

# The Sheffield Health, Work, and Well-being Framework

Sheffield Health and Work Strategy Group, c/o SOHAS, 3rd Floor, Queen's Building, 55 Queen Street, Sheffield S1 2DX, Tel: 0114 249 5903

MAY 2006

This framework defines values, standards, service levels and the system of provision for health and work services in Sheffield. It gives providers and commissioners in Sheffield a service model against which progress with delivery of services can be monitored.

## Values

Services should be:

- Accessible to all;
- Committed to personal development;
- Holistic in their approach (taking into account social, psychological, economic and physical health aspects to achieve successful outcomes);
- Open about the purpose of help being given;
- Encouraging and motivating.

**Why protect the health of the workforce and help those who are off-sick or unemployed to return to work?**

## Skills shortages and training people with disabilities

In the most recent skills audit in South Yorkshire 10% of businesses expected to have recruitment difficulties in the following twelve months. A higher than average proportion of manufacturing and construction companies expected to have recruitment problems. People with limiting illnesses are more likely to have last worked in manufacturing than other unemployed people.

Those with limiting illnesses are more likely to be unemployed and to have needs for basic skills. Skill levels were lower than for other unemployed people but they were more likely to have undertaken training recently.

**45% of people on disability related benefits want to work.**

A healthy and inclusive workforce and effective rehabilitation will help:

### Employers to:

- Overcome skills shortages and gain access to reserves of talent;
- Reduce staff turnover and recruitment costs;
- Build an inclusive workforce more in touch with the needs of a diverse customer base;
- Reduce sickness absence costs through removing the causes of ill-health at work.

### The health service to:

- See fewer patients with health problems caused by work and psychological problems due to unemployment;
- Sustain recovery from long-term conditions such as heart disease, depression, and neurological conditions by helping people back to work;
- Reduce unnecessary hospital admissions.

### The economy to:

- Meet the need for skills. If Sheffield is to reach national levels of employment 17,000 more Sheffield residents will have to enter the workforce.

### The local community to:

- Reduce inequalities in the city by Closing the Gap between areas with high levels of economic inactivity, large numbers of people on incapacity benefit, and workers in the worst working conditions, and the rest of the city.

### Individuals to:

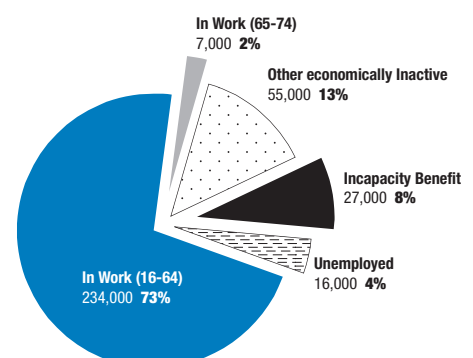
- Become economically active and have longer, healthier working lives and to keep their health into retirement.

### Central government to:

- Reduce social exclusion and dependency on social security payments.

## Statistics

Two-thirds of Sheffield's population is of working age:



## Of people receiving Incapacity Benefit in Sheffield:

15% have depression (as the main reason for their claim)

3% have anxiety; and 3% schizophrenia

8% of main causes of claims are for three neurological conditions (motor neuron disease, multiple sclerosis and epilepsy)

7% give back problems as the main reason

About half have been on IB for more than 5 years

There is a high turnover of IB claimants each year: 25% make new claims and 25% leave each year. The largest group leave because they fail the test for IB – 1500 each month (Closed certificate i.e. JSA or RTW: > 30% per year).

- Approximately **half** of all people in work state that their health has been affected by work. It is estimated that around **900** people in Sheffield leave work each year because of a work-related health problem.
- 10%** of people in work have a period of sickness absence of more than a week in any year.

### An integrated approach

Individuals make a wide variety of journeys into and out of work as a result of ill health or disability:

- from unemployment into work,
- from work to sickness absence and back to work, or
- from work to ill-health related unemployment or early retirement.

To enable different agencies to play their parts they must work together. This uses resources efficiently and effectively. We need to resist compartmentalised approaches, recognise and respect the skills of other providers, and communicate effectively between agencies.

Case management or ‘navigator’ roles can help individuals with severe or complex health conditions, though they are not needed by everyone: better understanding of services, more effective referral methods and feedback to referrers can avoid the need for what is otherwise an expensive and resource-intensive role.

### Standards

Effective interventions require:

- Staff with appropriate skills and competences
- Regular updating of skills
- Use of current best practice
- Services that identify the impact of resource constraints in order to maintain service standards
- Urgency or priority to be explicitly addressed
- Early intervention (patients and clients should be seen within 2 weeks of referral)
- Primary prevention as well as rehabilitation rather than prevention of worsening after the event

### Existing services: the potential need for Health, Work, and Wellbeing services in Sheffield

At work (241,000)	Off-sick (25,000)	Economically Inactive (82,000)
Primary Care (Most GPs do not have the skills or the time to provide prevention advice. Only one-third of practices have work and health advisors)	Primary Care (only one-third of practices have work and health advisors)	Job Centre Plus (Services are focused on recent IB claimants)
Individuals (only a quarter of the workforce has trade union safety representatives)	Secondary Care	Sheffield City Council (SCC has short-term finance for a number of Vocational Rehabilitation projects.)
Employers (only 20% of the workforce has a prevention service at work)	Employers (only 40% of the workforce has any kind of occupational health support at work)	Voluntary Sector (most voluntary sector organisations have waiting lists)
In-work at risk	Employed and off-sick	Unemployed or never worked

- Services that are integrated not fragmented
- Effective communication between service providers
- Explicit requirement to obtain the person's consent to transfer of confidential information

## Who does what and where the shortfalls are in work and health provision

### We need to know from providers:

- How many clients do you see each year?
- What is the scale of unmet need?
- What special requirements do your clients have?
- What kinds of intervention do you carry out?
- Who do you refer to?
- Do you receive feedback about referrals?
- What formal training or accreditation have your staff had?

### Activity

The work of these agencies involves:

- Advice on preventing health problems caused by work;
- Work adaptations, workforce development and education;
- Prompt, work-focussed treatment and condition management;
- Vocational guidance, training, job search, in-work support;

- Employer support and training on rehabilitation issues;
- Benefits and financial advice.

The level of help required by clients or patients varies across a wide range. The challenge for resource allocation is to direct appropriate levels of service to each client group via the most suitable service.

## Outstanding problems

We need stable relationships. Stable relationships between providers allow good practice to develop but this may conflict with a more competitive environment in which new providers can take over areas of work on the basis of better quality and cost. The balance between these approaches must be improved.

There are areas of severe under-funding. Under-funding has a structural basis. The benefits of rehabilitation are spread between the community, the economy and health care. This creates uncertainty as to the most appropriate route for funding to be channelled to Vocational Rehabilitation and reluctance on the part of any government department to take the lead. We need to identify appropriate commissioners for the services needed.

There are significant cost implications for our aspirations. We aim to reduce double-funding but this will not avoid the need for significant additional resources.

We are wary about talk of targeting resources. Targeting of resources can be a false economy; focusing on acute need that could have been prevented or reduced by earlier and more cost-effective interventions.

Benefits rules. There is still scope for improving qualifying rules for benefits, for example to increase the attractiveness of part-time work.

## Immediate action

Achieving the step change we are looking for will require closer work between employers, health and social care (statutory and non-statutory) providers, rehabilitation providers, and individual clients/patients:

- to identify the gaps in service provision and develop proposals to fill those gaps,
- to minimise risks of duplication,
- to help individuals to identify the services most able to meet their needs, and
- to improve referral routes.

A fully integrated approach will mean reconfiguring existing services.

Existing service levels are not sufficient to meet demand: we need to increase the capacity of existing services.

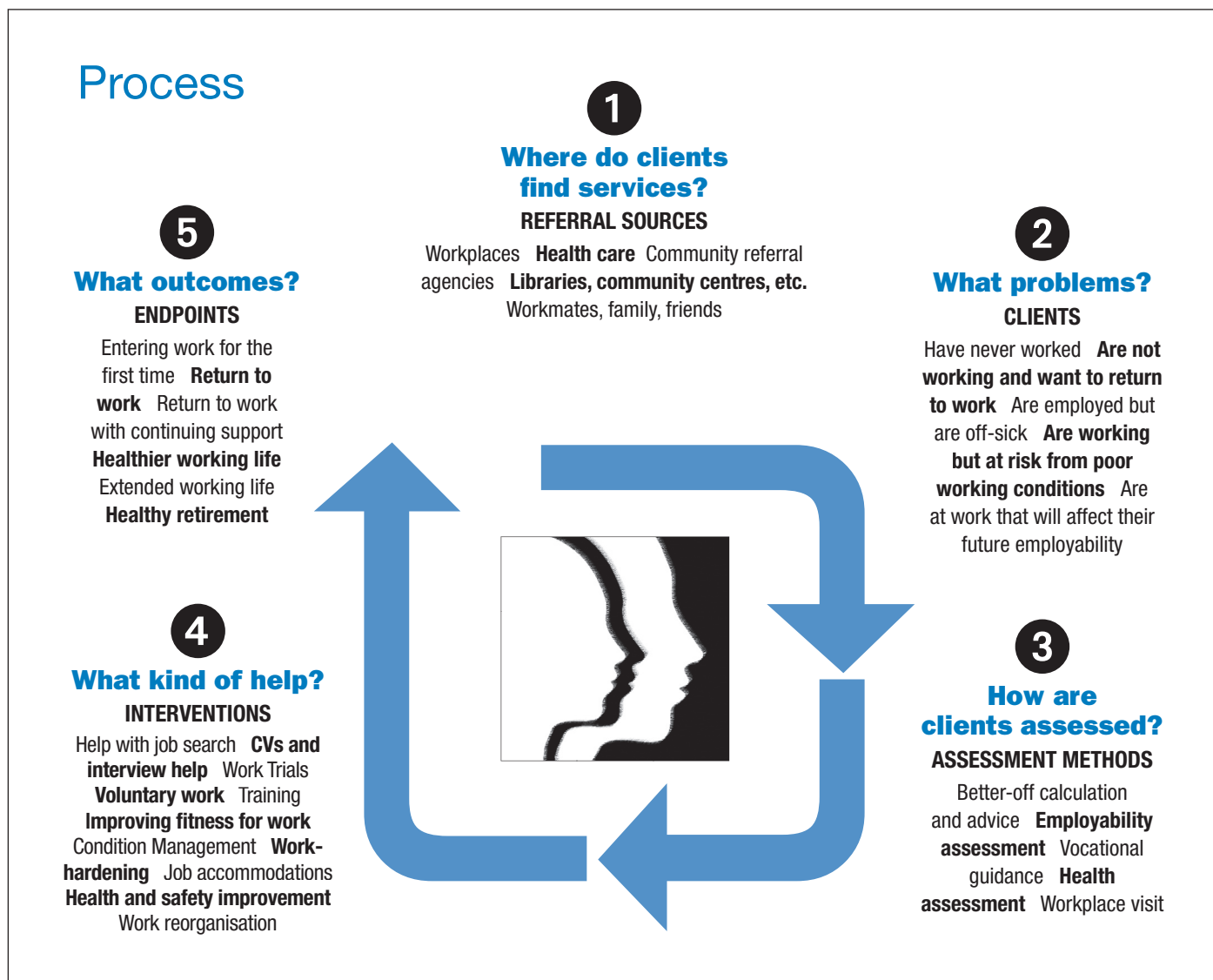
Achieved so far

- We have developed a Rehabilitation Hub (<http://www.whig.org.uk/groups/rehab>) to enable providers and clients/patients to see what services are available.
- Some providers have coordinated referral routes with one another.
- Sheffield Hallam University provides specialist training on vocational rehabilitation. Other organisations are also developing training for work and health interventions.

## Epilepsy and Work

3-4000 people in Sheffield have epilepsy. Around 800 individuals on Incapacity Benefit have epilepsy as the main reason they are off work. Under the National Service Framework for Long Term Conditions they should be receiving help with their VR needs. SOHAS is planning to implement VR support for this group within primary care.

- ▶ We have started to pool statistical data to identify needs and gaps.
- ▶ We have met Sheffield First Partnership Board to present the case for the benefits of Health and Work policy and the need for additional resources.
- ▶ The Local Area Agreement has formed the template for joint work between the NHS, JobCentre Plus and regeneration agencies.
- ▶ We have linked the work of the group to the National Service Framework Long-term Conditions Neurological Implementation Group.



**PRODUCED BY:**

Sheffield Health and Work Strategy Group  
c/o Nick Pearson, Sheffield Occupational Health Advisory Service  
55 Queen Street, Sheffield S1 2DX  
Tel: 0114 275 5760 • www.sohas.co.uk

**Sheffield Health and Work Strategy Group** members work in the following organisations: Sheffield Care Trust, Sheffield West Primary Care Trust, North Sheffield Primary Care Trust, Sheffield Occupational Health Advisory Service, Sheffield City Council (Neighbourhoods and Community Care), Burngreave New Deal for Communities, Deploy, JobCentre Plus and NIMHE.

Funded with a grant from Department of Health (Section 64).

**Written by Simon Pickvance with contributions from members of the Sheffield Health and Work Strategy Group**