17th February 2017

Response to Improving Lives:
the Work, Health and Disability Green Paper

Overview

The Faculty of Occupational Medicine (FOM) & the Society of Occupational Medicine (SOM) welcome the focus this green paper brings on work as a health outcome and on the importance of good supported work for people with long-term ill health and disability.

We agree with the Department of Health and Department for Work and Pensions that there is strong evidence that work is generally good for people's physical and mental health and general wellbeing.

Occupational health (OH) is uniquely placed amongst medical specialties to enhance the productivity of the nation whilst keeping workers healthy and safe[1]. We welcome the focus in Chapter 5 on the important role for OH and the need to strengthen the role of OH and related services, making them accessible to all.

We have consulted widely with our members, key stakeholders and colleagues on the green paper. Whilst the discussion and consultation are very welcome, the reality is that if the government wishes to transform the employment prospects of disabled people and people with long-term health conditions, then health and employment support systems need to be fundamentally reconfigured.

The government cannot rely solely on services delivered remotely from the patient, workplace and the community, or 'one stop shop' websites (as set out in section 168) that expect employers to spend hours proactively sifting through generic information. These have not previously inspired changes in employer recruitment behaviour.

Individuals need conversations with trusted health professionals who understand their medical needs, which may be complex, and can refer to a range of support services; medical and non-medical. Employers need direct, individualised and concise advice on how to support disabled people and people with long-term health conditions in their workplace. OH professionals are ideally placed to 'join-up' service access and advice between individuals, their health care professionals and their employers,

There needs to be strong ties with local commissioners, including the Health and Wellbeing Boards, testing out local solutions which utilise the strengths of local assets such as hospital based multi-disciplinary OH teams, the third sector and the private sector. There has long been discussion on devolving DWP money locally and pilots such as those in the West Midlands have shown clear innovation, with the West Midlands Workplace Wellbeing Commitment and the trialling of an innovative 'Wellbeing Premium', a tax incentive for employers who show their commitment to staff wellbeing.

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[1] Health, work and wellbeing – evidence and research https://www.gov.uk/government/collections/health-work-and-wellbeing-evidence-and-research

Ultimately there needs to be strong leadership and commitment across the UK. We welcome the government's statement that the public sector should lead the way. Health leaders across the public, private and third sector need to come together to agree an action plan on embedding work as a health outcome across the sector – and we are happy to facilitate this with support from the health and work unit.

Making the case for change: those with disabilities see themselves as work capable, as do employers

The UK needs to raise aspirations for those with disability. Employment as an outcome should be the expected result of all work/health interventions for most people with a disability.

In her opening remarks at one of the consultation events, Nicola Blackwood MP spoke about being told she wouldn't be able to work. Too often the interaction with health professionals focuses on what people cannot do – rather than what they can.

We also need to encourage those with disabilities to aspire to work as a positive aspect of everyday life, not just as a source of income. Support should be based on the bio psycho social model for a successful return to work, rather than a purely medical model. There should be programmes available to develop confidence, assertiveness and self-esteem, along with a wider range of support systems.

We **recommend the government develop, with employers, a specific supported apprenticeship programme for disabled people with mentoring and the flexibility to work part-time** – with access to OH support for the employer and the individual.

We believe **there is the need for social marketing analysis and intervention to establish the key messages for long-term unemployed disabled people to understand the health and social value of work**. The strong positive message about the beneficial impact of good appropriate work for those with disabilities and long-term health conditions should be promulgated, to the public and employers, through a wide public information campaign and embedded into the training of all health and social care professionals, including the organisational benefits they bring.

Similarly, work needs to be undertaken to make the case for employers to support and retain staff with health conditions. We note that NICE guidance NG13 states 'More research is needed on the effective contribution of OH, human resources and health and safety to supporting line managers in promoting workplace health and wellbeing'. We support the assertion that research needs to be undertaken to make the case to employers. We reiterate the offer we have made to NICE to build up the evidence base on the impact OH has on workplace wellbeing.

Targets, research and best practice

Research describes the concept of disadvantage as 'a sliding scale of employment probabilities affected both by the nature and severity of people's impairments, and by the willingness of employers to hire them.'[2]

Ultimately, we can show how best practice can work – but the key question remains: how do we get employers to 'step up' when evidence has shown current legislation has had limited impact? What are the specific incentives for employers to take on those with complex needs where there will need to be significant workplace adjustments?

Importantly, each individual must be addressed according to their clinical and functional requirements. 'One stop shops' and generic advice do not address the complex health needs of this group, nor do they facilitate the nuanced conversations that need to take place with employers and most importantly line managers.

Our experience in practice

We believe that introducing new supportive workplace policies will have limited impact unless the pre-existing workplace policies are reviewed at the same time, in order to fully integrate a positive disability employment stance across the workplace.

Too often, pre-existing workplace policies, such as those managing attendance and sickness absence, can result in people with disabilities feeling unfairly treated and undermined in their role or having lowered job security, resulting in loss of confidence in their employability. Managers and HR professionals can inadvertently leave the individual feeling blamed when attendance levels at work to not conform to preconceived 'norms' when a 'what can we do to help you at work and optimise your attendance levels?' approach is more likely to bring mutual benefit. Managers and HR professionals may not have adequate training in essential people-skills such as empathy, understanding mental health, supporting disabilities and equality and diversity. Addressing this will benefit the individuals, employers and the economy.

We agree with the Resolution Foundation report *Retention deficit: A new approach to boosting employment for people with health problems and disabilities*[3], that there has been less recognition of the importance of supporting people to remain in work as part of tackling unemployment levels of those with a disability or long-term condition. OH professionals have the skills and experience to provide this.

Workplace policy recommendations:

1. Workplace policies that are helpful are those which support access to:
    - mediation support;
    - disability workplace advisers;
    - flexible working arrangements;

[2] https://www.iser.essex.ac.uk/files/iser_working_papers/2011-03.pdf

[3] http://www.resolutionfoundation.org/app/uploads/2016/06/Retention-deficit.pdf

- performance review systems focused on 'outcome' rather than 'hours worked', supported by 'fair attendance' management processes conducted in a fair and empathetic way, with access to disability advocate support by the employee;
- Union support.

2. We suggest training is provided for all line managers and HR professionals in the people skills that matter when trying to support those with disabilities at work, and that this is built into quality management systems that organisations already use.
3. 'Access to Work' and its sister initiative, the 'Workplace Mental Health Support Service', must also be better promoted, with managers and HR professionals signposting employees to this service as early as possible, rather than at a delayed stage often via OH referral and subsequent advice and signposting.

Government policy recommendations:

1. Incentives to encourage investment in healthy workplaces and the uptake of OH and wellbeing initiatives.
2. Tax relief for Employee Assistance Programmes (EAP) should be retained and the benefits of such programmes to be more widely promoted.
3. The removal of the limit of £500 expenditure per employee per tax year exemption for medical treatments.
4. Removal of the tax liability for a wide range of OH and wellbeing interventions aimed at preventative workplace health risk management, promoting work attendance and effective rehabilitation back to work.
5. Employees should have rapid access to a fit for purpose OH service. Seeking expert advice earlier may be of greater benefit for many conditions.
6. Employers currently have to wait for 28 days to refer to Fit for Work – this should be reduced.
7. The kite mark 'Positive about Disabled People' needs wider recognition with a focus on being a disabled-friendly employer.
8. Expanding Personal Budgets in health and social care to include employment, giving individuals greater control over how they spend the money available to help them to live more independently.
9. Finally there needs to be OH workforce capacity to deliver this tailored support (we note the Council for Work and Health's March 2016 report on *Planning the future – implications for occupational health: delivery and training*[4]). The government has a unique opportunity to put OH at the centre of workplace health and for every worker to understand the role of an OH professional team.

Work as a health outcome

[4] http://www.councilforworkandhealth.org.uk/images/uploads/library/Planning%20the%20Future%20-%20OH%20and%20its%20Workforce%20April%202014.pdf

We very much welcome this element of the green paper. Too often the conversation with health professionals concerns what individuals cannot do, rather than what they can.

For the importance of work as a health outcome to be embedded into the healthcare system as a whole, we would suggest:

1. Adding OH into the undergraduate curriculum for health, education and social care professionals.

2. Embedding OH in other specialist curriculums.

3. Measuring and monitoring actual return to work – not just the existence of a return to work plan via, for example, Fit for Work.

4. Considering if work as a health outcome should be an incentivised performance target.

The Faculty of Occupational Medicine could help to provide generic advice and guidance to other professionals through joint working on curricula. FOM could work with the Royal Medical Colleges to develop speciality guidance on return to work for common conditions that could be used by a variety of health professionals in advising patients positively and consistently.

Fit note

We believe the reasoning behind introducing the fit note was right. However, the reality is that GPs are stretched, in time and capacity, and they receive no specific OH training to support return to work conversations.

We therefore support the call from the RCGP that this needs to change. However, we do not support the view from the BMA that self-certification should be extended to 14 days, effectively discouraging the individual from seeking early advice.

We understand the strain GPs are under. However, from a patient perspective it is in their best interest to have a conversation as soon as possible about how they might best return to work if they 'may be for fit for work'. That conversation starts with their GP and their employer.

Health at work – an independent review of sickness absence found employers rely on the fit note as evidence to verify that sickness absences of over seven calendar days are justified, and to inform them when an individual is, or is expected to be, fit enough to return to work.

Employers also rely on fit notes to identify those cases where an employee has a health condition which limits function, but could work if given sufficient support. A fit note written by the clinician who knows the patient does help, and an early

conversation can reduce the risk of long-term absence, or the individual falling out of work, and detriment to their health and wellbeing.

We acknowledge that the GP surgery is often the first point of call when an employee is unwell, but we feel it doesn't necessarily need to be a GP who goes through the fit note with the patient. We agree that a range of health practitioners, not just GPs, could take on filling in fit notes – ***but the crucial factor is whether they have undertaken training or a qualification in OH. The Faculty of Occupational Medicine would be very happy to support the creation of a bank of competencies needed to undertake an assessment and provide accreditation to allow health care professionals the right skills to make the fit note meaningful.***

Our members feel a best practice model would include having a health professional with training in OH, such as the Diploma in Occupational Medicine, in every GP surgery/confederation.

Working up models would need trials and closely involve GPs. It could be that having a trained lead available allows GPs to bring in a second option or ask someone to review cases. Or it could be that when a patient phones into the surgery for an appointment regarding getting a fit note, they would then be referred to that trained lead rather than the GP. ***We would support trials taking place in a number of GP surgeries to see if this frees up GP time and makes the fit note more effective for the employer and the employee.***

Similarly, as we comment later, we would like the ability for complex cases to be referred with funding to a commissioned OH service, from GP surgeries or work coaches in job centres, where the patent does not have access to an OH service via their employer. We do not feel a referral to Fit for Work in complex medical cases is effective or adequate.

Fit for Work

Our members, on the whole, feel Fit for Work is not working. We've been unable to access performance data, but anecdotally we believe that referral rates are poor, as are outcomes. We note that greater public transparency of the performance data would help inform judgements.

Modern OH services, with embedded case management and proximity to employers, who can effect adjustments to work, are key to supporting work retention and restoration for those with disability and long-term ill health. But there are challenges to implementation, including lack of access to OH services, which are currently provided by only some employers. Moreover, the current Fit for Work service is not functioning as envisaged, and referral rates from GPs are very low.

Therefore, policy should focus on steps to build capacity and rapid access to modern OH advice. Action is needed to implement a new tiered approach, which delivers consistent generic vocational advice for all patients but concentrates OH expertise on the most complex cases. This new model could be funded partly by replacing the Fit for Work service and re-modelling NHS OH services or commissioning local OH services.

We also feel this model would provide significant savings to government spending. 300,000 people every year fall out of work through sickness and find themselves on benefits. This is a travesty for the individuals, their families (impacted financially) and the economy, costing the country £13 billion a year in health-related benefits.

Our suggested model would see;

Tier one: non-complex cases: Facilitate consistent advice about work

- Educate all health care workers about the benefits of good work for this group and support consistent messaging about return to work
- Make work/occupation a measured clinical outcome for all patients
- Support the provision of vocational advice (including fit note completion) in primary care, using vocational advisers for uncomplicated cases

Tier two: complex cases: Fund rapid direct referral to OH by GPs, other clinicians and work coaches. This should be accessible irrespective of employment status. One opportunity for providing this, subject to funding, would be to use existing NHS OH services. Alternatively, this could be commissioned locally from within the private sector. The impartial position of OH between the employer and employee is critical in managing the perceived bias by either party, or by outside agencies that would otherwise be an important barrier to work. These aspects and the use of face-to-face motivational interviewing skills distinguish employer OH from the remote telephone-based Fit for Work service. OH could also support hospital clinicians by providing condition-specific guidance on fitness for work directly to patients through NHS clinical services.

SOM / FOM response to the specific questions posed

Chapter 2: **Supporting people into work**

What does the evidence tell us about the right type of employment support for people with mental health conditions?

Important factors from an OH perspective include: addressing stigmatisation; early intervention; education of line managers in mental health; and maintaining contact with workplace during periods of absence.

Chapter 4: Supporting employers to recruit with confidence and create healthy workplaces

How can existing Government support be reformed to better support the recruitment and retention of disabled people and people with health conditions?

Benefits assessment processes should be redesigned and integrated with health and OH processes to give a clear pathway towards employment without breaks and silos.

Information needs to be properly and carefully shared, and have common methodologies without duplication (e.g. many ESA claimants also have PIP assessments and systems don't share).

Should Statutory Sick Pay be reformed to encourage a phased return to work? If so, how?

We support this, but it would need to be done alongside medical recommendations and individual circumstances.

<u>Chapter 5:</u> Supporting employment through health and high quality care for all

How can we bring about better work-focussed conversations between an individual, healthcare professional, employer and Jobcentre Plus work coach, which focus on what work an individual can do, particularly during the early stages of an illness/ developing condition?

There is a strong feeling from our members that the importance of work and the positive impact of it on an individual's health needs to be built into every stage of education and training, and to be fundamental in the curriculum delivered to all student health and social care professionals.

There needs to be an established system of communication between these individuals which is routinely activated in cases of long-term ill health.

Feedback from our members included:

- Include liaison between GP and OH in the GP contract;
- Increase the pool of well trained and competent OH professionals;
- Engage with the CIPD to get OH included in the education of HR professionals;

How can we ensure that all healthcare professionals recognise the value of work and consider work during consultations with working-age patients? How can we encourage doctors in hospitals to consider fitness for work and, where appropriate, issue a fit note?

Ultimately this again comes back to recognition of return to work as a clinical end point, with measures of performance. It needs to be embedded in education and training at all stages.

Are doctors best placed to provide work and health information, make a judgement on fitness for work and provide sickness certification? If not, which other healthcare professionals do you think should play a role in this process to ensure that individuals who are sick understand the positive role that work can play in their recovery and that the right level of information is provided?

See our overall case above.

Turning to the fit note certificate itself, what information should be captured to best help the individual, work coaches and employers better support a return to work or job retention?

Our view is that rather than the fit note itself, it is the behaviours of those filling them in, the quality of conversation and the focus on what outcomes you want to achieve which needs reviewing.

Clearly it should include function, what the individual can do, current estimate of length of time a condition may last and encourage discussion with employer

How can occupational health and related provision be organised so that it is accessible and tailored for all? Is this best delivered at work, through private provision, through the health system or a combination?

Please see our above tiered model as outlined in our response – there needs to be clear timely referral opportunities to a multi-disciplinary OH team to address needs of the individual.

What kind of design would deliver a default position in which everyone who is eligible for occupational health assessment and advice is referred as matter of course?

Our members feel there are a number of models which could be explored, from mandating, the health insurance model or a referral model where OH is a commissioned service within the NHS. Ultimately it is for the government to decide where the burden of cost should fall and there could be regional variations in what works.

How can we encourage the recording of occupational status in all clinical settings and good use of these data?

Our members feel this should be mandated as both a best practice requirement in Good Medical Practice and an incentivised performance target and this should be audited with clear national targets.

It is also felt there needs to be consistent language and that training needs to be developed on the use of this.

What should we include in a basket of health and work indicators covering both labour market and health outcomes at local level?

Feedback from members included:

- Employed/not employed – possibly including variations such as self employed or zero hours contracts
- Currently working/currently not-working (duration of absence and return to adjusted or normal work)
- Proportion of cases in which barriers to work are identified and which are overcome
- Age-related numbers in employment
- Employment sector
- Disability and long-term conditions – employment and absence rates
- Absence figures by age, sex and type of employment
- Indicators of causes of absence from work - illnesses and accidents - and assessments of health problems not causing absence
- Need for temporary and permanent restrictions/adjustments
- Ill Health Retirement rates
- Absence rates
- RIDDOR report rates
- IIC payment rates

Ends

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*The **Faculty of Occupational Medicine** is the professional and educational body for occupational medicine in the United Kingdom. It seeks to ensure the highest standards in the practice of occupational medicine, overseeing the continuing*

professional development and revalidation of its members. It is also focused on promoting and supporting health at work, with its mission statement being 'to drive improvement in the health of the working age population.

*The **Society of Occupational Medicine** is the UK organisation for all doctors and other healthcare professionals working in or with an interest in occupational health. It is concerned with the protection of the health of people in the workplace, the prevention of occupational injuries and disease and related environmental issues.*