The VRA's Responses to the Green Paper

1. Achieving lasting change: investing in innovation

1.1 What innovative and evidence-based support are you already delivering to improve health and employment outcomes for people in your community which you think could be replicated at scale? What evidence sources did you draw on when making your investment decision?

Our members are committed to evidence-based practice wherever that exists, and rely in large measure on the well-known evidence of Waddell, Burton & Kendall, "Vocational Rehabilitation: What works for whom and when?" 2007). This has been incorporated within the VRA Standards.

(https://vrassociationuk.com/resources/vra-standards-practice/)

The key to resolving most workplace absences of any significant duration is to bring together all parties with an investment in the RTW outcome: the individual, their manager, their employer/HR, and a professional who can bring together the health and employment strands to find a solution to their absence.

Employers are often uncertain how to help back into work (RTW) those who have complex medical conditions such as cancer, traumatic brain injury stroke etc. (Coole et al, J Occup Rehabil 2013; 23(3) 406-18). They are best helped by having good explanations from their employees who in turn often need the support of their health professionals, ideally those who are in a position to visit the workplace.

2. Building work coach capability

2.1 How do we ensure that Jobcentres can support the provision of the right personal support at the right time for individuals?

The VRA has observed that with their focus on benefit entitlement, few Jobcentre staff have the skills to provide appropriate and early support into work for their customers.

Jobcentres must employ health professionals who understand the conditions that their clients suffer from, and vocational rehabilitation specialists with work rehabilitation / reintegration skills. In particular, DEA's, Work Coaches and Community Partners need to understand the value of a VR approach and have an education in the delivery of VR.

Professionals who understand the employment issues as well as the health issues are termed vocational rehabilitation professionals (Frank AO. healthcare 2016; 4(46) doi: 10.3390/ healthcare4030046).

There are many occasions when it is best to use rehabilitation professionals to support those who wish to RTW. It is unclear whether Jobcentre Plus should employ its own health professionals or whether they should buy-in services from the NHS or elsewhere, to provide specialist occupational rehabilitation support.

In one instance we are aware of, the DWP part-funded the brain injury rehabilitation unit Community Head Injury Service in Aylesbury. Traumatic brain Injury is a classic example of the need for specialist vocational rehabilitation services, but the need for a broad-based work rehabilitation approach to the DWP's management of ALL people with a disability or health condition, is even more urgent.

2.2 What specialist tools or support should we provide to work coaches to help them work with disabled people and people with health conditions?

There are a wide variety of tools for clients to self-complete which will assess the severity of the condition being managed e.g. chronic pain, back pain, neck pain, anxiety and depression, post-traumatic stress disorder etc.

Training is needed to ensure work coaches can elucidate mental health conditions and those with hidden disabilities or disadvantages e.g. illiteracy, lack of numeracy.

In addition to having access to tools and support, work coaches would also benefit from a broader remit, including the ability to provide additional support to clients after they return to work, should the need arise. This should not be time limited. Often good RTW plans work well until the unexpected occurs e.g. the manager who set up the work schedule moves roles. Employers also value the ability to seek advice as conditions may change over time, requiring a change in adaptations e.g. those with epilepsy, psychotic illness etc.

Our members also observed that the coach role would benefit from greater clarity on their remit, and an emphasis on the value of having a work rehabilitation mindset.

While some clients require an in-depth work coaching service, we believe that many other clients may benefit from the ready availability of a 'light touch' advisory service, run by work coaches or similarly skilled individuals. To avoid the dilution of coach skills, such a telephonic service should not be segregated out into a call-centre function, but should be part of a work coach's overall role.

Members also observed that coaches would benefit from additional training to work with people with disability and health conditions, including specialist disability awareness training, employer liaison experience etc.

3. Supporting people into work

3.1 What support should we offer to help those ‘in work’ stay in work and progress?

Coaches would benefit from a broader remit, including the ability to provide additional support to clients after they return to work, should the need arise. This should not be time limited. Often good RTW plans work well until the unexpected occurs e.g. the manager who set up the work schedule moves roles.

Employers also value the ability to seek advice as conditions may change e.g. those with epilepsy, psychotic illness etc.

Education programmes for employers, managers, co-workers need to be available using all available technology to reach the population in need.

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

The AtW MHSS model is excellent but needs to be more flexible and able to fund therapies where long delays in accessing them are caused by an over extended NHS.

4. Improving access to employment support

4.1 Should we offer targeted health and employment support to individuals in the Employment Support Allowance Support Group, and Universal Credit equivalent, where appropriate?

Yes.

However, answering this question is complicated by the difficulties associated with the current Work Capacity Assessment, which many have found to be not fit for purpose.

The government has clearly understood that it is not what one *cannot* do that matters, but what one *can* do, as recognised in changing the 'sick note' to the 'fit note'.

The VRA recommends that the government should at the outset focus on work rehabilitation, as practiced in other jurisdictions that the government has studied (e.g. Scandinavian and German models), leaving the assessment of benefit type to later in the process once all efforts at RTW have been exhausted.

6. Reforming the assessment process

6.1 Should the assessment for the financial support an individual receives from the system be separate from the discussion a claimant has about employment or health support?

Yes!

The government has clearly understood that it is not what one *cannot* do that matters, but what one *can* do, as recognised in changing the 'sick note' to the 'fit note'.

The VRA recommends that the government should at the outset focus on work rehabilitation, as practiced in other jurisdictions that the government has studied (e.g. Scandinavian and German models), leaving the assessment of benefit type to later in the process once all efforts at RTW have been exhausted.

8. Embedding good practices and supportive cultures

8.1 What are the key barriers preventing employers of all sizes and sectors recruiting and retaining the talent of disabled people and people with health conditions?

There has to be a complete re-think about the potential of recruiting disadvantaged employees. Barclays have shown the way by seeking out those with mental health conditions, offering pre-interview confidence-boosting sessions etc (see Cohen P. Barclays disability and careers toolkit at https://www.disabilityrightsuk.org/sites/default/files/pdf/Barclaystoolkit.pdf).

Poor management practice may result in inadequate monitoring of absence episodes, lack of understanding of their employee's real difficulties etc. Thus the absence policy designed to differentiate episodes of absence due to ill health, social reasons (family ill health) or malingering may be inadequate, or ineffectual due to lack of understanding and implementation of the policy at manager/supervisor level.

Management may not understand the need for a supportive culture. Pressure at work is unavoidable, but providing adequate support for employees may prevent ill health – particularly so-called stress-related illness (see Frank AO. Vocational rehabilitation: supporting ill or disabled individuals in(to) work: a UK perspective – healthcare 2016; 46(4), doi:10.3390/healthcare4030046).

There is a widely held belief that a disabled employee is inherently more risky than a non-disabled employee; (this needs to be challenged and tested as there is anecdotal evidence that suggests that employing these individuals can be a far less risky proposition for employers).

In all other aspects of business, employers would need to see greater value attached to pursuing a higher risk option, so if one believes that there is a greater risk in hiring people with a disability, it is not surprising to see evidence of this in lower rates of recruiting of these people as well.

There are few incentives to do the additional work that may be required to hire and retain someone with a disability or health condition; this may contribute to employers preferring to substitute them with an 'able bodied' recruit, rather than do the work to return them to health and employment.

When there are concerns about speed, efficiency, availability for work, and reliability which arise in relation to the person's disability, there will be barriers to recruitment and

retention. Where these represent non-trivial risks to the employer's profitability, employers will understandably look to reduce risk and if all else is equal, will recruit someone who does not pose these risks.

There is little support, advice and information on the benefits of recruiting people with disabilities and health conditions. Many employers also lack an understanding of the Equality Act and the cost/risk of disability discrimination claims.

8.2 What expectation should there be on employers to recruit or retain disabled people and people with health conditions?

The Equality Act is undoubtedly a force for good if implemented adequately. There remain issues of ensuring people are able to and comfortable in disclosing their disability in the workplace.

To halve the disability employment gap, the government may need to incentivise employers so as to encourage the kind of positive recruitment discussed previously (see Cohen P. Barclays disability and careers toolkit at https://www.disabilityrightsuk.org/sites/default/files/pdf/Barclaystoolkit.pdf).

It may be useful to set expectations for employers to improve their recruitment and retention performance, but in order to implement greater recruitment and retention, the average employer would likely need the advice and support from a VR professional to help them with such activities as making reasonable adjustments, and developing a graduated return to work programme.

For employers of sufficient size, mandating a minimum number of such employees is a start. However, mandation should not be the key strategy. Incentives and education are more likely to bring about lasting change.

8.3 Which measures would best support employers to recruit and retain the talent of disabled people and people with health conditions?

Strategies to improve the employment of people with disabilities and health conditions might include:

- De-risk the recruiting, by providing financial benefit that attaches to the employee (e.g. pay a proportion of salary for the first 12 months; pay a recruiting bonus; pay up to 4 weeks of sick pay/SSP during the first year of employment)

- Provide a mentor/advisor for both employee and their manager, to address any health & performance concerns as they arise

The positive contribution that disadvantaged employees can give to a company have been enunciated by Barclays (see Cohen P. Barclays disability and careers toolkit at https://www.disabilityrightsuk.org/sites/default/files/pdf/Barclaystoolkit.pdf)

Employer education on the benefits: for example, disadvantaged employees often offer greater loyalty and reduced staff turnover.

Some VRA members have expressed the strongly held belief that employment rates would rise if the government were to subsidise/Incentivise employers to hire and retain a certain target % of disabled workers. This is practiced in several continental European jurisdictions, but the VRA is not aware of the evidence to support the effectiveness of this measure. However, we acknowledge that even in the absence of direct evidence of a positive ROI, it may nevertheless have value even if it merely raises awareness and openness to recruiting people with a disability or health condition.

8.3(a) What information would be reasonable for employers to be aware of to address the health needs of their employees?

Knowledge that people with disabilities and health conditions have similar or better levels of reliability, dependability, commitment when compared to other applicants.

Knowledge of the services of Access to Work, and Fit for Work

Knowledge of the individual's limitations as they relate to the work they are required to do. Medical diagnosis is sometimes helpful, particularly when it is associated with a specific treatment/ condition management response. Sharing this information can potentially increase a sense of trust and shared concerns between employer and employee. However, medical diagnosis is not always of value in designing a return to work plan, and may in fact lead either employer or employee to make assumptions about what they can and cannot do based on diagnosis rather than functional capacity.

8.3(b) What are the barriers to employers using the support currently available?

Stigma attached to welfare/DWP benefit recipients.

Waiting times; low level of awareness of the existence of such support services.

Insufficient financial incentive (tax relief) related to provision of rehabilitation services signposted in the rehabilitation plan

8.3(f) What role can government play in ensuring that disabled people and people with health conditions can progress in work, including securing senior roles?

The government could create/support highly visible role models. To do so they will need to:

- do a ‘deep dive’ to find high-potential and high-achieving people with disabilities and health conditions;
- ensure these individuals get visibility;

- train them as mentors/ speakers/ advocates;
- provide them with the resources/support to take on these additional roles.

The government has a major role through the Department of Health and DWP to:

1. Educate health professionals about the serious ill-health consequences of being out of work

2. Designate health research funds to identify the skills and tools that health professionals will need in order to to maintain or improve their clients' work status, not just their functional status. This will be needed if work is to be seen as a health outcome against which their performance is to be assessed.

3. Ensure that employment support services are a core component of any commissioned health services, particularly services aimed to assist those with common mental health and musculoskeletal problems.

4. Strengthen tax incentives for employers to provide early intervention, and sickness absence services.

5. Support GPs and employers by providing access to Vocational Rehabilitation professionals to advise on such issues as graded RTWs, reasonable adjustments and accessing ATW funds.

8.3(h) Are there any other measures you think would increase the recruitment and retention of disabled people and people with health conditions?

Government recognition and reward at the highest level, for exemplary recruiting and promotion of people with disabilities and health conditions.

In addition to the services mentioned earlier, the VRA recommends greater access to and awareness of the Access to Work programme, as few people are aware of their services, and due to volumes there can sometimes be a significant waiting period for services, which is clearly unhelpful. Similarly, awareness of the Fit for Work service is poor amongst employers and GPs alike.

8.4 How can we best strengthen the business case for employer action?

Rebates/Bonuses:

Improving the employment of those with a disability or health condition is a workplace issue, and for any initiative to be effective, the change has to happen in the workplace. There are doubtless many long term benefits (both financial and non-financial) to be gained by increasing the recruiting and retention of people with disabilities and health conditions, but to change employer behaviour, it may be necessary to provide better immediate financial incentives, which will improve the business case in readily apparent ways. Essentially, by providing a financial incentive, you will be reducing the financial risk

that the employer may otherwise perceive in recruiting and retention of people with disabilities and health conditions.

Cultural change:

Many employers take a socially responsible view of employee ill-health and support their staff through periods of sickness. However, there are currently no consequences for employers who shift the burden of ill-health onto the state.

Through poor workplace practices, employers can create long-term sickness absence and eventually loss of employment, resulting in financial hardship and reliance on government welfare programmes. Providing consequences for such employers might be difficult to implement; however, it may be possible to change these practices if there were financial rewards for exemplary employers whose workplace practices resulted in relatively little of this cost-shifting.

Systemic change:

Other countries have successfully introduced schemes where employers who do not have in-house occupational health and vocational rehabilitation teams are required to contribute to a state-provided service. These so-called ‘Workers Comp’ schemes have achieved good RTW outcomes.

10. Staying in or returning to work

10.1 What good practice is already in place to support inclusive recruitment, promote health and wellbeing, prevent ill health and support people to return to work after periods of sickness absence?

1. There are a number of exemplary programmes which endeavour to change workplace cultures and disability stereotypes, reducing stigma and increasing employee engagement in inclusiveness. These include the Disability Confident programmes, 'This is Me', Mindful Employer programme, and workplace wellbeing charters.

2. In-house sickness absence and wellbeing programmes which focus on support and engagement for those newly absent or at risk of being absent, as opposed to a policy driven by medical incapacity assessments and fit-note certification by a GP, who often does not appreciate the importance of work.

3. Employer-wide education programmes - for example the Mental Health First Aid training; communications training

4. Early use of independent VR professionals to identify obstacles to recovery and RTW and to provide impartial advice and guidance on removing those obstacles.

Some members pointed to the lost value of programmes which are no longer offered or recognised. They highlighted the value that such programmes as ‘supported employment’ provided to those who were unable to participate in an open job market.

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

Employers are required to have some form of financial safety net for employees who are unable to work due to injury or illness. It appears that not all employers are compliant, and not all employees are aware of this requirement. SSP may require more comprehensive compliance as well as reform.

Some employers have generous sick pay schemes which protect the employee's income for a limited period, usually paying out between 50-100% of regular income. However, may employers pay the minimum permitted under statute. In this situation, a sliding scale payment system should be in place to allow for a graduated return to work. However, the system you have proposed does not provide any financial incentive for the employee to return to part-time work - essentially, the employer is getting the benefit of this part-time work without having to pay anything additional for it.

A more equitable solution would be to have a sliding scale which pro-rates pay and SSP benefit in proportion to the amount of time spent on each. Thus using your example, the employee would receive 10/25ths of their salary for working 10 of their usual 25 hours a week, and 15/25ths of the SSP allowance.... this would amount to £72 + £53.07 = £125.07.

While better than SSP alone, this is significantly less than their full pay, so there is still an incentive for the employee to increase their hours.

It's important that all incentives, including financial ones, support rather than inhibit the RTW actions we want to see in the workplace.

The current level of SSP is so low that the loss of financial security creates an additional shock or burden on the employee; for some, this sudden loss of security and financial equilibrium can incentivise the individual to strive even harder to RTW (and sometimes to their own health detriment). However, for others the fear associated with the sudden loss of income can add to their unwellness, and can have a demoralising effect, depressing them into a sense of hopelessness and helplessness. In short, the low level of protection under the current SSP system can create its own negative pressure on the RTW process. All sickness absence programmes should have positive elements/incentives associated with recovery and return to work, rather than attaching a financial gain to demonstrating how ill and incapable one is.

There should be financial incentives to employers for getting employees back to work, but there should also be financial rewards to employees. So, for example, if on a phased return to work, the employee receives a percentage of their full pay, even if only working reduced hours (employer pays for the hours worked and government top up so that it approximates their pre-absence pay either in part or in full). To encourage progress, this programme should only persist for a period of the phased return, as approved by the occupational rehabilitation team.

10.3 What role should the insurance sector play in supporting the recruitment and retention of disabled people and people with health conditions?

Traditional income protection products are based on an old-fashioned premise of permanent disability - that only the very sickest people would be off work for 6 months,

and probably they would be so disabled they could never again work and therefore should receive the equivalent of an early retirement pension.

The reality is that many people who are off work for that length of time are not severely or "totally and permanently" impaired from working due to a medical condition. However, their route back into work is made difficult or impossible by personal, social, cultural and organisational factors which can create insurmountable barriers to re-entry.

The key is to address absence in the initial stages to prevent these circumstances arising and barriers being created or reinforced. Sickness absence insurance (during the early days of an absence)could provide independent professionals with the skills and the interventions to advise both employer and employee on the best route forward to prevent unnecessary long term absence, and ideally would engage in prevention activities as well.

Another key opportunity for insurers is to provide group risk pooling. While employers may be reluctant to bring a disabled person on board due to poor medical history or risk of future medical problems, group insurance can limit or eliminate that risk, since there are few exclusions for pre-existing conditions.

Employers' Liability insurance represents a major missed opportunity for improving retention of people with disabilities or health conditions. Immediate notification (not a 12 month delay) would enable employers and their insurers to introduce a programme of early intervention, rehabilitation and return to work support for any employee claiming under this insurance programme, and employers should be required to engage, as part of their policy.

10.4 What are the barriers and opportunities for employers of different sizes adopting insurance products for their staff?

Education & Awareness Campaign:

Many employers (particularly smaller ones) are entirely unaware of the availability of insurance.

Improved Access:

Insurance companies typically do not provide many services in the early stages of absence, and very few provide more than cursory support for prevention.

Under current regulations, insurance must be provided via an intermediary/financial advisor. Financial advisors typically have limited interest in supporting the smaller employer because the fees paid are significantly smaller than for larger employers.

There is precedent in the banking sector for requiring providers to offer products to those under-served by traditional banking products, and there may be value in encouraging insurers to do likewise, by offering a basic low-fee insurance product which requires very little intermediary intervention, to ensure smaller employers have better access to affordable sickness absence insurance.

Mandatory Cover as a form of Remediation:

There may be an opportunity for the government to require companies which have traditionally had poor performance in cost-shifting onto the welfare system, to purchase a basic form of sickness absence insurance to reduce the burden they are placing on the state system in the long term by not managing sickness absence in the short term. The delivery of this service could be outsourced to insurance companies.

Linking/Bundling Adjacent Insurance Products:

Insurance awareness is generally low; it may help to raise awareness by offering income protection insurance at the same time that compulsory Employers Liability insurance is purchased. One barrier to this would be that the two types of insurance are typically offered by different sectors of the insurance market.

If occupational rehabilitation were a compulsory element offered by the insurer, employers would get medical and vocational rehabilitation support to assist their absent employees and therefore a swifter return to work. This in turn would help reduce claims costs and associated premiums.

11. Improving discussions about fitness to work and sickness certification

11.1 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?

At the earliest stage - usually at the hospital or clinic when the individual is just starting out on their treatment, as well as at the GP's office, the following are required:

- From the very beginning of our professional intervention, it is crucial that those providing treatment and adjunct services avoid inappropriate comments regarding the outcome - for example, giving a prediction that a return to work (RTW) is not possible
- All practitioners need to advise the individual that much can be done to get them back to work
- It is essential that we emphasise and explain the importance of all parties staying in contact with employer, and the risks and pitfalls of not doing so and not participating in a rehab and return to work programme as early as is possible to do so.
- The employee must be asked what aspect of their job they are still able to do and what difficulties they would anticipate in any RTW. This should be done as early as possible and repeated frequently.
- The service to the individual should be overseen by a case manager, to ensure all professionals are working effectively together, and that there is an accessible point person to connect with 3rd parties (employer, insurer etc.)

For individuals seeking a Fit Note from their GP, we would recommend several procedural changes which would have a significant impact on the work-focused conversations, as follows:

1. All GP patient records to include the person's occupation.
2. Occupation question is asked at least annually, and at each GP consultation.
3. Appointment booking process should include a question as to whether the patient's visit is in regards to a Fit Note - if yes, the employee to complete a brief job description form which collects basic information on their duties and activity levels; this would need to be completed prior to seeing the GP. Such job assessment forms are readily available and could be adapted for this purpose with very little effort.
4. A key question for the GP is to ask is whether the individual believes anything in the workplace has caused or exacerbated their medical condition. This should form part of the Fit Note report.
5. The GP should also probe whether this workplace factor would influence whether they could return, and if so why, and what would be needed to change the circumstance and improve chances of a RTW.
6. Offer vocational rehabilitation/ work coach support, particularly if the employee cites workplace issues as one reason for their absence.
7. Provide an 'activity prescription' along with any Fit Note, to ensure the person keeps active during their time off work.
8. Limit Fit Notes to a maximum of 4 weeks with an automatic referral to the Fit for Work service at that point rather than a further Fit Note. (There should be an "Opt-Out" option but only under appropriate circumstances - e.g. severe medical conditions where even a preliminary discussion about RTW may have no value.)
9. Educate all parties on the benefits of work and the additional health risks associated with *not* being in work; that it is particularly good for the physical and mental ill health of the individual, as it improves social contact and feelings of self worth. But also reassure the individual that they will be supported emotionally and physically with their return to work; for example negotiating reasonable work place adjustments and developing graduated return to work programmes, to ease them back into the workplace.

If the government can obtain key analytics on the highest and lowest performing doctors' surgeries (in terms of the number and duration of Fit Notes relative to the size of the population being served), they could establish a collaborative buddying system that brings together GPs from different sites to work together to identify causes for higher rates, and to identify solutions to improve each other's results.

11.2 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?

This is an educational issue and a cultural change issue (see above). The VRA would be willing to work with the appropriate government bodies to offer educational events / advice. VRA members who are doctors, therapists, nurses, psychologists etc must give advice as to how to tackle their own professions, to improve the occupational focus in any discussion within the health system.

Work has to be a primary discussion topic with any injured/sick/ill person. Whether this be in relation to their current employment or their aspirations.

11.3 Are doctors best placed to provide work and health information, make a judgement on fitness for work and provide sickness certification?

Doctors and medical practitioners do not typically have the training or skills consider a patient's fitness for work, and the government is placing an unfair burden on them when they require GPs to advise on the issue without providing them with the skills and knowledge to do so effectively. Hospitals and healthcare professionals should have Vocational Rehabilitation professionals working alongside them to address employment issues and guide the fit for work process. A VR professional can consider fitness for work in relation to their knowledge of the employment market, retraining, equipment adjustments etc., which a doctor may not have the time, expertise or skills to consider.

The VRA supports a move to using other professions who know the workplace, to assist an individual back to work and to provide updates on their progress towards that goal. This reporting should replace the current fit note.

11.4 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?

To make the fit note more useful,

- It should not be permissible to provide a Fit Note which merely says that the individual may be "fit for some work", without further explanation
- There should be space to record more detail about workplace adjustments, and a clear expectation that this detail be provided
- They should reference functional job descriptions, as well as a subjective account of what potential RTW obstacles the employee has identified.
- The Fit Note should have some generic health messages, in much the same way as disclaimers on investment brochures do. They could convey both positive and negative messages: the fact that good work is good for your health, that being out of work can have a negative effect on your health, and inappropriate and unnecessary Fit Notes can be harmful to both health and occupation.

11.5(a) Is the current fit note the right vehicle to capture this information, or should we consider other ways to capture fitness for work and health information?

While it is appreciated that some form of certification should probably continue, our members strongly felt that the current system is not working.

In fact some went as far as to say that good practitioner consultation skills are essential for understanding a sickness absence, rather than any questionnaire or certificate.

It would be less disruptive to simply amend the fit note than to replace it, but the fit note may be so tainted through years of misuse, that we need an entirely new method of certifying entitlement to SSP.

The VRA supports a move to using other professions who know the workplace, to support an individual back to work and provide updates on their progress towards that goal; this reporting could then replace the current fit note.

When there are complex issues surrounding an absence, practitioners advising on an individual's ability to return to work, may sometimes need more comprehensive assessments. Examples include FCEs and Vocational Assessments - which objectively assess the individual in terms of their functional capacity i.e. how long they can sit, stand, walk, lift etc and then in terms of their transferable employability skills, to then match them to potential jobs in their area. These assessments would need to be done by a qualified Functional Capacity Assessor and Vocational Rehabilitation Consultant.

13. Transforming the landscape of work and health support

13.1 How can occupational health and related provision be organised so that it is accessible and tailored for all?

The question of who provides 'occupational health' services is an issue of significant contention for the members of the VRA, whose members understand that while a medical condition may cause a person to be absent from work, the solution to that absence may not be a medical one.

We see this reflected in the use of the term 'occupational health'. Although the Green Paper defined 'occupational health' as a generic umbrella term to include other professions involved in the world of work and health, there are unfortunately many discussion points which conflate the task of 'occupational health' with the work of the specific medical specialists who have this title. The framing of this question is a good example of that.

Likewise, paragraph 259 refers to the shortage of health professionals with occupational health expertise, but what is actually being referred to here is Occupational Health physicians.

In a similar vein, the government set up a Fit for Work service which is a medical service using for the most part occupational health nurses.

If we believe that the medical model is in many instances unhelpful, and sometimes harmful to the outcome of an episode of sickness absence, then we need to recognise that other professions are in many cases better placed to support people back to work. To make this clear may require a change in nomenclature/terminology, by referring to the task of 'occupational rehabilitation' or 'work rehabilitation' instead of the medical job title of 'occupational health'. Once the task has been separated from the medical job title, the resourcing problem of a dwindling and ageing Occupational Health workforce, while worrying, becomes less of an issue for managing sickness absence in the UK.

The VRA and sister organisations have made numerous recommendations on the effective delivery of work rehabilitation over the years. For instance, in 2003 the British Society of Rehabilitation Medicine ("Vocational Rehabilitation - the way forward: Report of a Working Party") recommended that each health locality should have at least one employee able to give vocational advice.

While RTW advice has been incorporated into some specialist health teams (e.g. spinal cord and brain injury services), this recommendation was never adopted and the majority of health teams lack this expertise. The VRA believes this model is still relevant and viable today, and that locally available RTW specialists could provide a personal and effective service.

How can this be best delivered?

- [x] through employers
- [x] through private provision
- [x] through the health system
- [ ] other

Please explain your views

While it is in the government's absolute best interests to ensure every absence receives support to return to work, it is also possible that workplaces will want to retain their own RTW specialists, and they may want to use the services of an insurer to deliver a customised service. These parallel routes to service should be able to work with one another, providing choice and flexibility where this is needed.

14. Creating the right environment to join up work and health

14.6 What is the best way to encourage clinicians, allied health professionals and commissioners of health and other services to promote work as a health outcome?

To promote work as a health outcome will require a significant cultural change in the medical profession. We recommend both short and long term solutions. Firstly, this has to be tackled as an educational exercise using all educational faculties for health professionals. An understanding of the profound negative effect on health of unemployment must be conveyed to professionals at the outset of their training, and the need to protect an individual's current work as well as their ability to work, must be understood as a key driver of long term health and wellbeing, not as a decorative, nice-to-have-but-not-when-I-am-busy-on-important-medical-stuff, fuzzy, feel-good, optional extra.

This cultural change must also be integral to any further education in related areas such as, for example, the management of chronic illness.

Consideration should also be given to the linking of RTW outcomes, such as sustained (ie longer than 6 months) employment, to financial tariffs applied within the health system.

Clinicians will benefit in their practice overall from learning these additional vocational/ work rehabilitation skills, including:

- Goal setting
- Motivational interviewing techniques
- Knowledge of ergonomics
- Focus on RTW at the earliest opportunity.

More immediate recommendations for changes to current practice include:

- Multi-disciplinary team working with case management (rather than clinical) hub.
- Develop individual pathways, goals and expectations for the RTW journey from the outset
- Set performance expectations on the retention of employment as a clinical outcome
- Assess performance based on the individual's work outcome as well as their functional outcome
- Collect and publish data on performance to these standards.