HM Government

OCCUPATIONAL HEALTH: WORKING BETTER

Summary of Responses to the Consultation and the UK Government Response

CP 961

Occupational Health: Working Better

Summary of Responses to the Consultation and the UK Government Response

Presented to Parliament

by the Secretary of State for Work and Pensions and the Secretary of State for Health and Social Care

by Command of His Majesty

November 2023

CP 961

This publication is available at www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at **oh.consultation@dwp.gov.uk**

ISBN 978-1-5286-4566-9

E03016910 11/23

Printed on paper containing 40% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of His Majesty's Stationery Office

Executive Summary **5**
How We Consulted **8**
What You Told Us **9**
Our Response **29**
Annex A **34**

Executive Summary

1. Good work is good for health and good health is good for work[1] [2]. Making sure people are fit and healthy to work is a priority for the Government, which has a clear role to play. The UK Government's ongoing programme to reform occupational health (OH) will help deliver an ambitious set of proposals to increase OH take-up and develop OH workforce capacity. This will make a real difference in supporting employers to retain their workforce, increasing the role of employers in preventing ill-health[3] by promoting better work and health practices which will enable healthier working lives for all.

2. The UK Government's OH reform programme builds on Health is Everyone's Business and the UK Government's ambitious and wide-ranging £2 billion Spring Budget 2023 programme. The latter will help tackle economic inactivity due to long-term sickness as well as support disabled people and those living with health conditions. As part of this programme, the UK Government ran two OH consultations between 20 July and 12 October 2023: Tax Incentives for Occupational Health, led by HM Treasury and HM Revenue and Customs, and Occupational Health: Working Better, which proposed ways to increase OH coverage and was jointly led by the Department for Work and Pensions (DWP) and the Department for Health and Social Care (DHSC).

3. The *Occupational Health: Working Better* consultation specifically sought views on:

    a) The introduction of new national workplace health and disability standards including a minimum framework for quality OH provision;
    b) Whether there is applicable learning from best practice from other countries and other UK-based employer models that enable employers to provide support for their employees; and

[1] IS WORK GOOD FOR YOUR HEALTH AND WELL-BEING? (publishing.service.gov.uk)
[2] Losing life and livelihood: A systematic review and meta-analysis of unemployment and all-cause mortality - ScienceDirect
[3] Effectiveness of Workplace Interventions in Return-to-Work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners | Journal of Occupational Rehabilitation (springer.com)

c) Shorter and longer-term ways to develop and support a multidisciplinary OH workforce to help meet increased employer demand.

4. The majority of respondents supported developing a national workplace health and disability standard and a minimum framework for quality OH provision. Respondents from the healthcare sector emphasised the need for easily accessible high quality OH standards, which should build on existing legal requirements and be tailored to organisations by size or turnover. Some, across the healthcare and business sectors, also cited ease of access as critical to good OH provision. There was recognition that employers would incur additional costs and burdens in the case of legal requirements to provide OH. It was also recognised that there could be a range of benefits in terms of business productivity and employee retention, particularly if combined with tax incentives.

5. There has been wide support, particularly from the healthcare and OH sectors, to develop a sustainable, flexible, multidisciplinary health and work workforce including OH. This could alleviate pressure on the NHS, by reducing primary care referrals, and is critical in supporting increased OH uptake by employers. There were multiple suggestions to take advantage of the latest digital developments when developing the OH workforce to maximise efficiencies. There was wide support for focused efforts to increase the attractiveness of OH career pathways. Respondents suggested this could be achieved through earlier promotion (especially at further education and undergraduate and postgraduate levels), via career events, case studies, mentoring, placements and apprenticeships as well as better join up between OH and other healthcare professionals (HCPs) to understand the full scope of an OH career.

6. The UK Government is therefore taking action by:

    - Supporting businesses through a voluntary minimum framework for quality OH provision and exploring new voluntary national workplace health and disability standards;

    - Exploring options for a potential new Small and Medium-sized Enterprise (SME) group purchasing framework supported by a digital marketplace; and

    - Using the learning from our existing Workforce Expansion scheme to develop a long-term strategic OH workforce approach to build a multidisciplinary work and health workforce.

7. The UK Government is continuing to explore the case for providing further support to employers through the tax system and will respond to the consultation *Tax Incentives for Occupational Health* in due course.

8. Information on next steps can be seen in this response document under the ‘Government Response’ heading.

How We Consulted

9. To ensure that as many people as possible had the opportunity to contribute their views, we published the consultation on gov.uk on 20 July and engaged with employers, business representatives, HCPs, non-healthcare professionals and OH providers to seek their views. The consultation documents were published in a variety of accessible formats: standard, HTML, British Sign Language (BSL) and Welsh documents were available on gov.uk. We offered hard copies of the full publication, BSL, Welsh and large print versions. Respondents also had the opportunity to write and email their views.

10. We engaged with the devolved administrations ahead of the consultation. Health is devolved across all administrations. However, employment is a reserved matter in relation to Scotland and Wales and powers for preparing people for employment are shared. DWP and DHSC will continue to work with the devolved administrations to consider the implications of the proposals in the UK Government's response on devolved matters in Scotland, Wales and Northern Ireland.

11. There were 182 responses to the consultation with most respondents representing the healthcare sector. Responses were also received from the public sector, businesses, including manufacturing and construction industries, as well as the insurance sector, charities, and trade unions. Of those who specified their sector, 66 respondents were representatives from the healthcare sector, 19 were businesses and business representatives and seven were local authorities. Out of the respondents which specified their size, 90 were on behalf of organisations, 17 were small or micro employers, 12 were medium employers and 36 were large employers. 25 did not specify their size. A list of organisations that responded to the consultation is set out at Annex A.

12. We are grateful to everyone who contributed to our consultation. We will continue to work with relevant sectors as we take these insights forward.

What You Told Us

Sharing best practice, developing new guidance and defining a simple and clear baseline for quality OH provision[4]

Q1. "What would you consider to be a robust and reliable source of evidence to establish a simple and clear baseline for quality OH provision?"

13. Most respondents confirmed that guidance for the OH baseline for quality provision should be produced by the UK Government and the majority also suggested that this should be developed in collaboration with an expert group. Only a few further proposals were received on what could be considered evidence for the development of a baseline: patient experts, clinical trials, international guidance and the peer review of published papers and journals. Some respondents suggested that the Safe, Effective, Quality Occupational Health Service[5] (SEQOHS) guidance could form an effective evidence base for the baseline. Government recognises the important role SEQOHS plays in setting standards for OH service providers but, as these have been designed explicitly for providers, more consideration would need to be given to their potential use for employers, amongst other options.

Q2. What best practice examples have you seen where workplaces are used to better support employee health outcomes that could be used instead to bolster greater take-up of OH provision? What kind of model would you prefer for sharing this good practice, particularly to support Small and Medium-Sized Enterprises (SMEs)?

14. Respondents provided a range of best practice examples to demonstrate how workplaces are being used to better support employee health outcomes and increase OH take-up. These included health and wellbeing employee champions, supported by HR colleagues embedded within businesses (that can represent employees), and employee health schemes where staff could top up provision at their own expense. Pre-employment questionnaires and OH and

[4] The territorial extent of the standards is yet to be determined and will be worked through with the Devolved Administrations as the policy is developed.
[5] SEQOHS

wellbeing information provided to all staff at induction were also referenced. Some cited ease of access as critical to good OH provision. Central Employee Assistance Programme (EAP) services which enable employees to reach out for support, supplemented by a central hub of self-help information and guidance were provided as a good example of this.

15. A recurring theme was the critical role line managers play in creating work environments that facilitate positive health outcomes through OH. Respondents gave examples of line managers being able to do this through setting reasonable objectives, management of workloads and putting in place reasonable adjustments.

Q3. What benefits does, or could, access to OH services bring to your organisation?

16. Representatives from large businesses, SMEs, representative organisations and OH providers agreed that OH can benefit business. Key benefits cited by respondents included early identification and treatment of conditions, improved staff retention, prioritisation of staff welfare, reduced levels of burnout, increased motivation and productivity, as well as a competitive advantage when it comes to recruiting talent. Responses also suggested a cultural shift in the perception of OH from a punitive HR resource to a key tool in supporting the workforce to stay in and succeed at work. Several businesses also spoke of OH services delivering return on investment (ROI), value on investment (VOI) and return on experience (ROE). Finally, respondents highlighted the impact of OH service provision in reducing the workload of NHS primary care staff.

Q4. Are there particular benefits these measures could bring for people with protected characteristics? In what ways could this be achieved?

17. Overall, respondents agreed that OH measures would benefit those who share protected characteristics, including those with a disability, largely through raising awareness, reducing stigma and discrimination, facilitating implementation of reasonable adjustments, increasing physical and mental health, and increasing overall morale in the workplace. Some respondents

recommended using Group Income Protection Policies (GIP) to support people with protected characteristics.

Q5. What are, or could be, the costs of accessing OH services for your organisation?

18. Although several respondents were unsure of the costs of accessing OH services for their organisations, one large business stated they spend nearly £1 million a year on OH services, which equates to below £100 per employee. Other respondents estimated their costs in the range of £30 - £1000 per employee per year depending on sector, size of business, locality and services provided. Another large organisation provided costings on health surveillance undertaken by nurses at an hourly rate of about £90, and consultations with occupational physicians at around £300. Many respondents highlighted that while initial costs appear high, the benefits made it a worthwhile investment, as the implications of not providing OH services were more costly. A leading employee benefits insurer estimated sickness absence costs employers an average of £781 per employee per year.

Introducing a national voluntary standard and accreditation scheme on work and health, embedding a baseline for quality OH provision

Q6. a) What should such a national health at work standard for employers, embedding a baseline for quality OH provision, include, especially given the requirement to accommodate different employer needs?

19. The majority of the responses which addressed a national health at work standard were supportive of the proposal. There was a difference in opinion on whether this should be a voluntary or mandatory standard and there were varying views on what the standard should include. A small number did not think there should be a national health at work standard for employers.

20. Some responses called for flexibility within the standard to reflect the diversity of workplaces, with some highlighting the lack of resources available to SMEs. A small number of responses called for a minimum standard that all employers should adhere to. Multiple respondents discussed the need to adopt a holistic approach within the standard to address both mental and physical health.

21. A few responses emphasised the need for the standards to be simple and clear, with one response suggesting that the legal rights and roles of employers/employees should be specified. Some responses highlighted the need to ensure that services are readily accessible, including for those who require additional support, and that this could be provided via a combination of digital, face-to-face and telephone platforms.

22. Respondents also suggested pre-existing standards and tools (such as Disability Confident, ISO45001, ISO45003, Healthy Working Lives Programme), and specific health and wellbeing services (such as access to podiatrists, sight tests, mental health support) should be considered for incorporation into the standard. A small number of respondents suggested the standards should have an emphasis on risk assessment and management to

identify and mitigate workplace hazards. In addition, some responses highlighted the need for ongoing data collection and assessment to ensure continuous improvement of provision.

Q6. b) What should the OH elements of that standard look like, particularly to ensure a simple and clear baseline for quality OH provision?

23. Respondents emphasised the need for the framework to be simple, easily accessible and to focus on both mental and physical conditions. Many highlighted that a baseline should not be mandatory on the basis that the costs to SMEs particularly could be seen to outweigh the benefit. Some suggested the standards should cover measures ranging from legal compliance to those which are beneficial to wellbeing and proposed that the baseline should link to Access to Work[6].

24. Others proposed consolidating pre-existing frameworks, including Disability Confident and the Mental Health at Work Commitment, arguing that such an approach would avoid duplication. Some opposed this view on the basis that the baseline standards should be applicable to all employees; not just disabled people and those living with physical and mental health conditions.

25. Although one respondent maintained the need for differing levels of OH support for different industries, another suggested that standards, including national health at work standards, should be kept universal.

Q7. For an accreditation scheme, should the levels or tiers be based on business size and turnover? What other factors should we consider for the tiers? What incentives should be included in the higher tiers?

26. Responses suggested that levels or tiers of an accreditation scheme could be based on business size or turnover. Other factors to consider included sector, industry-specific mental and physical health risks, health and safety

[6] Access to Work is a UK Government programme delivered by Jobcentre Plus across GB which provides advice and a financial grant for practical support to overcome work related barriers due to disability. It is available to customers with a disability who are in employment or with a job to start.

requirements, and levels of deprivation locally.

27. A relatively small number of responses stated that a minimum professional service standard was needed to ensure equitable access for employees across a range of employer sizes. As a result, some of these responses suggested a single tier scheme would be sufficient.

28. Suggested incentives that could be included in the higher tiers were reduced insurance premiums, reduced accreditation fees, clear evidence of value, access to government grants, tax incentives, access to an accreditation logo and branding, access to a network of OH experts who provide tailored advice and support, and access to training opportunities and resources. Two organisations mentioned that accreditation should be incentive enough, or that incentives would encourage businesses to aim for the higher levels of the scheme for the "wrong" reasons.

29. Responses stated the need for an accreditation scheme to be straightforward and have easy-to-measure standards. A small number of responses stated an accreditation scheme could make it harder to engage with the standards. A further small number suggested accrediting OH service providers.

Q8. If you are an SME with fewer than 250 employees or a SME representative

a) how useful and/or practical would such an accreditation scheme be for you? Give reasons.

30. Most responses were positive about the usefulness of an accreditation scheme. Many of these mentioned that an accreditation scheme would provide reassurance and evidence that the OH services employers procure meet a minimum professional standard.

31. Some responses suggested such a scheme could create additional work or costs for employers, particularly SMEs. One response highlighted that the introduction of another framework could mean small businesses struggle to

navigate a landscape of multiple frameworks. Others suggested that an accreditation scheme needs to have clear incentives for employers and evidence the return on investment that businesses would typically see.

b) how useful and/or practical would benefits such as access to peer support be?

32. The dominant view from respondents was that benefits such as access to peer support would be useful and that it could improve employer knowledge and their attitudes towards OH services.

33. Several responses expressed concern about the usefulness of peer support. A small number mentioned that this form of support would only be effective if the information shared is of good quality and that it would not be a substitute for a quality OH service. Some suggested that it would also be beneficial to signpost to voluntary sector specialist organisations and schemes. Only one respondent mentioned they would not recommend peer support be included in a national standard due to the burden of responsibility it places onto peers. This respondent stated that if peer support is included, they would expect to see standardised training, assessment, and supervision of those involved.

Q9. How should such an accreditation scheme be monitored and assessed? What assessment or evidence should employers need to provide to achieve each level?

34. The majority of those who answered this question were in favour of an accreditation scheme being independently assessed, with many suggesting monitoring should be via a governing body.

35. Although a minority of responses were in favour of self-assessment, these acknowledged that external auditing would be required to ensure adequate monitoring.

36. Several responses were supportive of an accreditation scheme being developed in collaboration with industry experts and in line with existing schemes, including regional and international frameworks.

37. A large number of responses suggested accreditations be measured on evidence of outputs and outcomes to reflect the aim to help people to start, stay and succeed in work.

38. Of those who were not in favour of an accreditation scheme, most would prefer an independent body to review evidence rather than self-accreditation. Many also felt it is important to recognise and reduce burdens on employers, particularly SMEs, to encourage greater take-up of standards.

Providing additional Government-funded support to enable businesses to adhere to guidance

Q10. What Government support services would be most valuable for employers seeking to improve their support for health and disability in the workplace, including as they work by towards a baselined quality OH provision as set out in a national health at work standard for employers, embedding a baseline for quality OH provision, that the Government would develop?

39. Views were mixed on which services would be most useful, offering broad opinions on types of support, and how they should be delivered.

40. These opinions ranged from vocational rehabilitation and financial support, such as tax benefits and subsidies, to sector- and size-specific support, such as tailored SME support that recognises the unique challenges they face. Healthcare providers emphasised the need to focus on prevention, early intervention, and co-ordinating healthcare support.

41. Several responses highlighted the need to improve or extend Access to Work as part of the support offered, citing issues around payment and restrictions on what Access to Work can be used for.

42. On condition-specific areas, better support for mental health was commonly referred to. Several responses also agreed that a set of clear, achievable minimum standards with baselines to measure against were required. An interactive platform with evidence-based resources on health and disability, best practice, and key services to signpost to was recommended by some.

Q11. Should access to a Government-funded support package be conditional on accrediting to the proposed national health at work standard for employers, embedding a baseline for quality OH provision? Give reasons for your views.

43. Views were mixed in terms of whether access to a Government-funded support package should be conditional on accrediting to the proposed national health at work standard for employers, and most responses focused on the implications for OH provision rather than the wider standard. Of those in favour of access being conditional on gaining accreditation, most respondents thought that it would help employers ensure the quality and consistency of the OH provision they access. Of those opposed to the support package being conditional on gaining accreditation, most highlighted the risk that this approach may limit engagement and access to support among those organisations, and therefore their employees, who would need or benefit from it most (i.e., smaller employers, and/or those who do not offer services that would currently meet the proposed standard).

Lessons from international comparators and successful UK-based employer models to drive OH take-up

Q12. Drawing on examples from international comparators, what could be effective in driving employer demand to enable a shift towards higher rates of access?

44. More than a third of respondents who answered this question acknowledged that legislation or tax incentives could be an effective factor in achieving high rates of access to OH services in some international examples. A small number of responses attributed changes in behaviour to legal requirements, using the mandating of seatbelt wearing and the smoking ban as examples of this.

45. Some answers also highlighted a tapered approach based on employer size (that some international comparators had taken) or incentives and additional support for SMEs as being effective in helping businesses to manage any additional burdens as a result of legal requirements.

46. Further, several responses from insurers, public and OH sector organisations noted that Government should consider how measures to increase access to OH should be inclusive of other services that enable expert work and health support such as vocational rehabilitation and group income protection policies. These drew on lessons from international examples where insurance systems are in place to support employers to meet their legal obligations regarding their employee health and wellbeing.

Q13. What are the possible costs/benefits of legal measures to provide OH, and do these vary by the size of the business?

47. Answers focused on the balance between benefits and costs, or indicated a firm conviction that there were primarily either costs *or* benefits. Perceived costs were linked to expense, resource and legal risks. Benefits included increasing productivity, retention, recruitment, and wider health outcomes. Proportionality in any legal measures was a prominent message, particularly in terms of the risks to small businesses. Some responses offered mitigations in the form of tapered measures based on employer size or additional support for SMEs, both financial and in terms of facilitating simpler access to services.

48. Some of the suggested risks to introducing legal requirements included a likelihood of exacerbating existing market challenges and employers potentially feeling concerned about the responsibility of supporting their employees' health without financial assistance to implement support. Others added that SMEs should be supported; not mandated.

UK models of employer-funded provision for employees

Q14. What lessons could be learned from self-reporting models and Automatic Enrolment that could be applied to increase access to OH amongst employers? Please include which elements of these examples could be delivered for OH.

49. Limited responses were received in relation to the self-reporting models element of the question. Those who did respond appear to have interpreted the question differently, focusing on the merits of employees self-reporting to an OH provider rather than on whether businesses should be reporting annually to the UK Government on their OH offer.

50. The majority of the respondents recognised the positive impacts that Automatic Enrolment can have on achieving high participation rates. Parity of access and inclusion were perceived to be some of the benefits of Automatic Enrolment. Some answers conveyed that making something ‘automatic’ and for all employees, could minimise the administrative burden for employers. Several respondents noted that a regulatory body would be needed to develop a similar scheme for OH, which included those few that did not think Automatic Enrolment alone would increase OH coverage, and that Government may need to regulate to extend OH service provision.

Developing the work and health workforce capacity, including the expert OH workforce, to build a sustainable model to meet future demand.

Boosting recruitment and diversifying the pipeline into the OH profession

Q15. What more can be done to build the multidisciplinary clinical and non-clinical workforce equipped with the skills needed to deliver occupational health and wider work and health services? Please include any examples of creative solutions.

51. There was wide support, particularly from healthcare and OH sectors, for developing a sustainable multidisciplinary OH workforce. To equip clinical and non-clinical professionals with the skills they need to deliver quality services, respondents recognised the need for increased access to accredited training and flexible delivery channels (including online). Some advocated for a standardised multidisciplinary training program covering multiple roles in OH, and earlier inclusion of OH within existing undergraduate or postgraduate training. Continuous development opportunities and placement were considered important. Respondents noted that work has begun by the sector professional bodies to develop flexibility in the workforce via hybrid training posts between NHS and private sector.

Q16. What would professionals find helpful to refer into wider work and health or employment support services?

52. Respondents supported access to standardised pathways, clear guidance (sector specific) and support for referrals, and a better understanding of available services. They also asked for simpler online processes, platforms or forms to make the journey smoother. OH experts suggested embedding work and health training in all HCP training (undergraduate and postgraduate levels) to encourage understanding of work as a health outcome. The importance of the linkage between health and work support within primary care was highlighted as important in ensuring joined up support services.

53. There was also limited support for the establishment of a “Centre for Work and Health”, led by a clinical director with multidisciplinary leadership representing both NHS and commercial settings.

Building and diversifying the pipeline in the OH profession through promotion of OH as a career

Q17. How can we promote OH as an attractive career to encourage a wide range of professionals to join and/or remain in the profession?

54. Respondents highlighted pay, career progression, professional support, and work-life balance as important in encouraging people to join or remain in the profession. They suggested the career could be marketed through career events, case studies, mentoring, placements and increasing apprenticeships.

55. Respondents noted that a factor limiting uptake was the minimal understanding of the full scope of an OH career and that that people are not aware of the varied career opportunities within the OH profession.

Q18. What are the optimum touchpoints to promote careers in OH at entry level e.g., studying different disciplines to those who have left the NHS or are considering a career change?

56. Overall, responses supported diversifying entry points into OH with many suggesting focussing on career changers and healthcare leavers with promotion at touchpoints, which include having children, returning from a career break, or considering leaving/retirement. Suggestions supported ways of promoting OH to other relevant professions e.g., Health and Safety, and physical activity roles (such as in leisure centres/sports related jobs).

Developing a multidisciplinary workforce and encouraging SME OH providers to utilise different models

Q19. What actions or mechanisms (including technology) can be used to ensure that the multidisciplinary OH workforce will be utilised by service providers in an effective way to respond to an increase in demand for quality expert and low intensity work and health support (OH)?

57. Multiple respondents highlighted the importance of flexibility in enabling the effective use of a multidisciplinary workforce via the use of technology and Artificial Intelligence (AI). This could facilitate triage, online bookings and workflows, providing better collaboration and access to data across healthcare interventions and other accredited provider networks for sharing of skills and expertise.

58. Responses also suggested technology could offer self-management tools for employers and employees to manage health, with self-referrals providing an advantage of discretion.

Q20. How do we encourage and support small and medium sized OH providers to adopt a multidisciplinary approach? What are the key enablers and what opportunities are there to incentivise collaboration within the sector?

59. Most respondents agreed that SME OH providers should adopt a multidisciplinary approach to service provision. One suggestion for delivering this included collaboration and partnerships between providers for efficacy of skills sharing and specific expertise, such as via established accredited networks supported by professional bodies. Other ideas included cross-sector working and shared referral pathways. Respondents also highlighted the interprofessional education approach utilised in the healthcare professional training sector, which aims to encourage skill-mixing and collaboration.

60. Multiple respondents also underlined the importance of financial incentives for SME providers to either incentivise using a multidisciplinary workforce approach, or disincentivise not using one. Several suggested educating

providers on the benefits of multidisciplinary teams and the types of professions in OH, via guidance and frameworks, sharing of best practices and funding of multidisciplinary training. Promoting the mutual benefits for both employers and provider businesses by emphasising return on investment and the value of a multidisciplinary approach was also suggested.

Optimising additional workforce capacity via fit note and other mechanisms for health and work conversations

Q21. As part of the move to a more multidisciplinary workforce to deliver work and health conversations, should we consider further extension of the professionals who can sign fit notes? And if yes, which professionals should we consider?

61. The majority of responses suggested extending fit note certification to more professions, particularly paramedics and podiatrists, to help reduce GPs' workloads and improve the patient journey on work and health[7]. Many proposed that these professions were well placed to provide work and health advice but had to rely on their colleagues to issue fit notes, which aligns with other feedback received from our stakeholders. Others also mentioned psychologists, osteopaths, physician associates and dietitians as specific professions to extend to in recognition they could have more time and condition specific advice to support returns to work and 'may be fit' assessments. Respondents highlighted that the extension of professions to certify notes needs to be managed by a robust governance framework, guidance, and support for healthcare professionals to develop the necessary knowledge, skills, and experience. It was also suggested that Government could monitor the quality and structure of fit notes ahead of any extension, with better use of the 'may be fit for work' option, providing feedback to employers, enabling people to stay in work.

Q22: What further action can the Government take to support multidisciplinary teams to deliver work and health conversations in other settings (for example NHS or community settings), to improve health outcomes and address health inequalities?

62. Respondents agreed that an effective work and health conversation requires the patient and their healthcare professional to have sufficient time and

[7] However, it should be caveated that some of these recommendations may be skewed by the fact a lot of the respondents were from these professions – for example, a proportion of respondents identified as podiatrists or paramedics, which may have contributed to why these were highly recommended professions.

training to discuss their health conditions, how that might impact on their work, and what steps could be taken to stay in or return to work. Several respondents also highlighted the need for increased awareness of OH and its benefits for employees, employers, and the healthcare sector. There were suggestions that this messaging should come from the UK Government. Respondents highlighted the need for GPs to be able to refer directly to OH services in the public sector, as well as the importance of having a more streamlined IT system for patient records in which various healthcare professionals can see the different treatments someone is receiving.

Our Response

63. Responses to the consultation evidence continued support for our existing OH reform programme designed to boost access to OH. This includes the UK Government's OH subsidy pilot that is being developed for SMEs as well as further investment being made to progress the £1m Innovation Fund. Launched in January 2023, the Fund will enter its second phase in December 2023 (see paragraph 74). We are also building clinical workforce capacity through the OH workforce expansion scheme launched in July 2023, which we will consider scaling up based on evidence and learning. This existing activity provides an early foundation of support. It is also clear from the responses that we also need to do more to enable businesses and employees to engage with the benefits of OH services. Therefore, the UK Government will be exploring a set of measures to further drive increased OH take-up amongst employers and develop a long-term strategic OH workforce approach to build a multidisciplinary work and health workforce.

Exploring new workplace health and disability standards and developing an OH baseline

64. The consultation responses were broadly supportive of the UK Government's proposals to develop further guidance on workplace health and disability and a voluntary minimum framework for quality OH provision. Therefore, as proposed by consultation respondents, the UK Government will be establishing an expert group imminently to support the development of a voluntary minimum framework for quality OH provision. The voluntary framework will aim to set out the minimum level of OH intervention that employers could adopt to help improve employee health at work and will be tailored to differing business sizes. A diverse UK-wide range of OH, wider public health and business experts will ensure that OH, business and wider work and health workforce priorities and considerations are taken into account in the design of the framework. The framework will complement existing initiatives that support those with health conditions and disabilities in the workplace, including – but not limited to – Disability Confident.

65. We will explore whether Government should develop workplace health and disability standards to provide best practice guidance for employers to support people with health conditions and disabilities to start, stay and succeed in work. We would consider coupling these standards with a UK Government-funded support offer which will help employers reach the standards and incentivise adoption of the standards. We will use the consultation responses to inform our thinking on the potential design and content of new guidance and support services.

Bolstering the OH business offer, particularly for SMEs – a new digital marketplace

66. Consultees pointed out the need for employers, particularly SMEs, to have easier access to affordable OH services, given the known issue of costs being prohibitive for smaller businesses procuring OH services. To address this, the UK Government will consider options for a new SME group purchasing framework, underpinned by a digital marketplace. This initiative would aim to enable SMEs to pool their purchasing power to benefit from economies of scale. This could further bolster the UK Government support in place for SMEs, which includes the new service for employers providing guidance on supporting health and disability at work (currently in live public testing), and the upcoming OH subsidy pilot. As we explore options for an SME group purchasing framework and digital marketplace, we are keen to learn from the several business and public sector organisations that suggested ways for OH measures to be inclusive of group income protection and wider work and health support. In the longer term there may also be potential to consider linkage with associated products that support employee health.

Building a longer term multidisciplinary OH workforce with investment in further OH training for doctors and nurses and other HCPs in the shorter-term

67. Building on learning from our existing OH workforce expansion programme, the UK Government intends to identify long-term opportunities to develop

multidisciplinary work and health workforce capability. The UK Government has already commenced building clinical workforce capacity through the launch of the OH workforce expansion scheme in July 2023. Achieving the step change towards a sustainable multidisciplinary work and health workforce will also require development of a longer-term strategic Occupational Health workforce approach, working with NHS England and stakeholders across the public and private sector. Any long-term ambitions for the OH workforce will need to be aligned with the NHS' long term workforce planning.

Automatic Enrolment and potential impact of legal measures

68. Respondents also considered the applicability of lessons from Automatic Enrolment as a mechanism to increase access to OH. This was cited by some as potentially effective, but others highlighted that SMEs may need significant interventions to enable them to comply. Some responses reflected that Automatic Enrolment could enable more employees to have more direct contact with OH. However, others pointed to the risk of this potentially being withdrawn by SMEs when resources are tight. Respondents also reflected on the merits of mandating OH services. Some respondents acknowledged that there would be both burdens and benefits to being legally required to provide OH. They also voiced concerns over how mandating could be enforced. Others felt that regulatory levers would be important in driving OH uptake and ensuring consistency of service provision.

69. At this stage, in light of the mixed responses to these proposals, Government does not propose making OH provision mandatory for employers or introducing Automatic Enrolment for OH.

Extending Fit Note certification

70. The UK Government is keen to support healthcare professionals to deliver effective work and health conversations to support people to stay in, or return to, work. The UK Government welcomes the important contributions made in this consultation and agrees that the fit note can support these conversations,

including through increased use of 'may be fit for work'. Fit note guidance products on gov.uk have recently been updated to support this ambition.

71. The UK Government is also evaluating the impact of the 2022 regulation changes which enabled additional healthcare professionals to certify fit notes. Whilst we will not be further extending the professions which can certify fit notes at this time, we will take into account the responses to this consultation as we consider how we can best draw on a wide range of professionals to support people back into the workforce.

72. Government will continue to explore fit note reform and will trial new ways of providing individuals receiving a fit note with timely access to work and health support. Within test areas, individuals will be referred to a range of support tailored to their needs, including integrated employment and health support through their local WorkWell service pilot, care coordination to help individuals manage their treatment journey and wider social and psychological support, such as wellbeing programmes and financial support services. Alongside this, we are increasing tailored and personalised support for individuals, including rolling out new digital health tools and expanding support for mental health and musculoskeletal problems. The UK Government will also launch a consultation on reforms.

Wider OH reform activities

73. In addition to the proposals to help increase OH take-up and develop a multidisciplinary work and health workforce approach, there is great progress being made on the existing OH reform programme. Notably, Phase 1 of the £1 million Innovation Fund launched on 30 January 2023 is supporting 10 organisations to help increase access to and capacity in OH. The Fund supports the development of innovative models of OH tailored to SMEs and the self-employed with a focus on better use of technology[8]. There appears to be significant appetite for new design solutions to stimulate innovation in the

[8] The fund was regarded by the Financial Times as a positive step towards widening access to occupational health services and meeting increased demand.

OH sector to cater for SME business needs. Details of Phase 1 projects and their funded solutions can be found on Innovate UK's transparency page. The Phase 2 competition will open to Phase 1 participants in December 2023 and will close in January 2024 with projects due to commence by April 2024 and run until the end of March 2025. More details will follow in due course.

Annex A – List of Organisations who Responded[9]

1. Advisory, Conciliation and Arbitration Service (ACAS)
2. Association of British Insurers
3. Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE)
4. Aldwark Manor Estate
5. AstraZeneca UK Limited
6. Aviva
7. AXA Health
8. British Association for Counselling and Psychotherapy
9. British Association of Sport Rehabilitators
10. Birmingham City Council
11. British Chambers of Commerce
12. British Chiropractic Association
13. British Medical Association
14. British Occupational Hygiene Society
15. British Retail Consortium
16. Buckinghamshire Council
17. Bupa Global & UK
18. Business Disability Forum
19. Business for Health
20. Centre of Ageing Better
21. Chartered Institute of Personnel and Development
22. Chartered Society of Physiotherapy
23. City of Bradford Metropolitan District Council
24. Cordell Health
25. Council for Work and Health
26. College of Policing
27. College of Paramedics
28. Dispose with Dignity

[9] This list does not include responses from organisations who did not specify whether the response was on behalf of an individual or the organisation.

29. Emocien Ltd
30. Faculty of Occupational Health Nursing
31. Faculty of Occupational Medicine
32. Federation of Small Businesses
33. Fujitsu
34. Fusion Occupational Health
35. General Osteopathic Council
36. Group Risk Development
37. Good Shape
38. HA Compliance
39. Healthcare RM
40. Health Assured
41. High Speed Two (HS2) Limited
42. Impact on Urban Health
43. Institute of Chiropodists and Podiatrists
44. Institution of Occupational Safety and Health
45. Institute of Osteopathy
46. International WELL Building Institute
47. John Lewis
48. Lancashire County Council
49. Legal & General Insurance
50. Maitland Medical and Soma Health
51. Make UK
52. Mates in Mind
53. Mental Health at Work Leadership Council
54. Nestle UK & Health
55. NHS England
56. NHS Health Board
57. NHS Health at Work Network
58. Obesity Health Alliance
59. Optima Health
60. Parkinson's UK
61. Peppy Health
62. Professional Standards Authority

63. Public Health Scotland
64. Public Health Wales
65. Qured
66. Royal College of Occupational Therapists
67. Royal College of Podiatry
68. Royal Society for Public Health
69. Simply Business
70. Scottish Hazards
71. Society of Occupational Medicine
72. Society of Occupational Medicine (Business for health)
73. Sky UK
74. St Alban's District Council
75. Swansea Bay University Health Board
76. Swiss Re Europe
77. Symphony Healthcare Services Ltd
78. The Association of Occupational Health & Wellbeing Professionals
79. The What Works Centre for Wellbeing
80. The Confederation of British Industry
81. The Health Foundation
82. The Liminal Space
83. The Physiological Society
84. The Wales Safer Communities Network
85. Ukactive
86. Unison
87. Unite the Union
88. Unum UK
89. Verve Healthcare
90. Vocational Rehabilitation Association

978-1-5286-4566-9
E03016910