



Pathways to work | Helping people into employment



Ingeus responds to the invitation to shape change

Our business is built on recognising the **potential of every individual** and rejecting internal and external barriers to achievement.



Introduction

The Ingeus Group supports businesses with integrated human resource solutions and provides governments with effective, accountable employment-focused welfare services. Our business is built on recognising the potential of every individual and rejecting internal and external barriers to achievement. Ingeus is committed internationally to contributing to community empowerment and social inclusion.

The Ingeus Group of today has evolved from a small company which commenced operation in Australia in 1989. Work Directions Australia quickly established a reputation for inspiring people who were cut off from work due to disability, illness or injury, enabling them to rediscover their potential and access sustainable employment. In the 1990s this expertise was extended to provision of outsourced employment services for Government. By 2000, WorkDirections had become Australia's fourth-largest provider of the welfare-to-work programme known as Intensive Assistance.

In 2002, the company was rebranded as Ingeus Ltd. The group now employs around 800 people and delivers services through special-purpose subsidiaries in the UK and Australia:

- WorkDirections UK delivers innovative welfare-to-work services for people who are long-term unemployed on the Private Sector Led New Deal in Central and West London;
- WorkDirections Australia provides employment services, as part of the Job Network, and supports individuals on initiatives such as the Personal Support Programme and Transition to Work;
- Inergise provides pro-active, outcome-focused Corporate Health services, in particular - injury management, injury prevention, rehabilitation programmes, occupational health and safety and related training;
- Clements provides recruitment services in: labour hire, office and administration (permanent and temporary), technology, corporate and executive;
- Invisage provides management training, accredited vocational training and traineeships.

If only 20% (one in five) of Incapacity Benefit claimants could be helped into employment, more than £3 billion would be saved per year in benefit payments alone ...

Welcoming change and drawing on experience

The Ingeus Group welcomes this vital initiative to effect significant change in the way people excluded from work by injury or illness are supported. We recognise the far-reaching significance of the Government's strategy, for both society as a whole as well as for the lives of so many individuals. As unemployment in this country continues to fall, there are few trends as important as the millions of people moving to, or apparently trapped on, an Incapacity Benefit.

Over £300 million is paid out every week in Incapacity and related Income Support Benefits. This is over £16 billion per year.

We hope that there are valuable insights in our unique perspective, offered by the international synergy of Inergise's experience in rehabilitation and WorkDirections' experience in employment services.

The Secretary of State summarises the Green Paper proposals in his forward:

- Increased financial incentive to return to work;
- More support through and clearer referral channels for Jobcentre Plus;
- Groundbreaking rehabilitation programmes;
- Focus on people moving from an Incapacity Benefit to Jobseekers Allowance.

The Green Paper recognises the role of different stakeholders. It draws on some research of programmes both at home and overseas. It demonstrates an understanding of the factors which change attitudes and behaviour. The Paper's objectives, however, are not necessarily supported by the measures which it goes on to outline.

We will endeavour to take forward the debate by:

- Considering the *Case for Change* with an analysis of the wider costs to society of maintaining so many on an Incapacity Benefit, and the considerable benefits of addressing the flow onto these Benefits;
- Suggesting that a more refined analysis of claimants is needed, with *Holistic Assessment of Need* enabling individual, targeted interventions;
- Questioning the extent to which current practice is *Creating Incapacity*, proposing measures to stem the flow through drawing on international practice in rehabilitation, possibly linked to legislative changes to incentivise employers;
- Noting that in *Creating Choices* we can promote *Capability NOT Incapacity* but will only succeed if we have an integrated response using allied health professionals to build a bridge between mainstream employment and health services;
- Proposing that the learning offered by *Six Different Pilots* is increased if we try out different delivery models in each and that success is in fact dependent on drawing in a wider set of expertise;
- Summarising briefly the different *Funding Models* which might be innovatively used to drive performance;
- Discussing the potential desirability of *A Mandatory Programme* if we are genuinely to meet the needs of individuals, and through them society as a whole;
- Responding to the request for a new *Nomenclature* and noting the tendency to conflate Incapacity Benefits claimants, thereby missing the variation in their need.

The Case for Change

Over the coming year a further 700,000 people are expected to join the 2.7 million people currently claiming an Incapacity Benefit. Unless something changes in our systems or in the delivery of our services they will then stay there until they move from an Incapacity Benefit to a pension.

As the argument for greater expenditure on programmes to assist Incapacity Benefit claimants is presented to a wider



... and these new employees could generate almost **£1 billion** in tax and National Insurance every year.¹

audience, it would gain greater support if the wider costs of incapacity were considered, as well as the wider benefits of getting people back to work.

There is, of course, a great personal cost to each individual in receipt of benefit. But there is also a far-reaching cost to society of maintaining these people outside employment - socially excluded and more likely to be accessing health care, to be in publicly maintained accommodation, to be on the caseload of a social worker, to be followed into a life of dependency by their children. It is about the cost to society of failing to draw on the 'human capital' offered by these people - leaving skills untapped and vacancies unfilled.

Holistic Assessment of Need

Therese Rein, Managing Director of Ingeus, spoke at a series of seminars on Disability and Employment organised in London by the Institute for Public Policy Research. The paper coming out of this IPPR project, written by Marilyn Howard, a social policy analyst, will bring together the insights of a wide range of informed and involved individuals and organisations. It is hoped that the Green Paper proposals will be carefully considered in the light of this paper. A sophisticated understanding of disability is offered which must inform the nature of any measures introduced.

The 2.7 million people on an Incapacity Benefit are a diverse population. A more sensitive analysis allows a more effective response. The Green Paper notes, for example, the considerable regional variation, with the numbers of sick and disabled people in different areas ranging from 2.1% to 23.2% in Easington, Durham and 24.7% in Merthyr Tydfil. The trend for lower proportions in the

South of England is broken by London with an inner city rate of 9.3%.

During her seminar Therese Rein explained how a mature, professional service, which meets the needs of each 'disabled' individual, requires a sophisticated and multi-layered understanding of disability.

Moving beyond the homogenous view of incapacity and of work, Occupational Rehabilitation provides a managed process of rehabilitation which starts with an 'holistic assessment', including:

- Functional capacity assessment - to determine physical capability and tolerances;
- Psychosocial assessment - to identify the psychological impact of the injury or disability;
- Workplace assessment - if still employed, to determine the real job demands;
- Vocational capacity assessment - if not employed, to identify current work skills, specific industry knowledge, transferable skills, job related interests;
- Self-reports on home activity - to identify congruence and consistency with other assessments;
- Liaison with treating medical practitioners - to confirm diagnosis, current treatment requirements and medical considerations for return to work;
- Conditions in the Labour Market.

1. Assuming that they are employed mid-way between the national minimum and average wage.



It is possible on the basis of such holistic assessment to determine a suitable rehabilitation goal from a 'hierarchy of goals':

- return to pre-injury job, same employer, full pre-injury hours;
- return to pre-injury job, same employer, reduced hours;
- return to alternate job, same employer, full pre-injury hours;
- return to alternate job, same employer, reduced hours;
- return to alternate job, with a new employer;
- an avocational outcome.

Every Incapacity Benefit Claimant is an individual with individual needs requiring an individually tailored solution. To lose sight of this variation will blunt our response and hinder our ability to provide any one of those special pathways back to employment.

Creating Incapacity

The Green Paper contains some strong, well-considered suggestions with early interventions for people moving to an Incapacity Benefit and a more responsive service for people moving back to Jobseekers Allowance.

A proactive response must consider measures to halt the move onto the benefits in the first place. The political pressure which historically shifted many people to an Incapacity Benefit is well known, but to what extent does the system still encourage this drift.

The impact of mainstream programmes

Over the next year an estimated 300,000 people are likely to move to an Incapacity Benefit from Jobseekers Allowance.

Over 10% of New Deal for Young People participants leave the programme to take up another benefit. Over 20% of New Deal 25 Plus participants transfer to another benefit within 16 weeks of starting the programme.²

This drift from programmes of active intervention to Incapacity Benefits is interpreted by some as evidence of

the attractiveness of the more 'passive' nature of these Benefits. However, it might also indicate that it is only on a New Deal programme that an individual receives sufficient personal attention to identify their real underlying needs.

Research suggests unemployed people are twice as likely as people in employment to suffer from depression.³ It does not take much for the depression, which is almost a natural consequence of unemployment, to become the cause, or the reason, for a move from Jobseekers Allowance to an Incapacity Benefit.

No steps are taken to identify triggers and introduce treatment in response to the potential onset of mental illness for people who have been long-term unemployed. The programmes for people on Jobseekers Allowance focus, naturally, on achieving employment outcomes. They tend to be delivered by generalists with no specialist knowledge of ill health or disability.

A pilot conducted by the Institute of Psychiatry at King's College, London, demonstrated the potential impact of Cognitive Behaviour Therapy on the mental health and job seeking of long-term unemployed people. It suggested that people on Jobseekers Allowance attending such a programme will be more psychologically resilient, less likely to move to an Incapacity Benefit and more likely to find employment. This was a limited pilot and there are no plans to extend the provision.⁴

An incapacity benefit trap

Unless it is possible to move easily backwards and forwards between different benefits, reflecting the dynamic nature of illness and disability, then the application of the benefits system encourages the fossilisation of incapacity. A claimant will hold onto their disability in order to hold onto the safety net of the benefit which it was so hard to win.

Incapacity Benefits are viewed as a single Benefit, in much the same way as claimants can be perceived inaccurately as an homogenous group. A more responsive and, therefore, effective system would be sensitive to



variation within this population. It would encourage movement between different degrees of support. It would enable different provision to be targeted to the needs of particular claimants of particular Benefits. It would demand a different level of expertise to deliver, or a different degree of engagement with external allied health professionals.

From absence to incapacity

Workplace absence has fallen to its lowest level for 14 years, but the annual cost to the employer has increased by more than £1 billion. The total cost of absence rose to £11.8 billion in 2001.⁵

A more proactive approach to injury prevention and injury management in the workplace would help reduce both the cost to employers and the cost to the taxpayer of hours lost to absence and the drift to long-term Benefits. The public sector could be leading in this area, with an average of 10.1 days lost due to absence, compared to 6.7 in the private sector.

This situation is in direct contrast to Australia where legislation requires employers to:

- Establish a return-to-work programme for injured workers (including, if necessary, vocational re-training);
- Hold an injured worker's original job open for six months (this varies across States but averages six);
- Provide suitable alternative employment for an injured worker if they cannot return to the same job.

Workplace injury insurance premiums are discounted as an incentive for employers who are able to demonstrate that

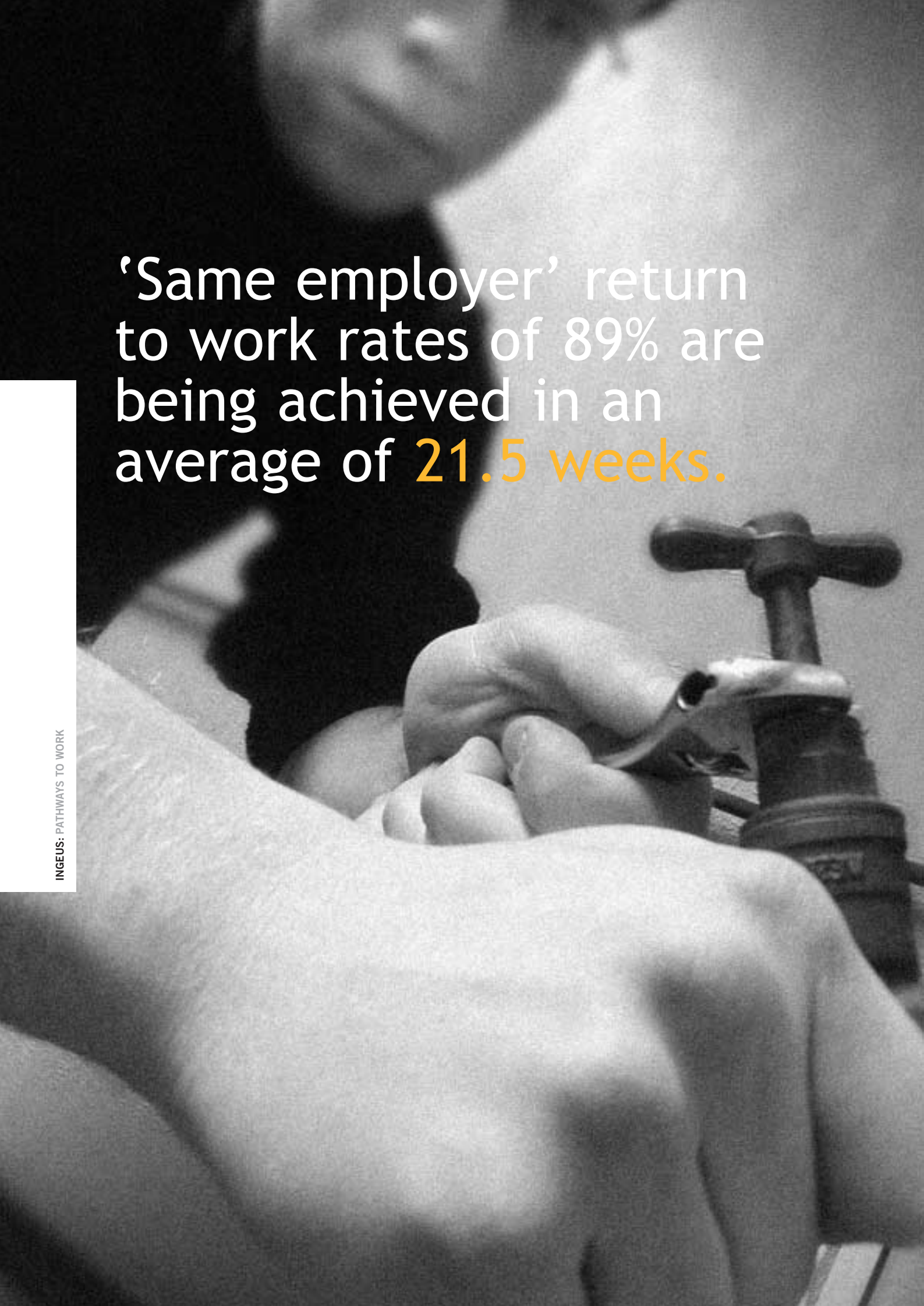
they have implemented programmes to improve workplace safety and return-to-work strategies for injured workers.

A specialist injury management provider, such as Inergise, will offer an employer:

- job analysis;
- worksite assessment;
- workplace modification;
- ergonomics advice;
- health and safety audits and advice.

Understanding and meeting the needs of the employer, who is viewed as a customer, goes hand-in-hand with provision for the employee.

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'Same employer' return
to work rates of 89% are
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Occupational rehabilitation

The Australian model takes people into rehabilitation almost immediately an injury or illness is identified. The individual has a statutory obligation to participate. The earlier the intervention, the stronger the likelihood of a return to full employment. It is in this way that organisations, like Inergise, are able to demonstrate such impressive results.

Occupational Rehabilitation is the restoration of injured workers to the fullest physical, psychological, social, vocational and economic functioning of which they are capable, consistent with pre-injury status. It is a managed process aimed at maintaining injured or ill workers in, or returning them to, suitable employment. The 'hierarchy of goals' has already been described. The person is usually still employed when referred for Occupational Rehabilitation and has either:

- sustained an injury or illness because of conditions in the workplace; or
- become ill or injured themselves outside of the workplace.

'Same employer' return to work rates of 89% are being achieved in an average of 21.5 weeks. In fact Inergise maintains a return to work rate of just under 95% with a typical large employer in the transport industry.



Similar support is offered to workers and employers in New Zealand, Canada and the United States, where there are active rehabilitation industries with early intervention and case management approaches.

There is also a wide range of good practice across Europe to be considered. These include initiatives for people still in employment or at risk or about to enter unemployment, such as:

- 'On sick leave - and active', run by the Danish Ministry of Social Affairs increases the likelihood of recovery and reintegration in autonomous working life through involving recipients of sickness benefit in a range of activities;
- Resource Centres for Suicide Prevention in Norway have trained vocational counsellors to recognise depression and possible suicide;
- Development Centres in Sweden target people facing redundancy with keep fit classes as well as counselling and retraining;
- The Sheffield Occupational Health Project identifies people in GP surgeries in need of occupational health advice, and particularly targets antenatal mothers to help them adapt and maintain employment. There is an education programme for midwives, who had not previously perceived employment problems to be part of their remit;
- The programmes of job 'alternation' in Finland or job 'rotation' in Denmark have the dual impact of reducing stress and its impacts through enabling extended leave or rehabilitation, whilst creating an opportunity for an unemployed person to gain experience and develop a work ethic.⁶



Creating Choices - Capability NOT Incapacity

There is clear empirical evidence that a return to meaningful activity, such as work, improves someone's health and well-being.⁷

The Choices Package proposed in the Green Paper identifies a number of pathways available for people moving back from Incapacity Benefits to work.

Given the fact that 40% of Incapacity claimants do not mention health as an obstacle to them getting a job, a large proportion might benefit from referral to existing mainstream programmes such as New Deal for Young People, New Deal 25 Plus and the Employment Zones. Either the intensive individualised support which is available in the best of these, or the simple frequency of intervention in others, may provide sufficient encouragement for many to find employment.

However, though this group do not mention health as an obstacle we must assume ill-health or injury has been the cause of their move to Incapacity Benefits in the first place. We must also recall the high number moving in the opposite direction from mainstream to Incapacity.

It is important to consider and disseminate the impact of New Deal for Disabled People. For a complete understanding of this achievement an interim evaluation might cover the:

- nature of the clients taking up the provision;
- type of support provided and its variance with best practice in other New Deals and on Employment Zones;
- performance with clients of different levels of need or disability;
- level of employment being accessed.

60% of Incapacity claimants do cite health as an obstacle to a job. Many of the clients currently on an Incapacity Benefit have a level of need for which no employment-focused rehabilitation currently exists.

Integrated professional rehabilitation

Moving beyond New Deal for Disabled People it is possible to graft on or marry a vocational focus with other developmental goals, providing focused, responsive routes to employment for people with significant barriers. WorkDirections UK has recently taken this concept further into Co-Financing proposals for Jobcentre Plus:

- Thinking Well for Work mixes job search with a programme of incremental independence for people suffering from depression or stress, using a therapeutic technique to help them develop resources for coping in the workplace;
- Jobs and Homes targets people sleeping rough or in insecure accommodation, mixing job search with a deposit and rent guarantee scheme, as well as life skills such as healthy living and budgeting.

The strength of our response for people on an Incapacity Benefit will be directly proportional to the extent to which we can integrate professional expertise and services. This might be described as the 'holistic professionalisation' of our response.

The Point Sante Jeunes in Gonesse in France is an example of an integrated approach bringing together social workers, doctors, psychologists and health insurers in a single place. The target group are young unemployed and a natural extension to the project would be the addition of a vocational counsellor. In Belfast the project V.O.T.E., run



by Action Mental Health, is a collaboration between Health and Social Services, the Further Education College, the Training and Employment Agency and local employers.⁸

In Australia, an Inergise rehabilitation team is multi-disciplinary. It includes occupational therapists, psychologists, rehabilitation counsellors and physiotherapists working closely in conjunction with the treating Doctor. A rehabilitation co-ordinator orchestrates the process according to a negotiated Rehabilitation Plan.

Vocational Rehabilitation programmes in Australia (as opposed to Occupational Rehabilitation for people still in employment) are achieving average 'new employer' return-to-work rates of 59% in 46 weeks. It should be noted that this group of clients have all recently been employed. However, they have generally been assessed as unable to resume their pre-injury occupation and their pre-injury employer was unable to provide suitable alternative duties.

The teams delivering welfare-to-work for Jobcentre Plus have considerable strengths but are not able to offer this level of professional expertise. This expertise is currently missing from the Choices Package and is beyond the scope of the advisor training suggested.

Building bridges with health services

Under the model currently proposed, public health services may have difficulty responding. 20% of the positions for Occupational Therapists in the UK are currently unfilled.

It may be that skilled health professionals would have to be sourced from overseas to meet the need.

General health professionals typically have no remit to consider someone's employability or employment prospects. The opposite might actually be the case. The health care system has the inbuilt assumption that someone with mental health, for example, should be protected from work. This expression of our modern understanding of 'care' actually serves to exacerbate the problem. This has been described as a 'disabling process'.

Given the clearly established health implications of engaging in meaningful employment, the Green Paper recognises the value of including vocational counselling, or at least awareness, in the curriculum of health professional training. This will need to go further, however, than assessing a potential GPs' knowledge of fitness for work and medical certification.

There is a generally accepted view that the employment 'industry' in Britain would benefit from a greater degree of professionalisation. When extending these services to meet the needs of people with mental and physical illness or disability, and looking to build a bridge with a treating professional, this need for specialised professionalism is reinforced.

Doctors will be critical stakeholders in the process of return to work for people with disabilities.

Vocational Rehabilitation in Australia is achieving average 'new employer' return-to-work rates of **59% in 46 weeks.**



It is our experience that Doctors are generally unwilling to discuss a patient's medical situation with a service provider unless they are an allied health professional. This is largely a matter of trust and involves issues of confidentiality, context, understanding and appropriate use of the information supplied. Even then, there will be an enormous amount of education required to ensure that GPs and medical specialists understand the role of the rehabilitation professional in assisting 'their patient' to return to work.

The pilots which will meet the needs of the most people on Incapacity Benefits, and which will offer learning across the country for people on all welfare benefits, will be those which utilise teams of integrated allied health professionals to build bridges between mainstream employment and health services.

Six Different Pilots

The allocation of an additional £97 million to the delivery of solutions for Incapacity Benefit claimants must be welcomed. We understand that the six pilot areas have already been selected, with three to begin operation in October 2003 and the remainder in April 2004.

Consultation with industry specialists at an early stage will strengthen the delivery of these important pilots. As already noted, there is learning to be gained from the success of New Deal for Disabled People, particularly as provided by the Shaw Trust, West Country Learning and Jobcentre Plus. Further input would be facilitated if more information could be made available regarding the nature of the pilots, including: duration, delivery model, breakdown of intended spend, performance targets, and timescale and focus of the evaluation.

We believe that the Department for Work and Pensions currently intends that all six pilot areas will be delivered according to the same model - by Jobcentre Plus in partnership with the local Health Trust.

It has been our experience when evaluating both our own programmes, and benchmarking our performance through external evaluation, that learning can be multiplied when

pilots enable the comparison of different models working with similar client groups. The implication would be that varying the delivery of the six pilots, whilst keeping the client group relatively constant, offers more scope for innovation, effectively reduces the evaluation timescale, and increases the likelihood of finding success.

Varying the delivery model might entail involvement of partners:

- to different degrees;
- with different experience to offer;
- from different sectors.

Expertise exists across the public, voluntary and private sectors in disability, rehabilitation, injury management, general health, mental health, vocational skills development, job search, recruitment and employer relations, health and safety, and workplace modifications. How are all these disciplines to be integrated? Our experience demonstrates that the degree of integration is a critical success factor.

An external provider could be involved in simply training Jobcentre Plus staff, though we do not believe this would be sufficient. Part of the provision might be sub-contracted, whether that is specialist training or health care. Or an external contractor could deliver a complete stand-alone, integrated, multi-disciplinary service.

It is our contention, in fact, that the pilots will require the involvement of allied health professionals, external to both Jobcentre Plus and the local Health Trust, if they are to succeed.

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Innovative Funding to Fund Innovation

The Green Paper focuses on spending to address the position of people either on or moving from an Incapacity Benefit. It has been argued here that this is only part of the solution and that programmes and spending must also target:

- People still in work but identified as ill or injured and at risk of long term absence;
- People on Jobseekers Allowance at risk of moving to an Incapacity Benefit.

In terms of the six pilots, which are the principal provision to be proposed by the Paper, there are funding models which have been utilised in the past to maximise outcomes and effectively increase the value of the public spend. Through outsourced provision Jobcentre Plus encourages competition and innovation.

There are three significant programmes outsourced directly by the Department or through Jobcentre Plus with fixed payment structures: Employment Zones, Private Sector Led New Deal and Action Teams for Jobs. In addition to these, Jobcentre Plus operates a detailed funding framework according to the target group, nature of intervention, location and outcomes. Funding for New Deal for Disabled People varies between contracts but has a heavily output-related structure.

Performance on existing programmes suggests that innovation is encouraged, and controlled, when:

- Funding is common between like contracts and contractors;
- The client group is carefully defined to ensure services are targeted on those most in need and providers do not 'cream';
- Payments are linked to clearly defined employment outcomes.

The greatest flexibility is afforded to the delivery agent through the Employment Zone contracts, in which benefit payments are redirected to assist the move to work rather than maintain someone in poverty out of work. There are three key features to the Employment Zones:

- Benefits are included in the 'pot' and become the responsibility of the delivery agent;
- Payments are heavily outcome-related, with the largest coming at 3 months of full-time employment;
- The provider is financially incentivised to move the client as quickly as possible into sustainable employment.

The Employment Zone contracts effectively pass on a large degree of the 'risk' of such delivery to the private contractor. It is not clear whether there is sufficient evidence to accurately predict the potential cost of a similarly intensive programme for people on an Incapacity Benefit.

The rehabilitation counsellor works with the client to build capacity not disability, to build **inclusion not exclusion.**



If it is agreed that the six pilots will offer more learning as well as create more opportunities for more people on an Incapacity Benefit if they are delivered by Jobcentre Plus in partnership with other organisations, then these partnerships can utilise different funding models. Without a comparator it is hard to benchmark the cost-effectiveness of delivery. The choice of model will depend on the:

- relative contribution of each partner;
- range of services a partner organisation purchases or outsources;
- degree of on-programme versus outcome-related funding.

A Mandatory Programme?

The most important stakeholder in any solution for someone on an Incapacity Benefit is the claimant themselves.

Empowering inclusion

Inergise achieves remarkable success in Occupational and Vocational Rehabilitation because of a belief in 'optimistic realism'. The rehabilitation counsellor works with the client to build capacity not disability, to build inclusion not exclusion.

'Solutions' imposed on someone without consideration of 'fit' can exacerbate exclusion. In order to be effectively inclusive, and thereby to provide a route to employment and inclusion, the participant must be active and willing. The theme which runs through successful programmes globally is the empowerment of the participants.

This does not necessarily contradict the argument for some mandatory elements.

Empowerment is one of the reasons for the success of the Adviser Discretionary Fund and its extension within Jobcentre Plus is to be encouraged. However, the Fund is far from a panacea and its successful application is directly related to the Adviser's ability to identify and respect the individual needs of each Jobseeker. It has been suggested that a Discretionary Fund is so effective in the Employment Zones because these programmes are outcome rather than process-focused.

The extension of a Return to Work Credit is a positive development. Experience demonstrates that the credit available under New Deal 50 Plus is a very effective driver. The wider application of working credits in Ireland has also had a considerable impact.

The approach at WorkDirections UK is to talk not just of sustainable employment but of sustainable livelihoods. We look to enable an individual to find a future for

themselves which looks beyond the next, immediate job vacancy. This is not possible without an holistic consideration of a client's needs.

The Green Paper, quite rightly, describes positive measures to assist people back to work. It does not explore any of the punitive steps which might be introduced if receipt of an Incapacity Benefit were included in the current debate around 'rights and responsibilities'.

Mandating positive intervention

The Green Paper also details how "the range of potential negative consequences from being out of work extends well beyond the loss of financial rewards." Social exclusion, either cause or result but almost automatically concomitant with long-term unemployment, means disengagement from society's standards, systems, and institutions.

Nobody intervenes in the decline of the person claiming an Incapacity Benefit. They do not access the resources



that might help them back to meaningful employment, because they access none of society's services.

At some point it is necessary to ask whether failure to mandate engagement with all or part of an employment service is actually failure to meet the needs of the client. This does not mean that punitive social policy is the best way to encourage inclusion. The opposite is more likely to be true. But given the scale of the problem with 2.7 million on an Incapacity Benefit, and given the crippling deprivation suffered by the majority of them, it would appear to be in their best interests to encourage so strongly that the encouragement becomes a mandate.

Allowing for mandatory elements of provision for people on an Incapacity Benefit would relieve some of the pressure on the line drawn between Incapacity Benefits and Jobseekers Allowance, and remove some of the anomalies between them. It would allow the Personal Capability Assessment to become a constructive tool in developing a solution for the individual.

This is likely to require a more sophisticated view of Incapacity Benefits reflected in clearer demarcation of different benefits for different levels of disability, more systematically and regularly reviewed for each recipient.

Nomenclature

The Secretary of State has invited suggestions for changes to the name of the benefits.

Many people refer to "Incapacity Benefit". They will talk of being "on the sick" or "on incap". Whereas, in fact, there are a range of Incapacity Benefits.

There is a tendency to conflate the group of people in receipt of one of these Benefits. This is more than a desire to simplify a complicated system. In viewing them as a single homogeneous group we lose the nuances of their needs and our ability to target them effectively.

In order to counteract this effect it would seem advisable to take the opportunity of renaming the Benefits to draw apart different allowances for different people. Under different titles allowances could come with variable levels of support or mandatory activity or frequency of intervention.

If it is still thought necessary to continue with a single umbrella term, then it is suggested that 'Additional Support Allowances' recognises the extra support provided to claimants whilst removing any negative connotations regarding an individual's ultimate ability to work. The use of the acronym 'ASA' would narrow the distance to 'JSA' and reinforce the message that no recipients are in a permanent state of incapacity but all have the potential to progress.

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WorkDirections®

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