SOM response

This response draws on SOM's broad range of clinical and occupational health expertise, particularly from its functional assessment group[1]. The group acknowledges challenges within the benefits system and supports the principle of reform aimed at improving outcomes for individuals with long-term health conditions. We note there is significant in work benefit spend by DWP.

Cross cutting themes are

- **An integrated approach, involving Occupational Health (OH**). Occupational health helps people access, remain in and return to work[2]. Early OH intervention and preventative support identities health-related barriers to work early and recommend clinically led reasonable adjustments to enable individuals to remain in employment. It aids people to stay in and return to work. OH with functional assessment expertise should support individuals access government schemes such as Access to Work. OH offers dynamic and personalised support.

  OH should be embedded through signposting and referral within systems e.g. via Access to Work. Through signposting and referrals from the benefit system to OH services the government can support people to both live independently and return to/remain in employment.

  OH needs to be part of collaborative and integrated signposting across local, regional and national support frameworks and services, linking the NHS, community, and voluntary sector services, mental health support, social prescribing, and local wellbeing initiatives.

- **Communication** - Changes should be in partnership with stakeholders. This collaborative approach is essential to ensure a smooth transition and minimise unintended negative consequences. SOM supports improved communication and coordination between multiple agencies including occupational health, the DWP, primary care, and the healthcare providers involved in assessments.

  Signposting, facilitated through Work Capability Assessment and post-assessment referrals, should occur to OH.

  Through an extension of the Health Adjustment Passport to all claimants with health conditions, not just jobseekers, OH information should be embedded alongside a link to local services. It is essential that signposting is clear, and accessible, as ambiguity may be a factor that disincentivises a return to work.

- **All assessments aim for a positive outcome.** There is a lack of trust in the benefits system, driven by complex assessments, fear of reassessment, and inconsistent support.

---

[1] SOM's Functional Assessment Medicine Specialist Interest Group comprises healthcare professionals (HCPs) who are from the field of Functional Assessment. It is made up of a diverse range of clinical disciplines and backgrounds including Benefits Assessment, Vocational Rehabilitation, Occupational Medicine, and Insurance Medicine

[2] https://www.som.org.uk/sites/som.org.uk/files/Occupational_Health_The_Value_Proposition_March_2022_0.pdf

Considering this, assessments should lead to positive outcomes, regardless of the benefit decision. Assessments should transform from gatekeeping into opportunities for meaningful engagement and support. The aim should be to ensure that no one is left behind or abandoned after an assessment.

The Policy Exchange report, "For Whose Benefit?" advocates for a more dynamic and joined-up system in which assessors are empowered to signpost or refer claimants to relevant services.

Occupational Health can serve as part of support and incorporate behavioural economic principles such as positive framing, nudges, and default options to enhance engagement and uptake of the support offered.

- **Overarching clinical governance and a training pathway -** Occupational Health provides evidence-based approach to help support overarching clinical governance through a single, unified framework.

  The SOM Special Interest Group for Functional Assessment has recently devised curricula that offers a structured approach to training and delivery for those involved in the work and health setting.

  SOM has drafted a national clinical governance framework – See the Annex and also a brief on Occupational health in Annex 2

Consultation Response

SOM welcomes further discussion around the points raised or the consultation in general.

Chapter 2: Reforming the structure of the health and disability benefits system

1.What further steps could the Department for Work and Pensions take to make sure the benefit system supports people to try work without the worry that it may affect their benefit entitlement?

- It is essential to account for variability in health and capacity, especially for individuals with fluctuating conditions.
- Any system should be dynamic and personalised that can adapt over time and allow for changes in a person's symptoms.
- Clarity of communication is a critical factor, and any system must be easy to understand, with clear, accessible guidance that clearly explains how working affects benefits. Any ambiguity may be a factor that disincentivises a return to work.
- Employer support also plays a vital role. The DWP could collaborate with employers to promote flexible working arrangements, phased returns, and access to occupational health services. Employers should be bought in to the concept of employing those with chronic health conditions and that any processes including recruitment help to encourage those who may need additional support.
- Rather than an expectation of full-time work, groups may only achieve a proportion of time in employment and might need support around this. However, this is likely to be more desirable than not engaging in work at all.
- Sanctions and conditionality are contentious - these are often counterproductive and can result in negative impacts of people's mental and physical health[2]. In addition, the challenges associated with conditionality in terms of WCA has been well described and it has been argued that this should focus on engagement rather than

compliance[1]. Ideally there would be an emphasis on positive incentives and supportive engagement.

2. What support do you think we could provide for those who will lose their Personal Independence Payment entitlement as a result of a new additional requirement to score at least four points on one daily living activity?

- Disabled People Organisation groups indicate that there is a large percentage of claimants that will be impacted by this change, and it is essential that there is a robust safety net for those who will no longer qualify. PIP was designed to help people with long-term conditions manage the additional costs of living with a disability. Many of those affected by this change—particularly individuals with musculoskeletal or mental health conditions are still likely to experience symptoms that significantly impact their daily lives.
- For this group, the concept of a "low" level of disability could be misleading and risk excluding people who still need meaningful support. Therefore, it should be ensured that alternative pathways to assistance are in place. This includes clear and compassionate communication when informing individuals of changes to their entitlement, with a focus on explaining the decision and highlighting where support can still be accessed. A key part of this support should be effective signposting to NHS, community, and voluntary sector services, including mental health support, social prescribing, and local wellbeing initiatives. Staff should be able to provide this guidance, even when individuals do not meet the new threshold.
- Healthcare professionals conducting benefit assessments should be able to do this signposting[3]. Ultimately it is felt that having a positive outcome, even when benefits cannot be awarded, would help to improve trust in the system.
- DWP must consider other benefits than PIP e.g. reduced gym membership costs and wrap around entitlements maintained for this cohort of customers. Benefits such as gym memberships can promote psychological and physical wellbeing. This could also include prescription costs, discounted rail costs, tax exemption such as for vehicles or reduction in council tax.
- The DWP should consider how the data gathered during assessments can be used more broadly. E.g. individuals who no longer qualify for PIP could be fast-tracked into employment support services, such as Access to Work or specialist employability programmes. This would ensure that the assessment process remains valuable and avoid additional assessments for other support.

3.How could we improve the experience of the health and care system for people who are claiming Personal Independence Payment who would lose entitlement?

The answer to 2 adequately addressed this question hence refer to this part of the document when considering the above.

4.How could we introduce a new Unemployment Insurance, how long should it last for and what support should be provided during this time to support people to adjust to changes in their life and get back into work?

Support to adjust to changes and get back to work should include triaged access to Occupational health expertise (such as a clinician with a Diploma in Occupational Medicine) to advise and safeguard a return to work. This will give people confidence to return to work, by understanding from a health professional the types of work that they are able to do.

5.What practical steps could we take to improve our current approach to safeguarding people who use our services?

- Safeguarding has always been an important part of delivering any health-related service and SOM supports moves to improve existing processes to help protect vulnerable

people. Benefit claimants are at risk of vulnerability and exploitation and any changes to welfare benefits can cause additional stress and worry to this population.
- For DWP, training, processes, guidance, and professional curiosity should be embedded in every level of the service. This should start at the front line within Job Centres to DWP senior leaders commissioning and designing services. DWP needs to ensure that its colleagues feel empowered to act and supported in doing so.

Chapter 3: Supporting people to thrive.

6.How should the support conversation be designed and delivered so that it is welcomed by individuals and is effective?

- The support conversation needs to take place as early as possible in the process to facilitate early intervention, it should be a holistic assessment of a customers' needs using a biopsychosocial model. For the conversation to be effective it needs to collaborate with the customer to enable and empower them to set and achieve goals. The customer needs to clearly see the benefit for them to promote engagement, and it may be most effective if this conversation occurs outside of the DWP.
- In terms of these conversations, evidence highlights how to have successful work and health consultations which can result in an effective return to work plan [4 5 6]. Support conversations should consider the principles of this evidence, and it should help to form the foundation of the interaction. Consideration will be required to roll these out on a national level and a critical early step is to determine who will be responsible for delivering these assessments, ensuring that delivery is both consistent and underpinned by appropriate training. To achieve fairness and equity across the country, the model must be evidence-based and standardized, guided by a single, unified framework.
- Evidence from a recent pilot suggests that some people might benefit from more than one interaction[7].
- When addressing outcomes, The Green Paper also refers to "thriving," a term frequently used in policy discussions but often lacking clarity. Establishing a shared understanding of what good outcomes look like will help align expectations and measure success. Finally, incorporating behavioural economic principles such as positive framing, nudges, and default options can significantly enhance engagement and uptake of the support offered.

7.How should we design and deliver conversations to people who currently receive no or little contact, so that they are most effective?

- To effectively engage individuals who currently receive little or no contact from the DWP conversations should be designed to be supportive, personalised, and led by trained, competent staff. The approach should be tailored, recognising that for some, steps like voluntary work may be more appropriate than immediate employment. Flexibility in how conversations are delivered is also key, with options such as phone calls, video chats, in-person meetings, or home visits for those who may not respond initially.
- Initial contact with primary care might be a way of determining the likelihood of engagement similar to a triage system as part of the SOM's suggestion for Universal Access to Occupational Health[3]. However, this may present challenges in terms of consent and data protection.

8.How we should determine who is subject to a requirement only to participate in conversations, or work preparation activity rather than the stronger requirements placed on people in the Intensive Work Search regime.

[3] https://www.som.org.uk/sites/som.org.uk/files/Manifesto_2024_a.pdf

, Everyone should have access to some form of support, regardless of how close they are to the labour market. Determining the right level of engagement should be done considering individual needs, health conditions, and personal circumstances. Individuals should be safeguarded from inappropriate expectations but not excluded from support. While participation in conversations can be encouraged, any follow-up requirements should be proportionate and sensitive, avoiding rigid mandates that may not suit everyone's situation. Work and health conversations, if delivered positively and empathetically, can be a helpful way to understand someone's situation and should be accessible to most people.

Occupational Health should be part of triaged support to help identify the appropriate level of requirement to be placed on people. Occupational health professionals understand the impact of health conditions on someone's ability to work and can therefore make an independent assessment on whether someone is capable of participating in the Intensive Work Search regime.

9.Should we require most people to participate in a support conversation as a condition of receipt of their full benefit award or of the health element in Universal Credit?

The concepts highlighted above are applicable.

10.How should we determine which individuals or groups of individuals should be exempt from requirements?

Requirements should be based on individual circumstances as identified through the support conversation; it should consider criteria around functional capability, capacity, and prognosis.

Any individuals who have a terminal illness should be exempt.

11.Should we delay access to the health element of Universal Credit within the reformed system until someone is aged 22?

Support should be based on individual health needs, not age. Young people often face a difficult transition from paediatric to adult services, and introducing delays in financial support during this period could add unnecessary stress and risk disengagement.

Although the Green paper indicates that there will be support available under the Youth Guarantee, the nature of this and whether it includes any financial assistance appears to remain unclear. Additional support for any age group is likely to be welcomed however this should not leave them economically disadvantaged.

12.Do you think 18 is the right age for young people to start claiming the adult disability benefit, Personal Independence Payment? If not, what age do you think it should be?

Anyone with ongoing health needs should receive appropriate support, regardless of age. Health-related support should include occupational health and be based on individual need, not arbitrary age thresholds. Support should be inclusive and person-centred, ensuring that no one is disadvantaged due to their age alone.

Chapter 4: Supporting employers and making work accessible.

13.How can we support and ensure employers, including Small and Medium Sized Enterprises, to know what workplace adjustments they can make to help employees with a disability or health condition?

There is a key role for SMEs to improve health at work and support retention and recruitment[4].[5] Occupational health (OH) supports people stay and return to work[6] and should be part of the offer from employers.

The previous Government started an OH for small and medium enterprise Ministerial task force led by Dame Carol Black. due to report in July 2024. It has not continued into this parliament. See:https://www.gov.uk/government/news/new-occupational-health-taskforce-to-tackle-in-work-sickness-and-drive-down-inactivity, An Occupational Health incentive pilot occurred in 2025 in North West England.

For the past three years, investment has occurred into the National School of Occupational Health for 200+ doctors and nurses to be trained in the short Diploma in Occupational Medicine to assist with OH capacity. This has not continued. See https://eastmidlandsdeanery.nhs.uk/occupational-health/national-school-occupational-health

There needs to be a systematic, preventative and evidence-based approach to managing health risks and promoting good work and good health outcomes (including expanding access to quality OH provision and early intervention etc). There should be particular considerations/approaches to support different demographic groups which could face particular health and life challenges at certain stages (e.g. menopause transition)

Small and medium sized enterprises (SMEs) often lack the internal human resource or occupational health infrastructure of larger firms. The Health and Safety Executive (HSE) report on SMEs identifies that occupational health is often neglected in small and medium enterprises due to limited resources, low awareness, and lack of perceived risk[8]. Managers, or "gatekeepers," are key to driving change and hence need to be engaged alongside employees[8].

Disability Confident can be tokenistic and providing targeted funding, alongside training and education is necessary.

A key concept when addressing this issue are workability plans linked to OH as referenced in the answer to question 6. Workability plans, when implemented properly, can clearly outline the adjustments an employee needs, helping employers understand and act on their responsibilities. As such provision of an evidence based, nationally consistent scheme would allow employers access to practical, bespoke steps to improve the workplace environment for service users.

The HSE's Health ↔ Work Toolbox provides practical, evidence-informed strategies that businesses can use to create supportive environments[9]. It encourages employers to make temporary, reasonable job modifications—such as adjusting tasks, reducing physical or psychological demands, or altering work environments—to help employees stay in or return to work. The guidance also recommends structured planning tools like Stay at Work, which can be tailored to individual needs. Importantly, it highlights the role of line managers in identifying obstacles and facilitating accommodations and stresses the value of early, open dialogue between workers and managers. Training line managers in health awareness and communication is a key enabler of this process.

Fit note reforms, with allied health professionals now able to complete them, offer an opportunity to link clinical advice with workplace planning and will alleviate pressures on

[4] Keep Britain Working: Terms of Reference - GOV.UK
[5] Wes Streeting to ask employers to pay for more staff medical checks
[6] https://www.som.org.uk/sites/som.org.uk/files/Occupational_Health_The_Value_Proposition_March_2022_0.pdf

primary care. There should be an opportunity to refer into OH via fit notes, as recommended by Policy Exchange[7].

14.What should DWP directly fund for both employers and individuals to maximise the impact of a future Access to Work and reach as many people as possible?

Occupational health to be able to access Access to Work with Occupational Health allowed to refer into Access to Work.

As stated above, OH significantly supports service users stay and return to work. Occupational Health mediates between businesses and employers ensuring tailored support can be provided effectively. OH professionals understand what employers should already be providing under legislation, so referrals into Access to Work from OH professionals would ensure only those adaptations which are genuinely going above and beyond legal requirements would be funded by Access to Work.

Increasing access to Occupational Health - case study

Without Occupational Health services available, employers lose out of many benefits. Evidence provided to SOM from Jaguar Land Rover showed that:

- 57% of workers who were absent from work and referred to OH for mental health reasons had returned to work by the time they were discharged.
- 68% of workers who were absent from work and referred to OH due to MSK were fit for duty by their final assessment.
- OH interventions led to an 80% improvement in anxiety levels and an 81% improvement in depression levels.
- Only 7% of workers referred to OH for mental health reasons required onward referral to a GP or other health professional.
- There is an average of 6 days wait for first appointment, much faster than NHS waiting times.

In another example, an energy company which used Occupational Health professionals to train their mobile technicians on how to look after their health, found this led to a 70% reduction in long-term injuries due to MSK and a reduction in sickness absence due to MSK by 80% within 1 year. Also see https://www.som.org.uk/occupational-health-case-study-smart-clinic

---

15.What do you think the future role and design of Access to Work should be?

There should be the ability for Occupational Health to refer into Access to Work. There is a clear synergy to having those professionals who assess people's health and work capabilities then be able to make recommendations on adaptations needed by the employer.

Everyone who interacts with the service should be able to receive a positive outcome involving OH advice —even if they are not eligible for direct funding. This could include signposting to other services, tailored advice, or onward referrals. Such an approach would help build trust and ensure that the system is inclusive and empowering. It must be a timely and responsive service. This concept, backed by The Keep Britain Working Review,[11] shows support needs to be delivered quickly, particularly at critical moments such as the onset of a health condition or during a return-to-work process. Delays in accessing support can lead to job loss, prolonged absence, or disengagement from the labour market altogether.

[7] https://policyexchange.org.uk/publication/not-fit-for-purpose/

The service should also be grounded in evidence-based practice. This means drawing on what we know works in behavioural science, and occupational health. A holistic approach is essential to recognise and address both clinical and practical barriers to employment.

Consistency is another key priority. It must be applied equitably across the country, and ensure that support is delivered fairly and reliably, regardless of where someone lives or which advisor they speak to.

To deliver this the service at scale, it should embrace digital transformation. A digitally focused redesign would improve efficiency and user experience, enabling streamlined applications, real-time tracking, and better integration with NHS, DWP, and employer systems. It would also allow for smarter use of data to identify trends, target support, and improve outcomes.

Ideally, it would not operate in isolation. Employers and insurers should be seen as strategic partners. Insurers, in particular, have a vested interest in supporting return-to-work journeys and should be encouraged to play a more active role in funding early intervention and vocational rehabilitation.

A gap is the one left when individuals lose access to PIP. Many people use PIP to cover the additional costs of working with a disability such as transport, equipment, or support workers. When PIP is withdrawn, Access to Work does not always fill this void. A future model must explicitly address this by expanding its remit or creating a complementary mechanism to ensure people are not financially penalised for working.

16.How can we better define and use the various roles of Access to Work, the Health, and Safety Executive, Advisory, Conciliation and Arbitration Service and the Equalities and Human Rights Commission to achieve a cultural shift in employer awareness and action on workplace adjustments?

The HSE's Health ↔ Work Toolbox is an important reference to be considered when addressing workplace support[9].

Efforts should focus on supporting occupational health to offer early intervention, as the experts who work between employer and employees' interactions with the system lead to a positive outcome. By aligning around shared values and promoting inclusive, evidence-based practices, organisations can help normalise adjustments as a routine part of good employment practice. It was felt by the group that any cultural change should focus on support and incentives and ideally avoid the need for unnecessary regulation.

A central theme is recognising that work as a health outcome is a concept that should be universally accepted, not limited to healthcare. A return to work should be seen as part of recovery, not something that follows it.

17.What should be the future delivery model for the future of Access to Work?

The answer to 15 also adequately addressed this question hence we refer to this.

Occupational health to be able to access Access to Work with Occupational Health allowed to refer into Access to Work.

As stated above, OH significantly supports service users stay and return to work. Occupational Health mediates between businesses and employers ensuring tailored support can be provided effectively.

References

1. Baumberg Geiger, B., 2024. *After the WCA: Competing visions of disability and welfare*. Available at: 2024-07-after-the-wca-full-report.pdf [Accessed 09/06/25].

2. House of Commons Work and Pensions Committee, 2018. *Benefit Sanctions*. Parliament.uk. Available at Benefit Sanctions - Work and Pensions Committee - House of Commons [Accessed 09/06/25].

3. Prager, J-A., Phillips, S. and Tait, A., 2025. *For Whose Benefit? Proposals to Reform Health and Disability Benefits & To Create a New Social Contract*. London: Policy Exchange.

4. Burton, K. and Bartys, S., 2022. The smart return to work plan – Part 1: the concepts. *Occupational Health at Work*, 19, pp.22–27.

5. Etuknwa, A., Bartys, S. and Burton, K., 2023. The smart return to work plan – Part 2: the build. *Occupational Health at Work* 19, pp.16–25.

6. Bartys, S., Edmondson, A., Burton, K., Parker, C. and Martin, R., 2019. *Work conversations in healthcare: How, where, when and by whom?* London: Public Health England.

7. Department for Work and Pensions, *Evaluation of the Employment and Health Discussion Proof of Concept*. Available at https://assets.publishing.service.gov.uk/media/6814c68c3c3bba3526f03b6e/ehd-evaluation-report.pdf [Accessed 06/06/25].

8. Stephens, P., Hickling, N., Gaskell, L., Burton, M. and Holland, D., 2004. *Occupational health and SMEs: Focused intervention strategies*. HSE Research Report 257. London: HSE Books.

9. Kendall, N., Burton, K., Lunt, J., Mellor, N. and Daniels, K., 2015. *Developing an intervention toolbox for common health problems in the workplace (RR1053)*. London: HSE Books.

10. van Sonsbeek, J. and Gradus, R., 2013. Estimating the effects of recent disability reforms in the Netherlands. *Oxford Economic Papers*, 65(4), pp.907–934. https://doi.org/10.1093/oep/gps043

11. Department for Work and Pensions, 2025. *Keep Britain Working Review: Discovery*. GOV.UK. Available at: **Keep Britain Working Review: Discovery - GOV.UK** [Accessed 09/06/25]

Annex 1 – Clinical Governance Framework for work and Health

Purpose - This framework uses the seven pillars of clinical governance and sets out an overview of how to achieve a structured, standardised clinical approach for delivering services at the interface between work and health across local UK government programmes, such as DWP initiatives that connect to welfare offerings, programmes embedded within NHS services such as Individual Placement and Support, Get Britain Working Trailblazers, and WorkWell. It aims to:

1. Ensure NHS organisations and partner services are accountable for delivering safe, high-quality care.
2. Provide a shared mechanism for continuous service improvement.
3. Offer national consistency in quality and safety while supporting the local flexibility and innovation that comes with neighbourhood service models

By aligning to this framework, services will self-report areas of compliance and gaps, enabling shared learning across ICBs and directing support where it is most needed. This framework has been developed in line with NHS England's 2025/2026 priorities and operational planning guidance.

Framework Objectives

This framework aims to demonstrate a route to standardising clinical governance in all locally delivered work and health programmes, driving progress towards the following seven pillars of clinical governance.

1. Person Centred Care
2. Clinical Effectiveness
3. Service User Patient Safety
4. Governance and Leadership
5. Information Management
6. Training and Education
7. Performance and Monitoring

Detailed below are objectives that service providers may incorporate into their local roadmaps to achieve governance across these domains.

1. Person Centred Care

Service user Patient and public involvement and engagement in service design and improvement with a focus on listening to, learning from and working with service users patients, carers and communities to drive improvements in all service user experience. For example, building on existing qualitative research interrogating provider perspectives by undertaking research that captures service user perspectives on the benefits and limitations of integration of work and health support. Services must operate within standards of professional confidentiality and understand how to apply this when navigating effective work and health support with stakeholders beyond the direct service user, for example, employers, union representatives and the public.

2. Clinical Effectiveness

Promote safe, timely, and effective return-to-work and rehabilitation support. Drive productivity and efficiency through prevention and early intervention, with a focus on prioritisation of resources aiming to achieve cost-effective, value-based care models that deliver a balanced net system financial position. For example, building on proven resource-efficient tiered models of care at the interface of work and health. This could include deploying a multidisciplinary team (MDT) of functional assessors with a range of clinical backgrounds to support with case management that is beyond the scope of non-clinical case coordinators to manage independently. Provider understanding of the occupational health landscape is also essential in directing prospective service users to workplace occupational health services where an existing offering through their employer meets their needs, to avoid duplication of work and leverage resources that are already in place. For the majority of individuals of working age who do not have access to occupational health support through their employer, local work and health services will need to correspond with (prospective) employers to enable the application of advice in the occupational context to achieve clinical effectiveness.

3. Service User Patient Safety

Upskill the clinical and non-clinical workforce in occupational health and general health risk detection and establish accessible high quality specialist advice and guidance for risk management. This could include routes into existing emergency and urgent health support, e.g. connecting work and health services with the mental health single point of access for service users presenting with acute mental health risk. Deploy occupational health expertise for support with occupational health risk management with clear thresholds of escalation.

4. Governance and Leadership

Ensure seamless integration between work and health services and wider public services, including NHS primary and secondary care. Establish and maintain minimum service standards and pathways for integration with NHS services including defined protocols for referral, rehabilitation, and return-to-work e.g. routes into structured work and health support after a cardiac event. Create optimised referral management pathways including direct routes to secondary care referral such as for work-related respiratory diseases including occupational asthma.

5. Information Management

Support the use of data for service improvement, prevention, and research taking a consistent, system-wide population health management approach by prioritising proactive care. Leverage secure and interoperable systems for data-driven research, service evaluation, and improvement. For example, investigating the benefits and limitations of informational continuity for individual service users while generating high quality data from work and health services that can be harnessed for analysis to improve wider neighbourhood service models.

6. Training and Education

Strengthen support for non-clinical staff with accessible and high-quality clinical supervision and escalation mechanisms. This should include training for non-clinical staff in risk recognition and referral and safe structures for clinical supervision that enable Integrated Care Boards (ICBs) to leverage case management models and a multidisciplinary approach. This could take different forms locally, for example, accessible clinical supervision for urgent concerns alongside a weekly MDT meeting for complex, non-urgent cases. MDTs may have different skill mixes according to local need, and may include allied healthcare professionals, for example, physiotherapists with a background in functional assessment to lead

management in musculoskeletal cases, alongside occupational health physician support. Data published by NHS digital on use of fit notes demonstrates allied healthcare professional ability to give 'may be fit for work' advice following changes to the fit note in 2022, suggesting the potential to scale this capability by cultivating the right skill mix. Over time, local work and health services may impact training and education of the wider clinical workforce around them, increasing the use of the 'may be fit for work' section in fit notes issued by the healthcare professionals they work alongside.

7. Performance and Monitoring

Use audit and feedback loops from service users, the public and other PPIE stakeholders alongside and big data as the foundation for innovative research to drive up standards. Bring learning through soft intelligence and data to wider stakeholders, disseminated via original research and policy forums. E.g. a partnership between a national work and health pilot and Department of Primary Care and Public Health at Imperial College London led to evidence generation underpinning policy dialogues around the direction of services towards a case management and tiered approach. .

Clinical Governance in Action: Example simulated case studies.

These case studies have been developed to showcase the relevance of delivering clinical governance in services delivering care at the work-health interface.

Case 1: Ms P. Mental Health Risk

Scenario

- A non-clinical WorkWell coordinator sees Ms P who is on week eight of sickness absence from her role as a housekeeper for a small hotel. She tells him that her main issue is anxiety and 'sometimes it's so bad she just wishes she wasn't here anymore.' He can see from her history that she is prescribed an antidepressant, but she says that sometimes she skips taking this and has had an attempted overdose around 10 years ago.

Challenge

- It is unlikely the WorkWell coordinator can be adequately trained in mental state assessment and stratification and management of clinical risk to triage and manage this scenario independently.
- The WorkWell coordinator needs to recognise the need for urgent clinical assessment and handover for triage and management of risk

Possible Solutions

- Immediate access to a GP with a 'clinical debriefs' slot bookable via electronic system with shared access to electronic health record.
- Access to a local ICB 'clinical queries helpline' where nonclinical personnel can escalate cases to a clinician with occupational health or clinical functional assessment expertise for their input.
- Complex cases discussed at weekly remote MDT which could include occupational health and functional assessment clinical team members (not adequately timely for this risk that could be acute).
- Single Point of Access referral option reserved for clear over- threshold cases.
- Service user and other local service feedback on outcome in both health and work domains, as well as experience to iterate on solutions deployed.

Clinical Governance Themes

- Person Centred Care/ Clinical Effectiveness/ Service User Patient Safety/ Governance and Leadership / Information Management/ Training and Education/ Performance and Monitoring

Case 2: Mr N. Fitness for Safety-Critical Role

Scenario

A non-clinical work and health coordinator has assessed Mr N, a security guard who has been on sickness absence for four weeks after he was found asleep at work twice. He is now being investigated for sleep apnoea. The work and health coordinator is unsure about how best to manage the risk of falling asleep at work with his role. The work and health coordinator is based on site at Mr N's GP practice and books a debrief slot with the GP who is also unsure about managing the risk of this presentation in his workplace, as this would go beyond the remit of a usual fit note.

Challenge

- Nuanced risk management advice required at the work/health interface which is out of scope for non-clinical work and health coordinator and GP who provides clinical supervision.
- This is not clinically urgent while Mr N remains off work but is a rate limiting step to successful return to work.
- Detection of potential 'risk' to self or others by the non-clinical work and health coordinator is key in this case.
- If Mr N is assessed as unfit for safety critical aspects of his role due to risk to self or others, there will need to be communication with his employer around recommendations to changes to his role. Mr N may also wish to involve his union representative. Communication must be handed within professional confidentiality ethical guidance, which may include assessing whether a breach of confidentiality is required if Mr N is unwilling to consent of release of information that may put others at risk.

Possible Solutions

- Referral to a Primary Care Network (PCN) or ICB-level 'complex cases clinic' run by an OH clinician with functional assessment clinician MDT support, with access to the primary care electronic health record system, where assessment and onward communication with Mr N and the employer is handed over to the OH clinician.
- GP and coordinator escalation to an OH or clinical functional assessment service or helpline for structured advice, where the work and health coordinator remains responsible for overseeing the case and communicating with Mr N's employer, acting on the advice of the OH/ functional assessment clinician.
- Service user and employer feedback on outcome in both health and work domains, as well as experience to iterate on solutions deployed.

Clinical Governance Themes

Person Centred Care/ Clinical Effectiveness/ Service User Patient Safety/ Governance and Leadership / Information Management/ Training and Education/ Performance and Monitoring

Key Themes from Case Examples- the need for Clinical Governance

- The boundaries between clinical and non-clinical work must be clearly defined and supported. This unlocks the potential of non-clinical personnel to lead a safe case management approach, which is more financially sustainable.
- Services need embedded risk management pathways, which trained non-clinical personnel can navigate easily.
- Supervision structures must be in place for non-clinical staff who must be able to identify when to ask for support. Subject matter expertise from OH clinicians must be accessible via helplines, MDTs, or specialist clinics.
- IT infrastructure must be used to support service delivery both operationally and through sharing service user data where GDPR compliant.
- Closing the loop on service user outcomes and experience across health and work domains to drive service improvement and efficacy.
- Local adaptation is necessary to achieve the benefits of a neighbourhood approach to health and care, but consistent national service standards ensure equity and safety.

Leadership and Oversight

A National Clinical Director for Work and Health will:

- Set and oversee minimum service standards and clinical guidelines.
- Monitor service performance nationally enabling shared learning across regional communities of practice.
- Coordinate cross-sector learning and innovation, using the seven pillars of clinical governance to elevate the quality of service delivery

At regional (ICB) level, access to occupational health leadership either embedded or commissioned will be essential to support consistent clinical quality and safe delivery across the different work and health initiatives underway.

Future Ambition

Introduce measurable Key Performance Indicators (KPIs) underpinned by quality management systems to track:

- Clinical safety and timeliness
- Training and supervision of non-clinical staff delivering work and health support
- Return-to-work rates.
- Service user satisfaction.

Embed an audit and feedback mechanism to identify improvement areas, support learning between services, and ensure sustained impact.

Conclusion

This document provides a coherent overview of how to achieve a structured, standardised clinical approach to delivering services at the interface of work and health, National Clinical Framework for Work and Health underpinned by the seven pillars of clinical governance to which local work and health services can align., This This approach aims to: will:

- Improve quality and safety across work and health services.
- Enable equitable access to work and health support across the UK.
- Strengthen data quality and establish standards for data sharing and consent to enable learning to inform future service iterations where appropriate.
- Build a more integrated, preventative, and person-centred model of care.

Annex 2 The Value of Occupational health: Why Occupational Health Matters

Occupational Health (OH) plays a critical role in safeguarding the health and productivity of the workforce. With rising levels of work-related illness and absence, investing in OH is essential for individuals, employers, and the wider economy.

- 1.7 million workers suffer from work-related ill health, resulting in 33.7 million lost working days (HSE, 2024). Stress, depression, or anxiety account for over 50% of these cases (HSE, 2024). Over 3.7 million people in the UK live with work-limiting health conditions (OHID & The Health Foundation, 2024).
- OH services reduce absence, support recovery, and enable longer, healthier working lives (DWP/DHSC, 2023).

Economic and Organisational Benefits

Investing in OH can deliver substantial returns by improving employee wellbeing and reducing costs associated with sickness absence and staff turnover.

- Early intervention by OH professionals can save an average of 20 absence days per affected employee. Every £1 invested in OH services can yield a £5 return. Employers with robust OH services report 25–30% fewer sickness absence days (SOM, 2022).
- For every £1 spent on supporting employee mental health, employers can see a return of approximately £4.70 to £5 through improved productivity, reduced absenteeism, and better staff retention (Deloitte 2024).
- Preventing a single job loss can save around £8,000, while supporting a disabled person into work saves society up to £28,000 annually (DWP, 2023).

Current Gaps in Provision:

Despite its benefits, access to OH services remains limited, especially among small businesses.

- Only 45% of UK workers have access to OH services (DWP/DHSC, 2023).
- 92% of large employers offer OH, compared to just 18% of small businesses (DWP/DHSC, 2023).

Supporting Mental Health and Reducing Inactivity

OH is a key lever in tackling the growing challenge of economic inactivity linked to long-term health conditions. Timely OH intervention can prevent health deterioration and facilitate sustainable return-to-work. OH support is crucial for helping older workers and those with long-term conditions remain in or return to work (OHID & The Health Foundation, 2024).

Policy Opportunities

Scaling OH, to maximise its impact, can occur by:

- Requiring larger companies to invest in OH, supporting local delivery via Work Well etc, voucher schemes, and tax incentives for SMEs (DWP & DHSC, 2023).
- Early intervention in mental health and long-term condition management
- National standards to ensure consistent quality of OH provision (DWP & DHSC, 2023).
- Supporting training and broadening routes into OH careers
- Driving engagement from employers and policymakers (Charlie Mayfield Review).

Increasing access to Occupational Health - case study

Evidence provided to SOM from a leading car manufacturer showed that:

- 57% of workers who were absent from work and referred to OH for mental health reasons had returned to work by the time they were discharged.
- 68% of workers who were absent from work and referred to OH due to MSK were fit for duty by their final assessment.
- OH interventions led to an 80% improvement in anxiety levels and a 81% improvement in depression levels.
- Only 7% of workers referred to OH for mental health reasons required onward referral to a GP or other health professional.
- There is an average of 6 days wait for first appointment, much faster than NHS waiting times.

In another example, an energy company which used Occupational Health professionals to train their mobile technicians on how to look after their health, found this led to a 70% reduction in long-term injuries due to MSK and a reduction in sickness absence due to MSK by 80% within 1 year ref https://www.som.org.uk/occupational-health-case-study-smart-clinic

References:

Department for Work and Pensions (DWP) (2023). The Employment of Disabled People. [online] Available at: https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2023

Deloitte 2024 https://blogs.deloitte.co.uk/health/2024/05/mental-health-and-employers-the-business-case-to-support-employees-and-in-particular-working-parents.html

Department for Work and Pensions & Department of Health and Social Care (DWP & DHSC) (2023). Occupational Health: Working Better. [online] Available at: https://www.gov.uk/government/consultations/occupational-health-working-better/occupational-health-working-better

Health and Safety Executive (HSE) (2024). Work-related ill health and occupational disease statistics in Great Britain, 2023/24. [online] Available at: https://www.hse.gov.uk/statistics/

Office for Health Improvement and Disparities & The Health Foundation (OHID & The Health Foundation) (2024). Health, Work and Economic Inactivity. [online] Available at: https://www.health.org.uk/publications

Society of Occupational Medicine (SOM) (2022). Occupational Health: The Value Proposition. [online] Available at: https://www.som.org.uk/sites/som.org.uk/files/Occupational_Health_The_Value_Proposition_March_2022_0.pdf