

**Business Support Strategies for Improving Retention and
Reintegration of Disabled Employees in SMEs**

**A Review of Evidence and Recommendations for Pilot Delivery
within Action Two of the London Workforce Futures
Equal Programme**

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SECTION ONE

Introduction

1.1 Background:

The cost to British employers of failing to retain employees who have disabilities or develop long term health problems is well documented. Costs borne by employers include not only those associated with early retirement, but also sick leave, lost production, recruitment/retraining costs, compensation, litigation and insurance. There are also significant personal costs to the individual in terms of suffering, loss of income, status and social identity.

Retention practices are, however, known to be less well developed within smaller employers, and people with disabilities are generally under-represented within their workforces. However, small employers constitute a significant fraction of British industry, employing 44% of non-governmental employees.

The London Workforce Futures Partnership (LWFP) is developing a Round 2 EQUAL programme which will focus on employment reintegration and retention of disabled people within SMEs.

The Partnership has commissioned a research programme within Action One, which examined the needs of both small employers (with less than 50 staff) and disabled employees in relation to reintegration and retention. This research programme aims to develop better understanding of what would enable small firms to address job retention and re-integration issues more effectively, and employees at risk to keep their jobs.

The Partnership commissioned the research agency TriNova to undertake this research.

1.2 Research questions:

The research sought to answer the following key questions:

- What is known about employer *perceptions* and *practices* with regard to retention / reintegration of employees with disabilities, mental illness or other health problems?
- What *barriers* do small employers and employees with disabilities or health problems face with regard to job retention and reintegration?
- What use do they make of *existing services* to overcome these barriers?
- What is known about *what works* in both anticipating and overcoming these barriers?
- What *lessons* are there from the experiences of:

- small employers in London;
 - disabled Londoners;
 - the research literature;
 - Round 1 pilots;
 - large employers
 - job retention practice nationwide?
- What *good practice* can be identified that could be further tested in Round 2?

The overarching aim of the research has been to provide an evidence base and broad recommendations to inform development of the prospective London Workforce Futures Partnership Action 2 EQUAL bid.

The research provides empirical data regarding the barriers disabled people face, and has begun the process of identifying strategies that small firms (and intermediary agencies that work with them) could implement to improve retention. It is hoped that the data gathered will help to ensure that the pilot programmes in Action 2 are demand-led, reflecting the needs of the target groups. It will also contribute to development of a new business case for better retention and re-integration practice.

The research will also help small employers to meet their obligations under the Disability Discrimination Act 1995, which has now been extended to cover small businesses. Such employers now have a duty to make reasonable adjustments for employees with disabilities to maintain their employment.

1.3 Target groups:

The scope of the research has been taken to include *both* disabled people and individuals with mental health or other long term health problems, who are at risk of job loss.

1.3.1 Definition of disability:

In keeping with the research brief, the research programme uses the definition of disability as set in the Disability Discrimination Act which defines a disabled person as someone with "*a physical or mental impairment which has a substantial and long-term adverse effect on his [or her] ability to carry out normal day-to-day activities.*" This includes people with a wide range of impairments and long-term health conditions, including sensory and physical impairments, learning difficulties and mental health conditions, and long-term health conditions.

As the Partnership subscribes also to the social model of disability (disability as a social phenomenon caused by the way in which organizations and individuals respond to an individual's impairments or health conditions) we have made the assumption that the basis on which disability is attributed should be '*self-definition*'. The sampling method and sampling frame reflect this assumption.

1.3.2 Employers:

Also in keeping with the research brief, a key focus of the research has been on organisations that employ fewer than 50 employees.

1.4 Methodology:

The research utilised *qualitative* rather than quantitative methods. This approach was taken as it was felt to be the best way to explore in depth the barriers, experiences and successful strategies in the arena of job retention and re-integration of disabled people within small firms.

In order to obtain a range of perspectives, the following research methods were utilised:

- **Literature review:** Literature was sought from a range of subject areas and disciplines, including: disability and employment; human resource management; disability management at work; occupational health and safety; vocational rehabilitation; business/employment studies; health promotion; social exclusion; and other areas. The following search methods were utilized: bibliographic databases; government department and research body websites; online library catalogues; internet engines (e.g. Google Scholar); calls for information to professional colleagues; professional networks; e-groups; scanning publications already known to us; and other sources. Early findings from the review were also used to identify key issues that the broader research programme should explore and to help shape the research tools used.
- **In-depth interviews with small employers and disabled people:**

In-depth interviews with the following groups were undertaken:

- 24 disabled people (both individuals successfully retained jobs and some who have lost their jobs).
- 36 small employers (senior manager/line manager/personnel manager as appropriate).
- **Focus/discussion groups:** Discussion groups were undertaken with six groups of disabled people that had experience of job retention, job loss or employment issues.
- **Consultation with key stakeholders:** A wide range of organisations were consulted using a semi-structured interview schedule, using a combination of face-to-face and telephone methods as appropriate. These included employer bodies, employee bodies, intermediary agencies, EQUAL programme managers and delivery agencies, regional and sub-regional stakeholders and relevant national agencies. A listing of agencies which were approached for consultation is provided in Appendix I.
- **Case Studies** focusing around individuals who have had both successful and unsuccessful experience of job retention and re-integration issues. We undertook

five Case Studies focusing around five disabled individuals who have had both successful and unsuccessful experience of job retention and re-integration issues. These are to be found in Appendix IV.

The use of a range of research methods allowed gathering and triangulation of data from a range of perspectives. The research programme was undertaken between 1st December 2004 and 16th February 2005.

1.5 Sampling issues:

A *purposive* sample was utilised for both small firms and people with disabilities/health problems. We sought to include within this sample as wide a range of target groups as possible.

Disabled People: Our sample here included:

- Employed individuals who have experienced successful retention.
- Employed individuals who have lost their jobs.
- Unemployed individuals with disabilities.
- Individuals from other EQUAL target groups facing double disadvantage - including BME groups, young people, lone parents, and older people.
- Individuals with a range of disabilities.
- A balance of male and females.

Where possible, an attempt was made to recruit individuals who had some experience - good or bad - of employment within small firms. These individuals were sourced through local disability organisations, employment support agencies, Job Centre Plus and employer bodies.

Employers: Our sample here included:

- Businesses from a range of industrial sectors.
- Businesses from the private sector, social enterprises and third sector.

These businesses were sourced through some of the following: Chambers of Commerce, Business Link for London, employment support agencies and local business directories. All businesses employed less than 50 permanent staff, and were based in the Greater London area.

1.6 Confidentiality:

In order to improve the quality of information gathered, all research participants were offered confidentiality and anonymity. All individuals with disabilities were assured that whatever they said would be treated in the strictest confidence, and would not affect their future receipt of services or employment prospects in any way.

1.7 Co-research with people with disabilities:

An important feature of the research programme was partnership working between the TriNova Research Team and the Disability Consultancy Service of Bromley Association of Disabled People (BATH). The key roles of the BATH team were as follows:

- providing input into refinement of the research questions;
- providing input into development of the research tools used;
- undertaking fieldwork.

The BATH team received training in social research methods and were facilitated in undertaking fieldwork by the TriNova team.

As well as providing valuable expertise on disability and employment issues, a key aim of this partnership has been to develop capacity within EQUAL target groups to conduct future benchmarking, monitoring and evaluation work within Action 2 programmes.

SECTION TWO

Findings from survey of small employers

2.1 Introduction:

A purposive sample of small employers was generated using a range of sources and contacts, including: local directories; professional networks; professional contacts; specialist employment support agencies; and personal contacts.

The following key criteria were used to identify research participants:

- Stand alone businesses employing less than 50 employees.
- Operating in the Greater London area - with a preponderance in the South London area.
- Operating across a range of industrial sectors.
- Operating in public, private and voluntary/third sectors

In order to learn as much as possible about retention issues, we attempted as far as possible to identify businesses that had some kind of *experience* of recruiting, employing and retaining employees with disabilities, mental illness or long term health problems. In addition, approximately one third of our sample were employers from the voluntary sector.

At the same time it was also important to record the attitudes and experiences of what might be called 'average' or 'typical' small employers - these being the core customers of any future programmes targeting SMEs. These employers have limited experience of employing disabled people or having to cope with long term sickness absences. Again, the sample included a significant proportion of employers who fell into this category.

In-depth interviews were undertaken with owners-managers using semi-structured interview schedules.

2.2 Findings:

2.2.1 Sample:

Thirty-eight employers were interviewed in total. Of these, 14 were in the voluntary or non-profit-making sector and 2 were social firms. The voluntary sector employers were wide-ranging in activity and included volunteer bureaux, a community theatre, community arts agency, a Housing Association and a number of charities. The social firms included a café and removals company.

The private sector employers covered a wide range of industrial sectors and were broadly typical of small firms across South London. They included:

printers	office cleaning company
commercial laundry	engineering
architects	dry cleaners
garage	building contractor
insurance underwriter	nursing home

and a range of retail outlets (e.g. cafes, delicatessen, shops) and offices environments.

Five of the 38 employers were family businesses. Nine of the owner-managers interviewed were from black and minority ethnic communities.

Ten of the interviewees employed 5 or fewer people, 10 employed between 6 and 15 people and 18 employed 15 – 49 people.

2.2.2 Employment of disabled people:

At the time of interview, 20 of the 38 organisations were employing someone with a disability, long-term illness or mental health problem. A further five employers from the private sector said that they had employed disabled people at some point in the past. Two employers stated that they did not ask people about disabilities at the time of recruitment so might be employing disabled people and not know it.

Of those employers that were employing or had employed someone with a disability, twenty one said that the employee had the disability when they were recruited. The posts these individuals occupied were wide-ranging and included: director of a small voluntary organisation; accounts manager; several other management roles; catering assistants; trainer; cleaners; and various administrative posts.

When employers were asked why they thought they were not employing disabled people, replies included the following comments ...

‘disabled people don’t apply’

‘there would be a health and safety problem’

‘people have to be very fit to work here – out on site for example’

‘don’t know. We don’t discriminate. If they can do the job that’s fine’

‘we’re a business – want people to start straight away – no hassles, no special arrangements’

‘we had one very bad experience and would hesitate before employing someone with a learning disability again’

‘benefits problems’

‘access problems’

2.2.3 Recruitment:

Some very small employers in the private sector reported that they rarely used an open recruitment process, but tended to attract new workers by word of mouth. They were also unlikely to have written recruitment procedures, although some did. Voluntary sector organisations, by contrast, mostly had recruitment procedures which included a positive statement about welcoming applications from people with disabilities, although some people employed in that sector has started in the organisation as volunteers.

2.2.4 Retention:

Both voluntary sector and private sector employers had had a range of experiences of an employee's job being at risk because of disability or health problems. Various strategies had been implemented, including:

- changing job tasks.
- flexible working hours.
- home working.
- providing car parking spaces.
- providing special equipment.
- encouraging support from colleagues.
- ensuring there was a colleague the employee could talk to about problems.

On balance, the voluntary sector employers were somewhat more flexible in terms of the strategies they were able to implement. In part this may have been due to the fact they had a greater awareness than private sector employers of agencies and initiatives which could help. The word 'flexibility' was used many times, involving such approaches as changing hours, sharing out of job tasks and phased return to work.

However some very small organisations had problems with these kinds of approaches. They paid no overtime, and staff were entitled to time off in lieu when they covered for an absent colleague. This meant the business encountered being short staffed more frequently.

There were some instances of private sector employers making great efforts to keep a job open. They cited commercial pressures as being a major factor in coping with absences. With a small workforce and contracts to fulfil, the absence of one member of staff could result in great difficulties for the others. Occasionally temporary staff were engaged but this was an expense which small firms found difficult to sustain for very long. One or two of the larger private sector companies had insurance which paid wages for people absent from work through sickness or disability. However, one employer said that a missing member of staff was more of a commercial problem than paying the wages. Larger employers (15+ staff) tended to find reallocation of job tasks within the remaining workforce easier.

Of those employers (8) who not managed to retain an employee who had developed long term health problems, all said they did not believe that there was anything else they could have done to keep that person on. These employers were from both the voluntary and the private sector.

2.2.5 BME owned or managed businesses:

There was some indication that ‘family businesses’ were better able cope with sickness absences by bringing in other family members. Many of the service industry businesses in the research sample fell into this category, and they were often owned or managed by individuals from black and minority communities. However, there were no clear correlations between business ownership by BME individuals and retention practice.

2.2.6 Use of external agencies:

Very few private sector employers had *used* any outside organisations to support retention and were mostly unaware of schemes like Access to Work or WorkStep. A few had taken on staff through links with voluntary sector agencies, but most were *unaware of* what sources of expertise and help existed.

Very small employers said that they had *no time* to find out what was available. Most were aware of Jobcentre Plus, but not necessarily the range of services and advice which are available from them. The voluntary sector was more aware, and took advice from a range of agencies with whom they networked in the local area.

Of those employers that had used external agencies, there were varying views about their *effectiveness*. Some respondents reported that Access to Work had been excellent, while others had found it slow, bureaucratic and inflexible. In one case, the promised support from a voluntary agency had not been forthcoming, and the employee had ultimately been dismissed.

Employers were able to identify areas in which they *would* have welcomed help:

- benefits advice.
- financial support.
- information about Access to Work.
- general information about disability.
- grants to improve access.
- counselling support.
- a specialist recruitment agency for disabled people.

In some cases, the advice or service they wanted is available in their area, but they were unaware of this.

2.2.7 Policies on sickness absence:

Apart from statutory regulations on sickness absence, many small employers did not have developed clear written policies – or were not aware of them in any detail. The small firms in the sample tended to cope with each situation as it arose – ‘*an individual response to an individual situation*’ as one employer put it. Employers who had limited or no experience of coping with significant sickness absence, also reported that they would deal with it on an individual basis. Implicit in some of the respondents’ answers was the sense that an employer’s response might be affected by their perceptions of the skills and experience of the particular employee concerned.

Overall, employers who had clear, written policies said that they worked well, as did those who operated on a more ad hoc basis. The common factor was a willingness to work out a solution acceptable to both employer and employee.

2.2.8 Support and advice:

Employers were asked what specific sorts of support and advice they felt might be useful for them - in terms of enhancing their ability to recruit and retain employees with disabilities and health problems. A rating scale was utilised to get a clear sense of likely employer demand. Respondents were asked to ask whether services they would like to receive would be “*extremely useful*”, “*possibly useful*” or “*not useful at all*”.

Although numerical data on employer demand for a range of support and advice services is provided in the table below, there should be caution in applying a quantitative analysis to these figures. Although the employers included in this survey included a wide range of small firm types, they did *not* comprise a stratified or strictly representative sample. Some did not want a particular service because they *already* had the service or had just undertaken a particular course. The data provided in Table 1 on the next page should, therefore, be interpreted as *broad indicators* of small employer demand, but should not be extrapolated to numerical estimates of employer demand.

Some employers did not know whether they would find a service useful or not, and these responses have been omitted from the analysis.

Table 1 **Kinds of support and advice small employers would welcome**

Extremely	Possibly	Not at all
<i>Advice on making workplace adjustments e.g. improving access, specialist equipment.</i>		
11	11	7
<i>Advice on sources of help, e.g. support workers, agencies offering counselling.</i>		
19	10	4
<i>Disability awareness training for staff.</i>		
10	15	9
<i>Mediation between employer and employee to encourage a planned return to work.</i>		
11	10	10
<i>Advice on return to work strategies, e.g. flexible work patterns, gradual return, job redesign.</i>		
13	8	12
<i>Advice on developing a healthy workplace e.g. reducing stress, encouraging fitness.</i>		
9	15	9
<i>Identifying and arranging skills training opportunities for your staff.</i>		
12	8	8
<i>Identifying sources of financial help/grant funding for staff training.</i>		
21	8	3
<i>Advice on career development for staff.</i>		
5	11	15

2.2.9 The Disability Discrimination Act:

Many employers had little idea about the implications of the DDA (including some voluntary sector organisations) for their business. Most knew that they did have related to physical access issues. This ties in with earlier findings that many employers take a very narrow view of disability. A common refrain from respondents was ...

“I know very little about the DDA but we don’t discriminate”

One employer reported good knowledge of the DDA and its implications, as such knowledge was a condition of their contracts with public sector clients. Another employer was trying to develop their policies in this area as they knew enough to realise they were vulnerable to possible infringements of the Act.

There was interest among respondents in learning more about DDA, but very little enthusiasm for *paying* for this. Comments included ...

“Would want it tailored to our needs”

“Yes, but only when we needed to know – too pressured the rest of the time, but concerned about the danger of unfair dismissal”

“Helpful but SMEs are about business not implementing social policy”

“It should be a ‘government service”

One or two of the private sector employers said that it would be good for their staff to have more disability awareness as it would help them deal better with customers who were disabled and, therefore, would be good for business.

2.2.10 Support from volunteers:

Respondents were asked how acceptable they would find having volunteers as either co-workers building their skills through a work placement, or as additional resources to enhance the retention support they could offer their employees in the workplace. This was generally acceptable, but with the strong proviso that the volunteers would need to be skilled, trained, and come from a reputable organisation.

2.2.11 Other help and incentives:

Finally, respondents were asked if they could think of *any other* help or incentives which might be useful. These included:

- using volunteers in the workplace.
- funding for workplace training and adaptations.
- funding while a disabled person is on a probationary period – “we take all the risk currently”.
- subsidy to help employers retain an employee and to help their rehabilitation.
- access to a list of local disabled jobseekers to recruit from.

- access to counselling.
- more flexible benefits system.
- funding for Disability Awareness Training.
- financial/personnel resources to supervise and support disabled employees.
- funding to cover low productivity/time off etc.

It is clear that most of the answers provided were confirmations of responses to previous questions, but the repetition of these themes provides us with increased confidence that these services are much in demand.

Again, in some cases the services are actually available in the locality, but obviously not known to the employers.

2.2.12 Sectoral patterns:

It is difficult to identify any clear patterns between employer attitudes, knowledge and behaviour, and the *industrial sector* they trade within. To some extent this reflects the small size of the sample, and a larger scale survey would be needed to reveal variations in employer behaviour according to industrial sector.

It is clear, however, that voluntary sector agencies are on balance more *aware of disability issues* than private sector ones, however this is not to say that the former are all paradigms of good disability management practitioners.

There was some suggestion of a correlation between the type of workforce activity and employer understanding of disability. For example, those employers whose business activity included a predominance of manual or physical handling tasks (e.g. retail outlets, care homes) had a tendency to conceive of disability purely in terms of physical impairments.

2.3 Summary of findings:

It is clear that there are broadly two kinds of findings that have emerged from this research programme: the problems that have been directly identified by the respondents themselves, and those which have been revealed indirectly.

The latter (largely, but not exclusively, a feature of private sector employers) are mainly concerned with the *lack of knowledge*. This lack of knowledge centres around what disability is, how workplaces can be made less disabling, and what information and services are available to help achieve this.

Many small firms see disability in purely *physical* terms and in terms of “unfitness”. This means that they tend to assume their particular workplace is unsuitable for *all* disabled people - for example, because the jobs are manual, no-one with a disability can do them.

There is a lack of awareness of what DDA means and implies for small employers. This may well lead some of them into problems with unfair dismissal.

There is a profound lack of knowledge about the agencies and organisations which *do* exist and which could help small firms and their employees resolve problems before job loss becomes imminent.

Other key findings that have been expressed clearly by employers themselves include:

- very small organisations and businesses have the greatest problems organising staff cover for absent employees, although this difficulty is present to some extent among all employers.
- flexibility is the key to developing successful retention strategies.
- successful retention strategies must take into account the *particular needs* of employers and their employees.
- any service offering support needs to be easily contactable, responsive and reliable. Support offered needs to be ongoing. Support needs to be offered to both employer and employee.
- small employers often have very limited HR capacity. There is demand among some small employers for general HR advice in particular relating to recruitment procedures.
- there is a strong demand for funding grants for staff training.
- there is a demand for funding subsidy to cover sickness absence and reduced productivity.
- service sector employers appreciate that improved disability awareness will improve customer service and be of benefit to their business.
- there is a demand for information on all aspects of employment and disability.
- some employers voiced criticism of the benefits system being inflexible – this can cause difficulties when they wish to increase employees' hours. They believed that benefits would be lost when hours were increased and if the hours were changed back then the employee would find it difficult to re-establish the former payment.
- small employers need to recruit people who are qualified for the job and ready to start work.

SECTION THREE

Findings from survey of disabled people

3.1 Introduction:

In all, 51 people who identified themselves as having disabilities, mental health or other long term health problems participated in the research programme. Twenty-five were interviewed on a one-to-one basis, the remainder participated in discussion groups. Group members were asked about their experiences of job retention, but owing to the nature of group discussion these experiences were not explored in as much detail as the one-to-one interviews.

Five individuals agreed to be the subject of more in-depth case study. Four of these are presented in Appendix IV. One individual decided at a late stage of the research programme that she would prefer her case study not to be published.

Some interviewees were employed at the time of interview, others had lost their jobs but were hoping to return to work at some point. Findings from both groups are presented separately below.

3.2 Findings from *employed* interviewees:

3.2.1 Profile of respondents:

Sixteen employed people were interviewed individually - 9 men and 7 women. Their ages ranged from 25 to 71. Two were from ethnic minority groups. One had a visual impairment, one a learning disability, four had experienced mental health problems and ten had physical disabilities. Individuals were employed in a broad range of occupations, although most were employed in the voluntary sector. Three worked for small companies in the private sector. Several were in management positions, some in administrative positions. Jobs ranged from cleaner, to receptionist, to web designer. Length of employment ranged from 6 months to 11 years.

3.2.2 Recruitment:

The interviewees had found their jobs by various routes, including:

- answering job adverts.
- started as volunteers and moved into paid posts. One person stressed that the paid job was gained through normal open recruitment procedures.
- word of mouth.
- through some type of specialist employment scheme.

All were disabled at the time of recruitment and work colleagues were aware of this.

3.2.3 Workplace experiences:

Interviewees were asked if they had experienced any disability-related problems connected with work. Some mentioned problems they had experienced in previous workplaces, contrasting that with their current employment.

'I've been very upset – had bad experiences at other jobs. People, some of the people weren't good'

'Attitudes have changed since the early days (of disability) – much improved'

A few said that their early days of employment were rather stressful, partly to do with not knowing the job and partly because of a lack of self-confidence.

Some had experienced practical problems which had been resolved in various ways through adjustments, so that they could continue working. For example ...

- positioning workstations to get optimal light for someone with a visual impairment.
- introduction of specialist IT equipment, e.g. large screens, adapted keyboards.
- introduction of special chairs for back problems.
- accessible transport.

A common difficulty was the variable or fluctuating nature of some disabilities or effects of the medication they took. Many employers had successfully accommodated these problems by offering flexible working hours, changing job tasks or working from home. Interviewees who had been recipients of these retention strategies gave great credit to their managers and colleagues for the support and understanding they had received.

'fantastic team and caring environment'

'manager very supportive – makes sure I'm not overloaded or stressed'

A few interviewees expressed concerns about a perceived 'extra load' on their colleagues ...

'I can't pitch in and help when there's a busy time'

'I feel a bit guilty that the others have to work a bit harder'

The interviewees all felt that they could talk to their manager or colleagues if they had a problem about anything.

3.2.4 Sick leave:

There is a common belief that disabled people take more sick leave than non disabled people. However most respondents felt that they took very little sick leave. When they did, it was often in response to fluctuating impairments which were accommodated by

working from home/flexitime. One person took sick days occasionally due to migraines which she found “*more of a disability than my disability*”.

3.2.5 Useful help and support:

Interviewees were asked to assess how helpful particular kinds of intervention would be in terms of helping them keep their jobs. A rating scale was used to determine whether interventions would be ‘*very helpful*’, ‘*quite helpful*’ or ‘*not helpful*’.

	<i>Very helpful</i>	<i>Quite helpful</i>	<i>Not helpful</i>
Part time working	9		4
Changing some job tasks	3	4	6
Flexible working hours	12	2	
Someone external to talk to employer and find solution good for you both	6	2	3
Additional training	6	1	5
Longer work trial or probation		3	6
Funding for employer to support you	10		2
Better understanding of disability by manager	9	3	
Better understanding of disability by colleagues	9	3	
Gradual return to work programme	6	2	5
Help arranging workplace support	3	3	5

NB: When asked which of the above was the **most useful**, almost all the interviewees said that it was *flexible working time*.

3.2.6 Advertising sources of help:

Interviewees were then asked to consider the best approaches to advertising these services. Respondents were asked to assess whether particular approaches would be ‘*very effective*’, ‘*quite effective*’ or ‘*not effective*’:

	<i>Very effective</i>	<i>Quite effective</i>	<i>Not effective</i>
Job centre	5	2	2
CAB		5	2
GP Surgery	3	2	2
Library	2	5	1
Local supermarket notice boards	1	1	6
Pubs or clubs		2	6
Local newsagents noticeboards	1	3	4
Directories of disability services	1		
Internet	1		
Social workers	1		

3.2.7 Disability Discrimination Act:

Knowledge of the Act varied greatly among respondents. Some felt that they knew all about it, while others said they knew “*a little*”. There were some doubts expressed about its efficacy.

“It’s a tiger without teeth. Who decides where or what is practical?”

“There needs to be more case law before it’s much use”

“It takes too long to do anything – too stressful to keep going with a case”

“We’re supposed not to be discriminated against but it still happens”

3.2.8 Barriers to work:

When asked what they thought stops disabled people from applying for jobs, several respondents expressed the view that there is a fear of employer prejudice and discrimination. Some felt that this prejudice is a consequence of misinformation about disability.

One person (an older person) said that age is a key factor. Older people are less aware of the various services which could help them find employment and offer support. They were also more likely than a younger person to believe that there was nothing they could do.

It was also suggested that a period of absence from work had two consequences.

- a gap on the CV which could be difficult to explain.
- lack of self-confidence.

One interviewee said that s/he did not reveal their disability until a few weeks had elapsed and s/he liked and felt comfortable with the employer.

3.2.9 Overcoming barriers:

The respondents had some practical ideas about *how* these barriers could be overcome. Many of these ideas stemmed from personal experience of successful strategies which had helped them. These ideas included:

- ensuring that special tools/equipment needed for the job are readily available.
- job re-design.
- careful preparation and re-integration strategies.
- someone to talk to in confidence when you have a problem.
- active promotion of equal opportunities in companies from the top down.
- better communication within large companies.
- detach information about disability from application forms prior to interview.

3.3 Findings from *unemployed* people:

3.3.1 Profile of respondents:

Nine unemployed people were interviewed - six women and three men - with ages ranging from 33 to 54. All described themselves as white British. None had been unemployed for more than three years. All those who chose to reveal a disability or health problem described some kind of mental health need, but some also had a physical disability. Most had worked for a voluntary organisation or in the public sector. Most had not revealed their disability or health problem while at work.

3.3.2 Workplace problems:

All the interviewees reported having had serious problems at work. These included:

- bullying by a manager - they had not disclosed their mental health problem and these had worsened whilst in this employment.
- no-one had time to listen to their colleagues' problems,
- becoming slower in carrying out job tasks.
- experiencing victimisation, but receiving no help from the union.

Most interviewees had taken time off work for health reasons. One person said that s/he was "*scared to take off ill time*". This was because s/he perceived that colleagues' attitudes towards him/her had changed and there was pressure not to take time off. Another person said that if one took more time off than other people, it became more difficult to explain it away. There was a suggestion that individuals would sometimes avoid taking sick leave in case it was ascribed to mental ill health.

One person whose disability was known to colleagues reported:

"I felt I was discriminated against. Worse because it was a charity. My lawyer said there was a legal case but I could not go ahead as it was too stressful and making me ill"

3.3.3 Useful help and support:

Interviewees were asked to assess how helpful particular kinds of interventions would be to them in term of helping them maintain their employment. A rating scale was used to determine whether interventions would be '*very helpful*', '*quite helpful*' or '*not helpful*'. Findings are summarised in Table Four on the next page.

Table 4 **Useful help and support**

	<i>Very helpful</i>	<i>Quite helpful</i>	<i>Not helpful</i>
Part time working	7	2	
Changing some job tasks	2	6	
Flexible working hours	8	1	
Someone external to talk to employer and find solution good for you	7	1	
Additional training	5	1	1
Longer work trial or probation	2	4	1
Funding to help your employer support you at work	6	2	
Better understanding of disability by manager	7	2	
Better understanding of disability by work colleagues	7	2	
Gradual return to work programme	6	2	
Help arranging workplace support	6	1	1

As with the employed respondents, *flexible working* was thought to be the *most useful*, following by *part-time working* and a *gradual return to work*. However, the unemployed people considered *changing job tasks* more useful than did the employed interviewees. Similarly, they all considered the availability of ‘someone from outside the workplace trying to find a solution for employer and employee’ more useful than did the employed group. The ex-employees were strongly in favour of having help to arrange for workplace support.

3.3.4 Advertising services:

Interviewees were asked to consider the best approaches to advertising these services. Respondents were asked to assess whether particular approaches would be '*very helpful*', '*quite helpful*' or '*not helpful*' at all:

Table 5 Best Approaches to advertising sources of help and support			
	<i>Very effective</i>	<i>Quite effective</i>	<i>Not effective</i>
Job centre	7	2	
CAB	4	3	1
GP Surgery	6	2	
Library	6	1	
Local supermarket noticeboards	1	5	1
Pubs or clubs		4	4
Local newsagents noticeboards	2	5	
Local radio/paper/TV	6		

Unemployed people favoured advertising in Jobcentres, CABs, libraries, and local supermarkets more than employed people. They also suggested local papers, radio and TV.

3.3.5 Disability Discrimination Act:

Most people said that they knew a little about the Disability Discrimination Act.

3.3.6 Barriers to employment:

A number of barriers to employment had been experienced by interviewees. These included:

- fear of failure.
- lack of self confidence.
- losing hope.
- fear of being rejected.
- fear of intolerant response.

3.3.7 Strategies to overcome barriers:

A number of strategies to overcome these barriers to employment were suggested by interviewees. These included

- re-arranging job tasks.
- arranging for a gradual return to work.
- the availability of a workplace supporter.
- being able to talk to other people who have gone back to work.
- planning support with, and getting feedback from, the employer.
- bring disability into the open.
- remove the taboo on mental health.
- getting employers to treat everyone as equal.

All respondents said that they wanted to work again and many of them were taking active steps towards that objective.

3.4 Summary:

Individuals who were currently in employment had, in partnership with their employers, utilised various successful strategies to retain their employment. These included:

- special equipment and furniture.
- accessible transport.
- parking places.
- flexible and home working - particularly where people had fluctuating conditions.
- support from management and colleagues.

Respondents considered these strategies to be the most useful job retention strategies. They would also welcome enhanced government funding for workplace support.

The majority of *unemployed* interviewees had had *poor experiences* of employment. Like the employed interviewees, many had worked for voluntary organisations, but in spite of this had not received adequate support. Very few had revealed their disability or health problem, and it is possible that some problems experienced (e.g. colleagues irritation with their slower work rate) may have been a consequence of this.

However, a repeated theme was **the lack of time or inclination** in these organisations to discuss any problems that had arisen.

Barriers to employment were perceived by the *employed* individuals in the survey to be around **lack of knowledge** (on the part of both employers and employees) as to what strategies might be used and **lack of self-confidence**.

The unemployed group exhibited a rather more bleak outlook in that they spoke of **fear of rejection** and **fear of intolerance**. This may be an indication of just how adversely job loss and unemployment affects people.

SECTION FOUR

Findings from consultation with stakeholders

4.1 Introduction:

During the course of the research many organisations and individuals contribute their views on job retention and re-integration issues. These ranged from hands-on providers of job retention services, organisations representing employers and employees, through to policy makers. A list of the agencies that provided an input is to be found in Appendix I.

Stakeholder feedback has been collated and analysed in terms of type of stakeholder.

4.2 The perspective of providers of job retention services:

There was general agreement that SMEs frequently experienced particular problems in the area of job retention. Unlike large companies, they did not have access to in-house Human Resource Management or Occupational Health services.

Very small firms were able to cope less easily with extended absence – one person off sick represented a greater percentage of the workforce than in large organisations.

On the other hand, several agencies said that many SMEs they had worked with had proved to be more flexible, less bound by bureaucratic procedures, than the large companies. It was also more likely that the manager or owner knew each member of staff well, and that closer personal relationships engendered a willingness to look for retention solutions.

4.2.1 Common challenges facing SMEs:

There are some key challenges that SMEs frequently face, including:

- a lack of understanding of disability and mental health. Stereotypes often come into play and could militate against integration.
- a lack of awareness of services which could support retention/re-integration. Many SMEs do not use Jobcentres to advertise vacancies, so do not hear about JCP support services - for example the Access to Work Scheme.
- a lack of knowledge of where to go for advice. This often means that by the time some outside agency becomes involved, the situation has deteriorated to a point where retention has become very difficult. For example, an employee with mental health needs may have become distressed to the point of wanting to give up work. Early intervention could have prevented that.

- many employers do not understand the Disability Discrimination Act.
- there are often no formal systems of staff supervision or appraisal where problems could come to light.
- small firms would find it difficult to afford to buy in Occupational Health or Human Resource advice.
- small firms can find it difficult to afford to pay for a temporary worker, or to pay someone who is off sick for an extended period or during a period of gradual return to work.
- small firms whose business operations involves significant levels of unskilled and semi-skilled work may face higher incidence of worker injury and health problems.

4.2.2 Suggested approaches to working with SMEs:

- SMEs want to have *one point of contact* for an agency which will arrange *all* the services they need. Not all the services need necessarily to be provided by that agency directly. Many SMEs do not have the time (or inclination) to work with a number of separate agencies themselves.
- A job retention service has to be *free to SMEs*.
- SMEs need to be shown the *value of retention* – i.e. *the business case*. A number of arguments can be deployed - for example, retention is more economic to retain than re-hire and re-train; retention demonstrates good employment practice which enhances reputation in the local community and can be good for business (SMEs often depend on local custom).
- SMEs need to feel that job retention advice is being proffered by someone who *understands business needs*, not someone who is approaching them from a medical or social work point of view.
- At the same time, the employee at risk must also *trust* the retention adviser. A *neutral stance* is therefore required in order to mediate a strategy satisfactory to both parties.
- There must be availability of *ongoing support* for both employee and employer – help that is only a phone call away and can be relied upon.
- Job retention agencies need to deploy a *range of strategies* including flexible working hours, home-working, gradual return to work, re-arranging job tasks etc. Some agencies have used WorkStep to compensate the employer for reduced hours/productivity during a phased return to work.
- *Early intervention* is the key to success. Agencies consulted try to tackle in different ways. Some agencies are ensuring that they have an active presence

in GP surgeries, to get referrals when people first contact the doctor. In one locality, a psychiatric nurse working on an acute ward has taken on responsibility for job retention issues, working in partnership with an outside agency.

- ***Partnership with business networks and support agencies:*** There were several examples of agencies working in partnership with local Chamber of Commerce, and receiving active marketing support from the Chambers for their work. In other areas, agencies were had less success in engaging Chambers although all had tried to do this via business breakfasts etc.
- ***Individual case-work paves the way for preventative work:*** Employers find it difficult to focus on job retention in the abstract – they will only do so when the situation actually arises. Building up workplace support and understanding through individual casework not only helps the retention situation at the time, but paves the way for prevention work in the future.
- Individual case-work is just that - ***each case is unique*** and the employer's situation should be treated as such.
- ***Developing healthy workplaces:*** Once a relationship has been established with the employer, then it is possible to encourage preventive measures such as healthy workplace / stress audits.
- ***Building a good relationship:*** The major key to success is building a good relationship with the employer. If this is achieved, employers will come back for advice at an early stage if another retention situation should arise. They will also recommend the service to other employers.

Investors in Health was not seen as providing much of an incentive for SMEs as they perceived it would involve them in a protracted period of form-filling and general bureaucratic procedures which had little obvious value. It was pointed out that if Investors in Health became a requirement for obtaining public sector contracts, it could be of an advantage.

4.2.3 Suggested approaches to marketing:

The service providers were asked about their approaches to marketing their services to small employers. All had tried this in various ways, but there was no clear consensus on what methods worked best.

- Some agencies had been providing a job finding service for people with learning disabilities and/or people with mental health needs. They therefore already had some contacts with local employers and were trying to build on these for job retention work.
- All the agencies had tried marketing through local business organisations such as Chambers of Commerce (e.g. business breakfasts), with varying degrees of success. One agency operated from a Chamber premises, and the Business Co-ordinators from the Chamber actively marketed the service. Other agencies

had had less success. One interviewee said that what was needed was to find a ‘champion’ within business organisations who would promote job retention services ‘from the inside’. That particular agency had just found such a champion within the local PCT, although it had taken two years.

- There was little support for blanket leafleting. It was thought to be expensive and SMEs were unlikely to read what they probably thought of as junk mail.
- All agencies worked hard at building relationships and partnerships with local organisations and networks of employment and health-related agencies.

4.3 The perspective of human resource management support agencies:

Several professional human resource consultants contributed their experience of working with SMEs to the research. Job retention work was often approached under the framework of “performance management”, and pertained to a range of personnel issues, such as:

- induction practices.
- training needs.
- flexible working and family-friendly policies.
- staff development and appraisal systems.
- absence/sickness monitoring.

4.3.1 Challenges facing SMEs:

Their perception of the challenges that SMEs face in relation to retention issues, was that they had little or no knowledge of the issues listed above or of their responsibilities under the Disability Discrimination Act. Their experience was that as far as disability was concerned, SMEs were hesitant about recruiting disabled people in the first place, as they believed it would entail extensive sick leave and/or expensive adaptations.

4.3.2 Suggested approaches to working with SMEs:

The following approaches to working with SMEs were suggested:

- a specialist agency to mediate and support a range of return to work strategies. This agency would need to be *very responsive* and *non-bureaucratic*.
- *A broader approach* than just offering job retention services might be necessary, as retention issues may not occur very frequently in the life-time of an individual SME. Therefore, offering broader general HR guidance and support might be a more fruitful approach.
- a telephone help-line.
- some training needs could be addressed by schemes such as the Small Firms Learning Account.

- help with adaptations of premises.
- relaxation training for all staff to reduce workplace stress.

4.3.3 Suggested approaches to marketing:

The following approaches to working with SMEs were suggested:

- The tone of the approach is however, very important. Whatever the approach, it should not seem like government interference or being preached to.
- The DDA might be used as a marketing tool – not in a threatening way – but to make clear to employers how they might be open to legal problems and potential fines.

There were mixed views about the most effective marketing channels:

- Approaches through emails or the Internet could be effective sometimes, however some firms are inundated with emails and many not linked to the net.
- Marketing through employer organisations/network could be effective.
- There was consensus that a range of channels should be tried.

4.4 The perspective of social firm/enterprise support agencies or networks:

The experience of these agencies is based mostly on micro businesses or enterprises. The challenges that social firms or social enterprises face are similar to those identified in for SMEs generally, but can be more acute. Resources in social forms can be even tighter than in other firms and it was felt that re-training, for example, could be beyond the means of many micro firms. Redeployment was also more difficult in a very small firm.

Social firms have an ethos of keeping jobs open when employees become ill. This has created difficulties when more than one person has been away from work for a protracted period. Return to work has generally been gradual so that productivity can be lower than is required commercially.

4.4.1 Suggested approaches to working with SMEs:

The following approaches to working with SMEs were suggested, with the proviso that any *services would be low/no cost*.

- a specialist agency to facilitate return to work strategies and be the main point of contact for employer and employee. This service should not be based within the public sector.
- a telephone help-line.
- trained volunteers to support an employee if the situation were handled sensitively.
- the provision of general HR advice and support.

- offering training audits and staff training, but as time is at a premium in an SME, there would need to be a way of subsidising time out of the workplace.
- healthy workplace audits.
- disability awareness training.

4.4.2 Suggested approaches to marketing:

There were various suggestions about fruitful marketing strategies.

- marketing information about the *DDA* and *employers responsibilities*. SMEs need to be aware of these and spend so much time “growing the business” that staff issues tended to get put to one side.
- putting the *business case for retention* - i.e. the cost-effectiveness of retention as opposed to recruitment. There may be mileage in this as the bottom line for small employers is the effectiveness of employees.

The following marketing channels were suggested:

- through Chambers of Commerce or the Federation of Small Businesses.
- email/internet.
- strategies such as cold calling or blanket leafleting are ineffective - the former because people are suspicious of telesales generally, the latter because it is extremely expensive.

Initiatives such as Investors in Health were not seen as appealing to SMEs.

4.5 The perspective of business support agencies:

There is recognition among business organisations that many SMEs, particularly smaller ones, lack awareness of disability and mental health issues and the requirements of the DDA. This is as a result of the extreme pressures on time and resources, which in turn can create problems in job retention.

The particular challenges faced by SMEs identified were those already identified by other stakeholders, and included:

- the lack of in-house Human Resource or Occupational Health expertise.
- little scope for sharing out job tasks if one staff member is off sick for any appreciable length of time.
- difficulties in re-training an employee whose job had been re-designed.

4.5.1 Suggested approaches to working with SMEs:

- a one-stop shop providing the advice, guidance and ongoing support. SMEs do not want to be continually re-directed to different agencies. SMEs are “*fed up of too many organisations coming in to do various diagnostic exercises*”.
- generic HR support.
- subsidised training especially regarding compliance with legislation.

4.5.2 Suggested approaches to marketing:

- employer-to-employer mentoring by SMEs successful in job retention.
- SMEs are too busy to read marketing leaflets.
- promotion of services through Chambers of Commerce, but they would need funding to do this.
- Investor in Health awards could be marketed as an incentive for employers of as part of Investors in People.

4.6 Summary:

There was consensus among the different types of organisations consulted about the nature of the challenges that SMEs and their employees face in relation to job retention issues. These included:

- minimal in-house HT and OH resources.
- a small workforce so limited cover available for extended absences.
- not knowing where to go for advice on job retention issues which prevents early intervention.
- little understanding of the DDA, disability and mental health issues.
- lack of money to pay for services.

However, several stakeholders pointed out that SMEs could often be more flexible than larger companies, were less bureaucratic in the way they dealt with problems, and had a more personal relationship with their employees.

What SMEs need to help them with job retention issues includes:

- **one agency** to deal with. That agency might not directly deliver all the services the employer needs (e.g. occupational health expertise might be brokered in from a partner agency), but SMEs do not have the time and resources to organise these things themselves.
- the agency must present a **professional** face to employers and demonstrate an understanding of their business needs. The role must be that of **a mediator** and *not* an advocate for one party or the other.

- a *reliable* service that can be contacted if problems arise in the future.
- a *free* service.

Agencies were agreed that individual case-work on job retention paves the way for more preventative work (e.g. healthy workplace audits) in the future.

SECTION FIVE

Job Retention of Disabled People by Small Employers

A Selective Literature Review

5.1 Background:

The London Workforce Futures Development Partnership is seeking to develop new pilot programmes through its Round 2 EQUAL programme that will support small employers in South London, and explore how best to enhance their capacity to recruit, employ and retain people with disabilities or health problems. Small employers are known to be less effective than larger ones in recruiting and retaining disabled people within their workforces (Goss & Goss, 1998; Goss et al., 2000).

An important backdrop to this activity, is the ending of the exemption of micro firms under the Disability Discrimination Act (DDA) 2004. From 1st October 2004, the DDA Part II was extended to cover all employers (bar the armed forces). These changes extended the scope of DDA employment legislation to employers with less than 15 staff – some 1.1 million additional employers and seven million additional jobs. The changes also brought ‘382,000 disabled employees in the existing workforce into consideration by SMEs’ (DRC, March 2004). The new regulatory framework provides an opportunity to work with small employers to enhance their capacity for retaining disabled employees.

5.2 Scope:

The subject of how employers manage health or disability in their workforces is an extremely broad field. As resources available for this review have been finite, this literature review has therefore sought to take a narrower focus on small firms and what is known about their behaviour in employing and retaining people with disabilities or health problems. There is some material on disability management and retention practices within larger employers, but this is necessarily brief. The review is therefore selective. We have attempted gather data that may be of a ‘practical’ value in helping those charged with drafting the London Workforce Futures Action 2 bid in their design of new pilot programmes.

For the purposes of this review, job retention is taken to mean staying with the same employer with same or different duties or conditions of employment, and includes return to work (re-integration) after a paid or unpaid absence. In the main, the review does *not* deal with return to employment for individuals who have already lost their jobs.

5.3 Methodology:

Literature was sought from a range of subject areas and disciplines, including: disability and employment; human resource management; disability management at work; occupational health and safety; vocational rehabilitation; business/employment studies; health promotion; social exclusion; and other areas.

The following search methods were utilized: bibliographic databases; government department and research body websites; online library catalogues; internet engines (e.g. Google Scholar); calls for information to professional colleagues; professional networks; e-groups; scanning publications already known to us; and other sources. We were also greatly aided by an in-house literature review kindly supplied by the Disability Rights Commission (Howard, 2004), which provided an invaluable starting point for the review.

One difficulty encountered has been that studies of employer behaviour do not always disaggregate findings according to employer size. Or where they do, a different definition of 'small' employer is used to that used set for this review – businesses with 1 - 49 employees. Nevertheless it has been possible to distil findings from the wide-ranging literature that impinge on the subject of this review that do throw light on small employer behaviour.

Full bibliographic references for all publications referred to within this review are listed within Appendix II. A glossary is provided in Appendix III.

5.4 Findings:

5.4.1 Disabled People in the workforce:

5.4.1.1 The London Workforce:

Data from the 2001/02 Labour Force Survey indicates that 17% of working-aged Londoners have a disability - equating to around 810,000 people (GLA, 2003). These individuals are much less likely (50%) to be active in the labour market compared with non-disabled people (80%).

Employment rates are particularly low for disabled women (46%), disabled people from BME groups (43%), and for those with mental health problems (18%) - who have the lowest employment rates of all disability groups. Londoners with disabilities also face much higher rates of unemployment - about twice the rate for non-disabled people. Young disabled people and those disabled people from BME communities face the highest rates (GLA, 2003).

Each year approximately 3% of individuals in work become '*limited in daily activities*'. About half of these report an ongoing disability (MacIntosh, 2005).

5.4.1.2 Mental health problems in the workplace:

Nearly three in every ten employees in the UK will have mental health problems in any one year. Approximately half a million employees believe they are experiencing stress, anxiety and depression as a direct result of work (Mental Health Foundation, 1999). Stress-related conditions are now the commonest reported cause of sickness absence. 865,900 adults on Incapacity Benefits in England (about a third of the total) report their primary condition to be mental ill health (DH, 2005).

5.4.1.3 Types of occupation:

Disabled workers are more likely to work part-time, and earn less than non-disabled workers. Londoners employees with disabilities are more likely to work in manual and low skilled occupations, and less likely to work in managerial, professional and high skilled occupations (GLA, 2003); Meager et al. 1998; 2001). More severely disabled people are particularly concentrated in lower level occupations.

5.4.2 Disability and job retention:

5.4.2.1 The importance of improving retention rates:

Disabled people experience a greater movement in and out of the labour market than the general population. About a third of those who find work will be out of work by the following year – as compared with a fifth of non-disabled people starting work (Burchardt 2000). Of those individuals in work who become '*limited in daily activities*' and report an ongoing disability, about 17% lose their jobs within one year (MacIntosh, 2005). Employment status is more volatile for disabled people, and improving retention rates would improve employment rates of disabled people overall.

5.4.2.2 Mental illness, work-related stress and job retention:

Those employees experiencing mental health problems face particular challenges in maintaining their employment. About a third of individuals who use mental health services report being dismissed or forced to resign from their jobs (Read and Baker, 1996). In a survey of 516 individuals that use mental health services, 53% had a job at the time of their mental health crisis, however only 20% were still in employment at the time of survey interview (Rogers et al, 1993).

In a survey of small employers in the London Borough of Merton, over half reported that stress was a factor in staff sickness, and almost a quarter of staff absences were stress-related. Just under 40% thought that other mental health problems were a factor in staff sickness. However, only 30% had any systems in place for employees who suffered from stress or mental health problems. (Hill et al, 2003; Rinaldi and Hill, 2000). The authors highlighted the need for employers to take an organisational, holistic approach to monitoring and managing work-related stress, rather than solely interventions targeted at individuals.

5.4.2.3 Job retention support for disabled employees in the UK:

Until recent years, this has been a neglected area. Governmental programmes and vocational rehabilitation initiatives have primarily been concerned with return to work for those who are unemployed or have lost their jobs. Policy and practice in job retention has been left in the hands of the employer (Thornton, 1998). Employer practice in job retention is highly variable, but may include welfare support, occupational health, employee assistance schemes and disability management practice.

There are a number of Job Centre Plus (JCP) initiatives that employers can draw upon. WorkStep, Access to Work Scheme and New Deal for Disabled People are available nationally and can each provide some degree of support for employees at risk (ODPM, 2004), however only a minority of employers are aware of, and can access, these schemes. Pathways to Work is available in selected areas.

5.4.2.4 Specialist job retention programmes:

There are a small but growing number of specialist job retention programmes across the UK which specifically target individuals with disabilities or health problems at risk of losing their jobs. Many of these work primarily with large employers, and many target employees with mental health problems. Few have set out to target SMEs, although several have highlighted the need to tailor services to this group (Lennard, 2004). A fuller discussion of these services is provided in section six.

5.4.2.5 Major initiatives:

There are a number of recent policy developments and governmental initiatives that impinge on job retention issues. These include:

- **Job Retention and Rehabilitation Pilots:** The Department of Work and Pensions (DWP), Department of Health (DH), Health and Safety Executive (HSE), Scottish Executive and Welsh Assembly are currently operating a large scale randomised controlled trial to test and compare the effectiveness of healthcare and workplace interventions to help people off work and at risk of losing their jobs remain in work. The pilot is aimed at employed individuals after sickness leave of between 6 and 26 weeks. Full evaluation findings which will examine the effectiveness of different kinds of interventions will not be available until December 2005. (www.natcen.ac.uk/jrrp).
- **Healthy Workplace Initiative:** Jointly sponsored by the DH and HSE, this aims to '*place health in the mainstream of business thinking and organisational development, thereby raising the profile of occupational health and safety, and putting it firmly on the business agenda*'. The HSE has a range of initiatives and publications with a focus on work-related stress, including: new management standards for stress in the workplace (www.hse.gsi.gov.uk); and research into the effectiveness of the management standards approach for managers of small businesses.
- **Safe and Healthy Working:** An occupational health and safety service for SME employers and employees launched in Scotland in 2003. Funded by the Scottish

Executive, its key elements are: a free and confidential national advice line for employees and employers; workplace visits from trained occupational health and safety practitioners; expert advice and guidance; and a website specifically designed for SMEs (www.safeandhealthyworking.com).

- **NHS Plus:** NHS Plus is a network of more than 100 occupational health departments in the NHS which can offer support to non NHS employers, including SMEs, on a commercial basis. To what extent there is take-up by SMEs of these services service SMEs is unclear.
- **Workplace Health Direct:** Building upon a number of existing pilots, HSE have announced a new round of pilots which will explore best practice in the provision of occupational health, safety and return to work (OHSR) services for SMEs. Six pilots will commence in early 2006, providers having been selected through a tendering process. HSE is looking for innovative groups of partners interested in delivering locally based ‘problem-solving’ pilots. These will test the model for occupational health, safety and return-to-work support developed by HSE following work undertaken within the Securing Health Together programme (see below). The pilots will offer: free telephone advice for employers on work-related health, safety and return to work; free workplace visits; a website; and access to specialist support if required. A key aim is to enhance employer retention of employees with disabilities or in poor health. (www.hse.gov.uk/workplacehealth).
- **DH Pilots to promote health and well being through the workplace:** The DH has announced pilot programmes to explore how best to promote health and well being through the workplace - each pilot will focus on a specific type of workplace, such as an NHS organisation, local authority or business. The programme will assess innovative approaches to support active living and promote health eating, smoking cessation, emotional and mental health, and other areas (Choosing Health, 2004).
- **Promoting Health of NHS Staff:** There will also be a range of initiatives to help NHS organisations develop as healthier workplaces, including: research; guidance and dissemination of good practice; and leadership development programmes (Choosing Health, 2004).
- **Reform of Incapacity Benefit:** The government has announced a significant reform of incapacity benefit which will affect all new claimants by 2008. The name ‘Incapacity Benefit’ will be scrapped so that people are not immediately classed as incapable. Medical assessment will take place earlier – within 12 weeks, and be accompanied by a new Employment and Support Assessment. Individuals will then move onto one of two new benefits “Rehabilitation Support Allowance” and “Disability and Sickness Allowance” which will differentiate between those who have a severe condition and those with more potentially more manageable conditions. Placing employment advisers in GP's surgeries will also be piloted.
- **Pathways to Work:** The DWP Pathways to Work pilots which are supporting individuals on incapacity benefits to return to work will be extended to a third of

the country, covering 900,000 people on Incapacity Benefits. This will be rolled out over 14 new pilots by October 2006.

The extent to which the above initiatives are co-ordinated (if at all) is unclear.

5.4.2.6 Key strategies:

There are also a number of key strategies that are also relevant to job retention issues:

- **Securing Health Together:** Securing Health Together is the government's occupational health strategy, launched in July 2000. It has a 10 year vision of tackling the high levels of work related ill health and as a consequence reducing the personal suffering, family hardship and costs to individuals, employers and society. The strategy represents a joint commitment by Government bodies concerned with occupational health, and bodies outside of Government including individuals, large and small employers and trade unions to work towards common goals and targets. The strategy has five key programmes of work relating to, compliance, continuous improvement, skills, support and knowledge. The Strategy is supported by a website www.ohstrategy.com that hosts a useful database of good practice projects - several of which involve SMEs – on the website.
- **Revitalising Health and Safety (HSE, 2000)**

A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond: The Health Service Commission strategy for workplace health safety published in February 2004, recognises that tackling occupational health and safety in the workplace needs a strategic and partnership based approach, involving the public and private sectors.

Building Capacity for Work: A UK Framework for Vocational Rehabilitation: There is an intention by government to develop a strategy for work-focused rehabilitation, building on the framework of vocational rehabilitation (Cabinet Office, 2005; DWP, 2004). The Framework highlights recent government concerns about the methodological quality of much vocational rehabilitation research (e.g. small scale studies, lack of controls), and the lack of clear evidence that vocational rehabilitation is effective.

5.5 Small employers as employers of disabled people:

5.5.1 The importance of small employers:

Two thirds of all jobs in Europe are within small and medium sized enterprises (SMEs). In 2003, the DTI estimated that 99.1% of businesses were small employers. Over 90% of the 3.5 million or so businesses employ fewer than 10 people (HSC, 2004), and almost 44% of UK employees work for small employers (Howard, 2004). Small employers are therefore an extremely important potential source of employment.

Small firms may offer particular advantages to job seekers with disabilities. In some European countries (e.g. Ireland, Spain and Italy) there is a tradition of

roles being available for disabled people among small employers (often family businesses), and this is attributed to the absence of large organisation bureaucracy and the embedding of these firms in the local community (ECOTEC, 2000).

Small business may also provide the most *practical* opportunities for disabled individuals seeking work within easy travelling distance (Goss & Goss, 1998).

5.5.2 Some general characteristics of small employers:

In her excellent literature review for the Disability Rights Commission, Howard notes that, although diverse in activity and sector, small and micro employers share some common characteristics. These include: informality of employment relations; limited HR resources; a lack of awareness of employment legislation; a lesser focus on health and safety issues; concerns about the costs of complying with legislation or regulations; and limited use made of external advice.

Small employers recruit less, and less often, than large employers. Levels of recruitment will obviously vary with size and nature of activity, but will typically vary between zero and six recruitments a year (Meager et al, 2001). The most common method of recruitment used by the very smallest employers is word-of-mouth, with press advertisement used by larger employers.

5.5.3 Participation of disabled people in small employer workforces:

In a survey of 51 South London SMEs, only 14% of employers reported employing anyone with a disability. This reported scarcity of disabled employees may however, reflect a number of factors, including non-disclosure of disability, and employers' narrow conceptions of what disability can entail. (Kitchen, 2002).

1 in 8 employees in micro workplaces are disabled (Meager et al. 2001, cited McIntosh 2005), and London has one of the highest proportion of disabled people in micro workplaces as compared other regions (Howard, 2004). 32% of disabled employees have fewer than 20 people at their workplace, and 18% work in organisations with fewer than 20 employees (Meager et al., 1998).

However, it is clear from the literature that the presence of disabled employees in workforces increases with employer size (Roberts et al, 2004). Reporting from a survey of 1005 employers across the UK, Meager and others (2001) note that only 12% of micro-sized employers (1-14 employees) claim to have disabled employees, rising to 28% using 'DDA-defined' disability (as compared to 31% and 53% for employers with (20-49 employees). More than half of small employers claimed never to have employed a disabled person – at least not knowingly.

Workplaces with small numbers of employees are far less likely to report having disabled employees than larger employers. For example, Goldstone and Meager (2002) reported that only 22% of small workplaces (with 5-9 employees) reported having disabled employees, compared with 87% in the largest workplaces of 500 or more employees.

Women, older people with disabilities and those with severe disabilities face additional barriers in accessing employment in SMEs across Europe (European Foundation for the Improvement of Living and Working Conditions, 1998). However, Meager and others (1998) notes that small employers are as likely as large employers to employ people with a *severe* disability.

Businesses with higher levels of recruitment activity are more likely to have disabled employees (Meager et al, 2001), as are those with equal opportunities policies.

5.5.4 Small employer owner managers with disabilities:

Almost a tenth of (DTI, 2004) of small business owner/managers have a disability of some kind. This is important as the literature suggest that employers who have personal experience of disability are more likely to employ people with disabilities. In small firms the personal commitment of the owner or manager, sometimes arising out of personal experience of disability, can be critical (Thornton, 1998).

5.6 Small employer recruitment:

5.6.1 Small employer recruitment practices:

Many smaller employers do not use standard recruitment procedures and the recruitment process is based on job descriptions requiring multi-skilling and multi-tasking, which may effectively exclude many disabled applicants (Stuart et al., 2002). The absence of job demarcation can also sometimes provide barriers to employing disabled people.

The smaller an employer is, the less likely it is to have taken *proactive* steps to recruit individuals with disabilities (Goss and Goss, 1998). Only a very small fraction of small employers have *actively* encouraged applications from disabled people, although figure rises in the public sector. (Meager et al., 2001). Most organizations take a reactive rather than proactive stance towards people with disabilities (Stuart et al., 2002).

5.6.2 Policies on employment of disabled people:

Most small employers do not have a formal written equal opportunities policy (Meager et al, 2001). There is a correlation between employer size and having a policy on the employment of disabled people (Stuart et al., 2002), and the latter is usually part of the general equal opportunities policy. There is also a correlation between having a policy on employing disabled people, being aware of the DDA, and making workplace adjustments (Roberts et al 2004).

5.6.3 Small employer perceptions of *barriers* to recruitment of disabled people:

A number of small business surveys have asked employers *why* they think they have so few employees with disabilities. The most common reason given is '*lack of disabled job applicants*' (Meager et al., 2001; Goss et al., 2000; Kitchen, 2002; Stuart et al, 2002)). This may reflect reluctance of some disabled people to apply for jobs with conventional employers due to previous discrimination (Goss et al., 2000), however it may also reflect narrow conceptions of disability held by employers, and non-disclosure of disability by job applicants and employees.

In his study of South London SMEs, Kitchen (2002) lists a number of potential disadvantages associated with employing disabled people, as *perceived* by employers in his sample. These include: access and mobility problems in the workplace; potential costs of making adjustments to premises; perceived capabilities of disabled job seekers; and perceived difficulties in dealing with disability agencies. Health and safety considerations are also a common concern. SMEs may be concerned at the impact on their workforce of employing disabled people (CBI, 1997, cited in London Workforce Futures EQUAL Action 2 Bid).

Goss and Goss (1998) report that small employers are not '*unsympathetic in principle to the provision of fair employment opportunities for people with disabilities, but rather, lacking in the specific knowledge, incentive and opportunity to take initiative in this area*'. They suggest that spread of good practice to the small firm sector will require '*the deployment of considerable resources in terms of education and advice*' and '*an approach that is prepared to look fairly and open-mindedly at the problems faced.*'

5.6.4 Small employer perceptions of *benefits* of employing disabled people:

Four in ten small employers accept that there would be benefits for employing disabled people, however small employers were less likely to identify benefits than larger ones (Goldstone and Meager 2002). Only a minority (15%) see *business* benefits accruing from recruiting disabled people (Meager et al., 2001). Where benefits are perceived these generally relate to staff morale, the skills of disabled employees, and the external image of the company. However, the proportion which see business benefits accruing rises to 30% when firms are considering retaining an *existing* employee who has developed a disability or health problem.

5.7 Small employer use of external support:

5.7.1 Access to HR expertise:

Most small employers do not have a distinct personnel/HR staff member or department, or a formal written equal opportunities policy (Meager et al, 2001). The incidence of dedicated personnel specialists increases with employer size from 16% in small organisations to 59% in large ones (Goldstone and Meager, 2002). Although the presence of dedicated HR support within a business is no guarantee of good practice, the literature suggests that disabled people have a better chance of gaining and keeping jobs where these resources exist (Goss et al., 2000). Good practice and proactive approaches to recruitment and retention are *more likely* where the employer

has access to expert HR resources, is a 'two ticks' employer, and seeks external advice.

5.7.2 Access to occupational health and safety expertise:

Some small businesses are fearful of approaching statutory agencies for health and safety advice for fear of enforcement action (HSC, 2004). Small employers are less likely to conduct health screening, have a specialist in charge of health and safety, or to use the services of an OH practitioner. Very few small companies provide access to occupational health support for their employees, either in-house or bought in. The percentage of small companies that do provide this kind of support could be as low as 6%, or 2% for micro companies (HSE, 2003). The lack of support for managers, when employees have mental health problems can be a particular concern for SMEs (ODPM, 2004).

Small employers who do not have in-house OH services could purchase it from external sources (e.g. NHS Plus, Employer Forum on Disability, the voluntary or private sector (ODPM, 2004), but the costs may seem prohibitive. Small and micro companies spend less on OH support, and are more likely to identify cost as a reason for not providing OH support than medium-sized companies (Pilkington et al, 2002). However, many small employers may be willing to consider sharing their OH services with other companies locally on a chargeable basis.

The HSE has set up the Worker Safety Adviser Challenge Fund which makes funds available for organizations to work in partnership to promote worker involvement through Worker Safety Advisers in SMEs (www.hse.gov.uk).

The lack of access to OH expertise is highly relevant to retention issues, as there is evidence that health and safety issues are frequently used as a (false) rationale for dismissal of a disabled person (Hurstfield et al., 2003). There is also evidence that SMEs across Europe perceive health and safety as an impediment to employing disabled people in the first place (European Foundation for the Improvement of Living and Working Conditions, 1998).

An effective job retention service will probably need to encourage good practice in employment and retention of disabled people not only by helping employers meet their obligations under the DDA, but also by strengthening their occupational health and safety practice (Stanley and Regan, 2003). Efforts to improve the health and safety environment of workplaces to prevent job loss through sickness or disability work need to be supported and extended - particularly to SMEs (Riddell et al., 2005).

5.7.3 Awards Schemes:

There are a number of award schemes (national, regional, local or sectoral) that seek to motivate businesses in terms of their workplace health and safety practice. A number of these include categories for SMEs or are wholly targeted at SMEs. For example ...

- **Scotland's Health at Work (SHAW)** is a national award programme (Bronze, Silver and Gold Awards) set up in 1996 which rewards employers who demonstrate commitment to improving the health of their workforce. There is a toolkit for SMEs (designed in partnership with the HSE and Federation of Small Businesses) to guide them towards the Bronze Award.
- **Health at Work: Corporate Standard** is the quality mark for workplace health promotion in Wales. Administered by the National Assembly for Wales, it is awarded to public or private sector organisations which implement policies and practices designed to promote the health of their employees. The mark is awarded in bronze, silver and gold categories, and is available to organisations of all size, including small employers.
- **The North Staffordshire Healthy Workplace Initiative** gave awards to local employers to encourage good practice in respect of health at work. There was a special 'SME Award'.
- Health at Work in Tyne and Wear offer a **Health at Work Award Scheme** targeted at SMEs. As well as the award scheme, businesses have access to regular seminars, workshops and health professional visits.
- **Work Well Together 4C Awards** - These are a range of awards to businesses in the construction and allied industries that achieve significant improvements in health and safety. There is an award category for SMEs.
- **'Investors in Health'** is a new 'healthy business assessment' being developed by government in partnership with Investors in People UK. This will be incorporated into the IiP standard when it is next reviewed in 2007.
- London First are developing a user-friendly, triple bottom line **Wellness Index for Business** which will enable companies to assess their year-on-year performance with respect to the measures they offer to protect the health and well being of their employees and the impact such initiatives have on the bottom line.

There also a number of schemes (national and local) that recognize good practice among employers in relation to disability. These include:

- Job Centre Plus **'Two Ticks'** Disability Symbol (which includes employer commitments regarding recruitment, employment, retention and career development of disabled employees).
- **'Realising Ability Award'** - a Business in the Community sponsored award which recognizes best practice in addressing disability as a corporate social responsibility.
- The **Local Business Awards** (South London Business and Richmond Chamber of Commerce) (www.localbusinessawards.co.uk) encourage business excellence in south-west London covering the boroughs of Richmond, Wandsworth, Sutton, Croydon, Merton, Bromley and Kingston. Each borough has its own set of awards and categories, with one focused upon 'disability awareness'. This is for an employer that has demonstrated good practice in the recruitment or retention of disabled people.

These award schemes may be useful ways to raise awareness of good disability management and occupational health and safety practice, and to market job retention services across employer networks. However, the extent to which these schemes are effective is unclear.

5.7.4 Drawing upon help from external sources:

Awareness of external support agencies (e.g. DEAs, Access to Work) is less among small employers than larger ones (Nice and Thornton, 2004; Goldstone and Meager, 2002). In Rinaldi and Hill's survey (2000) of SMEs in the London Borough of Merton, only 41% of employers had heard of DEAs, and of these only 65% knew how to contact them.

Small employers rarely seek help or advice from expert advisers or agencies (Roberts et al, 2004; Meager et al, 2001), and it is likely that cost is a key factor. Only a minority seek help from external agencies in making adjustments. However, those that have see this as very important in helping them recruit and retain disabled people. The most frequently sought help is guidance on obligations under the DDA and on adjustments.

Many small employers anticipate needing better information, advice and support on their obligations under the DDA – particularly those firms which have recently come into scope of the Act. There is a preference for written materials, internet-based information, and telephone help-lines (Meager et al. 2001). They would also benefit from access to external expertise on handling mental health issues in the workplace (Blackwell et al, 2001).

5.7.5 Guidance materials:

There is also now a wide range of guidance materials specifically developed for small business which pertain to job retention issues. There are a range of human resources issues covered, including: managing sickness absence (HSE, 2004); managing workplace stress (Business Link, 2005; HSE, 2001; CIPD, 2004); employing people in small firms (ACAS, 2004; good practice on equality and diversity (CRE, 2004); and employing disabled people (DRC, 2004b).

There also a number of guidance materials that, while they do not specifically target small firms, will include material that is relevant to their needs. For example, the EEF (2005) have published 'Fit for work: the complete guide to managing sickness absence and rehabilitation'. The government will be publishing guidelines on the management of mild to moderate mental ill health in the workplace during 2005.

The Institute of Occupational Medicine are developing a prototype sickness absence recording software tool aimed primarily at SMEs to help them record and analyse sickness absence information. The tool will also provide linked web pages, which will help them identify individual and organizational interventions encourage return to work and better control workplace health and safety risks.

5.7.6 Access to support with workforce development:

There is some evidence that small firms can be receptive to help to develop company training and development plans, training programmes for their staff and to identify 'training champions' (LSC London South, 2005; DfES, 2005). The Small Firms Learning Account Scheme operated by LSC London South successfully provided such help for small firms in South London, including grants towards the cost of training. A DfES Small Firm Development Account pilot programme similarly

offered up to 12 months support to small firms to identify a training champion' who would develop and implement a training plan, and offering subsidies towards employee training programmes.

These schemes enable small companies to provide training for their staff in a more proactive and structured way than would otherwise have been the case. Evaluation of the DfES pilot suggested that key factors for involving small firms were the low cost and limited commitment required from employers. Employers were offered information and guidance from an independent source, and were given time and resources to gain experience and an awareness of what to expect from training.

5.8 Small employers and job retention:

5.8.1 Risk of job loss:

Analysis of Labour Force Survey data reveals that, for individuals with disabilities (both DDA-defined or SSP or IB recipients), being employed by a small employer is associated with an *enhanced risk* of leaving work at onset of sickness or disability (Burchardt, 2003). Those individuals reporting mental health problems, and those employed in manual occupations are at the greatest risk. However, the relationship between employer size and risk of job loss following sickness absence is not completely clear. Some data suggests that sickness absence rates are lower in smaller firms, while other studies suggest that smaller firms are less likely to dismiss or offer early retirement to a disabled person on health and safety grounds (Hurstfield et al. 2003).

5.8.2 Retention practices:

SMEs generally have less motivation, knowledge and resources to address workplace health and safety issues (NHS Health Scotland, 2004). Small employers are known to be less effective than larger ones in recruiting and retaining disabled people within their workforces (Goss & Goss, 1998; Goss et al., 2000). In a recent survey of employers, almost half reported that their workplace would find it difficult to retain an employee who develops a disability (Roberts et al, 2004). Rinaldi and Hill's survey of employers in the London borough of Merton (2001) reported that only 20% of the small employers in the survey would consider employing a person with a disability.

A TUC survey found that only 8.6% of employers who recognise unions considered themselves 'very successful' at re-integrating employees after a long period of sickness. Sectoral differences are a significant factor in the quality of rehabilitation practice – for example comparatively higher levels of good practice are found in 'other community services sector', but low levels in construction (TUC, 2002).

5.8.3 Why are small employers less effective at retention?

There are a number of reasons cited in the literature as to why small employers may find it harder than larger ones to retain employees who have developed disabilities or health problems.

Owing to their size, smaller employers may *lack experience* in employing (and retaining employees with disabilities, and this feature itself means they are less equipped to adopt retention strategies when the need arises (James, 2003). They may have *fewer redeployment* opportunities (James, 2003), and lack the *financial capacity* to keep a job open for extended periods if an employee is off sick (ODPM, 2004). They may have *limited resources to find out about* and draw upon external sources of expertise and support (Thornton, 1998). Smaller employers are less likely to have employee representation (James, 2003), which can be an important factor in identifying employee needs for rehabilitative support.

5.9 Small employers and making adjustments:

5.9.1 Making adjustments:

Smaller firms are *less likely* to make workplace adjustments for their employees than larger ones (Goss and Goss, 1998; Nice and Thornton, 2004). Attempts to make adjustments to retain employees who have developed disabilities generally increase with employer size (Goldstone and Meager (2002).

Micro employers are much less likely to offer flexible working and more likely to say they would find it difficult to keep a disabled employee - as compared medium-sized or large employers (Roberts et al. 2004). Small employers are also less likely than larger ones to implement measures to address stress at work (Pilkington et al, 2001). However, small employers are more likely to make adjustments for an *existing* employee than a new recruit (Meager et al, 2001), but less likely to made changes in response to requests from employees (Stuart et al. 2002).

5.9.2 What kind of adjustments?

Small employers often have a narrow conception of disability in terms of physical, sensory and visible impairments (Roberts et al, 2004), and as a result their conception of making adjustments is often limited to physical adaptations to building to improve access (Stuart et al., 2002; Rinaldi and Hill, 2000).

80% of smaller firms that have made adjustments found it 'easy' or 'very easy' to do so (Meager et al., 2001). Interestingly, smaller employers (and small workplaces) are more likely than larger ones to report adjustments as easy (Goldstone and Meager, 2002). Many firms that have employed disabled people report that some of these employees have not required adjustments or additional support.

5.9.3 Costs of making adjustments:

The potential costs of taking action to improve health and safety in the workplace (NHS Health Scotland, 2004) or of making adjustments (Roberts et al, 2004) is of concern to many small employers. Small employers are more likely (than larger ones) to have made adjustments for disabled employees that had incurred *no costs* (Goldstone & Meager, (2002).

However, Meager and others (2001) report that only one third of small employers who make adjustments have incurred any direct costs, while less than 50% experience

indirect costs. Employer anxiety regarding cost usually relates to the prospect of physical adaptations or changes, however many adjustments involve only changes in working patterns and these costs therefore do not materialise. The *average* cost of adjustments per employee (for whom adjustments with a cost were undertaken) was £772. This figure drops to £184 per disabled employee if we take into account that most adjustments do not involve cost, and many firms with disabled employees do not make adjustments at all.

An employer survey commissioned by Leonard Cheshire, Microsoft and Totaljobs.com reported that two-thirds of companies employing disabled people have incurred *no extra costs* in making reasonable adjustments, while 40% of those who did incur costs believe these were less than £1000 (Jobability, 2002).

Some writers have noted that many employers will actually make *savings* by retaining staff who have become disabled (Watson et al, 1998, cited Rinaldi and Hill, 2000).

5.9.4 Why do employers make adjustments?

A recent survey (Robert et al, 2004) reports that the most common reason cited by employers (who had made adjustments for disabled employees), for making these adjustments was that it was the '*right thing to do*' - and that the benefits would outweigh the costs. However, over one third they did so partly as a result of legislation.

5.10 Small employers and the DDA:

5.10.1 Awareness of the DDA:

Small employers are less likely than larger ones to be aware of the Act (Stuart et al., 2002), and know that they are covered by it (Goldstone & Meager 2002). Although many small businesses will have heard of the DDA, many are unaware of the details of the employment provisions (Meager et al., 2001), and unsure of their obligations under them (Roberts et al, 2004). Many will be unaware that they are no longer exempt. For example, only a quarter of small firms (of 15-19 employees) which came into scope in 1998 were aware of this.

A recent survey by Unum Provident (2004) conducted just before the recent extension of the Act, reported that 62% of SME owner-managers in London were unaware that they would fall within the scope of the Act. 63% of owner-managers did not realise how or to what extent their businesses would be affected by the new law. 29% believed the changes to the Act would have absolutely no impact on them. Only 10% thought the extension would have a large effect on their business. At the same time, there was confusion over the cost of making workplace adjustments. 29% believed they would incur no costs, while 21% thought they would have to spend more than £5,000 to become compliant.

However, most small employers are in favour of the Act (Meager et al., 2001). 73% believed that the DDA is the best way of combating discrimination against disabled people (Unum Provident, 2004).

Where employers *have* considered their obligations, they will frequently have considered implications of either Part II (as employers) or Part III (as service providers), but not both (Stuart et al., 2002). There is some evidence that small employers are more concerned about their obligations as service providers, rather than employers.

5.10.2 Impact of the Act:

In his 'threshold' study (2001), Meager reports that few small employers report having changed their practices in relation to employing disabled people as a result of the Act. Most of those that came within the scope of the Act in 1998 were not aware of having done so, and the great majority reported no impact on their business. Meager concludes that a key reason for the low impact is that few firms are aware of its obligations or have taken steps to comply - believing the Act is not relevant to them as they do not get disabled applicants or discriminate. Many employers have 'a limited understanding of the concept of a disabled person that the DDA involves' (Stuart et al., 2002). Because they do not recognize many of their employees as having disabilities, they see neither the relevance of the Act to them, nor the need to make adjustments.

There is some uncertainty as to what impact anti-discrimination legislation internationally has had on employment rates of disabled people. The European Foundation for the Improvement of Living and Working Conditions suggests that quotas and legislation across Europe seem to have had little impact in practice on SME behaviour (1998). In the USA employment rates of disabled people have dropped since the enactment of the Americans with Disabilities Act, however the causal links are unclear.

However, there is some consensus that removal of the exemption *alone*, will not enhance the ability of small employers to recruit, employ and retain disabled workers, and that information, education and guidance on practical measures will be necessary (Goss & Goss, 1998).

5.11 Job Retention Strategies:

5.11.1 Retention practice within small firms?

There are few robust evaluations in the literature that clearly focus on *what* might be effective retention strategies for small employers and their employees at risk.

Grants towards workplace adaptations and special equipment, and fully subsidized support workers can have a significant impact on job retention, as demonstrated in a recent review of the Access To Work Scheme (Thornton and Corden, 2002).

A review of *post-employment* support programmes for long term unemployed workers in OECD countries (Kellard et al., 1992) identified a number of 'in-work support initiatives' that may enhance job retention. Most of these initiatives have not been evaluated rigorously, and the review did not focus specifically on work with SMEs and disability, however there is some evidence that job retention rates *may* be improved by the following interventions: earnings supplements for employees; wages

subsidies for employers; the availability of childcare; job coaching support; skills training; mentoring by a co-worker or external volunteer; and case management job retention support (if carefully resourced and focused).

5.11.2 Retention practice within large employers:

There are many accounts of ‘disability management’ or HR practices undertaken within the corporate sector, that may contribute to improved retention rates. These include:

- Absence monitoring and staying in touch.
- Flexible patterns of work - gradual return to work, part-time working, flexi-time, family friendly hours, annual hours, home-working/tele-working, job-sharing.
- Mediation and conciliation services.
- Return to work/disability case management.
- Improving supervision and training.
- Job redesign.
- Redeployment.
- Enhanced childcare provision.
- Disability leave or career breaks.
- Improving support: Employee Assistance Programmes, counseling, independent help-lines, peer support, mentoring.
- Occupational health and safety programmes:
 - wellness programmes, health screening, health clinics.
 - identifying ‘hotspots’ through surveys of sickness absence/performance.
 - identifying vulnerable individuals through risk management tools.
 - specific return to work input.
- Adjustments - making significant investments in adjustments and monitoring.

Many of the above approaches *may* be applicable to retention practice by small businesses, however the extent to which any of these strategies have been adopted by SMEs has not received attention in the literature. This may reflect the fact that, as noted earlier in this review, small businesses are handicapped by the lack of access to HR or OH resources, with which to implement these approaches.

Some larger employers may also be able to offer income protection schemes through insurance schemes which enable them to cover their responsibilities to their employees who are off sick. In order to keep insurance premiums and payouts low, there are incentives for these employers to offer at least some degree of rehabilitation support to shorten periods of absence. However, there may also be pressure on employers to get rid of people with poor attendance records. To what extent these kinds of insurance-based schemes are available to and taken up by SMEs is uncertain.

Further examples of large employer practice can be found in Appendix V.

5.11.3 Retention Strategies for different disability groups:

It is difficult to generalize regarding what might be effective retention strategies for particular disability groups, as each individual’s situation will be complex and multi-

factorial. The kind of impairment they have may or may not be a significant factor in successful retention. There is little in the literature regarding this, with the exception of studies that examine job retention of individuals with mental health problems (see below). However, it is possible that the final evaluation of the Job Retention and Rehabilitation Pilots (due at end 2005) may provide some useful information in this area.

5.11.4 Critical success factors for retention of employees with mental health problems:

A comprehensive literature review on this topic (Thomas et al, 2002) highlights a number of key features that a job retention service needs if it is to be effective. These include:

- offering early intervention;
- a primary allegiance to the employee;
- provision of confidential vocational and mental health counseling;
- promoting positive and realistic perspectives among employees at risk;
- expertise in DDA and other legislation;
- provision of support to the employer on making adjustments and managing mental health in the workplace;
- facilitating natural supports;
- facilitating communication between employer and employee;
- and ongoing support.

These findings have been corroborated by current providers of specialist job retention services for people with mental health needs in the UK (Lennard, 2004; Robdale, 2005).

It is likely that many of these elements would be important for a job retention service that targets a wider clientele - including people with physical, sensory and learning disabilities, as well as those who have developed long term health problems.

It also suggested that financial incentives and mental health education packages (e.g. brochures, websites and training seminars) for employers might encourage better management of mental health in the workplace. Job retention services also need to market themselves effectively to GPs to ensure fast referral of clients (Robdale, 2005).

5.11.5 What kind of skills do job retention workers need?

An evaluation of a pilot job retention service operated by the Avon and Wiltshire Mental Health Partnership Trust (Thomas et al, 2003) noted that job retention case managers working with clients with mental health problems need a range of knowledge and skills, including mental health; employment issues; empathy towards client; understanding of employers issues; an objective stance offering support to both parties; while taking a more legalistic stance if required.

5.11.6 What model of job retention is most effective?

There is little clear evidence in the literature on which 'model' of job retention is the most effective. A recent literature review of job retention and mental health (Thomas, 2002) compared a number of models of job retention in terms of effectiveness, including employee assistance programmes, the social process model (Gates, 2000), and case management. The latter involves a central worker who facilitates communication between employer, employee, health, employment services and other agencies, and acts as advocate for the employee at risk. The review concluded that case management is the most effective of these approaches. The case management model - implemented by the Australian CRS service over the last fifty years - has received support from a number of quarters (British Society for Rehabilitation Medicines, 2003; TUC, 2000).

5.11.7 International lessons:

There is some evidence that return to work rates for individuals experiencing health problems or injuries vary significantly between different countries. According to a TUC study (cited by the College of Occupational Therapists in a recent conference brochure) *'a worker who suffers a major injury has a 50 per cent chance of returning to work in Sweden, a 30 per cent change in the US, but just a 15% chance in the UK'*.

This variation may reflect the fact that each country has quite differing environments in terms of regulatory and legislative frameworks, social and private insurance systems, compensation and rehabilitation schemes. For example, Holland and Denmark have legal obligations on employers to develop plans for retention in the case of long-term sickness absence. In Holland, all employers are also required to purchase occupational health services. Sweden has rehabilitation programmes for employees under the social insurance system. Australia, Canada and USA have state compensation and rehabilitation schemes for workplace injury, while Canada and the USA have employer or employee private insurance plans which provide for rehabilitation. Thornton (1998) notes that in many countries, strong regulatory frameworks and business incentives (e.g. performance-related insurance premiums) have produced a greater involvement of employer in job retention activities than found in the UK. For example, disability management practice is well developed in Canada and USA where workers' compensation and insurance systems provide incentives to employers to rehabilitate sick employees (Thornton, 2003).

Retention *measures* also vary from country to country. In Australia, retention support is treated as a priority and delivered alongside other services (e.g. vocational rehabilitation, occupational health and safety support by CRS Australia). Germany offers retraining programmes for those needing to change their working roles, as well as subsidies for employers to cover reduced productivity and making adaptations. In Holland, employers have access to special, flexible funds which they can use to provide any form of support needed to enable their employees to stay in post (ECOTEC, 2000).

As in the UK, job retention initiatives in many other countries have had until recently a lower priority than return-to-work initiatives. However, there are reports of successful job retention programmes and approaches (e.g. CRS Australia;

Arbeitsassistenten in Austria; National Institute for Working Life, Sweden), however there is a need to be cautious in extrapolating from experiences in other countries, where conditions are so different.

Thornton notes that small firms have a marginal position in most programmes which support job retention and return to work (Thornton, 1998). Data on retention work within SMEs is sparse, and studies from different countries are difficult to compare.

5.12 Delivering job retention services to small employers

5.12.1 Marketing services to small employers:

Services offered to small employers need to be *'demand-led'* and enterprise focused (New Economics Foundation, 2004). Small businesses may lack confidence in public sector business support agencies, and it is important that services are tailored to their needs, and impose neither delay nor bureaucracy on their customers.

For marketing to be effective, language must be used and issues framed in ways that are *'culturally familiar'* to businesses (Lennard, 2004). In other words, business language should be used in publicity materials and in communication with employers.

Information and publicity needs to be presented to employers in a simple way, tailored to their particular needs, and the standards of presentation are important (Lennard, 2004). Any information needs to be coordinated with that from other local support agencies, so that employers are not confused or overwhelmed (New Economics Foundation, 2004; LSC London South, 2005).

Howard (2004) suggests that firms are more likely to respond to information and publicity that is *'supportive and persuasive'* (rather than adversarial).

Some writers argue that messages based on principles of normalization may (Riddell et al, 2005) may prove to be counter-productive. For example, a claim that disabled people are the same as, or better than, non-disabled workers may be unhelpful if it leads to unrealistic expectations amongst employers. Riddell suggests that recognizing genuine differences, while avoiding stereotypes, may be a more useful approach to take with employers.

As many small employers may not use the Internet or be members of employer networks, it may be important to use a *range* of channels to reach them. Direct mail shots can be an effective way of raising awareness of services for SMEs (NHS Health Scotland, 2004).

Many small employers, for example, tend to use banks and accountants for advice, rather than trade associations or external support agencies (New Economics Foundation, 2004; Howard, 2004). Howard also notes that *'there is limited evidence of life cycle points at which to target information at micro employers, with the exception of business start-ups'*.

5.12.2 Tailoring job retention services to the needs of small employers:

There is very little in the literature as to exactly how *job retention services per se* should be tailored to the needs of small employers.

However, some writers (Thornton (1998; James, 2003; TUC, 2000) suggest that extra funding towards making the costs of making adjustments could, in certain circumstances, be made available to those employers who might be deterred by the costs of making these adjustments. Thornton suggests that different cost-sharing arrangements could be explored. It would be important for there to be '*minimal bureaucratic requirements*' and '*minimal delays in assessment and supply*'.

Howard (2004) notes that a free, preventive service could be work well with SMEs, as has been delivered by through some health and safety initiatives (see www.safeandhealthyworking.com).

5.13 Summary:

- 17% of working-aged Londoners have a disability - around 810,000 people. However they experience much **higher unemployment rates** than non-disabled people. Rates are particularly high for women, young people and people from BME groups who have disabilities, and those with mental health problems.
- Disabled people experience **greater movements** in and out of the labour market than the general population. Improving retention rates would address under-representation.
- **Stress-related conditions** are now the commonest cause of sickness absence and those experiencing mental health problems face particular challenges in keeping jobs.
- Disabled people are **under-represented** in the workforces of small firms. Small employers are less effective in recruiting and retaining disabled people.
- Small employers are however the largest source of new jobs and are therefore an important **source of employment** to disabled jobseekers.
- Small employers are diverse but share **common characteristics**: informal employment relationships; limited access to OH/HR resources; lack of awareness of legislation; and concerns about costs of adjustments.
- Almost a tenth of small business owners have a disability of some kind.
- Small employers claim **lack of disabled applicants**, however this may reflect discrimination, narrow conceptions of disability and non-disclosure.
- Only a minority see **business benefits** from employing disabled people.
- Employers see more benefit from **retaining an existing employee** with a health problem or disability, than taking on a disabled job applicant.

- Being employed by a small employer is associated with an **enhanced risk of leaving work** at onset of sickness or disability. Smaller firms are less likely to make adjustments for their employees than larger ones. There are sectoral differences in the quality of rehabilitation support offered.
- Disabled people have a better chance of retaining jobs where the employer has **access to HR/OH resources**, is ‘two ticks’ registered and seeks external advice.
- **Awareness of external support** agencies is low among small employers - and they rarely seek help from these. Cost is a likely factor.
- Small employers are **less effective at retention** because they: are less aware of retention strategies; have fewer redeployment opportunities; lack financial capacity to keep jobs open; have limited resources to find out about and draw upon external help; and are less likely to have worker representation.
- The **assumed cost** of taking action to improve health and safety or of making adjustments is of concern to many small employers.
- Only a third who make adjustments actually incur direct costs. Most firms that have made adjustments found it ‘**easy**’ or ‘**very easy**’ to do.
- Employer anxiety regarding cost frequently relates to physical adaptations, however many adjustments only involve **changes in working patterns**.
- Employers make adjustments because it is the ‘right thing to do’ and the benefits outweigh the costs, however some do so to **comply with legislation**.
- Many small employers want better information on their obligations under the DDA. Many are unaware that they now fall within its scope.
- **Critical success factors** for retention of employees with mental health problems include:
 - early intervention.
 - vocational and mental health counselling.
 - expertise in legislation.
 - advice to employers on making adjustments/managing health problems.
 - facilitating natural supports.
 - facilitating communication between employer and employee.
 - providing ongoing support.
- The **case management approach** to job retention has received support from a number of quarters.
- The research base on how job retention services should be tailored to the needs of small employers is poor. However, the following **strategies** may be effective:
 - case management retention support.

- earnings supplements for employees; wages subsidies for employers.
 - extra funding towards costs of making adjustments (in some situations).
 - job coaching support.
 - skills training.
 - mentoring by a co-worker or external volunteer.
 - facilitating cost-sharing arrangements for external support.
- Marketing of services to small employers should involve:
 - A commercially orientated approach.
 - Simple, tailored information and publicity materials.
 - Co-ordination with other local support agencies.
 - Immediacy of response - minimum bureaucratic delays in service supply.
 - Supportive and persuasive - rather than adversarial.
 - Use a range of channels.
 - Free, preventive service.
- Job retention services need to market themselves effectively to health services to achieve early intervention.

SECTION SIX

Current practice in job retention

6.1 Current approaches to job retention:

There are a small number of services across the UK that are working with employers to prevent job loss through health problems or disability. These services fall into two main types:

- **Specialist job retention services** - these services are often operated by independent sector agencies, but also local authorities and NHS Trusts. They mostly target particular disability groups, although currently the majority of services service individuals with mental health problems. The service they offer is capable of being intensive and can involve - early intervention, case management, return to work planning, mediation and ongoing support for employer and employee. Commonly, these agencies are also working in the allied field of employer recruitment of disabled people. Most services work with employers of all size, including SMEs.

Walsall Employment Retention Project:

This project aims to take an holistic approach to health and to improve the health and welfare of people in the Walsall borough. The project offers support for employed individuals who at risk of losing their job because of the nature or length of their illness. The approach is based on the principle that early intervention is the key to successful job retention. The service has three strands:

- ***The Mental Health Service:*** Employment status is an integral part of the local Care Programme Approach, and an Adviser (a psychiatric nurse) liaises with in-patients' employers to facilitate return to work strategies. Referrals are also made by Community Mental Health Teams.
- ***The Coronary Heart Disease Service:*** A rehabilitation nurse at the local hospital operates in much the same way as above. GPs also refer patients.
- ***The GP Service:*** All GPs in the area are aware of the service and some make regular referrals. These can be connected with any type of illness. All surgeries have posters advertising the service and patient self-referral cards are available.

In addition, a ***Depression and Anxiety Management Service*** offers a range of support services to clients including complementary therapies, one to one counselling and short courses (e.g. anxiety management). These take place in the evenings so that people in work can attend without taking time off work.

The service manager is based at the local Chamber of Commerce and Chamber staff actively promote the service to local employers. Employers do not directly refer their employees to the service, but encourage self-referral. The service also offers disability awareness training to employers.

- **Occupational health and safety advice services** - these are usually operated by independent sector agencies, although some are operated by local authorities, or involve a consortium of public and private sector partners. These services are led by OH practitioners, and focus primarily on offering occupational health and health and safety advice and support. An important feature of these services is offering advice and support to individuals at risk or potentially at risk of job loss - usually within primary care settings. However, support is predominantly at the level of **advice and encouragement**, rather than extended interventions in the workplace. Liaison with the employer, where it takes place, is usually at the level of **written communication** on behalf of clients. Full integrated case management involving mediation with employers and development of return to work plans is uncommon, as most services are not resourced to offer this. These services do, however, deliver a wide range of occupational health, and health and safety programmes to SMEs - some preventative, some problem-solving. Some have sought to enhance workforce involvement in health issues through programmes funded through the HSE funded Workers Safety Adviser Challenge Fund. Most of these OH-led services are members of the National Work and Health Network which has nine members at the time of writing.

Sheffield Occupational Health Advisory Service (SOHAS):

SOHAS is a charitable organisations which has been providing workplace health advice to Sheffield residents and local employers for the last 24 years. Its workplace health programme aims to support and empower people to manage their workplace health.

Advisers are based in GP surgeries and health centres across the city. The advisers provide occupational health advice on prevention, rehabilitation, employment law and rights, and benefits. 60% of clients seen are referred by GPs, the remainder through self referral and other agencies. Approximately 65% of clients work for SMEs. Between 50 and 60% of SOHAS work is concerned with preventative advice, return to work an rehabilitation, however interventions are primarily provision of advice. The agency is not resourced to undertake prolonged or extensive mediation work with employers.

A Black and Minority Ethnic (BME) Workplace Health Programme has sought to raise workplace health awareness among Sheffield's black and minority ethnic communities, using trained volunteers. Funding through the HSE Workers' Safety Adviser (WSA) Challenge Fund has enabled SOHAD to traget health and safety advice at voluntary sector agencies across Sheffield. SOHAS has also been a provider agency (WorkCare) within the government Job Retention and Rehabilitation Pilots.

Both types of services work with both employees and employers, and ways of working with both groups appears to be broadly. A variety of referral routes are usually accepted, including self-referral. Services targeted at individuals at risk and those aimed at employers are *marketed* in quite different ways, and sometimes

delivered from different locations. The siting of agencies varies greatly - some operate from NHS or local authority premises, while others are based within Chamber of Commerce - with outreach to GP surgeries, acute wards and others settings.

6.2 How effective are existing services in working with SMEs?

There is a paucity of robust evaluative data available from existing specialist job retention services. Many are young services and have not yet undertaken evaluations, while others are currently in the process of doing so. Most evaluations that have been completed are of programmes serving people with mental health problems. Many are internal evaluations written primarily for funders, rather than independent evaluations commissioned of external agencies. As such they are often rudimentary, and provide limited data on work with SMEs. Some have been undertaken quite early in the life-time of the project, and there is little longitudinal data as yet.

Similarly, it is hard to assess the degree to which the retention work undertaken by OH-led services is effective. Although there is some evidence (Jackson, 2004) that the supply of OH advice through primary care settings results in a reduction in ill health symptoms and health hazards in the workplace, there has been little focus so far on retention outcomes. The lack of resources these agencies have available to follow-up clients that do receive such support makes it difficult to gauge the effectiveness of their retention work.

Despite the weakness of the research base, it is possible to make some broad conclusions. Many job retention agencies do seem to be achieving good outcomes, and some report impressive retention rates (e.g. SW London and St. Georges NHS Trust, Avon Job Retention Service, Enable) - in some case well over half service users returning to work. These rates frequently include individuals who have returned to work but not with the same employer - the best option for some individuals.

Enable Job Retention Service:

The Enable Job Retention Service has been supporting people with mental health problems in retaining and returning to their existing employment since October 2002. Clients are individuals who, due to the nature or length of illness, may be at risk of losing their jobs. The Service aims to prevent people with mental health problems become enmeshed in long term mental health services, reduce long term sickness absence, and improve employer retention rates. The Service works closely with primary care (49 GP surgeries across Shropshire) and occupational health departments, especially within the NHS and Shropshire County Council. The service is funded by Shropshire Primary Care Trust

Between October 2002 and October 2004, the Enable Job Retention Services worked with 125 individuals. Over 60 individuals were supported to return to or stay in their jobs, while the remainder were helped to exist their current employment, secure severance pay, medically retire, take up further education or other outcomes.

South West London and St.Georges NHS Trust

Over the last few years the Trust has implemented evidence based supported employment aimed at supporting people with mental health needs into work or training/education and helping people who are in employment to maintain that status. The service, which is embedded in the CMHTs, has three elements.

- An **Occupational Therapist (OT)** is the designated clinical vocational lead within the team. The OT devotes at least one session per week in direct work with clients and providing support and advice on vocational issues to other members of the team.

The OT works in conjunction with:

- an **Employment Specialist (ES)** is also integrated into the Community Mental Health Team and builds links with local employers, DEAs, mainstream and specialist employment/training agencies, local colleges etc. The ES carries out the vocational assessments and enables clients to access training and/or employment opportunities.
- The Employment Specialist also works with the **Individual Care Co-ordinator** whose role is to provide ongoing support for the client once they have secured employment, education/training or voluntary work. Assistance from the OT is also provided as appropriate.

All members of the team can link in to the Trust Welfare Rights Service to provide up-to-date benefits advice for their clients.

During the year April 2003 to March 2004 the service supported 1182 clients in total. Of these, 96.8% were on enhanced CPA, 60.1% with a diagnosis of some form of psychosis, and 67% had been in contact with the CMHT for over 12 months. The proportion of people from black and ethnic minority communities using the service is greater than that in the general population.

At the start of that year, 125 clients were in employment. 104 clients were assisted to retain employment, a retention rate of 83%.

This service model was cited in the Commission for Health Improvement Clinical Governance Review (February 2003) as an example of good practice from which other Trusts could learn and in the Mental Health & Social Exclusion report (ODPM) and the Choosing Health White Paper (DoH).

The Trust has also implemented evidence based supported employment in the Early Treatment and Home-based Outreach Service. This works with young people (17-30) with first-episode psychosis. As far as job retention is concerned, the numbers involved were small, 40 people. Of the four people in open employment at the start of the study, all maintained their jobs whilst others who were unemployed were helped to gain and maintain jobs or education/training. At the end of the year only one person was left unemployed or not engaged in education/training.

Both the above service models demonstrate high levels of job entry and job retention which can be achieved by working within the secondary care health system.

There are also some common themes that emerge within these evaluations, and these concur with the findings of our primary and secondary research. Early intervention is crucial. The importance of working with both employee *and* employer to mediate a successful outcome. The importance of taking a neutral stance with both parties. The need to speak business language with employers. The need to offer a range of easy access points to reach individuals at risk, and for multiple marketing approaches to reach employers.

6.3 Two agencies or one?

All the agencies that were consulted for this study provide services for both employees at risk and employers within the framework of a *single agency*. However, services to the two customer groups are *marketed* in quite different ways, and services are delivered to each group in *separate settings* that instil credibility, confidence and trust.

For example, services to employers are sometimes based in Chambers of Commerce or other ‘employer’ territory, and marketed to employers through their networks and communication channels. Similarly, services to employees who may be experiencing difficulties at work are delivered in range of healthcare or community settings - where there are no obvious links to their employers or their occupational health department.

This ‘twin-headed’ approach appears to be effective, and there were no reports from agencies consulted of significant difficulties created by conflicting loyalties to employer and employee that couldn’t be resolved in some fashion (see below). It is also the approach taken by the well-established CRS Australia service which provides a broad range of workplace health and safety, occupational health, case management retention support and rehabilitation support services to both employers and employees.

There are also a number of important advantages to the ‘twin-headed’ approach. There is one body (and officer) undertaking mediation between employers and employees rather than two, and who will be aware of both perspectives and all relevant facts. There will be no ambiguity in terms of which agency clients will need to talk to receive services. It will probably be more cost-effective (less overheads) to have one agency, and probably more time-effective (less liaison necessary between agencies) as well. These are strong advantages which seem to us to outweigh the potential disadvantaged alluded to above.

6.4 Handling conflicts of interest:

Most agencies report only occasional situations where agency staff experience feelings of split loyalties between their employee and employer clients. This has been revealed by close supervision or, in one instance, by the retention worker him/herself. The problem has been addressed in one of two ways. Either the manager has taken over the case, or a third party from another organisation has been brought in. In both instances this was with the agreement of employer and employee.

6.5 Maintaining customer credibility:

Issues of maintaining customer confidence are managed by these services in a number of ways:

- presenting a *professional, businesslike* approach and demonstrating quickly that the agency understands the employer's problems.
- siting services within a *business organisations* and networks such as Chambers of Commerce and marketing their services through these bodies.
- ensuring that staff receive thorough training in the role of *mediator* - not champion of employee or employer.
- *sharing information* and discussing strategies with both parties openly.

6.6 A suggested approach:

There is no one clear 'model' out there on which to base the design of a service serving SMEs, rather services that have incorporated a number of approaches tailored to local conditions and availability of local partners and funding opportunities. They do, however, have common features that we can identify that seem to be critical to success. We have drawn these out in our recommendations in section seven.

SECTION SEVEN

Conclusions and Recommendations:

7.1 Conclusions

7.1.1 Barriers:

The primary and secondary research has revealed that small firms experience particular challenges in retaining and re-integrating staff who have developed health problems or disabilities.

Small firms face a number of barriers in this area. They face particular difficulties in coping with long sickness absences, and many are less able to consider redeployment, job redesign or flexible working practices. They have limited access to HR or OH resources, and they don't know about or use local services. Many lack knowledge of disability, have narrow conceptions of disability, and are consequently unaware of their obligations under the DDA. Many view disability as being something primarily to do with wheelchair access, and are unaware that the DDA covers the full range of disability and mental health conditions. Many see disability as potential extra burden, and are unaware of the business benefits of retaining staff who develop health problems or disabilities.

7.1.2 Opportunities:

Small firms do, however, represent an important source of employment opportunities to people with disabilities, who are under-represented in their workforces. If small firms can be supported to improve their, often poor, retention (and recruitment) practice, this will go some way to improving the participation rates of disabled people in London workforces.

Small firms should be seen as an opportunity. They can sometimes be very supportive to staff with health problems or disability - especially where owner-managers have experience of disability, or have developed good personal relationships with their employees. There can sometimes be better communication within small firms, and so difficulties can be identified earlier. Sometimes, adjustments can be made more easily, as such firms have less bureaucracy. Many micro firms are family businesses, which are sometimes more able to cover long term sick leave with their family members.

7.1.3 What small employers want:

Many small firms would be willing to look at improving their recruitment, employment and retention practices, but will only do so if given the *right kind of help*. Employers would welcome a single, responsive, business orientated service that can help to resolve difficulties, as and when they arise. Services need to be free, or reasonably low cost.

Small employers have a focus on the short-term, and often find it more difficult to focus on longer term issues. For this reason, the small firms in our sample were generally less interested on more ‘preventative’ approaches to job retention - for example, advice on workforce development, human resource management, health and safety issues. There was certainly some demand for these kinds of services, but it was less frequent and uncertain.

Some small employers will welcome these kinds of proactive approaches if they are offered in the right kind of way, but for others their interest in looking at staff management systems, workforce development or the workplace environment will only be aroused *after* exposure to a particular problem they faced in workforce management.

This suggest there will need to be a ‘*twin track*’ approach to marketing preventative approaches to small employers - direct ‘cold’ approaches to some, but also selling such programmes to customers where individual problem-solving casework has been undertaken and trust built up.

7.2 Recommendations:

Based upon the findings in the primary and secondary research we make the following recommendations for Action 2 pilot programmes in the London Workforce Futures Round 2 Equal Programme.

7.2.1 Principles:

The following principles should underpin pilot programmes developed by LWF Partnership in Round 2:

- ***Demand-led*** - user-led, not service-led, programmes.
- Offer both ***reactive*** and ***preventative*** measures to enhance job retention and re-integration.
- ***Holistic*** - offer a range of multi-disciplinary input.
- ***Equality*** – ensure all groups have equal access.
- ***Simplify the service landscape*** - build on what’s already there that works.
- ***Subsidiarity*** - identify the *best placed* agency/partnerships to deliver services.
- ***Partnership working*** - encourage partnership working between specialist and mainstream agencies in delivery to achieve sustainability and mainstreaming.
- ***Empowerment*** - of employees to fight discrimination, identify adjustments they need and champion health issues within their workplaces; of employers to address health issues organisationally and for individual employees.
- ***Learning*** - further develop the evidence base on what works and for whom.

7.2.2 Pilot programmes:

The Partnership should seek to develop a ***single organisation*** whose central mission will be to ***improve the health and well being of small firms and their employees***. It will seek to achieve this through two broad approaches:

- ***A job retention programme*** offering individual case management to prevent job loss of employees with health problems or disabilities whose employment may be at risk.
- ***Preventative approaches to job loss*** through supply of occupational health and health and safety expertise, generic human resource management and workforce development to small firm owner-managers and their employees.

7.2.3 Beneficiaries:

Programme beneficiaries will include:

- Employees with disabilities (DDA defined or self-defined) who feel they are or may be at risk of losing their jobs.
- Employees with health problems who feel they are or may be at risk of losing their jobs.
- SME owner managers.

The intention will be primarily to target employees in small businesses who are at risk, however there are ethical and practical issues that need to be considered about providing support for those employees who work for larger firms. For example, it would seem harsh to turn away an employee at risk purely on the basis they work for a large (or medium sized) employer, particularly where there are no alternative sources of support available to them in the locality.

7.2.4 Services for small employers:

Services for small employers will be delivered through a single, ***one-stop business support service*** which would ***broker*** tailored packages of support - from a comprehensive menu of options.

The ***menu of options*** that employers could select from would include:

- ***Workforce health:***
 - Health and safety - workplace visits, audits (by qualified practitioners), action planning, policies, compliance etc.
 - Occupational health:
 - Managing sickness absence.
 - Health promotion (e.g. stress management, work- life balance).
 - Encouraging worker involvement e.g. 'health' champions/teams.
 - EAP programmes/helpline/counselling.
- ***Human Resource Management:***
 - Performance management and appraisal systems.
 - Retention strategies (e.g. flexible patterns of work, job redesign).
 - Workplace support (e.g. Access To Work, WorkStep).
 - Time-limited, tapering funding subsidies to cover gradual return to work.
 - Recruitment support (e.g. disabled job applicants).

- Disability/mental health awareness training.
- Advice on DDA compliance.
- Referral to expertise on employment law and legal advice.
- **Specialist job retention support:**
 - Early intervention - a range of easy access points.
 - Case management model – brokering a multidisciplinary approach.
 - holistic problem-solving.
 - Mediation – facilitate communication between employee and employer.
 - Return to work planning and facilitation.
 - Ongoing support (through support workers, ATW, natural supports).
 - Productivity subsidy – time-limited fund to cover ‘unreasonable’ adjustments, part-time working, time-out for retraining.
- **Workforce development:**
 - Company training audits and plans
 - Brokering local training programmes.
 - Identifying learning grants (e.g. Small Firms Learning Account).

7.2.5 Brokerage:

- A key feature of the one-stop business support service is that it would actively *broker* a tailored and flexible package of services to employers, rather than simply signposting employers to them.
- The advantage of the brokerage approach would be threefold:
 - Employers would only have to deal with **one agency**.
 - The broker would take the strain of cutting through bureaucracy.
 - The broker would try to ensure speedy delivery of services.
- The agency would deliver *some* services itself (e.g. assessment), but a key role would be to *facilitate* prompt delivery of other services, some through partner agencies and others from local service providers (e.g. Job Centre Plus).

The stance of the service to **employers** would be:

- Independent and confidential - no links to enforcement agencies.
- Business-orientated.
- Supportive, not adversarial.
- Problem-solving brokerage.
- Offering flexible packages of support.
- Offering immediacy of response.
- Using *carrots* (business case arguments, free/low cost help, tailored help, brokerage cutting through bureaucracy, fast response) and *sticks* (help to comply with DDA and H&S legislation).

7.2.6 Services to employees at risk:

- **Occupational health:**
 - Information and advice on work-related health problems.
 - Sources of help.
 - Advice on legal rights - health and safety, and DDA legislation.
- **Specialist job retention support:**
 - Early intervention - a range of easy access points.
 - Case management model – brokering a multidisciplinary approach.
 - Holistic problem-solving.
 - Mediation – facilitate communication between employee and employer.
 - Return to work planning and facilitation.
 - Ongoing support (through support workers, ATW, natural supports).

The stance of the service to **employees** would be:

- Independent.
- Confidential.
- Supportive and empowering.
- Problem-solving.
- Free or low cost.

7.2.7 Types of service:

That the following kinds of support would be available to customers (as appropriate to their needs):

- information (through telephone helpline; surgeries, website).
- problem-solving advice (telephone helpline, email, surgeries, site visits).
- brokerage of services.
- in-depth work (by a range of expert consultants).

7.2.8 Sites of service delivery:

- Employer-focused services and employee-focused services would be delivered from *different sites* - in locations that inspire confidence and trust in each customer group.
- Both types of service will need to develop a *range of access points* to maximise service take-up of the service.
- It will be important to deliver employee-focused services in a *range of settings*, which might include: GP surgeries, walk-in centres, hospitals, acute wards, CMHTs, coronary heart disease services. Other community settings could also be explored e.g. job centres, town halls.

7.2.9 Marketing of services:

- Marketing of services of both SMEs and employees at risk will need to be ***intensive and sustained***. This will be important both to reach small firms, but also to engage with key referrals agencies/professionals such as GPs.
- Marketing materials will need to be ***customised*** for employers, individuals at risk, health professionals and other intermediary agencies.
- Marketing materials should stress the ***independence*** of the service and that there are no linkages to enforcement agencies.
- Employer focused services will need to sell their service in terms of bringing ***business benefits***. ***Key messages*** might include:
 - Reducing sickness absence and associated costs.
 - Developing a healthier workforce - leading to increased productivity.
 - Developing a more skilled workforce - leading to increased productivity.
 - Reducing recruitment costs.
 - Lowering liability insurance premiums.
 - Good diversity policy and practice improves company image - leading a wider customer base, improved chances of gaining preferred supplier status for public contracts.
 - Helping with compliance (DDA, Health and safety).
 - Linking to sources of help.
- ***A range of marketing channels*** will need to be explored, and could include:
 - Employers networks/business support agencies (e.g. Chambers, Business Link, FSB, Rotary Clubs, Trade Associations) – using newsletters, business breakfasts, tailored seminars etc.
 - Business-to-business marketing - using exemplar employers (experts by experience).
 - Leaflets, emails may be useful in some circumstances.
 - Website – customised pages for different groups, good linkages to sites used by GPs, employers.
 - Utilise employer links already made through other initiatives.
- Round 2 pilots would test out the ***effectiveness*** of different marketing ***messages and channels***, and these would be refined as the programme develops.
- It will be important to ensure that services reach individuals in BME communities - both owner-managers and their employees - and other EQUAL target groups facing particular disadvantage (e.g. lone parents; older workers approaching retirement age). Marketing approaches and materials will need to reflect this.

7.2.10 Employer incentives:

- In some circumstances, wage subsidies could be offered to compensate employers for period of reduced productivity during gradual return to work or retraining (some agencies have used WorkStep in this way). These would need to be time-limited and conditional to making adjustments to avoid exploitation by employers.
- A local award schemes for exemplar employers could be a useful approach to both marketing services and encouraging employer good practice, but to engage employers this must avoid bureaucracy and not require significant investment of time or money. 'Investors in Health' may be effective for those willing go down the Investors in People route.

7.2.11 Evaluation:

- Monitoring and evaluation structures would be built in from day one - involving target groups in developing these structures, benchmarking, monitoring and evaluations. Target groups should include people who have lost their jobs as a result of illness or disability.
- The evaluation process would seek to measure:
 - demand for interventions supplied by the one-stop agency.
 - effectiveness of these interventions.
 - whether there are any correlations between particular interventions and particular disabilities.
 - to what extent mainstreaming strategies have been effective and which approaches have been most effective.
 - how service profiles have varied according to a) employer demographics in different localities b) socio-economic characteristics of residents in different localities.
- It is important that the methodology of programme evaluation is sufficiently robust to address recent government concerns about the quality of vocational rehabilitation research, and is seen to contribute to enriching the evidence base.

7.2.12 Options for delivery of pilot programmes:

The recommendations made above call for the establishment of a *single pilot programme* - a one-stop employment service delivering both employer-focused services and employee-focussed services.

However, within this broad objective, there is perhaps scope to explore a number of questions about service delivery to SMEs (perhaps in different localities), that remain outstanding from this research. Some very worthwhile areas might include:

- Within the London context, are there factors of small employer distribution, population demographics or provider service landscape that suggest whether

regional, sub-regional, or local services are most appropriate? Are there sensible *economies of scale* or geographic focus that suggest themselves?

- What are the *best ways to embed services* into primary care and secondary mental health services to achieve early intervention? The employment service operating at South West London and St. Georges, embedded in CMHTs, is already working successfully in job retention.
- What are the *best approaches to developing joint working* between specialist job retention agencies and business support agencies to achieve mainstreaming? What kind of approaches are possible, and which ones seem to be the most effective?

We suggest that these are strategic matters for consideration by the London Workforce Futures Development Partnership.

7.2.13 Tailoring programmes to local conditions:

- Once the Partnership has made strategic decisions about the nature of pilot programmes, it will be important to ensure that programme design reflects the needs and priorities of particular localities. It will be important to get *feedback from key local stakeholders* - particularly existing provider agencies - on:
 - how programmes could be tailored to reflect local conditions (e.g. business sectoral patterns, population demographics)?
 - what geographic scope or economies of scale make sense to them?
 - what roles they would like to have in the programme?
- For example, one approach would be a half-day event co-hosted by Chambers of Commerce, Business Link for London and local PCTs to give potential partners the opportunity to get together and discuss how they might work together before the tendering process (see below) begins. [the feasibility of this will to some extent depend upon the time-frame for Action 2 programme development].

7.2.14 Identifying delivery agents for Action 2 pilot programmes:

- A tendering process may be an effective way to identify suitable delivery agencies/consortia. This process could be a mechanism to facilitate the formation of *partnership consortia* between existing special job retention agencies and mainstream business support agencies who are willing to work together.
- The Partnership may prefer to use other mechanisms to identify delivery agents for Action 2 pilot programmes e.g. *round table discussions* involving a range of interested parties.
- Key principles that should underpin any process of identifying delivery agents should include:

- Building on what's already there, and what is known to work.
- Identifying the best placed agency/partnerships to deliver services.
- Encourage *partnership working* between specialist and mainstream agencies in delivery to achieve sustainability and mainstreaming.

7.2.15 Further strategic level recommendations:

- Look towards simplification of the service landscape through:
 - Developing better *information and signposting systems* to provide navigational aids for SMEs, employees and intermediary agencies.
 - Seek to improve *networking and joint working* of intermediary agencies involved in business support/retention work by using e-bulletin and discussion forums to enhance sharing of good practice.
 - Lobby government for further *simplification* of the business support landscape.
 - Work with other regional/sub-regional partners towards developing a *comprehensive service provision* for SMEs and employees at risk.
- Consider potential roles for LWF Partnership in relation to the 2006 DWP Workplace Health Direct pilots:
 - as delivery agency for London region pilot.
 - to inform and influence its development.
- Consider potential roles for LWF Partnership in relation to the DH pilots to promote health and well-being through the workplace (announced in Choosing Health White Paper).
 - as delivery agency within a pilot for SMEs in London region.
 - to inform and influence development of pilots to include SME focus.
- Consider potential roles for LWF Partnership in influencing development of '*Investors in Health*' being developed by government with Investors in People, with particular regard to the resource constraints faced by SMEs.

Appendix I

Stakeholder agencies and individuals approached during research programme

London Workforce Futures EQUAL programme:

Programme Coordinator
Transnational Coordinator
Personnel Plus
Twinings Job Retention Service
Merton Volunteer Bureau
Sutton Volunteer Bureau
Kinesis

Services offering return to work/retention support:

Bromley Job Retention Service
SABRE
Status
Work Life Partnerships
Enable
Walsall Job Retention Service
Birmingham and Solihull Trust/Mental Health Matters
Richmond Fellowship Employment & Training

Occupational Health Services

Workers Health Advice Team, Bradford
Health Works in London
Better Health at Work Partnership
Sheffield Occupational Health Advisory Service
Health at Work, Liverpool.

Employer bodies

Chambers of Commerce (several)
Federation of Small Businesses
London Business Support Network
South London Business
South London Diversity Network
BEMF/SLEMBA
Disabled Entrepreneurs Network
Employers Forum on Disability
London First

Social Enterprises:

Social Firms South East
Social Enterprise London

Health sector:

South West London & St Georges NHS Trust
South West London Strategic Health Authority
Health and Safety Executive
London Health Commission

Other stakeholders:

SERTUC
Centre for Economic Research and Intelligence
Small Business Research Centre
Campaign for Racial Equality

Appendix II

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Appendix III

Glossary

DDA	Disability Discrimination Act
DRC	Disability Rights Commission
DH	Department of Health
DTI	Department for Trade and Industry
DWP	Department for Work and Pensions
HR	Human Resources
HSE	Health and Safety Executive
NDDP	New Deal for Disabled People
OH	Occupational Health
ODPM	Office of the Deputy Prime Minister
SME	Small and Medium Enterprises
TUC	Trades Union Congress

Appendix IV

Case Studies

Case Study One:

A woman now in her mid-fifties has a history of both physical and mental health problems.

Unsuccessful retention

For 9 years she worked as an Admin Assistant in a sheltered workshop, part of a voluntary organisation. For the first few years she was happy there. Both her line manager and colleagues were very supportive. She developed IT skills and became more confident in her role.

A change of personnel seems to have created problems. The new line manager was very busy and seemed not to have the time to listen to problems in the same way as his/her predecessor. In addition, the new line manager had no Human Resource experience or training in how to manage workplace problems. The work load was also increasing.

There were strong differences of opinion on certain matters between the employee and the head of the organisation. She felt that she was being pressured to leave. This affected her mental health adversely. The Supported Employment Worker did not appear to offer any advice or support.

Although she was advised that she had a case under DDA she felt that she could not cope with the stress of pursuing the case. A previous employee of the organisation helped to negotiate a redundancy package.

Successful retention

When unemployed she went to a local voluntary sector Supported Employment Agency which specialised in finding jobs for people with mental health needs and supporting them in employment. With their support she started work in a local publicly-funded agency which provides social care services for people with learning disabilities. She works as a receptionist, initially part-time but now full time.

At first she lacked self-confidence, particularly as she did not know how to carry out certain procedures connected with her job. However, all the staff are aware of her health problems and are very helpful. Her line manager is aware that s/he can always contact the SE Agency for advice as is the employee herself. In addition, there are regular meetings between the support worker, the line manager and the employee.

Sometimes the job becomes stressful. The line manager tries to ensure that she is not overloaded with work and assures her that she should take a day off if she feels she cannot cope. However, the employee reported that sometimes coming into work when she feels depressed has helped, as concentrating on work has helped her forget the depression.

The organisation has been very accommodating about time off for psychiatric counselling. Although the course has finished, the counsellor keeps in touch which is

“...good as I always feel there’s an open door in case I need support and help further”.

She has been in her current employment for five years, over four years of that in a full time capacity. She feels that she has achieved a great deal.

“My (other) job was sheltered, but now it’s open employment. I feel I have achieved...I’m the same as everybody else...I would never have thought I would be working in open employment with my many disabilities and health problems”.

Case Study Two:

A woman aged 41 has worked for a voluntary organisation for 5.5 years and in her current post for less than a year. When she started she did not regard herself as having a disability. She has since been assessed as having dyslexic and dyspraxic conditions.

She feels that although the organisation has been supportive, she needs to leave her job because she is finding it too stressful. Her job entails a lot of organising and information processing which her disabilities make difficult.

Emotional & psychological impact

She feels that it is the wrong job for her. The impact of the results of the assessment has undermined her self-esteem. Although her employer has been supportive and has had good intentions, these have not always worked. She feels that some colleagues are unaware that some of the tasks she finds difficult are the result of her condition and not that she is “stupid”.

Physical impact

She has a problem with the lights in the office and is disturbed by proximity to the printers.

Attitude of manager and colleagues

The current manager is extremely understanding, unlike the predecessor who took the attitude that everyone had problems of some kind so people should just try to carry on. She does not discuss her condition with colleagues unless they ask about specific aids that she uses.

The Personnel Dept contacted Access to Work to obtain the necessary equipment. She feels that a problem was that although she had the tools for the job, there was no real understanding of how her condition would still affect the tasks she had to carry out. These difficulties were beginning to be discussed with her employer and, she believes, might have been resolved, but she decided to leave because of the stress she was feeling.

Strategies for improvements

She believes that *all* employers should raise staff awareness of disability, physical and mental conditions and how understanding of these problems could make workplaces less disabling. Full workplace health and disability audits – including stress audits – should be carried out. Employers and staff need to realise that workplace problems are not just caused by physical access difficulties, but that more subtle factors such as attitudes and the general environment are equally important.

Case Study Three:

A man in his mid-thirties has been living with mental health needs for about three years. He has been working for a small private sector company for about ten years in the accounts section, eventually as manager.

Employment difficulties

He began experiencing problems in the workplace before he sought medical/psychiatric help. An early manifestation of this was difficulty in relationships with colleagues. He felt extremely stressed and was unable to cope with the work load and although he recognised that he was having mental health problems he did not wish to make this known. He took several periods of sick leave for a “bad back” over a period of a few months. His employer was becoming concerned about these absences which added to his stress. He had a young family and did not want to lose his job.

Interventions

Eventually he sought help for his mental health needs and received medication which gradually stabilised the condition, but affected his ability to perform well in the mornings. He had still not revealed the true situation to his employer and the relationship with his colleagues was deteriorating.

A member of a local voluntary mental health organisation mentioned that there was a service in the area which might be able to help him and he approached them. A support worker from the service visited the employer, with him, to explain his mental health situation and try to arrange ways of working which would accommodate both the needs of the employer and the employee.

It was agreed that he could be flexible in his hours, coming in later in the mornings if necessary. As he had a home computer, his employer also agreed that he could work from home. In addition, he agreed to tell his colleagues about his mental health problems. This resulted in the re-allocation of some work tasks. For example, there were times when he found using the telephone a problem and it was arranged that someone else would do that for him when necessary.

Outcome

The employer was relieved to be able to retain the services of an employee who was good at his job and with whom he had always got on well. His colleagues were very supportive once they knew the reasons for the problems they had been having and how it was being resolved. One colleague in particular felt able to say that he had been experiencing periods of depression but had not told anyone in the workplace about it.

The employee felt that being open about his mental health and talking through it with his colleagues had in many ways been a relief and removed some of the stress he had been feeling. He now works from home less often than in the early stages, but believes that the knowledge that this option is open to him when he needs it has also relieved pressure.

Case Study Four:

A man in his fifties has a progressive physical impairment which has now resulted in using a wheelchair. He worked for fifteen years for a financial organisation on IT systems for data control and producing statistics. He was a single parent.

Employment difficulties

With the progression of the condition he began to experience increasing difficulties in doing his job. The attitude of some colleagues was not helpful and he believed that they felt he was making his disability an *excuse* for his work problems. However, he did not take sick leave. His line manager was unsympathetic and did not appear to have tried to understand the problems. This resulted in an adverse appraisal. He was called in to the Human Resource Officer to discuss this and was convinced that he would be dismissed. However, HR took time to find out his views on the appraisal and he explained his circumstances – the nature of his disability and his family circumstances.

Interventions

Once the situation had been made clear, HR found a solution. He was offered part-time employment and given assistance to apply for a Disability Working Allowance to help to offset the loss of earnings. The line manager was “rapped over the knuckles” for not being more understanding at the time of the appraisal.

Outcome

Eventually, following a change in his personal circumstances and a house move, he was no longer able to journey to work. The employer offered him the opportunity to work from home. There were technical problems with this and he retired from his job with a pension. He believes that his employer – apart from the line manager – was extremely supportive and did all that they could to keep him in employment. This was at a time when they were experiencing difficulties themselves.

He was still keen to work and through the internet found a local IT firm who offered him part-time work doing software and web design. He was able to do this from home on permitted earnings.

He now works part-time for a voluntary organisation doing web design and managing their IT systems. The organisation has provided a special chair and other equipment such as an adapted keyboard which enables him to carry out all his job tasks efficiently.

Appendix V

Good practice in job retention in large employers

This appendix examines job-retention policies and procedures in two large employers and identifies elements of good practice which could be applied and transferred to small and medium size employer organisations. Detailed documentary information, from human resource departments, from these two organisations indicate a comprehensive approach to job retention as well as guidance to staff on the Disability Discrimination Act. The two organisations involved consists of a major private sector employer with national with international interests and the other is a national public sector employer, with local policies and procedures within a national framework of human resource management and development.

The policies, procedures and guidance, from these two employers, are also underpinned with significant training and support to staff at all levels and trade union representatives to ensure that these policies and procedures are implemented correctly, fairly and in compliance with anti-discrimination legislation.

Findings from the large employers:

(a) Human resource infrastructure and equality in employment

Both employers have large human resource departments and support from their occupational health units. They have trained human resources personnel, equal opportunities specialists/advisers and a comprehensive employee assistance programme. In these large organisations, commitment is demonstrated at the highest level i.e. the Chief Executive Officer (CEO) and the Board, with an equality and diversity policy, strategy and action plans. Regular review and monitoring forms part of the management accountability as an 'Equal Opportunities Employer'.

Both organisations have the 'two ticks symbol' from the Employment Service for employing people with disabilities.

They also promote the implementation of their equal opportunities policies eg. recruiting and employing people with disabilities, with wide ranging support resources such as equality advisers, specific equality staff forums which act as advocates and advisers to policy development, and equality awareness training.

Both employers have comprehensive policies, procedures and guidelines covering the Disability Discrimination Act. There is constant cross-referencing to these policies and procedures when line managers have to address the issue of job retention, rehabilitation and return to work.

Detailed support literature is produced to guide and support line managers eg information about the Access to Work scheme, external disability and voluntary

organisations who can provide further expert advice and information, disability etiquette and how to work with employees with specific disabilities, the use of appropriate language and information which explodes myths about employing disabled people. This information is often in the form of actual employee CASE STUDIES and national role models such as Professor Stephen Hawking and David Blunkett MP.

Detailed guidance provided in the documents also include a set of frequently asked questions to assist line managers, employees and their representatives.

(b) Job retention policy and procedures

The issue of job retention is dealt with under the policy of ‘Managing changing capabilities’. Employer A (private sector employer) cites the following:

‘Managing changing capabilities effectively is not just the right thing to do, it makes excellent commercial sense retaining skills and experience while also containing recruitment and training costs.... So, when an individual’s capability changes following an accident or a change in medical condition speedy action must be taken to ensure that they continue to have every opportunity to realise their full potential.’

Employer B’s (public sector employer) job retention is dealt with under the organisation’s ‘Sickness absence policy and procedure’. There are separate but linked procedures for both short and long term absence. Management response *‘will be reasonable and subject to all the circumstances of the case and may include the need to seek further clarification and specialist advice, redeployment to alternative duties on either a temporary or permanent basis, rehabilitation or an application for ill-health retirement.’* In addition, Employer B cites the following:

‘The benefits of rehabilitation are twofold. It means (the employer) has an employee back at work earlier than expected performing at least some of their duties and contributing to the work of the organisation. The employee feels valued and will in all probability recover quicker than those left at home.’

Therefore, both employers recognise the business case for operating good job retention policy.

They have in-house occupational health specialists who deal with capability assessments and can also call upon further external resources. The role of occupational health physician would also include liaising with the individual employee’s own GP/specialist. The public sector employer also clearly states that the employee will be entitled to see any occupational health reports and make any amendments with consent from the Occupational Health Department. If consent is withheld because of a disagreement, the employee is entitled to add a personal statement to the report.

Good practice identified:

The following good practice guidelines were identified from both employers:

- The review process to include the employee, his/her trade union representative, and/or a friend or colleague as an additional support
- Use of occupational health input in the early stages
- Access to confidential employee counselling (either in-house or externally, with self referral as an option)
- A rehabilitation action plan agreed with the employee and all concerned, with a phased return to work
- Employer B offers up to 2 months full pay on initial partial return to work, to encourage a staged return.
- An examination of options in making reasonable adjustments. These may include review of employee's role, job description, location of work, support to access aids and adaptations, extended search for a suitable role, re-training, temporary and eventually permanent redeployment.

Both employers provide further details on 'reasonable adjustments':

- adjustments to premises.
- allocation of some duties connected to the post to other colleague/s or by swapping some tasks.
- altering working hours eg length of working day or flexi-hours.
- allowing job-shares or part-time working.
- allowing home working/teleworking for a period of time.
- assigning employee to a different workplace.
- transferring to fill an existing vacancy, with retraining or other necessary adjustments.
- allowing absence for treatment.
- arranging additional/special training.
- acquiring or modifying equipment or instructions.
- modifying productivity targets.

Applicability and transferability to the small business sector:

Many of the above good practices were also identified from employer and employee respondents in the research. Arguably, small businesses, in general, are aware of the business case for job retention as recruitment, induction and training costs could be more of a burden on their company's budgets than large employers.

However, small businesses do not generally have human resource infrastructures and access to many of the in-house support services highlighted above. They also do not have the financial resources to purchase support and rehabilitation services such as counselling or occupational health assessments and advice. Many small businesses also do not have written policies and procedures on job retention and equal opportunity recruitment and employment policies. Nevertheless, many operate elements of good practice similar to those highlighted from the large employers, to

retain loyal and skilled staff. This is particularly true for family run businesses, as role flexibility is required from all members of the family in keeping the business afloat.

Many of the small businesses may be reluctant to explore some of the above good practices operated by larger employers due to business pressures, without external help. Therefore, they may inadvertently discriminate against the employee who may acquire a disability or health problem which could place him/her at risk of losing his/her job.

The key job retention issues for small businesses appears to be:

- the lack of timely, realistic information and advice which works for them
- More *practical* ideas about job retention strategies which has proven to work with other small businesses and which do not place an undue burden on the organisation, its business partners, the rest of the staff and the company's finances
- assistance such as grants/subsidies to help them access occupational health services, counselling services and workplace adjustments such as aids, adaptations and training/re-training, with minimum bureaucracy

In conclusion, the small business respondents did not generally express a need for *comprehensive written* equal opportunity and job retention policies and procedures, human resources manuals, help to produce guidance materials, achieving work/life balance or having healthy workplaces etc. They require timely, effective, low or no cost practical assistance when job retention situations arise from statutory and voluntary agencies.