STATES OF JERSEY

REPORT ON JERSEY'S INCAPACITY BENEFIT SYSTEM BY DR. LES SMITH, APRIL 2018

Presented to the States on 10th April 2018
by the Minister for Social Security

STATES GREFFE

Report on Jersey's Incapacity Benefit System

Dr Les Smith
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1 Introduction

This report summarises the review carried out by Dr Les Smith, Consultant in Occupational Medicine, of incapacity benefits within Jersey's contributory Social Security scheme. The review was conducted during October 2017 to January 2018 and commissioned by the States of Jersey Social Security Department.

1.1 Author Profile

Dr Les Smith MBChB MRCGP FFOMI MFOM CMIOSH CAvMed

Dr Les Smith is a Consultant in Occupational Medicine, Member of the Faculty of Occupational Medicine, an accredited specialist, a Fellow of the Irish Faculty of Occupational Medicine and a Member of the Chartered Institute of Occupational Health and Safety. He has a background in General Practice and is a Member of the Royal College of General Practitioners.

His previous positions have included Chief Medical Officer to Scottish Power Group, Medical adviser to Eon UK (Powergen) and Head of Employee Health Services for Pfizer.

He is an Appraiser and Examiner for the Faculty of Occupational Medicine and previously a tutor in occupational health.

His specialist expertise includes modern vocational rehabilitation based upon the Biopsychosocial model of health care, and the importance of clinical governance in developing quality-driven occupational health and wellbeing strategies/programmes.

1.2 Purpose and Scope

This work forms part of a major review of Jersey's Social Security Fund and the contributory benefits that are paid from the Fund. The current system of incapacity benefits was introduced in 2004 following the last major review of the scheme. The Fund pays out over £35 million a year in working-age incapacity benefits. This stage of the review combines academic research with local evidence to identify broad options that can be developed further as the overall Review progresses.

This report was commissioned to help inform a possible redesign of Jersey's Incapacity Benefits system. It would be geared to manage existing needs but also look to the future in terms of best evidence-based practice, as included in the expert reports commissioned by Jersey's Social Security Department. It is informed by identified inevitable changes in Jersey demographics and working practices over the next 20 years. The research carried out has included understanding the present processes and delivery of the services, and from an expert perspective identifying areas which could be improved. Services and policies have been explored and consideration given as to whether changes can and should be made.

This report meets these overall aims in two ways. It provides a peer review of the academic research undertaken by Professor Bruce Stafford and Dr Ben Baumberg Geiger, both of whom who have undertaken critical reviews of other incapacity benefit systems internationally. Initial information gathering was undertaken by the author to support the peer review including additional research to understand more fully the concept of "what works in work capability assessments" in the UK and Europe.

The second part of this review took the form of qualitative research on the ground in Jersey. It was important to gain detailed knowledge of the existing incapacity systems through interviews with SSD officers, and through undertaking interviews with individual Jersey health professionals and other key stakeholders. This involved canvassing their views on the local system, its strengths and weaknesses, and identifying core groups of practitioners who could support the development and delivery of any new system over the next five years.

To facilitate this activity the Donabedian Audit model was adopted. This helped to engage with key early adopters who may form part of the future working party to help to develop and implement the ideas and recommendations included in this first report. The Donabedian audit model is based upon a detailed review in 3 main areas: the structure of the present service, the processes undertaken, and outcome measurements.

In the author's view it was essential that the people of Jersey; politicians, stakeholders and especially employers; should recognise that the Review is conducted according to the underlying belief that being in work can and should enhance individual health and wellbeing. By improving the quality of the "service" provided by the benefit system, and by reducing an individual's time spent away from work, it should be possible to reduce the known negative effects of absence from work. The author has remained focussed on both the physical and mental health aspects of "worklessness".

A presentation to the Minister in late January highlighted the review's findings.

1.3 Brief history of Jersey Incapacity Benefits 2004-2018

2004

In 2004 changes to the Incapacity Benefit System were introduced.
Three new benefits were introduced –

- Short Term Incapacity Allowance (STIA). Benefit is paid (normally at the standard rate of benefit, which currently sits at £209 per week) to a working-age individual who is unable to work due to incapacity. The incapacity is normally certified by the individual's GP and the individual is not permitted to work whilst receiving this benefit. STIA claims can last a minimum of two days and a maximum of 364 days.

- Long Term Incapacity (LTIA). This benefit is paid to working age individuals who have a long-term loss of faculty. This is assessed by a medical board of doctors employed by Social Security. The individual is able to work and claim this benefit at the same time. The benefit is paid on a percentage basis (relative to assessed percentage of incapacity) and can be claimed until pension age.

- Incapacity pension. If an individual applies for LTIA and the medical board agrees that the individual is unlikely ever to return to work then an incapacity pension can be awarded instead of LTIA. This is based on the individual's contribution record. An individual receiving an incapacity pension is not permitted to work whilst receiving this benefit.

In particular, these changes introduced the "loss of faculty" approach to all claimants for long-term incapacity. Loss of faculty is defined as "any loss of power of function of an organ or part of the body which causes an inability to do things". A loss may be physical or mental. Loss of faculty is expressed as a percentage disablement.

The loss of faculty assessment had previously been used in Jersey in respect of long-term incapacity related to an accident or injury - it was originally taken from UK war pension

legislation which ultimately originates in the period following the First World War. A similar process was historically used in the United Kingdom for industrial accidents claims, and certain prescribed diseases. In recent times many comparable systems have moved away from this type of assessment.

1.4 2017 Review by Prof Bruce Stafford and Dr Ben Baumberg Geiger

Given the significance of the assessment process within the provision of working age incapacity benefits, the Department sought advice from two separate experts in this field.

In September 2017 Professor Bruce Stafford was commissioned to undertake a review on working age incapacity.

The author would describe this piece of work as a comprehensive, contemporary literature review of international evidence related to working age incapacity. It has been completed in context of an awareness of the States of Jersey's Strategic Plan 2015 to 2018, as well as the Island's Social Security review". The review was based upon the assessment of incapacity and took into account both the financial and non-financial support that people may require.

Also in September 2017 Dr Ben Baumberg Geiger (of the School of Social Policy, Sociology, and Social Research at the University of Kent) produced a report. It also advised Jersey's Social Security Department on working age incapacity. The author views this as a strong literature review which considers international models of incapacity assessment. It resulted in a concise report with very clear recommendations for Jersey.

The author's conclusion is that both reports have a great deal in common, resulting in broadly similar advice and recommendations, albeit with a wide range of suggested strategies. They represent a strong complementary approach in that the authors address the issue from different angles but reach a number of overlapping conclusions. This indicates that Jersey has key areas that should be addressed in any objective review of ways to redesign and/or modernise its incapacity benefit system.

The author reached this conclusion following a peer review of both research papers. Clarification was sought by meeting Dr Geiger at Canterbury University and through a telephone discussion with Prof Stafford. Some specific observations follow.

1.5 Overview of additional research undertaken

To complement the peer review of the academic papers, the author also undertook additional research to gain a working knowledge of Jersey's incapacity legislation. This was placed in a wider context of vocational rehabilitation in general by meeting with the UK's Department of Work and Pensions (DWP) and the Isle of Man Incapacity Team. The author also reviewed industrial injuries benefit assessments in the UK to more fully understand the use of Baremas (percentage disability scales) in this type of assessment The author also considered areas where public sector employers in the UK (for example local councils and education authorities) utilise a tiered approach in their ill-health retirement assessment process. Where a tiered approach is used, this is fundamentally based on a candidate being permanently incapable of undertaking their current role, and then whether or not the person is capable of undertaking other employment immediately, within three years, before their normal pension age or not at all before normal retirement age. The author wanted to understand this process as a possible approach in Jersey.

Further research was also undertaken to understand Jersey's recently-launched Mental Health Strategy and comparing this with IAPT (improving Access to Psychological Therapies)

services in the UK. The author also referred to meetings with UK Occupational Therapy providers and Occupational Physiotherapists to fully understand Functional Capability Assessments.

The author also drew on his own personal knowledge of the Guernsey incapacity benefit system and the recent changes that he has helped to develop and implement. There are useful comparisons, although it is clear that the role of incapacity legislation is different in the way that it interacts with the distinct working culture and the role of medical professionals in each island.

2 Professor Bruce Stafford report September 2017

Professor Stafford's paper on incapacity is based on the belief that whilst incapacity has no common definition, for the purposes used in benefit administration it usually means inability to do paid work. He uses different ways of addressing this concept to elaborate on the different types of models that are used to explain and assess the concepts of disability and/or incapacity. Foremost of these is the capability approach, which focuses on what people can do (functioning) and what they could do (capabilities). For Jersey's benefit system and similar models worldwide, in assessing incapacity the primary aim of the assessment is to verify entitlement to benefit, which has come to be inseparable from the perception of a total (or near-total) inability to work in most jurisdictions. However, the inherent limitations of the competing assessment models in addressing the scope of human experience demonstrate that work incapacity cannot be simply equated to a medical condition's functional limitation. Attention should always be paid to the interplay of other, multiple factors that can influence an individual's ability to work.

Professor Stafford's report confirms that there is no perfect system, no "one size fits all" and that Jersey should give strong consideration to developing its own bespoke benefit process. Whilst there is best practice, identified in this report and the report by Dr Baumberg-Geiger, there is nothing available "off the shelf" globally.

To elaborate, there are three broad approaches used by countries to assess incapacity:

- loss of functional ability;
- loss of earnings; and
- loss of faculty.

Jersey has adopted the loss of faculty approach to assess LTIA claims, which uses so-called Baremas scales, or impairment tables. In this method percentages are used to assess for incapacity, for example a percentage that arises from the loss of a limb. Prof Stafford states that the use of Baremas scales is controversial and heavily criticised; the author agrees and would point out that modern systems of incapacity assessment seldom utilise this model.

A previous review undertaken by Professor Stafford in 2007 also recommended changing the LTIA from a "loss of faculty" assessment to a functional assessment. Loss of functional ability appears to be the approach favoured in most countries with comparable objectives. The author agrees with this recommendation and is comfortable agreeing that Jersey should consider implementing a "loss of function" based assessment.

It is important to note that different jurisdictions structure their benefits differently. A key example is the role and responsibilities of employers, or whether there is one benefit to cover short and long periods of sickness or two. Likewise, intervention timescales vary. These factors complicate the range of recommendations offered by both academic reports, as there are many competing models to consider.

Professor Stafford's report identifies the Netherlands' approach for particular attention. It is recognised as being one of the most effective in terms of long-term outcomes and uses functional assessments.

In the Netherlands, strict screening of benefit claims is undertaken at six weeks' absence from work by an occupational physician. There is then a case management approach involving the employee, employer, and a case manager utilising a return to work plan with identified interventions on a timeline to return to work (reintegration). However, although Professor Stafford was impressed with the Netherlands' approach, he ultimately discounts its

appropriateness for Jersey's small population, in the main because of the high costs and resources required for delivery.

The author agrees with Prof Stafford in its overall unsuitability for Jersey. However a similar, more cost-effective and early interventional approach, with stricter screening of benefit claims, should still be considered. It is noted that STIA is presently awarded for an unusually long period of time, and earlier screening would enable this to be reduced.

Some other countries take into account non-medical personal factors when assessing incapacity. Such factors are currently excluded from Jersey's definition of incapacity and loss of faculty.

Professor Stafford's previous review in 2007 called for employers on the Island to have a more active role in sickness management. He also called for more research on employers' management of sickness absence. Whilst the report mentioned the use of financial incentives for getting employers more involved it did not recommend that employers should take responsibility for funding (short) periods of sickness leave, nor privatising Short-Term Incapacity Allowance. However, this latest review suggests that the earlier recommendation may have been too cautious.

This report highlights the importance of giving employers a much more strictly-defined role as is the case in the Netherlands. Employers need to be engaged with the SSD and understand more fully the importance of active line management in sickness absence. Training and educating employers is therefore one of the recommendations to be considered. The author met with employers' representatives, and this confirmed the need for educating employers in their role, as well as role of SSD. The author concluded that employers and HR professionals are likely to welcome a greater understanding of this process.

The high importance of the General Practitioner (GP) in certification was identified in the report. A lack of clarity, and of training in occupational certification, as well as general practitioners not always attaching sufficient importance to their role in this process, are known causes of poor work capability assessments. The author's interviews with GPs found this to be the case. Certifying doctors can often have limited knowledge of benefit rules. The Stafford report suggests solutions including training for general practitioners, and using occupational health physicians or multi-disciplinary teams. The research showed that General Practitioners trained to Diploma level in Occupational Medicine of the Faculty of Occupational Medicine were more likely to have positive attitudes towards their patients returning to work than those not trained. The complex nature of the patient-doctor relationship affects the issuing of certificates.

The author found that very few Jersey GPs are trained in the Diploma in Occupational medicine. A Jersey-based training course for General Practitioners, provided by a Consultant Occupational Physician, may be a quick short-term solution to consider.

In Jersey, Short-Term Incapacity Allowance does not allow claimants to undertake any work. Long-Term Incapacity Allowance, in contrast, is an in-work benefit that compensates for a loss of faculty. Professor Stafford's report suggested transitioning to one single work-focused benefit which measures incapacity and functional ability to undertake work. The author was able to confirm through stakeholder meetings that this would be a positive change and Jersey may wish to consider this.

Other countries have income maintenance and replacement benefits for short and long-term periods of incapacity. If Long-Term Incapacity Allowance were to be changed to a single assessment there would be a case for a compensatory "extra cost" benefit to meet the additional expenses that disabled people incur. This is as a result of social barriers and their

medical condition. The Social Security Department may therefore wish to also consider the introduction of a “Disability Extra Costs Allowance.”

The report confirmed the author’s experience that early intervention by vocational rehabilitation can have a vital role in returning an incapacity claimant to employment. Rehabilitation involves looking at what someone can do and their potential. Training in vocational rehabilitation for key stakeholders such as GPs is recommended.

Professor Stafford’s report also highlighted the need for strong anti-discrimination legislation, which would support employing people with disabilities both in the work place and applying for work. The need for workplace adjustments is required by law in the UK and the author has substantial knowledge of the importance of disability discrimination and work capability since the introduction of the Disability Discrimination act in the UK over 20 years ago. Jersey is in the process of introducing an anti-discrimination Law and in the author’s opinion this should have an important impact on the culture of the local employers.

Any changes to the present Incapacity Benefit System needs to be Jersey-specific, taking into account

- Population size
- Costs, resources and cost benefit
- Jersey demographics, an ageing population, migration.

New ideas, policies, and practices will need to be carefully adapted to Jersey’s circumstances if they are to be successfully implemented and effective.

In summary, the following suggestions were recommended by Professor Stafford’s detailed report and are supported by the author’s knowledge of Vocational Rehabilitation and Occupational Health and wellbeing.

Jersey’s Social Security Department may wish to consider these suggestions.

- Involve disabled people from the outset in the design of any reforms
- The Social Security Department and employers need to work in close collaboration both on policy development, but also on the delivery of services and even at the level of individual cases
- Financial incentives on employers and providers of rehabilitation services should encourage an early return to work. However, equally, benefits must provide a decent standard of living to those that are unable to do so
- Moral hazards in the system must be addressed. How far policy goes in tackling moral hazards needs to be carefully weighed, some policies if developed and implemented would be controversial (see below)
- Improving the quality of information used in benefit and assessment decisions will require clearly stated criteria, and transparency between the actors involved
- A “whole systems” approach to reform is required – in particular reform of incapacity benefits should not be considered in isolation from the impact on unemployed people
- Quality of decision making can be undermined by imprecise criteria, high workloads, incomplete information, staff shortages, poor quality assurance processes …. (see de Boer *et al.*, 2004).
- Having a departmental champion for mental, intellectual and cognitive impairments who is responsible for ensuring that claimants with these conditions are not disadvantaged in existing or future processes
- Staff training so that claimants experience more empathy as they journey through the claim and assessment process. This will involve explaining in accessible and user

friendly way the process, what is expected of them, what the outcome of assessment means, and what support going forward is available to them

3 Dr Ben Baumberg Geiger report, September 2017

Dr Geiger's report supported many of the findings of Professor Stafford's report, confirming to the author a consistent approach in both papers and similar recommendations.

Dr Geiger is also an academic and it was important to discuss his research in the context of the practicalities of implementing recommendations from both papers in Jersey from a practising Occupational Health expert's perspective.

Dr Geiger reviewed incapacity models from 10 countries and refined his summary to 3 types of disability assessments:

1. Structured assessments

   Structured assessments of work capacity are based on assessing the claimant's functional capacity and comparing this to actually existing jobs. The Netherlands model (also discussed by Professor Stafford) uses this approach and is internationally recognised to be best practice.

   However, both researchers recognised that given the large resources required it may not be possible to adopt such a system in a small jurisdiction such as the States of Jersey.

2. Demonstrated assessments

   This is based upon the actual experiences of the individual in the labour market to utilise a "demonstrated assessment of work capacity." This may involve work trials to try to find the work environment which most suits the individual.

   Again, this type of assessment also requires substantial expertise and investment and may not be feasible to introduce in small jurisdictions.

3. Expert assessments

   These assessments are undertaken by a professional who uses their expertise to judge whether an individual is capable of work. The current Jersey model uses experts (in different parts of the benefit system) to certify incapacity for work and loss of faculty. There will always be the requirement to manage concerns over the validity, consistency and reliability of their judgements. In the author's view Jersey should continue with the expert assessment approach but mitigate risk by ensuring that appropriate expertise, training and clinical governance is established. Standardisation of processes and procedures need also to be ensured.

Dr Baumberg Geiger thought that Jersey incapacity benefits are currently confusing and do not offer sufficient protection against incapacity to work. The author agrees, following stakeholder meetings. The current basis for the assessment of LTIA is entirely unrelated to modern conceptions of incapacity, and it was recommended to replace incapacity pension with a reduced work capacity allowance, complemented by adding an incapacity component to the means-tested Income Support benefit for those with insufficient contributions.
The report describes LTIA as an old fashioned Barema, which proves to be inadequate for assessing either incapacity or the extra costs of disability (the Stafford report also found this to be the most controversial element of the current system). Dr Geiger also recommended that LTIA should change to be more focused on the extra costs of disability, and rebranded by changing the name to "disability extra costs allowance".

The report recommended expanding the role of incapacity benefits and improving the accuracy of the assessments by ensuring that medical assessors have substantial occupational health expertise. Replacing or complementing doctors with allied health professionals with a greater understanding of work incapacity should also be considered. A structured framework and guidelines would help the assessors understand the threshold of reduced work capacity and improve the quality and rationale of the assessor's decision. This will require appropriate training for the assessor. A research study on the requirements of work in Jersey could be undertaken in the future.

The report also identified the importance of the claimant's perception, understanding and trust in the system and concurred with the Stafford report that this would be improved by a more transparent system. This would involve introducing a structured framework for the medical assessors, including communicating the reasons for the decision to the claimant. The 14-day deadline for appeals was also considered to be too short, the recommendation was that more time should be allowed.

The value of utilising incentives to experiment with work was emphasised in this report and in the author's discussions with Dr Geiger. Claimants should be allowed to test, experiment with work, do voluntary work, and also work flexibly i.e. change their hours of work or place of work.

A recommendation is made to consider allowing claimants to leave benefits, but to keep open the possibility of returning to the same claim, if they try to work but ultimately are not capable of it, perhaps if a fluctuating condition deteriorates. Claimants should be incentivised to work part-time alongside benefits, to a level they are considered capable of undertaking. This should not jeopardise their entitlement to incapacity benefits. The report also recommended that Jersey should again consider how best to provide early intervention to those with reduced work capacity.

Short-term incapacity is at present assessed by the claimant's GP. The report acknowledges that GPs are not necessarily the right professionals to be undertaking such assessments. Dr Geiger recommended considering whether the current timings of the system should be changed. This could include shortening the payment period with the incapacity assessment moved forward from twelve to six months. GP's would continue to perform the assessment but should be provided with additional guidance, training, reporting frameworks. This again is in line with the Stafford Report.

4 Stakeholder Interviews

The second part of the peer review task was designed to test the academic evidence against the views of a range of Island stakeholders who were familiar with the existing scheme and the local health service and labour market . It was essential to understand the particular needs of Jersey residents and businesses. Academic reports do not necessarily reflect the real life situation.

Structured interviews were undertaken with identified local knowledgeable people: key stakeholders within the Social Security Department; external stakeholders from Health and Social Services; Primary Care (general practitioners); Jersey-based charities; the local branch of CIPD; and the occupational health provider to the States of Jersey. This gave a much greater practical understanding of incapacity benefit from an occupational health and vocational rehabilitation perspective by the author.

The author also met with a senior officer of the UK's Department of Work and Pensions to get an update on the new UK fit note and a UK Government green paper: "Improving Lives: The Work Health and Disability Green Paper, October 2017."

Stakeholder Meetings

Internal meetings (SSD)

- Policy and Strategy Director
- Policy Principals (staff responsible for developing legislation and procedures to administer benefits)
- Head of the Income Support team
- Manager, Contributory Benefits
- Head of Governance
- Advisor, Occupational Support Unit
- Safeguarding and Occupational Support Unit Manager
- Employment Schemes Manager
- Work Right and Foundations Manager
- Health Zone Senior Advisor
- Senior Advisors, Income Support
- Risk and Quality Manager
- LTIA boarding doctor (author attended an LTIA Board)

External Meetings

General practitioners

- Co-Operative Medical Care GPs and Practice Manager
- Island Medical Centre Practice Manager and GPs
- Health Plus Medical Centre – Practice Manager and GPs
- Jersey GP (Castle Quay) who sits on Primary Care Board

Health and Social Services

- Director of Specialist Services, Community & Social Services / Professional Head of Psychology and Jersey Talking Therapies
- Senior Occupational Therapist
- Pain Clinic (Clinical psychologist)
- Consultant Psychotherapist
- Senior Psychological Therapist

Charities

- Director MIND Jersey
- Jersey Recovery College Manager

Jersey Chartered Institute of Personnel and development

- Jersey CIPD, Co-Chair CIPD
- CIPD Policy Committee HR Specialist

Occupational Health Provider

- Axa Occupational Health Physician and administration staff

The author also attended a GP Conference in Jersey and spoke at a monthly lunch-time Clinical meeting at the Hospital

Stakeholder interviews

The stakeholder interviews with SSD and HSSD officers were an essential part in understanding and gaining detailed knowledge of the existing systems, as well as the history of the present systems over the course of a number of years.

By meeting people who are users of the service or working within SSD this enabled the author to compare academic research into understanding what is actually happening “on the ground.” This approach will be invaluable if Jersey takes the decision to make changes to the system, as it will enable policy development to be conducted in the light of what is distinct about Jersey’s needs and experiences. At each stage, the author compared the broad principles identified in the academic research to the more complex realities that present themselves through stakeholder engagement.

Despite understandable dissatisfaction with elements of the system, all of the stakeholders interviewed were very keen to support this review and to provide ideas and evidence on how the SSD is functioning in its role as provider of incapacity benefits. This openness helped establish how the present system is viewed by stakeholders, its good and bad points and where improvements could easily be made. Further work will enable a critical analysis of what “best practice” might look like in a Jersey context.

4.1 Internal Stakeholders (SSD Staff)

4.2 STIA team

The author met the manager and team members of the operational team that processes STIA claims. They deal with over 25,000 claims year, paying out over £13 million in benefits.

Detailed comments on the operational aspects of the current system were collated and will be fed into the next stage of the review, when new benefit processes are being considered. The author discussed some of the shortcomings of the current system with the team and gathered valuable feedback on their ideas for improvements. Key areas are set out below.

In most cases, the claimant's GP completes a medical certificate which the claimant submits to the Department. The certificate is also used by the claimant to confirm their absence from work to their employer. Both research papers emphasised that it will be essential for all employers to take ownership of employee absence. However despite the employer receiving a copy of the certificate, the current system does not require the employer to take an active

role in employee absence. There is very little information provided on the current certificate to help the employer support the employee.

The inflexibility of the current STIA benefit also makes it difficult for employers to provide adjustments to support employees, for example, with a gradual return to work.

The research showed that several countries allow other allied health professionals to sign the certificate. The “treating specialist” such as a physiotherapist or psychologist may often have a better understanding of work capability and returning to work. For example, in Australia medical certificates can be issued by ten types of ‘registered health practitioner’, including pharmacists, acupuncturists, chiropractors and traditional Chinese medicine practitioners. However, general practitioners continue to have a key role in the return to work process. The current Jersey benefit legislation identifies general medical practitioners as the only type of health professional who can automatically provide sickness certification.

The research identified that STIA continues for up to 365 days and individual certificates for each episode can be far too long. Despite the length of the certification period there is little face-to-face or telephone contact with the claimant. The research identified the need for an earlier functional capability assessment and this should be considered between five and six months rather than waiting for an LTIA award after one year. Preceding functional capacity evaluations may also be of value. This could be undertaken by an occupational therapist or occupational physician trained in functional capacity assessments, or potentially by training Back to Work staff in the field of vocational rehabilitation and case management.

In order to have a more structured approach the author discussed the development of a new intervention timeline with the team. This would include a much closer involvement of the Back to Work team. The use of other health professionals other than doctors should also be considered. The previous review completed by Prof Stafford in 2007 and the latest papers both advised that local GPs could be trained to undertake a functional work capability assessment. More detailed objective assessments could be undertaken by an Occupational Therapist or Physiotherapist before, during or after the assessment board (if the claimant were found fit for some work).

The author recommends that specific strategies should be developed for the commonest health conditions, including mental health and musculoskeletal disorders. This would involve the use of occupational therapists trained in mental health. Psychologists and physiotherapists could also be engaged with the Short-Term Incapacity team and Back to Work team.

4.3 LTIA Team

The author discussed the assessment and processing of LTIA claims with the operational team that manages this process within the Department. There is considerable overlap with the STIA team in terms of long experience of administering the benefit. Further discussion was held with policy developers.

Most LTIA claims are triggered by a claimant reaching 364 days of an STIA claim. The claim process includes receiving a written report from the claimant's GP or hospital consultant and eventually attending a medical board. The medical board comprises one or two doctors and the medical board will allocate a percentage value to the level of loss of faculty, as well as a review date in the future at which next assessment should be undertaken.

The Department processes a significant workload of new claims and reviews across the year. There are currently over 4,000 claimants with total benefit cost of over £20 million a year. The

author received valuable feedback from the team which be fed into the next stage of the review.

The type of assessment undertaken to award the benefit is a percentage loss of faculty (using Baremas Scales). The evidence is clear that this type of assessment can be highly variable and inconsistent in outcome measurements. This was highlighted in both research papers, which recommend that this type of assessment should be changed to a functional work capacity assessment. It is no understatement to say that the current approach to assessment is a major cause of confusion for both claimants and their GPs.

The researchers recommended a change of name for the assessments. It was suggested that LTIA could be phased out and replaced with one Work Capability Assessment at 6 months. The long time period before the assessment (364 days) may mean that the number of ailments increases, particularly psychological health problems. The outcome is that multiple conditions may need to be assessed separately at the time of the board, rather than the single initial condition. Evidence shows that the longer someone is away from work the more difficult it is to return to work. This is commonly seen in cases of back pain, and many other of the most common ailments cited in long-term absence from the workplace.

The concerns expressed by both academics regarding inconsistency and variability on the part of boarding doctors using a percentage-based loss of faculty approach are not unexpected. This is a widely recognised problem in the assessment type. Fluctuating conditions are difficult to assess and it is known that mental health problems (particularly anxiety and depression) can even be made worse by the assessment.

If this method of assessment is to be continued, then high level clinical governance and training by experts needs to be undertaken, to ensure the best possible evidence-based outcomes. It is persuasively argued in the commissioned academic research that the current system is inconsistent. Clinical Governance would involve a continuous audit process of the clinician's work, in this case meaning the LTIA boarding doctors. This would include peer review, 360 degree feedback from colleagues, and a supportive pathway of continuous professional development and reflective learning. This is to ensure a quality management process is in place for the LTIA assessment. It would include a series of clear assessment protocols and a more systemic approach to the assessment in general - as recommended in the academic research.

The most common conditions assessed in LTIA are cases of mental health and musculoskeletal disorders. Consideration should therefore be given to having specific protocols for these cases, supported by the use of OTs trained in mental health as well as physiotherapists. At the present time the boarding doctor is the decision maker, and this should be changed to the Determining Officer – who is the decision maker for other SSD benefits.

Professor Stafford also recommended that rigorous re-assessments should be undertaken after medical board decisions; the author's view is that this should be actively considered as a means to address inconsistency and strengthen the quality of decisions.

4.4 Back to Work Team

As part of the overall response to the global recession, a significant investment was made in Back to Work Services in 2012 and the service has continued to evolve since then. With the recent improvement in the local labour market, the Department has made additional investment in providing specialist support for individuals who have significant barriers to work, including those with complex health conditions.

The author therefore prioritised meeting with those key staff members in the Back to Work team who are most likely to interact with incapacity clients. He met with managers and frontline staff from a number of smaller teams within the service. Engagement with employment-focussed teams provides a different perspective on a benefit system, and provide insight into services that can be developed to support incapacity claimants.

Back to Work offers a range of services including training and employment schemes such as Advance Plus for unemployed adults and Advance to Work for unemployed school leavers. The Work-Right team is the largest team supporting the unemployed and job seekers with potential barriers to employment.

The Occupational Support Team helps people with complex conditions such as mental health and addictions. A mental health nurse is employed within the team. Advisors are able to refer cases to Jersey Talking Therapies. They also work closely with the Occupational Therapist from the pain management clinic.

The Back to Work team does not currently include specific Occupational Health expertise or occupational therapists employed within the team. From the author's experience and work in the field of Occupational Health this is an area that SSD may wish to explore in the future.

Functional Capacity Evaluations (FCE) or Work Capability Assessments (WCA) are presently not undertaken. These determine a person's current physical or mental ability to perform work duties, to help them return to work, or find new employment. The assessment focuses on abilities rather than limitations and helps to identify if the person is able to match the demands of a job. Specialised Occupational Therapists are trained in undertaking FCE and WCA assessments. Occupational therapists could therefore be employed as assessors and produce a report that outlined what the person could do (a Capability Report) for employment advisers, as well as an assessment of the person's incapacity.

The academic research identified the importance of training in several areas including SSD staff, employers, claimants, doctors and other health professionals. The training courses already being undertaken could be expanded to include these training needs working with particularly mental health training organisations such as the Recovery College.

4.5 Health and Social Services Department Staff

4.6 Pain Management Services (Recovery and Rehabilitation)

The author spent a productive period engaging with Jersey's pain management services. The HSS Department includes a pain management service comprising physiotherapists, a psychologist and an occupational therapist. The pain clinic receives referrals to the service by their GP or hospital specialist. The services has a waiting list, and does not currently accept referrals from non-medical sources.

The need to meet with the pain management team emerged as an essential part of the review as chronic pain and disability is a very common reason for inability to work, particularly chronic back pain - which has become a global problem. The team treats a wide variety of painful conditions working with the consultant in pain management.

The team was very enthusiastic about utilising their knowledge and expertise to help people by preventing long-term absence from work, and the associated problems that come with it. They expressed a desire to work closely with SSD and to be part of any future coordinated approach to vocational rehabilitation and supporting patients returning to the workplace. The

perspective of this team offers a parallel with the employment advisors of Back to Work in that they are not directly involved in administering a benefit, but are of crucial importance to the client in helping them understand how their life can adapt to change brought on by illness. There will be considerable benefit to helping these teams share knowledge.

4.7 Mental Health and Jersey Talking Therapies (JTT)

The HSS Department has recently launched a new mental health strategy. One of the new services included is the Jersey Talking Therapy service, which is modelled on the UK model of the Improving Access to Psychological Therapy Service (IAPT).

The author met with the new HSS Professional Head of the Psychology and Jersey Talking Therapy Services and also with a High Intensity Therapist and team leader. The team take referrals from SSD sections, but also deal with Islanders who are less likely to engage with Jersey's benefit system.

JTT enables patients with common mental health problems, mainly anxiety and depression, to access treatment services based on a Cognitive Behavioural Therapy (CBT) approach, either as an individual or in a group setting. JTT currently provide services to patients referred via their GP or other HSS services. Back to Work can also refer, as well as the Pain Clinic, MIND and the cancer charity MacMillan.

The process is designed around what is known as a "stepped care approach" to the treatment of mental health problems. Low level advice and group therapy, combined with "signposting" advice is undertaken by Psychological Wellbeing Practitioners. Higher level treatment is by High Intensity Therapists who are able to offer individual CBT treatment for a defined number of treatment sessions. Cases with more severe or complex mental health problems are redirected to the secondary care mental health services.

Early access to psychological therapies, including but not restricted to Cognitive Behaviour Therapy, is recognised as being highly effective in treating common mental health conditions such as anxiety and depression. Early access to talking therapies is therefore essential in any vocational rehabilitation programme, to increase the likelihood of an earlier return to work. The author engaged with the JTT staff at a period when the service was still bedding in, and it has experienced the expected challenges in terms of resourcing. The present service is actively under review to further enhance the performance and quality that it offers the Island. The author was able to share experience and contacts within IAPT, and is enthusiastic about returning to discuss with JTT and learn how the service has progressed.

As identified in the academic reports, and contemporary literature on incapacity, it is impossible to underestimate the growing importance of joined-up support for common mental health problems amongst the working population. By creating conditions where JTT can work more closely with Back to Work and SSD there are great opportunities for a coordinated approach to supporting individuals back to work and addressing the long-term social costs of absence from the workplace.

4.8 General Practitioners and Practice Managers

The research papers emphasised the importance of the GP in incapacity and the need for training GPs in certification, in the role of SSD, and in occupational health and vocational rehabilitation.

It was therefore essential that the review included meeting GPs and to understand Jersey Primary Care. The author has previously been a GP and so has good insight into the work of

GPs and primary care. In addition to meeting several GPs for detailed conversations, the author was fortunate to network with most of the Island's GPs at a conference held in Jersey. He also gave a presentation on Vocational Rehabilitation to an audience of local GPs and hospital doctors at a regular education session at the General Hospital.

GPs are usually the first contact in the work capability process and their knowledge and understanding of vocational rehabilitation often comes to defines the subsequent period of work absence. The importance of this cannot be understated when considering the need to engage stakeholders in any review. In an ideal world the GP should be able to support and encourage their patients to return to work, a process that begins from the very first day of absence. A "workability" discussion should be part of the consultation and returning to work as an important measure in any clinical pathway.

Jersey General Practitioners work in private practice, mainly grouped in large medical centres around the Island - with a concentration in St Helier. Patients make a payment for the services they receive. The provision of most GP services in Jersey is based around a traditional "Family Medicine" approach where the individual GP is responsible for the primary care of the individual patient. This includes, for example, taking blood samples and other clinical procedures. There is limited use of practice nurses and ancillary staff. Consultations are mainly face to face, with little evidence of the growing trend of telephone consultations in the UK.

Conversations with individual GPs identified the significant gaps in understanding of the benefit system on the part of the GPs themselves and their patients. This is particularly true of the current system of LTIA percentage disablement assessments.

The GPs who were interviewed were keen to improve their working relationship with SSD and to better understand their role in sickness certification and how this might be improved. This is in line with the work carried out by the academic researchers who also identified the need for the development of a training and education programme for Jersey GPs, as well as improving communication overall.

It will be crucial to develop the relationship between SSD and primary care and to train general practitioners in vocational rehabilitation, occupational health and their crucial role in sickness certification. Some GPs were interested in developing skills and qualifications in occupational health. There is very little specialist knowledge of occupational health in the Jersey GPs interviewed, although a small number of GPs, especially those who are new to the Island, do have limited knowledge and hold the Diploma in Occupational Health. They also showed an interest in supporting SSD in undertaking a specific pilot study related to work incapacity in the future, as well as training programmes.

4.9 Jersey Charities

Charities are an important source of information and support for people suffering from a health problem. They are often up to date with the latest research and treatments available. They offer support help lines as well as signposting to online resources.

4.10 Mind Jersey

Mind Jersey is an independent mental health charity, affiliated with Mind in the UK. It provides support to people living with mental illness. It provides information, advocacy, care and family support and training It also runs a residential service for up to eighteen people experiencing acute mental illness.

The charity has a strong presence in Jersey life and is highly supportive of improving mental health and well-being in Jersey. It is actively engaged in raising awareness, and in working with employers to improve understanding of mental health.

The charity recently conducted a survey (January 2018), across all of the Channel Islands, which showed that 94% of the Islanders who responded believe that there is a stigma attached to Mental Health Issues. In the author's experience mental health in the work place is a major problem across the range of incapacity benefit systems. As noted in the section about JTT, there are major benefits to "getting this right".

SSD may wish to consider the benefits of working more closely with MIND in the future in the prevention and management of mental health at work. MIND would be supportive of this proposal, as they have identified problems in the workplace as being a driver of initial mental health problems and long-term worklessness.

4.11 The Recovery College

The author met with the manager of the Jersey Recovery College.

Jersey Recovery College is a community-based independent mental health charity. It offers education and training to people experiencing mental health difficulties. This help is extended to friends and families, but also professionals who may be supporting them. The recovery college evolved from work carried out under the States of Jersey Mental Health Strategy (2016-2020). This new strategy involved many of the stakeholders identified as part of this report, as well as staff from SSD itself. In some respects the Strategy is identified as the driver behind themes that were highlighted in the academic research.

As a newly established organisation the Recovery College is developing training programmes in mental health, with the aim of helping individuals and employers in understanding mental health. The college founder is keen to work with SSD by using the college training resource and training programmes for the unemployed, as well as claimants on incapacity benefit, to support a return to work.

SSD may wish to consider supporting this training resource as part of a mental health strategy within Back to Work. It will also prove to be valuable in testing ideas for benefit reform, as it is newly-formed compared to other charities and organisations.

4.12 Employers (initial information from Jersey CIPD)

To gain information on Jersey employers the author met with the chairpersons of the Chartered Institute of Personnel and development (CIPD).

The importance of the role of the employer in managing sickness absence was highlighted in the two pieces of academic research. Employers should be managing absence and be monitored to "check that they are doing what they should be doing" when an employee is absent. They should be following a sickness absence policy, checking for evidence of sickness and identifying temporary modified or alternative work.

Under the current benefit system, the Social Security fund provides for the cost of sickness benefits and there is no requirement under employment law for the employer to provide any form of statutory sick pay. A more proactive role from employers is likely to be a feature of any revised benefit system, and so attention should be given to areas that might benefit from a shift in the balance of responsibility between the employer and the government.

The CIPD confirmed that there is a strong feeling that the employers have delegated the management of employee sickness absence to the state, and that they are not undertaking a proactive and significant role.

The CIPD also confirmed that there is little access to occupational health services across the Island. Large employers may have access to UK-based occupational health services but SMEs (Small and Medium sized Enterprises) and local organisations typically do not use this type of service.

It is essential that SSD engages with employers and employer organisations at the very start of any review of the incapacity benefit system. This could include the CIPD membership, the Federation of Small Businesses (FSB), and the Chamber of Commerce. This is an area of stakeholder consultation which should be identified for immediate attention.

The CIPD offered to undertake a questionnaire-based analysis of their members to understand how organisations in Jersey manage the health and well-being needs of their employees, as well as the types of contractual benefits provided. This would enable SSD to understand more clearly what other benefits a claimant may be entitled to via their employer - such as Private Medical Insurance, Group Protection Income and Employee Assistance programme or Occupational Health.

SSD may wish to consider developing a specific strategic plan for supporting SMEs. The author understands that Jersey has a higher-than-average number of SMEs and that their views are important in considering many areas of employment policy.

5 Occupational Health

The author is qualified as an Occupational Health Physician and it was clear from the academic reports that the review needed to include insight into occupational health in Jersey. Occupational health is a specialist branch of medicine that focuses on the physical and mental well-being of employees in the workplace. The aim of occupational health is to prevent work-related illness and injury. Vocational rehabilitation is a key component of an occupational health service

Occupational health Services in the UK have expanded rapidly over the last 10 years and are an important factor in supporting return to work by individual case management. In comparison there is a major lack of occupational health expertise in Jersey. The only occupational health service identified on the Island is by a national UK provider for the States of Jersey employees. The author spoke to one of the visiting UK Occupational Physicians from the private occupational health provider who travels to Jersey from the UK on a regular basis.

The review has not established whether other companies, particularly in the finance sector and large retailers on the Island, may have occupational health support provided via the UK. Occupational health services do not seem to be taken up by the smaller companies which make up the majority of employers in Jersey.

Both academic experts identified that training was needed in occupational health particularly for GPs and Boarding doctors. Therefore, SSD may wish to consider investigating the introduction of occupational health services and expertise in the future. It is essential in any vocational rehabilitation programme and to support incapacity benefit, in the author's view.

5.1 Importance of Clinical Governance, Quality Assurance and Training

Clinical governance is achieved by a comprehensive mechanism for ensuring that high standards of clinical care are maintained by all health professionals. It aims to ensure that the quality of service is continuously improved. Good medical practice demands that all doctors registered with the General Medical Council are fully capable and competent of the work they undertake and have an annual appraisal to ensure that they are up-to-date, peer-reviewed, and demonstrate reflective learning and 360° feedback. There also has to be patient and colleague feedback as part of the appraisal process.

The current system of incapacity assessments uses local doctors. The author concludes that any review of the assessment process and design of a new benefit system should include an appropriate governance structure for the assessment role.

The academic research confirmed the author's view that a vital component of any assessment process is a robust quality assurance mechanism. There are various aspects of the assessment process that might be monitored.

- the coherence and integrity of the whole *system/organisation* and the wider *network* within which it is embedded;
- the skills, knowledge and experience of *professional and other staff*;
- the assessment *process*;
- *outputs* (such as the quality of any reports); and
- the *outcomes* (or wider impacts on society) of the assessment process.

The following measures could be considered to assure good quality control

- handbooks and guidelines,
- protocols and standards,
- staff development - training, coaching and CPD,
- case discussions,
- using more than one assessor for each case,
- using feedback from court cases.

5.2 Training Needs

The importance of training SSD staff, boarding doctors, GPs and employers was highlighted in the research reports.

A “training needs analysis” of staff may be considered including the establishment of a dedicated training and development function. This could include training for the boarding doctors as well as establishing a training programme for general practitioners. This would fulfil a doctor’s ongoing training requirement by the General Medical Council. This will also be a means of consolidating quality assurance and clinical governance.

6 Conclusion

In the limited time available to him the author was able to get an understanding and an overview of the unique aspects of the benefits system in Jersey. Whilst there are dissatisfactions with the current system he felt privileged to meet so many people who were so positive about supporting the review and improving the overall health and wellbeing of the population. This is not always the case, and is a strength the Island can and should draw upon.

When considering the history of work already carried out the author was very impressed by the forward-thinking initiatives that were started around the development of Income Support. It offers a strong model for the development of a new system and contrasts positively with similar reform attempts carried out in the UK. The preparatory work and delivery of an assessment process incorporated the use of eminent experts in the relevant fields, as well as the appointment of a highly-knowledgeable physician as Medical Adviser to the Social Security Department. The specific choice of academic experts to undertake more recent research reports is also to be highly commended.

The author notes that the current model of Incapacity Assessments was developed in the late 1990s. As highlighted in the research papers and by the author, this model is no longer appropriate for Jersey's changing needs. After speaking to all the stakeholders interviewed, both internal to SSD and external, there is consequently a strong desire for change and to refresh and review the present way of doing things.

It therefore became clear that the commissioned academic research is applicable to policy development for the Island, but also that further stakeholder engagement must be carried out in order to develop a system or systems that meet Jersey's unique requirements. The academic research offers clear steps that can be taken to move closer to firm suggestions for change.

There is a great deal of knowledge and expertise already existing in Jersey, which can be utilised to help inform and drive reform. Many of the stakeholders interviewed were very keen to be involved in supporting vocational rehabilitation. The author's view is that this is an opportune time to consider changes to the present system of incapacity benefit. It should be understood that whilst the research papers were useful in analysing other systems around the world from an academic perspective, overall there was no outstanding system to follow which would meet the requirements of the Island. In the author's opinion and from the knowledge gained during this review of the incapacity benefit system, there is no need for Jersey to follow other jurisdictions. The Island has the skills and resources to set upon the path of developing a world-class system which draws on best practice but is unique to itself.

Finally, it is important for policy makers, health professionals and the public in Jersey to recognise the strong evidence that "work is good for health and wellbeing" (Waddell and Burton 2006). Long term worklessness is detrimental to a person's health and well-being, and is harmful to both physical and mental health. Safe work is also the most effective way to improve the well-being of individuals their families and the community as a whole. To summarise the current thinking:

- Employment is generally the most important means of obtaining adequate economic resources, which are essential for material well-being and full participation in today's society;
- Work meets important psychosocial needs in societies where employment is the norm;
- Work is central to individual identity, social roles and social status;
- Employment and socio-economic status are the main drivers of social gradients in physical and mental health and mortality;

Conversely, there is a strong association between worklessness and poor health. There is strong evidence that unemployment is generally harmful to health, including:

- higher mortality;
- poorer general health, long-standing illness, limiting longstanding illness;
- poorer mental health, psychological distress, minor psychological/psychiatric morbidity;
- higher medical consultation, medication consumption and hospital admission rates.

Re-employment after a period of incapacity leads to enhanced self-esteem, improved general and mental health, and reduced psychological distress. Claimants who move off benefits and return to work generally experience improvements in income, socio-economic status, mental and general health and well-being. However, those who move off benefits but do not enter work are more likely to report deterioration in health and well-being. Conversely, recent research has identified the concept that “bad” work is not necessarily better than no work at all. Jersey will benefit not just from reducing long-term absence from the workplace, but from considering the quality of work and its effect on the individual’s health.

7 Appendix – Summary of 2007 Review (Professor Bruce Stafford)

In 2007 Prof Bruce Stafford was commissioned to undertake a report to review the policy changes to the incapacity benefit system in 2004, and to advise on issues which arose in the first 18 months post-implementation. The report recommended changes to improve the clarity and targeting of interventions, by making changes to the assessment process for greater transparency and by improving communications with key stakeholders such as doctors and employers.

His recommendations included:

- Change benefit names
- Use data analysis to give a profile of STIA to LTIA claimants
- Identify (local) barriers to returning to work
- Develop a screening process for early interventions (move to 5 weeks when possible)
- Identify requirements for Rehabilitation Services
- develop a test based on functional assessment for LTIA
- consult on levels of award
- develop job specification and recruit local GPs for advice and undertaking boards
- ensure key service providers have pertinent information on benefits available
- target benefit “training” to key agencies
- improve information to customers: award letters, leaflets on specifics
- promote a culture where work is seen as a positive for health (this will require support from H&SS)
- identify ongoing ways to directly involve practitioners in rehabilitation process
- consult with employers to identify support requirements