹⁵ exist in the area for people who wish to progress to work? Is it:
 - * Piecemeal and uncoordinated
 - ** Operating in some community areas (e.g. the most deprived) but not in others. Which areas / communities?
 - *** Operating for some categories of people, but not for all (e.g. people with [some] disabilities, lone parents, people with learning difficulties, substance mis-users). Which groups?
 - **** A wide range of provision, effectively networked, encouraging access to everyone who wants to progress to work
 - ***** A strategically drawn network determining priority needs are wholly met, and those in most need are drawn into and encouraged to access work

How accessible is information about outreach and engagement support, and how easy is it to refer people into the network of support?

- What specific services cater for identifiable minority groups? For example:
 - 'Foyers' providing hostel accommodation and employment services to young homeless people
 - Employment for disabled people (e.g. Remploy)
 - Disability assistance for disabled people (e.g. JCP 'Access to Work')
 - Directed towards offenders:
 - Employability training (e.g. in prisons)
 - Unpaid work /community payback as part of community order sentences.
 - Directed towards people with mental health conditions, e.g. employability schemes in mental health trusts?
 - Equalities work directed towards older people, BME communities, faith groups, and LGBT groups.

¹⁵ Note: If local support is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 5 asterisk support.

- To what extent does Jobcentre Plus use the local voluntary sector and social enterprise support agencies to support those clients who need specialist support?
- How open are outreach providers to referrals from other organisations?
 - How effectively do they promote their services?
 - How accessible are they to NHS sources of referral?
- Is there scope for NHS outlets to adapt their current work to include onward referrals to outreach organisations?
- Can NHS locations become outreach locations?
 - Would current staff add to their current activities?
 - Could other organisations use the locations to extend the scope of their outreach activities – especially if they focused on the patient-group being dealt with there?



5 Engaging the public

Working with service users and communities to aim for their needs and requirements to be at the centre of service provision, and for quality assurance systems to be in place that makes the services acceptable to service users

1. Worklessness and health

- Are representatives of the '8 strands of equality' (age, gender, disability, minority ethnicity, LGBT, faith, carers and Human Rights) engaged in the worklessness agenda?
- Is Business in the Community (BITC) involved in the worklessness agenda?
- Is transport to work from deprived areas an issue that has been discussed with deprived neighbourhood representatives?

2. Job Readiness and Job Broking

- To what extent is there a strategic drive to encourage support organisations to adopt a common approach to supporting people to find work and stay in their job?
- To what extent have employers been involved in this?
- Is there a recognised organisation that is responsible for designing and arranging delivery of the processes that will support its use?
- What measures exist to gauge employer satisfaction with local employment services? Are these collated and used in strategic development?
- To what extent are there agreed common standards amongst providers about what constitutes good job application skills? Which features (if any) does this include:
 - awareness of job demands set against self-awareness
 - understanding of transferability of skills
 - vacancy searches, speculative approaches
 - letters of application / CVs

- preparation for interviews
 - attendance and performance (especially attitude) at interview
 - seeking / taking feedback from employers
- How are common standards agreed (if this is the case), monitored and quality assured?

- To what extent do support organisations engage with employers to gain their input to job application skills coaching?
 - Are employers used for 'mock' interviews, independent evaluation of CVs, or similar?
 - To what extent do job seekers learn the specific methods used by local employers to be included as part of their provision? For example, are there particular 'automatic' prohibitions (e.g. phoning if the vacancy specification says write; aversions to 'stock' CVs being submitted; negative response to speculative approaches; sample tests which employers use). .
- To what extent do NHS trusts participate in working with support organisations in these activities?
 - What services could the NHS trusts contribute that link health to job readiness?

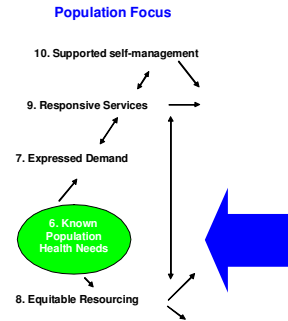
3. Marketing for employer's vacancies

- To what extent do the strategic leaders engage with employers on the issue of worklessness?
 - Are employers involved on the issue in LSPs?
 - To what extent are positive messages about engaging workless people part of the economic framework?
 - Do employability support provider (ESP) employers act as ambassadors for the recruitment of workless people?
- Jobcentre Plus has a large database of vacancies for jobseekers.
 - To what extent does JCP give positive messages about recruiting workless people?
 - To what extent can JCP improve access for support organisations to the vacancies?
- How does the local community of support organisations use the JCP database?
 - To what extent is it helpful to them?
 - How would they advocate this service is improved for their particular needs (and that of their clients)?
- How, in general, are local support organisations involved in a structured approach to gaining **vacancies where priority will be given to workless people**¹⁶:

¹⁶ Note: If local the approach is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 5 asterisk levels.

- * Support organisations respond to ad hoc needs for individual clients to acquire a specific opportunity for that client. If the client does not get the job, or there are other jobs available, the provision does not have the resource or facility to act on them.
 - ** Some organisations (perhaps in cooperation with JCP) canvass for vacancies for workless people, probably use them primarily for their own client(s), and if unfilled, share them with JCP and the others in the group
 - *** There is recognised group of providers, because they are specifically funded for the purpose, canvass for vacancies, and share them with others in this group probably using the JCP database¹⁴.
 - **** The situation in the previous point is enhanced by the sharing of the vacancies to a wider network of support organisations – ideally to all in the strategic network
 - ***** As in the previous point, with a strategically driven facility for the recording and distribution and handling of the vacancies at a dedicated location (or website) which runs in parallel with JCP's database¹⁷.
- To what extent are NHS trusts engaged in positive activities in dedicating vacancies, in the first instance, to workless people?
 - Is this part of the trust's strategic drive?
 - Do the trusts participate in promoting the positive policies and practices in the wider strategic arena (local employment partnership (LEP etc)?)
 - To what extent do trust employees promote positive messages about recruitment of workless people as part of their everyday activities?

¹⁷ Once a vacancy goes onto the JCP database it becomes available to other agencies nationally and internationally. If the vacancy has been given to the support organisation with undertakings about the nature and quality of the handling of the vacancy, it becomes more difficult to retain that level of 'personal service' because of the access by the wider community.



6 Known population needs

Aim for a realistic assessment of the size of the problem locally, and its distribution geographically and demographically and the level and type of service being based upon this assessment.

1. Worklessness and health

- What are the local levels of unemployment, ‘actively seeking work’, disability, skills levels, aspiration levels?
- What work is available locally – in terms of type, complexity and skill levels?
- How does the local supply match labour market demand?
- How are jobseeker and employer needs (as informed by the 3 questions immediately above) discerned? How is this brought together and used?
 - What collated information is available about local worklessness?
 - Which organisations are the key sources (e.g. Jobcentre Plus, Connexions, local authority, colleges)?
 - Are other organisations providing information (e.g. charities, third sector companies, community organisations)?
 - What information does the NHS have (e.g. JSNA)?
- How is this brought together and used in relation to NHS services? (For example, general information on numbers of jobseekers, their skills and skills gaps, labour market needs, relationship between skills gaps and learning provision. For NHS – information on local health, health-related causes of worklessness etc.)

2. Range of service options for worklessness

- Is there evidence of gaps in meeting some jobseekers’ or employers’ needs? Is there evidence of over-provision and duplication in some areas of learning and development?

3. Employment and health

Low pay and long hours

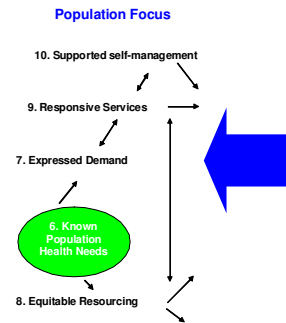
- Is there local support to the National Minimum Wage Act role of HM Revenue and Customs (HMRC) to enforce the national minimum wage – assisting complaints made about employers suspected of not paying the minimum wage, and facilitating visits to a sample of employers about

whom no complaints have been made?

- Is there local compliance with the EU Working Time Directive legal requirement to record employees' working hours, and opt out conditions?
 - Workers signing individual opt out agreements, with no penalty for refusal
 - Employers maintaining records of staff working more than 48 hours a week –available to the appropriate authorities.
- Have groups of workers working long hours been identified?
 - Over 55 hours per week (8% nationally)
 - Over 60 hours per week (3.2% nationally)
 - In excess of 70 hours per week (1% nationally).
- Has action been taken on specific groups?
 - The exemption, which allowed doctors in training a longer period of time to reduce their working hours down to 48 per week, ended at the beginning of August 2009?
 - Truckers/coach drivers/taxi drivers?

4. Work conditions

- Are the basic requirements of the Health and Safety at Work Act met by local employers? That is, the Health and safety of:
 - Plant and systems of work – machinery, equipment or appliances including portable power tools and hand tools
 - Use, handling, storage and transport of articles and substances
 - Information, instruction, training and supervision to aim for employees carrying out their jobs safely.
 - Workshops are safe and healthy with proper means of access and egress.
 - Workplace environment safe and healthy, with an uncontaminated atmosphere.
- Is there locally a good understanding the impacts of health and safety hazards on health?
- Are there specific programmes targeted at work-related health issues, such as:
 - asthma
 - musculoskeletal disorders/ back pain
 - chronic fatigue syndrome
 - COPD
 - infections
 - skin/latex allergies
- Is there a programme/s to address the health needs of self-employed people (such as taxi drivers):
 - Reluctance to take time off work
 - Reluctance to admit to conditions that affect employability (e.g. diabetes/ uncontrolled blood sugar affecting driving)
 - Regular night shift work



7 Expressed demand

Aim for as many people as possible suffering from the problem or its precursors, to present to services in a timely and appropriate fashion, through informing, educating and supporting the population

1. Worklessness and health

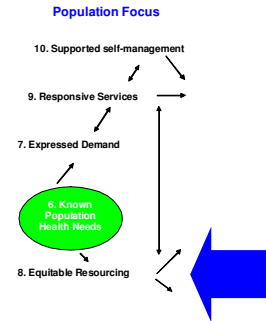
Employment and Support Allowance

- Is there adequate local health support for employment programmes?
- Are there local arrangements to help people who have health conditions on Jobseekers Allowance?
- Is there active engagement of health services (mental health in particular) in the local employability programmes?

2. Employment and health

Workplace health

- To what extent are workplaces actively pursuing health at work for all their employees? Examples at different levels might include:
 - action taken on workplace absence – for example the HSE's Management Standards
 - some HR policies that address support for health (e.g. on alcohol and drugs)
 - one or more major employers with occupational health services, working in cooperation with employees' GPs
 - occupational health used as an effective means of reaching men
 - Proactive occupational health services, supporting personal health targets.



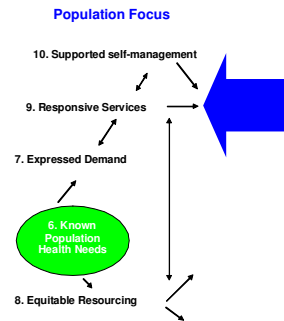
8 Equitable resourcing

Aim for the distribution of finance and other resources to support equitable outcomes according to need

1. Employment and Health

NHS as corporate employer

- Is there a local NHS cadet or apprenticeship scheme, working with local schools and colleges?
- Does the apprenticeship scheme access a number of professional and/or support level careers, for example midwife, radiographer, speech and language therapist, dietician, occupational therapist, porter, healthcare scientist or medical records officer?
- Is there employment of local people for proactive health work (e.g. NVQ level 3 staff employed to identify patients with risk conditions on GP registers)?
- Are health trainers appointed from seldom seen/heard groups including new migrant communities as a gateway to these groups/communities and a pathway to employment for the trainers?
- Is there a triple-win approach to working with trainees from seldom seen/heard groups?
 - Service re-design to improve access
 - Skills development leading to employment
 - Delegation of appropriate tasks from health professionals to trainees



9 Responsive services

When people present to services, aim to make sure they are afforded equal access to timely beneficial interventions according to need.

1. Worklessness and health

Diagnosis, action planning and allocation

- To what extent is action planning done:
 - To develop a SMART¹⁸ medium-term plan, demonstrating timed progress, with a clear end-product?
 - On the basis of 'Try this and we'll see where you go from there...' (that is, a 'suck it and see' approach), usually based on what services are on offer.

- To what extent does the quality of action planning depend on
 - local strategic commitment to high quality
 - the ease of access to opportunities and providers
 - the range and extent of provision

- Do advisers have access to a central point where information is available to design Action Plans (e.g. is the information collated and available via a web site)?
 - How easy is it to access?
 - How open are organisations to receiving referrals?

- Is there a common referral system (i.e. common protocols, common recording of outcomes to feed into monitoring), used by most organisations, or does each organisation have its own process?

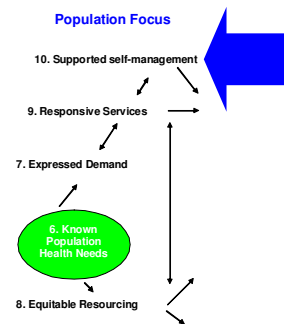
- Do organisations cooperate systematically to support transition of people from one learning or development to another?
 - Do they prepare clients and the next provider for the transition?
 - To what extent do funding regimes, requiring documented statistical outcomes inhibit this type of cooperation? (With a large number of funded programmes, one client may only feature statistically once, so transfer to another provision may mean loss of a 'success statistic' to one of the providers).

¹⁸ SMART Specific, Measurable, Attainable, Realistic, Time-bound

- To what extent is there a system to monitor progress, to minimise dropouts?
 - Does any such system feed back to providers any issues of quality in the outcome from their work with jobseekers?
 - How is that managed and controlled. (E.g. is there agreement that sets down which organisation is primarily responsible for the transition: the one which referred the client, the provider that client is leaving, or the next provider in the action plan).
- What is the level of expertise of local advisers?
 - Is there any strategic effort to 'raise the bar' in the quality of performance of local advisers?
 - Is it possible to quantify the extent to which the level of expertise of local advisers impacts on the quality of advice given? (For example, an ESOL course that could give better support if it included more 'labour market language'; a food hygiene course to include more on fast food retailing. There may also be need to feed back on overall quality issues).

2. Employment and health

- Is there a local service to provide support to employees who may be at risk of spending long periods away from work with health problems?
- Are local healthcare systems and practitioners aware of the evidence that work is generally good for health and that returning to work at the appropriate time is part of the recovery process?
- Do local services coordinate help with:
 - health and treatment
 - employability
 - wider support services – for example debt, relationship or housing problems
- Is there a local return to work service conceived in terms of providing:
 - personalised support
 - timely back-to-work support
 - case managers who will aim to ensure that clients are helped to access the most appropriate forms of support
- Is there a local commitment for such services to be sustainable over the longer-term?



10 Supported self management

Where appropriate, help service users to be empowered to make choices about their circumstances and service offer on the basis of good information, and to be supported to utilise the service offer to best effect

1. Worklessness and health

Transition to work

- In general, what provision¹⁹ exists?
 - * Very little and job entrants are largely left to sink or swim on their own
 - ** A small number of providers have funding to do a limited range of input (e.g. benefit transition, mediation in difficult situations such as minor workplace discipline issues etc)
 - *** A wider range of support activities is available (e.g. mentoring by provider; training for workplace mentors; training for supervisory staff; 'buddying' provision etc)
 - **** Good provision supported by awareness-raising activities by providers for employers on best practice in retention

- Where provision exists, to what extent is it targeted at specific groups, such as people whose first language is not English; disable people; long-term workless people etc? How does this impact on other jobseekers and employers?

- Do JCP or other private or voluntary providers offer services in this area?
 - How is it accessed?
 - To what extent is support exclusive to clients of who are funded by other providers?
 - Can other clients be drawn in?
 - Does such sharing exist?

- To what extent do NHS trusts engage in positive retention practices?
 - To what extent do they engage with support organisations that are delivering these services?
 - Is there scope, opportunity and resource for additional involvement?

¹⁹ Note: If local the provision is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 3 and 4 asterisk levels of provision.

2. Employment and health

Workforce planning

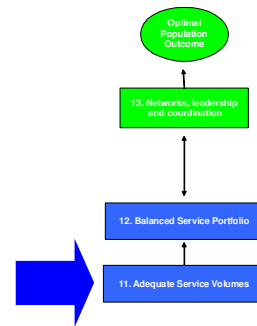
- To what extent are there programmes to promote workforce planning across the area? Who delivers them? How are they delivered?
- In general terms, is the approach by employers to workforce development²⁰:
 - * Small scale, short term, often in response to a crisis (e.g. loss of an order because the employer had not developed workforce skills in anticipation of demand). Little recognition of the benefits to employees of skills and qualifications in terms of sustaining employment and employability.
 - ** Wider responsiveness to promotions but with greatest emphasis on the lower-skilled jobs. Little objective recognition of the economic cycle of skill development for survival and/or growth. Growing awareness of benefits to employees and commitment to support them
 - *** Certain industries being advanced in their workforce planning, based on awareness of the constant change in technologies and communication (e.g. aerospace, ICT)
 - **** A more strategic approach, especially amongst larger companies, but still with some perspective that training is a cost rather than an investment. Slightly wider awareness of the economic dynamics of skill development, such that employers may wish their efforts to be badged e.g. through 'Investors in People' or similar.
 - ***** A strategically driven approach with large numbers of employers dedicated to realistic and forward-thinking workforce planning in the context of sophisticated market awareness. Market forecasting which is then translated into forward planning for recruitment and staff training e.g. planning for the constant change in technologies and communication
- To what extent do **NHS trusts** engage in workforce planning for economic and/or personnel benefits?
 - Is this strategically driven across all of the trusts?
 - Are the economic and personnel arguments given equal status?
 - Does positive action exist in some but not all parts of the trust?
 - What are the causes of the variations?
- To what extent can NHS trusts play a role in the wider strategic development of workforce planning?

Retention

- To what extent is the **LSP** including retention of employment as a positive aspect of preventing worklessness?
 - Do systems exist to promote the concept for economic prosperity?
 - Which organisation(s) lead in delivery?

²⁰ Note: If the local approach is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 5 asterisk levels.

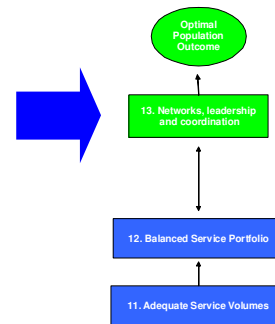
- Is there a systematic approach by employers regarding the management of individuals who have health conditions to seek to retain their employment and make the most of their potential?
- To what extent are there in-work healthy living programmes, promoting fitness, healthy eating, stress reduction, etc to sustain people's ability in their workplace?
- What are the NHS trusts' roles in initiating or participating in such campaigns?



11 Adequate service volumes

Commissioning adequate service volumes to aim for acceptable access times

- Are there limitations in capacity that would limit activity?
- Is there sufficient capacity in local employability support and job-readiness programmes for the number of customers ready to embark on employability programmes?
- Is there sufficient health capacity to support wider partnership activity that enables people to return to work and retain employment?



13 Networks, leadership and coordination

Designating leadership and coordination so services are commissioned and networked to meet population need and the population is supported to use services and interventions appropriately

1. Strategy and action plan

- Does a strategy exist for local worklessness and sustaining employment?
 - Does it exist / apply in all local authorities?
 - Is there any central driver of priorities and practices?
- How coherently are the various government departments' priorities coordinated (e.g. DWP, CLG, DH)?
 - Where / how are the resultant strategies managed?
- Is local provision of services for workless people directed and managed at a strategic level?
 - Who delivers this service?
 - How is it funded – core or non-core?
 - To what extent:
 - is provision set up by individual organisations without reference to strategically discerned needs
 - do some organisations consistently gear their provision to local strategies
 - is there a very high level of adherence to local strategies in acquiring funding for provision
 - How is this coordinated and managed?
 - How does this reflect in the completeness of local provision?
 - Are there gaps, overlaps etc (e.g. too much IT basic skills, not enough occupational; insufficient relevance to local labour market needs)?
- Is there a strategic framework for determining the provision of outreach / engagement for workless people?
 - What role does the Health and Wellbeing Board play?
 - To what extent does the NHS currently play a role?
- To what extent are all relevant organisations engaged in strategic development – inputting local needs information, feeding in information on the needs of jobseekers, responding to national, regional and local

drivers?

- Is it just the major ones (JCP, NHS, LAs)?
- Are community, voluntary and community organisations, and private providers, etc engaged and coordinated?
- What role do NHS trusts take in aspects of strategic development?
 - Who are they in active partnership with at senior management level (e.g. Jobcentre Plus, local authorities, LSC, others)?
 - In which strategic areas are they most involved?
- To what extent are employers engaged in the formulation of policies, strategies, etc?
 - Do they input information on priorities, needs etc?
 - Are they involved in determining the nature of local provision?
 - Are they well-informed about worklessness?
 - Do they receive, respond to and give out positive messages about workless people, and the benefits of positive action both economically and socially?
 - What role do local NHS trusts play as employers?

2. Partnership

- To what extent are worklessness and employment priorities²¹ within both the Local Strategic Partnership (LSP) and Health and Wellbeing Board?
 - * Given marginal consideration across the locality
 - ** Discussed but low priority for action
 - *** High priority for some parts of the locality where there is need
 - **** High priority to all parts of the locality, allowing for different levels and types of need
- To what extent are services for workless people created and operated in partnerships both within trusts and with other support organisations?
 - Do they maximise the use of existing provision, (e.g. adding value through specialist input, minimising duplication of activity – assessments of fitness for work / psychometric testing)?
- Has the development of the strategic plan led to cooperation and networking across all relevant organisations (e.g. is there evidence of cooperative bidding for funding, acceptance by organisations of the specialist skills of other providers; a controlled and monitored flow management of jobseekers throughout their progress)?
- To what extent do local NHS trusts' policies and strategies actively seek to engage in partnerships to support workless people's progress to work?
 - To what extent is this engagement as active participants in LSP and

²¹ Note: If the local approach is assessed as 1 or 2 asterisks, it will be important to make a plan to work towards 3 and 4 asterisk levels.

- similar strategic bodies?
 - How do the various NHS trusts in any locality coordinate their partnership input to strategic development (to represent 'health' rather than their own trust's agenda)?
- To what extent are local trust structures working in effective partnership (e.g. links to Surestart: coordination of GP Practices; PCT with specialist mental health trusts)?
 - Is there need for/evidence of any drive towards more extensive (appropriate) coordination of NHS services?
- At delivery level, which NHS workers are actively engaged in partnerships? To what extent is trusts' partnership effective with other key organisations, such as:
 - JCP and other local employment providers (eg Work Programme providers)
 - LA's social services and Connexions services (especially the latter's work with NEET (Not in Education, Employment or Training) young people?
 - with any existing local network(s) of organisations that are specifically working to support workless people? Is the pattern to work with individual support organisations rather than with the networks (if they exist)?
- Is there any partnership activity with employers or employers' organisations (e.g. Chamber of Commerce, Institute of Personnel and Development, LSP Employers Forums, other local employer meetings) for the purpose of, or which include developing support for workless people who are seeking work?
 - What role do the trusts play in these for the benefit of workless people – e.g. strategic, operational delivery, advice and guidance?
 - Are all the appropriate staff engaged in this work?

3. Data and data sharing

- To what extent is the range of provision (directed strategically) based on high quality information about the needs of the local labour market – both jobseekers and employers?
- How are information-flows created and maintained to evidence the need for such services?
 - To what extent is information from external sources used in these decisions e.g. from LSP, JCP, Connexions, LA Economic Development Departments, Skills Funding Agency, colleges, local employers partnerships
 - Are all service areas aware of the potential for developing such services, and the consequent need for input of information to create the business case?

- Do structures exist to enable this, and to aim for it to receive due attention?

4. Commissioning and provision

- To what extent do commissioners and providers follow the strategy to support workless people's job-search and job entry activities?
 - To what extent do the contracts awarded, through social clauses, specify the ways in which the contractors should support this activity?
- To what extent is the work planned and delivered in conjunction with other trusts and local authorities, especially on common services (e.g. transport)? (There may be need for multi-trust collaboration, in some areas of commissioning to establish economies of scale).
- To what extent do NHS trusts' policies and strategies positively influence the procurement of labour market related services for workless people as an integral part of its equalities initiatives? For example a mental health trust setting up a social enterprise to employ and develop the skills of its patients.
- Does the NHS commission health and social care from within support organisations for jobseekers including the local VCS?
 - Is volunteering in health offered as a pathway to work?
 - Do NHS estate building contracts have 'social clauses' to recruit locally?
- Is there any recognised process of evaluating commissioned/ provided services?
 - If they are successful, are there methods of mainstreaming those services?
 - How is this process managed and quality-assured?
 - Does this apply to both direct and indirect patient services (e.g. direct may be Health and wellbeing contracts; indirect may be catering, construction, and/or building maintenance contracts)?

5. Transition to work

- To what extent is there strategic recognition of and commitment to the benefits of supporting the transition from worklessness to employment?
 - Do structures exist to support the recognition and commitment?
 - How are they managed and monitored?

6. Marketing for employers' vacancies

- To what extent do the strategic leaders engage with employers on the issue of worklessness?
 - Are employers involved on the issue in local strategic partnerships, etc?
 - To what extent are positive messages about engaging workless people part of the economic framework?
 - Do local strategic partner employers act as ambassadors for the

recruitment of workless people?

7. Long-term sustainability of employment

- To what extent do high-level local policy and strategy decision makers promote sustainability of employment issues on their agendas?
 - Have systematic approaches been developed and put in place to support the policies?
 - Which organisations take lead responsibility for management control and quality assurance?

8. Recruitment

- To what extent do the local strategic leaders (local strategic partnership, etc) promote positive policies on recruitment, especially with those employers who are part of the strategic body?

Optimal population outcome

Aiming for intermediate and health and wellbeing outcomes to be meaningful locally, and drive the programme

1. Worklessness and health

Awareness of health/worklessness links

- To what extent is information on this topic recognised at strategic level as key for NHS workers?
 - How does this translate into trusts' policies and strategies?
 - How is information to employees managed to aim for appropriate levels of knowledge amongst employees?

- What level of awareness is there amongst frontline staff of health/work links (i.e. the symptoms and effects as described below, and the longer term impacts on health)?
- The common symptoms and causes of mental health conditions – eg anxiety, depression, isolation, low self esteem and self confidence
- Knock-on effect in performance in job applications, interviews etc
- The 'protective barriers' commonly cited as reasons for not seeking work (e.g.: "I've tried and failed; I've no skills; Employers don't want the likes of me; I'm too old / young / inexperienced.")
- Lack of success in dealing with employment and worklessness issues on the part of customers/clients/patients will continue unless frontline health and statutory sector staff are supported to be aware of health/work links
 - How well aware are non-JCP staff about the JCP process for people out of work?

2. Access to Worklessness Support Network

- To what extent do frontline staff know what, if any, infrastructure of support exists to help people progress to work?
 - * In-house provision only

 - ** Ad-hoc searches for support in particular situations

 - *** Links to a narrow range of external providers who have introduced themselves to the service

 - **** A wide range of providers as a result of initiatives taken to access external support

 - ***** Access to a comprehensive network of information that gives access to most or all provision

3. Extent of knowledge/awareness

- Is it clear for which frontline staff it is KEY that they have:
 - the understanding of the health / worklessness links - and/or
 - access to the local labour market support for people who want to progress to work

- To what extent do key people have the above-mentioned knowledge/access?
 - How is the knowledge disseminated?
 - To what extent is there certainty that it exists in all functions where it is necessary?

- Is it clear for which staff it is desirable that they should be informed on either awareness of health/worklessness links and/or access to the worklessness support network for the benefit of the patient?

Appendix 1: Health Inequalities National Support Team – Potential Key Actions for Reducing Mortality

1 Strategic coordination

- Exploiting all possible levels of coordination:
 - LSP-led strategy that reflects national, regional and local priorities. All agencies committed to and actively contributing through processes that underpin the strategy and are geared to the needs of jobseekers and employers
 - A coordinating partnership/ steering group /strategy management body
 - Subject-specific ‘task and finish’ groups
 - Cluster or sector strategy

2 NHS partnership

- Active engagement of PCT and acute trusts in
 - A coordinating partnership/ steering group /strategy management body
 - The ‘Employer Offer’
 - Post-entry sustainment of employment
 - retention of employees who have health conditions

3 Awareness

- All relevant people fully aware of the health / employment cycle, know the progression and how to access infrastructure of support to help workless people progress towards employment.
- Everyone dealing with public have a) awareness of health/work links and b) skill and knowledge to refer into employment support infrastructure.

4 Marginalised groups

- A cross-partnership understanding of the employability, health and social support and services needs of more marginalised groups to help them a) towards employment and b) sustain them in employment.

Marginalised groups include:

- Young people/NEETs – National Apprenticeship Service, ‘Foyers’
- Lone parents
- Disability assistance for disabled people (e.g. JCP ‘Access to Work’)
- Directed towards people with mental health problems (e.g. employability schemes in mental health trusts)
- Offenders - Employability training (e.g. in prisons, unpaid work, Offender Learning and Skills Service)

5 Outreach/Engagement

- Outreach targeted and coordinated strategically:
 - community and statutory outlets used (e.g. GP surgeries, Children’s Centres)
 - Well networked organisations and individual advisors are able to

- identify people's needs, including pre-work issues (e.g. health, housing, money) and refer to source of help
- Barriers addressed – abuse, mental health conditions, learning difficulty

6 Range of options for individuals

- Full range of options available in a framework of constructive and individually tailored action plans that demonstrate clear progression – from basic personal development (self esteem etc) to generic and job-training, work sampling (etc), volunteering etc, job application skills. Specialist generic/job specific training includes:
 - Access for advisors to the programmes available
 - Appropriateness of the options
 - to meeting the clients' needs
 - to meeting employers' needs
 - Special provisions for special groups of jobseekers (Black and minority ethnic community members, people with disabilities, young, old, etc)
 - Progression management (i.e. avoiding drop-outs, one-off experiences, multiple experiences but with no discernable progress to work)
 - Possibly a 'Job Ready' assessment

7 Marketing for employers' vacancies and recruitment

- Campaigning for vacancies where workless people will get priority consideration
- Expert marketing, positive messages
- Networked – vacancies shared across all support organisations
- Database (complementary to JCP) for vacancies where employers are committed to using workless people as their first source of recruitment
- Expert input (including from NHS) to employers on dealing with workless people.
- Criteria to define 'good' employer recruitment practices for workless people. Formal recognition of good practices (e.g. by LSP):
 - Employers have policies and processes that aim for access to all potential applicants.
 - Simplified application forms relative to job complexity, giving access to testing / interview processes to pre-train applicants.
 - Promotion of 'corporate responsibility' through recruitment – All recruitment decision-makers committed and engaged.

8 Transition to work

- Provision available aiming that:
 - jobseekers are need assessed and support is delivered as needed
 - employers are 'educated' about issues and are positive
 - provision can identify transitional needs, engage proper support service(s), provide intervention if crises arise, have mentoring / 'buddying' etc available. Good uptake on training for supervisors and employers.

9 Long-term sustainability of employment

- Promotion of workforce and training as high-value investment (not cost).
 - Positive retention and development policies and practices
 - Encouragement that new employees should be fully trained, qualified and thus they and company more stable
 - Extensive training needs analysis and planning
 - Access to support including professional mediation when individual workers need help

10 Work conditions

- **Low pay and long hours**
 - EU Working Time Directive - workers signing individual opt-out agreements. Employers maintaining records of staff working more than 48 hours a week
 - Identification of groups of workers working long hours
 - Action on specific groups: Doctors in Training reduction of working hours to 48 per week as of August 2009. Truck /rail /coach /taxi drivers
- **Health and safety**
 - A good understanding the impacts of health and safety hazards
 - Employer policies for tackling work-related stress
 - HR policies that address support for health (e.g. on alcohol and drugs)

11 Workplace health

- **Occupational health**
 - One or more major employers have occupational health services
 - Small and medium employers are encouraged to access support – eg the free national occupational health advice line
 - Occupational health is used as an effective means of reaching men
 - Occupational health services are proactive, setting personal health targets
- **Employment retention programmes**
 - Job retention programmes (eg Fit For Work Services) address mental health issues and musculoskeletal disorders in particular; also asthma, back pain, chronic fatigue syndrome, COPD, infections, skin/latex allergies
 - Programmes include social support (e.g. debt problems, becoming a carer etc)

12 NHS as corporate employer

- **Local NHS cadet or apprenticeship scheme**
 - apprenticeship scheme accesses a number of professional and/or support level careers (for example), midwife, radiographer, speech and language therapist, dietician, occupational therapist, porter, healthcare scientist, or medical records officer

- **Appointment of health trainers from seldom seen/heard groups:**
Triple-win approach to working with trainees from 'seldom seen/heard' groups:
 - Service re-design to improve access
 - Skills development leading to employment
 - Delegation of appropriate tasks from health professionals to trainees

13 NHS as commissioner

- Volunteering in health is offered as a pathway to work
- NHS commissions health and social care from within the local VCS
- NHS building contracts have 'social clauses'
- Health commissions local organisations to deliver on social determinants (e.g. mental health commissions debt services, and debt services are commissioned to include smoking cessation as part of expenditure reduction)

14 Health and Social Care Enterprise

- There is an agency (possibly in the voluntary, community or faith sector) with a role to support and develop social enterprise
- Local Health and Social Care Social Enterprises have developed (e.g. from former healthy living centres)

Appendix 2: Health and Safety Executive Regional Contact Details

Health and Safety Executive - contact HSE via their [online enquiry service](http://www.hse.gov.uk/contact/ask.htm)²² or by telephone on 0845 345 0055.

London	West Midlands	East Midlands	North West	Yorkshire and North East
Rose Court 2 Southwark Bridge LONDON SE1 9HS Fax: 020 7556 2102	Birmingham 1 Hagley Road Birmingham B16 8HS Fax: 0121 607 6349	Northampton 900 Pavilion Drive Northampton Business Park Northampton NN4 7RG Fax: 01604 738333	Manchester Grove House Skerton Road Manchester M16 0RB Fax: 0161 952 8222	Leeds Marshalls Mill Marshall Street LEEDS LS11 9YJ Fax No: 0113 283 4382
Westminster Office Sanctuary Buildings 20 Great Smith Street LONDON SW1P 3BT Fax: 020 7227 3802	Worcester Haswell House St Nicholas Street Worcester WR1 1UW Fax: 01905 723045	Nottingham City Gate West Level 6 (First Floor) Toll House Hill Nottingham NG1 5AT Fax: 0115 971 2802	Preston Marshall House Ringway Preston PR1 2HS Fax: 01772 836 222	Sheffield Edgar Allen House 241 Glossop Road SHEFFIELD S10 2GW Fax: 0114 291 2379
Construction Division Rose Court 2 Southwark Bridge LONDON SE1 9HS Fax: 020 7556 2109	Stoke on Trent Lyme Vale Court Lyme Drive Parklands Business Park Newcastle Road Trent Vale Stoke on Trent ST4 6NW Fax: 01782 602400		Carlisle 2 Victoria Place Carlisle CA1 1ER Fax: 01228 548482	Newcastle Arden House Regent Centre Regent Farm Road Gosforth Newcastle-upon-Tyne NE3 3JN Fax: 0191 202 6300
			Bootle Headquarters Redgrave Court, Merton Road, Bootle, Merseyside, L20 7HS	York HSE Chemical Regulation Directorate (CRD) Mallard House Kings Pool, 3 Peasholme Green YORK YO1 7PX Telephone: 01904 455775 Fax: 01904 455733

²² <http://www.hse.gov.uk/contact/ask.htm>

Appendix 3: Glossary, acronyms and abbreviations

The following terms are used in the workbook. Many of them reflect a usage that is particular to activities the labour market, especially for people without work.

Access to Work	JCP funded programme providing adaptations to employers' premises or work equipment etc to aid entry to / retention of work, especially for disabled people.
Action plan	A plan agreed between the jobseeker and support advisor, detailing the steps he / she will take to enter employment.
Allocation	The process of setting up a stage of the Action Plan.
BME	Black and minority ethnic
CMP	Condition Management Programme
Commissioning	In this workbook, termed Labour Market Commissioning / LM Commissioning to distinguish from DH terminology. The process of procuring services that will support people in their progress to work.
Connexions	Government funded provision for young people. It focuses on the age-range 14 – 19. Its services include preparation for and entry to the labour market. It includes careers guidance, sometimes for adults.
DCLG	Department for Communities and Local Government
DH	Department of Health
Disability Employment Advisor	Jobcentre Plus employee who is expert in supporting disabled people to enter employment.
DWP	Department for Work and Pensions - the 'parent' Government Department responsible for Jobcentre Plus.
Employer engagement	Positive active work to encourage employers to give priority consideration to workless people in their recruitment processes. See also LEP – Local Employer Partnerships ²³
ESA - Employment and Support Allowance	From October 2008 Employment and Support Allowance replaced Incapacity Benefit and Income Support paid on incapacity grounds for new JCP customers. The Work Capability Assessment assesses what customers can do, rather than what they cannot, and identifies the health-related support they might need.
ESOL	English for Speakers of Other Languages
ESP - Employability Support Providers	See Providers
FFWS	Fit for Work Services – an example of retention services
Funding	The broad term used to describe revenue that procures services (in this context) that will help workless people re-enter the labour market. Some of this is centrally driven for national programmes – eg JCP's provision. Other funding may be from statutory authorities' core funding, (eg local authority, NHS), used to meet local needs within the authorities' statutory responsibilities.

²³ <http://www.communities.gov.uk/localgovernment/local/localenterprisepartnerships/>

	Further funding eg from the European Union, DCLG, development agencies and charities, may also be accessed to meet local needs, within the rules of its availability, often related to the local level of deprivation.
HMRC	HM Revenue & Customs
HSWA	"Health and Safety at Work etc Act 1974"
Incapacity Benefit	The forerunner to Employment and Support Allowance. Beginning in 2011, all Incapacity Benefit customers will be re-assessed for eligibility for ESA.
In-work support	Services to employers and employees to sustain people in work. This might include grants to an employer, support with the training costs, adaptation to premises and equipment. Jobseekers may receive personal grants, training 'vouchers', or have the support of mentors, 'buddies' or 'advocates'.
Job Broking (sometimes called brokering)	The process of acting as intermediary between the employer and the jobseekers. It includes, searching for vacancies / jobseekers, discussing candidates, gaining commitments from employers, arranging interviews, follow-up etc.
Job Readiness	An emerging term denoting an objectively-assessed state of readiness to apply for work. The assessment applies to jobseekers to a) give them encouragement that they have the right skills (or potential) and the right attitude for work, and b) to encourage employers that these candidates will be low-risk recruits.
Jobcentre Plus / JCP	Jobcentre Plus is the major government body responsible for payment of benefits and delivering programmes for workless people to return to work. It delivers services directly through a network of JCP offices. It commissions services from other providers to complement its nationally-designed services, and usually seeing to reflect on local needs.
LGBT	Lesbian, gay, bisexual, transgender
Local Employment Partnership (LEP)	A JCP-led programme of engagement with major employers to gain their commitment to giving full and fair consideration to workless people in their recruitment processes.
LSC	Learning and Skills Council, now succeeded by the Skills Funding Agency and Young People's Learning Agency
LSP	Local strategic partnership
NMW	National Minimum Wage
OT	Occupational therapist - Occupational therapy is about helping people do the day-to-day tasks that "occupy" their time, sustain themselves, and enable them to contribute to the wider community.
Progression Model	An emergent concept that structures the range of support provisions available for workless people. The approach is used to structure action plans and give jobseekers greater clarity of their likely progress. Progression models can also provide

	strategic overviews of provision set against needs.
Providers	This is a generic term used for all organisations that are actively engaged in delivering services that support progress to work for workless people. They each may deliver all or some of the following services: outreach, personal development, training, job application skills, job broking, in-work support. They may also specialise in their client groups (e.g. ethnic minorities, people with disabilities, specific disabilities, age-related groups). Their funding sources are diverse – see Funding.
Referral (systems)	The process and interaction between support organisations in arranging entry to provision for a jobseeker.
Social clauses	A term describing contractual obligations in commercial contracts that will deliver social benefits for communities. In this context they relate to labour market benefits.
Skills Funding Agency	One of the successor organisations to the Learning and Skills Council.
Support agencies	Providers of services to help progress to work for workless people.
Sustainability of employment	Activities and support services that will help people retain their jobs. There may be two aspects. 1. There is high risk that people moving from worklessness may not find the transition to work easy for many reasons (e.g. cash flow after benefits, discipline, etc). Services seek to stabilise these circumstances. 2. Employers may see dismissal as the only option when a long-serving employee presents problems – from substance abuse to acute illness. This ignores the value of their input. Services seek to intervene to explore and implement more positive options.
Transition to work	See Sustainability of Employment
Vacancy Management System	JCP has an excellent national / international system for bringing people and jobs together. In some areas it is considered appropriate to introduce a complementary system that will enable priority to be given to workless people.
VCS	Voluntary, community, faith sector
Work Capability Assessment	See Employment and Support Allowance
Workforce Planning / Development	An industry-wide process of forward planning of labour levels and skill development. Often the focus of government-driven initiatives.
Worklessness	The broad term for all people who are inactive in the labour market, and have the capacity and/or the wish to be active. It includes those irrespective of whether they are in receipt of benefits (e.g. to include partners of benefit recipients, or simply those with no entitlements).
Young People's	One of the successor organisations to the Learning and Skills Council.

Learning Agency	
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