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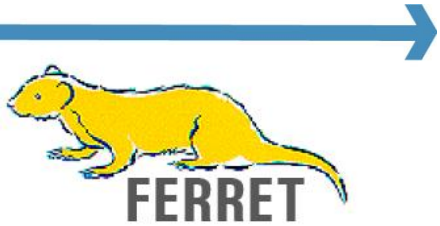

Social Security Review: incapacity benefits

Expert report on future design of incapacity benefits system

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1 Introduction

1.1 Background to review

The Government of Jersey is undertaking a multi-year review of the Social Security system, in order to ensure that it is fit for the future and is fiscally sustainable. A key strand of this has been a review of incapacity benefits, comprising the support (financial and non-financial) that is provided to working age people who experience ill health, injury or impairments. This review has included reports in 2017 from Professor Bruce Stafford and Dr Ben Baumberg Geiger on assessment models for incapacity benefits; and a report by Dr Les Smith in 2018 based on qualitative research with Jersey stakeholders and service users.

In this current stage of the review, the Institute for Employment Studies and Ferret Information Systems have been commissioned to advise on how the incapacity benefits system could be reformed in the future, in order to ensure that it can support people to better manage ill health and injury, to safely return to work where they are able to do so, and to be financially supported while they cannot work.

The review is looking at the whole system for supporting those who are affected by ill health – so including the short-term and longer-term financial support that is available; how individuals' entitlements and needs are assessed; how and when individuals are supported to prepare for and return to work; and the role of health services, employers, the Social Security system and individuals. It is intended to build on the previous work carried out in 2017 and 2018, as well as the government's recent commitments in its Disability Strategy and the Jersey Care Model.

1.2 Process followed for this review

The review commenced in November 2020 and has comprised three stages as follows.

1.2.1 Scoping – November 2020-January 2021

The first part of the review involved a desk-based review of the current Jersey model, previous reports and evidence supplied by the Government of Jersey. This was supplemented by data gathering on recent UK and international developments in work and health; early assessments of the potential impacts of the Covid-19 pandemic; and insights from review team members and government officials on what works.

The review team then conducted five consultation workshops in late November, engaging with a range of stakeholders in Jersey in order to gather feedback on the current system, key strengths and areas for improvement, and to test potential options and avenues for

future reform. Participants included political representatives and senior policy officers; GPs, hospital consultants and occupational health (OH) specialists; experts in disability, supported employment and benefits administration; employers, unions and HR and employment law specialists; and voluntary sector representatives. These workshops were then supplemented with a number of follow-up interviews, conducted by policy staff from the Government of Jersey.

1.2.2 Options appraisal – January-March

The second stage of the project involved analysis of findings from the first stage and development of potential options for future reform – in particular looking at short-term absence; longer-term absence; assessment models; return-to-work support; and the roles of employers, health services and the Government of Jersey.

This was then followed by two participatory workshops, which explored potential options for reform and scenarios for how individuals with different circumstances and needs could be supported. The first workshop was conducted with representatives from employers, health services, social partners and the voluntary sector; while the second workshop was with politicians and officials from the Jersey Government.

1.2.3 Proposal Development – March-May

The final stage of the project has been to develop proposals for future reform, drawing on the findings from previous stages. These proposals are set out in this report alongside findings from the review.

1.3 Review context – the current system

1.3.1 Financial support for working age people affected by ill health, injury or impairment

Jersey operates a contributory social security system for those who have to leave work due to ill health, injury or an impairment. On initial absence from work, workers signed off by their GP and who have paid social security contributions for a full prior quarter of the year are entitled to **Short Term Incapacity Allowance** (STIA) at £225 a week. STIA can only be paid when workers are fully off work – i.e. it cannot be paid during phased or partial returns to work – and is limited to a maximum of one year. There are around 25 thousand claims for STIA each year, although most are relatively short in duration (with half of all claims lasting seven days or fewer).

Those with longer-term illness or impairment can claim **Long Term Incapacity Allowance** (LTIA), which is assessed by a social security doctor and where payment is made as a percentage of the maximum standard award based on an assessment of the extent of the individual's 'loss of faculty'. Individuals can work while claiming LTIA, although as many as half of all claims do not do so. There are around 400 new LTIA claims each year, while the total number of claimants of LTIA has grown steadily over

recent years, from 3,600 at the start of 2013 to 4,400 at the end of 2019 – driven in particular by the ending of entitlement to Invalidity Benefit, meaning that many of those who would have claimed this benefit now claim LTIA instead. Two thirds of claimants receive less than half of the maximum award, with around one fifth receiving less than 20%.

In addition to the two Incapacity Allowances, individuals who have a low income and also meet requirements around continuous residence in Jersey can claim **Income Support** to top up their income. This does not have social security contribution requirements, and it includes a payment for disability support needs that uses a different, more modern assessment process based on assessing the individual's functional capability. Individuals can claim both Income Support and LTIA/ STIA, although the latter are treated as income for the purposes of assessing entitlement to Income Support.

1.3.2 Return to work support

There is no system-wide approach to support those who are off work due to ill health or injury to return to work, although a range of support is available through Jersey's wider health and employment services. In particular, the island's Pain Management Centre offers a range of services including support with back pain and persistent pain, physiotherapy, occupational therapy, psychology and multi-disciplinary support; while Jersey Talking Therapies provides free and confidential psychological therapy. In recent years there has been increased focus in health services on OH and work, with the new Jersey Care Model emphasising in particular the therapeutic and wellbeing benefits of good work.

In addition to health service support, the Jersey Employment Trust provides specialist employment and vocational training support for disabled people (funded through government grant and donations); and anybody who is unemployed and has been in Jersey more than 5 years (including those on STIA/ LTIA) can also access the government of Jersey's 'Back to Work' service, which supports jobseekers and employers to fill vacancies. Skills Jersey can also provide support with access to careers guidance, careers guidance, and pre-employment or workplace training.

Finally in some workplaces – especially the public sector – employees have access to OH support whilst in work or during any health-related absence.

1.3.3 Issues identified with the current system

The Jersey system has a number of important strengths. In particular, this review and previous work has found that residents really value their relationships with and access to their GPs, while the system for short term and self-limiting absences (like seasonal flu or recovering from accidents and injury) appears to work well. However, the research conducted for this review, as well as the reports carried out previously, identified a number of significant areas where the overall system is in need of reform. Four themes in particular stand out:

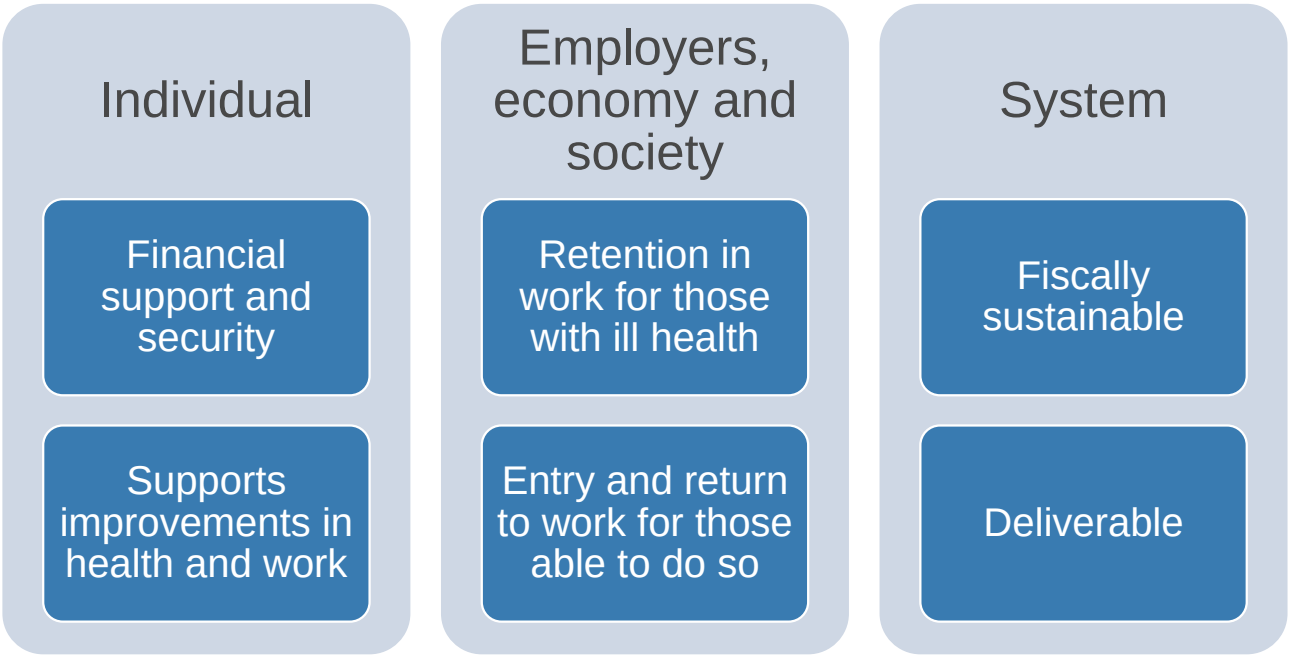
- The lack of any systematic approach to return to work support through the contributory Social Security system, or general availability of OH services for those on STIA or LTIA, means that many of those off work due to ill health or injury are not able to access tailored support that is focused on helping individuals to return to work (in their current or a different job).
- The design of the contributory benefit system does not encourage proactive management of health and returning to work – which is compounded by a benefits system that can disincentivise phased returns to work during the first year of absence (because STIA payment does not allow for any work).
- The assessment model for LTIA is outdated and inappropriate – using a 'loss of faculty' model which does not take account of the impact of the individual's health condition or impairment on their functional capability to work.
- The system is confusing for residents and employers, complicated to administer, and does not support effective collaboration between services (health, employment-related, social security and workplace).

1.4 Agreed aims and objectives of a new system

This review seeks to set out proposals for how the current system can be improved, and the issues identified with it can be addressed. In particular, this means moving from a passive to a more active model, and one that can support a more holistic approach to supporting good health, good employment and wellbeing.

During the review process, six key objectives for a reformed system were identified and agreed with stakeholders. These are set out in Figure 1.1 below and grouped around three themes: objectives for the individual; for employers, the economy and society; and for the wider social security system.

Figure 1.1: Key objectives for a reformed incapacity benefits system



Source: Institute for Employment Studies and Ferret Information Systems

Taking these objectives in turn, this means for:

- **Financial support and security**, that the system should seek to ensure that those unable to work have adequate financial assistance while they are out of work – which in turn means lower rates of poverty and insecurity, and less demand for emergency support;
- **Supporting improvements in health and work**, that people are better able to manage ill health and injury – resulting in improved health outcomes, higher employment participation, reduced absence from work, lower levels of incapacity benefit receipt and improved productivity;
- **Retention in work for those with ill health**, that fewer people leave work due to ill health or injury – which again would support higher participation, reduced absence and more productive and rewarding work;
- **Entry and return to work**, that those able to do so can return to work – in the right job – as quickly and safely as possible;
- **Fiscal sustainability**, that the costs of the incapacity system (both social security and support costs) can be met over the short, medium and longer term by citizens, employers and the state – with improved support and better outcomes ultimately feeding through into lower social security spending; and

- **Deliverability**, that changes can be effectively delivered by public services, health services, employers and civil society, and are acceptable to citizens and those accessing services.

Clearly there are interdependencies between these six objectives and many are mutually reinforcing, particularly around supporting improvements in health, employment retention and re-entry. Feedback from participants in workshops for this project were also supportive of the principles that (decent) work is supportive of good health, and that the system should support improved health management, retention and returns to work.

At the same time however, there are also trade-offs and no one set of reforms would be able to achieve all objectives perfectly. While good work supports good health, poor quality or insecure work can be damaging to health and a contributing factor in health-related absence – so focusing only on employment-related outcomes or only on health outcomes can miss the interaction between health, work and wellbeing.

There is also a trade-off between levels of financial support, the costs of return-to-work services and the fiscal sustainability of the system. There is a range of evidence that the benefits of effective health management and early intervention can more than pay for themselves in fiscal and economic terms, particularly around mental health[1] and musculoskeletal conditions[2]. In general, this evidence tends to point to the business benefits of reduced sickness absence, economic benefits of improved productivity, and fiscal benefits from lower health service and social security spending. There has been less analysis specifically on whether early intervention can pay for itself solely in social security spending, although there is a very high likelihood that it would do so in Jersey given that the direct costs of sickness absence are met through social security rather than by employers.

Overall then, our strong view is that in the medium to longer term, investments in good quality return to work services will lead to lower social security spending and a more sustainable system. However in the short run, we have also assumed that the up-front costs associated with providing new services would need to be met through short-to-medium term savings in benefit expenditure.

1.5 Structure of this report

The remainder of this report sets out key findings and proposals for each key aspect of the incapacity benefits system.

[1] See for example Deloitte (2020) *Mental health and employers: Refreshing the case for investment*, Deloitte, January 2020

[2] See for example Bevan, S. (2015) *Back to Work: Exploring the benefits of Early Interventions which help people with Chronic Illness remain in work*, Fit for Work Europe, April 2015

- Chapter 2 therefore focuses on how the system supports the management of short-term absence from work, including the design of STIA, the role of GPs and health professionals and how to support returns to work;
- Chapter 3 then looks at financial support for longer-term absence, the gateway to benefits, assessment models and the design of financial assistance;
- Chapter 4 discusses the design and delivery of return to work support, including different models of OH and rehabilitation, how services are delivered and the potential role of wider employment services and workplace support;
- Chapter 5 then explores the role of employers and wider health services in the incapacity benefits system; and
- Finally in Chapter 6 we discuss the potential sequencing of reforms and how different elements might be taken forward over the coming years.

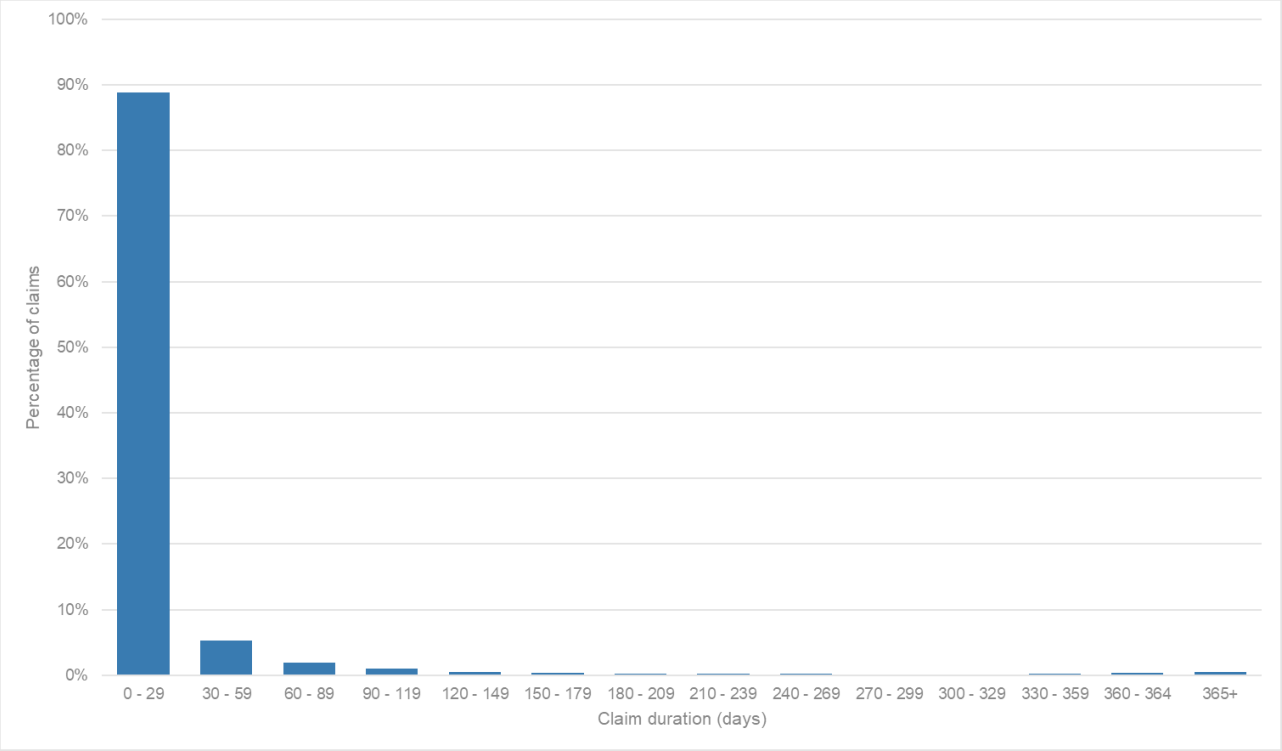
2 Managing short-term absence

2.1 Key findings from review process

2.1.1 The assessment and certification process

The desk-based research and consultations with stakeholders found that the process for being signed off work and starting claims for STIA appears to work reasonably well. As noted in Chapter 1, we heard that residents value their relationships with GPs; that GP services are accessible; and that the process itself is relatively straightforward for individuals and GPs. This was particularly the case for self-limiting and short-term absences like colds and flu or for injuries following an accident. Analysis for this review, shown in Figure 2.1 below, illustrates that the very large majority – nearly 90% – of new claims to STIA are closed within a month.

Figure 2.1: Duration of Short-Term Incapacity Allowance claims



Source: Government of Jersey NESSIE database, 2021 incapacity benefits review dataset

However while the process appears to be effective for the large majority of cases, one in nine STIA claims will last for more than a month – and the assessment and certification

process works less well where individuals may need more support to return to work and/ or are at risk of longer-term absence.

Previous reviews pointed to concerns around GP expertise in occupational certification, understanding of their role in the assessment process and limited understanding of the benefits system. In our consultations, we also heard a broad consensus around three issues: generally low levels of occupational health (OH) awareness and training; the need for a stronger focus in the certification process on fitness for work; and the need for earlier access to OH support where appropriate.

We would recommend taking action in all three of these areas. On **GP awareness and training**, many stakeholders emphasised that GPs do not need to be OH experts but do need to be able to provide initial advice and to refer on to specialist services where these are needed. If GP awareness is improved, then one option to **strengthen the focus on fitness for work** and to provide initial advice to patients and employers could be to develop an equivalent to the Statements of Fitness for Work (or 'Fit Notes') that have replaced sick notes in England, Scotland and Wales. These allow GPs to record where individuals may be able to return to work with changes to their hours, duties or workplace, and to include specific advice on supporting a return to work.

The third key issue, around **access to OH support**, is covered in section 2.1.3 below.

2.1.2 The level and duration of financial support

We heard in consultations that STIA provides a decent if not overly generous level of replacement income – with £225/ week equivalent to just over a third (37%) of median wages in Jersey, and more than half of average earnings in low-paying sectors like retail and hospitality. By comparison the UK Statutory Sick Pay (SSP) is equivalent to just one sixth (16%) of average earnings.

There are arguments for having a higher rate of replacement than this, to reduce the financial shock of lost earnings. In a number of European countries like the Netherlands, Germany, Denmark and Ireland, as well as in Japan, replacement rates can be two thirds of usual wages or higher – financed through higher employer and employee contributions. However there are also arguments for a relatively low rate given that most absences are short, and lower rates means lower contribution costs. Overall we did not hear compelling arguments for making changes to the level of financial assistance, and no support for increasing contribution rates.

However a related issue raised by stakeholders was the costs of GP appointments for certification, and particularly the impacts of this on lower-income residents. We did not quantify the scale or extent of these impacts, but the recent introduction of a new health access scheme that will limit the cost of GP consultations to £12 for low income households is a very positive step that should help to address this issue for many households.

As noted in Chapter 1, STIA is described as a short-term benefit but can be claimed for up to a year. Previous reviews have considered that this is an unusually long period for a

short-term sickness benefit to be paid, given that in the UK by comparison statutory sick pay is time limited to 28 weeks. Again looking internationally, practice varies and it is not uncommon for sickness benefits to paid for a year or longer – although there are notable examples where entitlements are time limited at less than six months, including Denmark (which has among the highest replacement rates) and Canada. However, it is also important to note that many other countries do not have as clear a distinction between 'short term' and 'long term' sickness benefits, with individuals having to fall back on means-tested social assistance at the point when entitlement to sickness benefit is exhausted (in Jersey by comparison, LTIA is available indefinitely and can be paid alongside means-tested benefits like Income Support).

Reducing the time limit for STIA, for example to six months, would have two implications:

- First, it would release some savings that could potentially be reinvested in other support – although given that only 2% of claims last for more than six months and many of these individuals would be entitled to the longer-term benefit, then these savings would be small (likely less than half a million pounds per year).
- However importantly, it would bring forward the point at which longer-term support needs (financial and return to work) would be assessed. This would support earlier intervention than now, but given the criticisms of the LTIA assessment process raised during our consultation it would also need to happen as part of wider reforms of the assessment and support for longer-term needs (as Chapter 3 sets out).

We found broad support in our consultations for reducing the maximum time that STIA can be claimed for, and in our view it would be beneficial to assess longer-term support needs at an earlier point in absence. We would therefore recommend reducing the STIA time limit to six months in future.

2.1.3 Supporting returns to work

As noted in section 2.1.1, there was a strong consensus among those consulted for this review that the current incapacity benefits system needs to provide earlier access to rehabilitation support for those who are off work and either unable or unlikely to return to work quickly, so as to reduce risks of long-term absence and prevent further work impairment. The evidence base for early intervention is also very strong, as Box 1 highlights (from an international review of early musculoskeletal (MSK) interventions).

Box 1: Clinical and economic benefits of Early MSK Interventions

Effective early intervention can:

- Reduce sick leave and lost work productivity among workers with MSDs by more than 50%. Early intervention is commonly more cost-effective than 'usual care';
- Reduce healthcare costs by up to two-thirds;
- Reduce disability benefits costs by up to 80%;
- Reduce the risk of permanent work disability and job loss by up to 50%;

- Reduce the risk of developing a co-morbid mental illness
- Deliver societal benefits by supporting people with work-limiting chronic conditions to optimise their functional capacity and remain active at work and maintain economic independence

Bevan, 2015

Clinical studies show that intervention as early as within five working days for those with MSK or common mental health problems increases the probability of successful return to work, and there is growing consensus among OH practitioners that interventions no sooner than 2 weeks and no later than 4 weeks are the optimal timing. This allows the many people whose condition resolves within 10 working days to recover and return to work without intervention (or risking over-medicalising relatively minor ailments – 'creating your own patient' as one OH professional told us). At the same time, interventions after four weeks of onset can risk exacerbations of several conditions and make the successful management of return to work more difficult.

Given that we are proposing a shorter STIA period of six months, and that STIA continues to be a cash benefit where assessment and certification is predominately initiated by GPs, it would seem appropriate that return to work support during the STIA period would be delivered through onward referral by GPs or other healthcare professionals, and that any new funded service would be a relatively light touch but specialist intervention, which could then refer on to more intensive support based on clinical need (including existing provision like the Pain Management Centre or Jersey Talking Therapies, or more specialist OH provision described in Chapter 4).

Good practice examples

There are a number of examples of similar models and services that Jersey could learn from and build on, particularly in the UK, Austria, Ireland and the Netherlands. In England, a number of local areas have been trialling models of early referral from GP surgeries into specialist early intervention support, delivered by non-clinical staff trained in case management working with clinical Occupational Health professionals. Most notably, pilots in Leicester and Newcastle (of a service called 'The Link') have trialled physical co-location; while a new service in Greater Manchester (called 'Early Help') has trialled rapid access to remote patient/ employer support following GP and employment service referrals.

Both of these models build on the evidence from earlier trials of a 'Fit for Work Service' in England, which offered telephone-based support for those who had been off work for at least six weeks, with referral via GPs or employment services. The service offered OH assessment, return to work planning and then remote case management. Evaluation evidence for the service found significant implementation problems, particularly around low awareness among GPs and over-use by larger employers. Both The Link and Early Help have sought to address these issues by focusing on GP and health service engagement, awareness raising and partnership working.

However the Fit for Work Service evaluation also suggested a number of key success factors in delivering support – particularly around intervening at the right time; having strong links with primary care; the importance of having specialist OH practitioners (even where support was being delivered remotely and was relatively light touch) ; and on having return to work plans that can then align with the GP 'fit note' certification and access to wider supports (both health support and wider issues like debt, housing and family – again a focus in The Link model).

As noted, a number of other countries have similar models of early access to OH support, albeit with very different contexts. Most notably in the Netherlands, employers are required to contract with OH professionals to provide diagnosis, assessment, a return to work plan and case management for any employee off work for six weeks or more. This was introduced as part of a wider set of reforms to disability benefits, which have been extensively evaluated and shown to have reduced disability benefit receipt and health-related absences from work.

An 'early intervention' model for Jersey

Based on these models and the feedback from the consultation process, we believe that there would be significant value in investing in specialist OH support that could be made available for those claiming STIA and absent for between two and four weeks. Based on our review and discussions, we would recommend that this should be:

- Developed in consultation with GPs and existing health services, to ensure that its design meets Jersey's needs and that there is engagement and support for the model;
- Referred in to by GP surgeries and other healthcare professionals, with GPs trained and supported in identifying when referral would be appropriate;
- An OH assessment, alongside development of a return to work plan, ongoing case management and support, and employer advice;
- Delivered either remotely or in person – this is a key design decision that should be taken in consultation with GPs, in our view there are strong arguments in favour of remote delivery (as this allows for lower transactional costs and greater specialism) but also a strong case for physical co-location (which supports referrals, joint working and sharing of expertise);
- As far as is feasible, directly linked to certification – so the return to work plan would inform the advice given to the employer and patient on supporting a return to work; but would not be linked to benefit payment or conditions; and
- Able to then refer on to more intensive and specialist support where necessary, based on clinical need – for example Jersey Talking Therapies, given that a quarter of longer-term STIA claimants have a main condition related to mental health; and the Pain Management Centre given that one fifth have a musculoskeletal condition.

In Chapter 4, we set out in more detail the evidence and design features for effective occupational health and rehabilitation support, and propose the development of a broader 'work and health centre' model that could provide tailored support to those reaching

longer-term absence. So we would propose that this early intervention service would be an integral part of this wider Work and Health Centre, providing early intervention support and onward referral.

Potential volumes and costs for early intervention support

It is difficult to make precise estimates of the demand for a new service, but we believe that 'The Link' model trialled in Newcastle and Leicester gives us a good basis for estimating potential volumes. The Link model served overall a 'working age' population of around 100,000 people across the two cities and ran between March 2019 and February 2020, with 269 engagements over that eleven month period (with the majority of these occurring during a six month period). The average unit costs were £600 per engagement, which are in line with the Greater Manchester Early Help pilot, but somewhat below the £1,000 average cost in the Fit for Work Service.

The working age population in Jersey by contrast is around 65,000 (so approximately two thirds of that served by The Link), so at the same take-up rate and with broadly the same point of intervention as for The Link service, this would imply around 200 engagements a year. However we believe that it would be prudent to assume a somewhat higher level of engagement for an established and well-embedded Jersey service, and so would recommend budgeting for 300-500 engagements per year at an annual cost of around £250-350,000. This would be equivalent to being able to support a fifth to a quarter of all of those reaching a month on STIA, which feels reasonable.

2.1.4 Supporting flexible returns to work

There was strong agreement among those consulted that the current STIA rules that prevent individuals from working while claiming the benefit need to be reformed. In many cases those returning to work after an extended period off will do so on an initially phased basis, or may come back on reduced hours and duties. This can support both earlier returns to work and also minimise risks of individuals falling out of work again. The design of STIA on the other hand, by making individuals choose between the benefit or their wage, risks encouraging individuals either to wait too long or to come back too soon.

A number of countries have 'partial capacity' benefits that allow for individuals to return to partial work at a reduced rate of benefit for a period of time (including in Ireland, Denmark and Austria). These can either be paid at a flat lower rate for a period of time, or tapered off as hours and earnings improve. In the UK, there is a similar but more limited system of 'permitted work' that allows for partial working while continuing to claim benefits.

However while there are clear potential benefits from allowing partial work and partial sick pay, there are also risks – by introducing complexity into the system (particularly if it leads to the benefit in effect becoming means tested and so requiring the reporting of earnings and hours); and potentially creating risks of unintended consequences (and/ or abuse) whereby partial sickness benefits are used to 'top up' short-time working or where it becomes the default approach to allow for STIA run-ons as people return to work. This latter risk could be particularly significant, as even a small increase in average durations

on STIA would lead to significant increases in costs (of around 5% for each additional day in average STIA duration).

On balance however, we think that the benefits of reforming the rules around working while claiming STIA would outweigh the risks, if it is designed carefully. We would therefore propose that this is explored with a view to being taken forward, with three key design features:

- For simplicity, allowing STIA to be paid in full rather than at a reduced, tapered or means tested rate, regardless of the hours worked;
- This is time limited for two months, as a reasonable period for supporting a phased return to work (i.e. those who have worked continuously for two months would stop receiving STIA at this point); and
- To minimise risks of unintended consequences, payment of STIA in work would be linked to the agreement of the employer and appropriate health services. We think that the best way to achieve this would be through the new 'early intervention' service, with the GP (or potentially, an AHP in the early intervention service) then certifying this.

Given the risks and uncertainty around potential impacts of these changes, we would also recommend that the payment of full STIA is reviewed annually over the first few years of implementation. If there is evidence that this may be leading to significant increases in average STIA duration, then we would recommend considering paying in-work STIA at a reduced rate or potentially linking it to hours worked.

2.1.5 Employer based payments and work-related conditionality

Finally, the review has also considered but ruled out making changes in two further design elements that are common in overseas approaches: employer (co)funding, and introducing requirements on individuals to undertake work related activity.

On **employer funding**, many countries require employers to either pay sickness benefits themselves or to contribute substantially to their funding through social insurance. In Germany for example, employers pay for the first six weeks of absence; in France it can be up to 18 weeks; in Italy 36 weeks and in the Netherlands up to two years. In the UK, Statutory Sick Pay is paid by employers for the first 28 weeks of absence for most employees.

There are strong arguments for employer co-funding, as it should give employers a stronger stake in supporting rehabilitation of their employees. However these benefits are not always clear cut, with employers in the UK for example generally under-investing in OH support; and even in the Netherlands there have been a range of additional regulatory requirements to encourage or compel employers to support rehabilitation (as noted above). Consultations for this review found no appetite, and could not see any compelling benefits, for introducing employer funding of sickness absence in Jersey. However there was strong support for being clearer about the requirements and responsibilities that

employers should have in supporting good health at work and effective returns to work for those who leave. This is set out in more detail in chapter 5.

Work related conditionality most commonly comprises requirements to agree an action plan, attend regular meetings and undertake agreed activities to prepare for work. This has been a common feature in the UK over the last 15 years, but also exists to an extent in other countries including Sweden and the Netherlands. It is far less common – and ethically challenging – for benefit conditions to be specifically related to undertaking health-related activities (i.e. making benefit payment conditional on treatment).

While there is a prima facie case for using work-related conditionality to encourage behaviour change, international evidence suggests that the practicalities and consequences of this for those with significant health conditions can often be so difficult (and counterproductive) as to outweigh any positive benefits. In particular, evidence suggests that the threat of benefit withdrawal for non-compliance can be particularly harmful to the health of people with underlying health conditions; and that where sanctions are applied they can cause significant harm. Based on this evidence, and a lack of support for this amongst stakeholders, we would not recommend strengthening conditionality for those claiming STIA.

2.2 Proposed approach

Drawing together the findings and proposals set out above, we are recommending significant changes to the support available during shorter-term absence from work, but within the broad framework of the current STIA system. In other words we are proposing reforms that will *build on* rather than *replace* STIA.

Specifically, we recommend:

- **A programme of awareness raising and training for GPs**, in particular focusing on raising awareness and encouraging engagement with the new early intervention service, improving understanding of the (reformed) STIA, and encouraging greater understanding around key principles of OH assessment, return to work planning, work adaptation and onward referral (perhaps including by funding or co-funding access to professional development in these areas);
- **Development of a 'Fit Note' approach to certification** – to allow GPs (and potentially, allied health professionals working in the new early intervention service) to set out what work people *may be able* to do, and advice for patients and employers on how to support effective returns to work;
- **A shortening of the maximum duration of STIA to six months**;
- **Co-design and then commissioning of a specialist early intervention service**, as part of a wider Work and Health Centre model described in Chapter 4, with the early intervention model accessed via primary care and providing return to work assessment, advice and support to those out of work for around four weeks; and

- **Extension of STIA to support phased returns to work**, where this is agreed/ recommended by the new early intervention service and time limited for up to two months. The level of payment should be reviewed annually in order to minimise any risks of unintended consequences.

In our view, these proposed reforms meet the objectives set out in section 1.4 – in particular they are deliverable, will support improved health management for individuals, and would improve both retention in work and returns to work.

Our strong view is that in the medium term these reforms would also lead to fiscal savings, and even in the short term should be self-funding – through a combination of the (modest) savings yielded from shortening STIA alongside a reduction in claim durations due to improved returns to work and health management.

3 Financial support for longer-term incapacity

In considering potential changes to support for longer-term health conditions we have been able to consider a wide range of reviews, comments, and experience of the operation and intentions of the current system. In particular we focussed on its role supporting claimants both financially and in their return to the workplace.

From these considerations, it is clear there is wide consensus that the current system does not deliver in its aims in the current environment. We find no reason to disagree. The current system of support cannot achieve the aims and objectives that would be necessary in any modern system and, given the other requirements of Jersey's employment market and system for illness/disability support, change has to take place.

Fundamental reforms to the LTIA system are needed to achieve the necessary change, and we believe that the climate of agreement which exists around this offers an opportunity to consider and implement fundamental improvements. This would be aligned with our other proposals around support for individuals and the workplace, described elsewhere in the report.

3.1 The current system

The current basis for financial support of those with illnesses or disabilities that last for a longer period is based on Long Term Incapacity Allowance (LTIA). LTIA is a weekly benefit, payable every four weeks as compensation for a loss of faculty. It is a contributory benefit, with eligibility dependent upon the payment of sufficient contributions for a total of at least 6 months, before the end of the current quarter and at least one month's contributions, paid or credited, in the relevant quarter. 'Sufficient contributions' are determined by earning over the lower threshold level. For self-employed earners, the claimant must have paid Class 2 contributions at the required level. Late payment of contributions will disqualify applicants from LTIA awards.

It is possible to work whilst in receipt of this benefit, although in practice many people do not return to work after a prolonged absence that leads to an LTIA award. Following an LTIA award, data from Jersey's Customer and Local Services Department showed a significant effect on both economic activity (working at all) and on earnings levels even when the person did return to work.

3.1.1 Percentage Awards and claim patterns

The medical assessment is intended to find out the level of impairment of an illness or disability by comparing them to a person of the same age and sex who doesn't have the

illness or disability. A percentage impairment is assessed which is then used to determine the rate of benefit to be paid, if any.

These percentages are generated by the Barema method, which is an arbitrary ordinal scale which attaches progressive percentage values to define disabilities based on loss of faculty. The disabilities of the claimant are compared to those in a table for which there are scale values and a percentage is thereby obtained. This is an outdated method which is increasingly falling out of use elsewhere.

- Assessments of below 5% do not lead to an award.
- Assessments between 5% and 15% lead to a single lump-sum payment calculated for a specified period.
- Assessments over 15% will qualify for the percentage assessment, applied to the maximum LTIA rate, paid every 4 weeks in advance.

As referred to in previous expert reports, the average percentage rate of assessment for LTIA claims in payment in 2017 was 37%. This percentage had remained more or less constant over the previous five years of data and the claim average continues to lie between 35% and 40%. This suggests that there has been no significant increase or decrease in the average percentage award of a claim.

The average degree of incapacity assessed for the most common conditions, in 2019, was:

- Depression 40%
- Pain - Back 29%
- Injury – Back 31%
- Anxiety 37%
- Accident/Injury (Other) 39%
- Stress 36%
- Carcinoma 60%

The maximum rate of benefits at 100% assessed incapacity is currently £224.98 a week. This matches the STIA rate.

Although LTIA is typically applied for on the expiration of STIA it may be claimed earlier. LTIA may be paid, unlike STIA, while work is being carried out and this is often the reason for an earlier claim, even though LTIA will in the majority of cases be paid at a lower rate than STIA. LTIA may be paid for many years until pension age. The existence of lump sum cash payments for smaller awards (between 5% and 15%) is thought to lead to a culture of deliberately small claims. Government of Jersey staff report anecdotal evidence that some claimants may apply for LTIA with the aim of a smaller immediate gain rather than the possibility of a regular payment spread over a much longer period.

Receipt of LTIA may entitle the recipient to credits of Social Security contributions for assessments over 20%. The length of time for which contributions can be credited reduces as the percentage assessed reduces.

3.1.2 Medical assessment: loss of faculty

The assessment of the applicable percentages for each applicant is carried out by specialist doctors with experience in these assessments, making use also of GP reports and other evidence.

The current loss-of-faculty percentage-based approach used to determine the value of benefit provided, has little direct relevance to the capability of work or barriers to working. This becomes relevant when it is considered that LTIA is not intended to operate as a "financial safety net" in the Jersey context, with this role being played by Income Support, albeit with greater restrictions on entry. LTIA is a working-age benefit available to people who have been in employment, and following consultations with local stakeholders we believe it should be viewed in terms of its role in the Island's contributory insurance model; this suggests a greater importance should be placed on the practical effect on the claimant of the illness or disability which might make it more difficult for them to remain in work. Understanding the ways in which work may become more difficult, and supporting return to work initiatives, needs a clearer assessment that takes a more appropriate view of the health barriers facing the claimant.

It has been recognised in previous studies that the faculty-based model of a Barema scale currently used for LTIA assessment is inappropriate, and largely discredited, as a way of assessing the need for longer term financial support because of health difficulties. Few administrations now use this type of measure, as its measurements offer little of objective value to the needs of the client group.

In practice the arbitrary values assigned to the Barema scale do not measure the capability for work, nor wider participation in society, nor the incapacity preventing it. The scale functions more closely as a disability compensation payment and even there it bears little relationship to actual extra costs related to any impairment. The use of the scale was a Victorian modernisation of a legal concept (going back to Saxon "wergild" and beyond) of direct compensation for personal injury. In its time it was seen as rationalising the appropriate compensation for schemes that predate insurance-based social security schemes and was therefore adapted for a state-run compensation scheme for those suffering an injury - primarily in heavy industry or the armed services – to cover for the absence of a liable/ person or entity from which legal redress could be sought. Scales of direct physical injury may have been more relevant and the system has subsequently attempted to add flexibility by allowing a process of drawing equivalence. The problem this creates shows up particularly in mental health, where Victorian understandings were very different and so modern day classifications are often contested. Percentage-based awards may look objective but can be arrived at by a very subjective process, depending on the view of a particular assessor. Barema scales may still have a place in quasi-legal compensation schemes for mainly physical injury, but are less fit for purpose for a general incapacity benefit wanting to make awards more closely based on limitations on work.

The lack of a clear articulation about the purpose of the assessment leads to considerable stakeholder confusion around the transition between long and short-term incapacity benefit, where some continuation of STIA level of cash benefit or equivalent is often the expectation. Instead, except in the most severe cases, a drop in financial support takes place, which is often substantial and may be unexpected. This occurs even where there is no measurable change in condition. Government of Jersey staff report widespread dissatisfaction and confusion attached to the transition from STIA to LTIA.

LTIA offers little to encourage and support those seeking to return to work, other than bolstering income for those disadvantaged in work. It also does not identify the strengths of claimants, which could then be worked with and built upon. This could potentially address additional negative trends within the system, such as the under-employment of persons with disabilities or long-term absence resulting from certain types of treatable health condition.

3.1 Potential approaches to assessment and entitlement

There are a number of ways that other governments have sought to look at the effects of an illness or disability on the claimant's ability to function. We believe that Jersey requires a new model for assessment of long-term conditions, and that there are good models that can be adopted to provide this.

3.1.1 Examples of 'real-world' assessment

As opposed to the loss-of-faculty approach, 'real-world' assessments use a mix of medical diagnoses and assessments, typically using the International Classification of Functioning, Disability and Health (ICF) from the World Health Organisation (WHO). These assessments, and the support offered, are more individualised, typically requiring a range of specialist skills to deliver including a specialty in more modern bio-psycho-social assessments.

Examples include:

- The Craig Handicap Assessment & Reporting Technique (Chart) in the USA, where six measures are assessed:
  - Physical independence – the individual's ability to sustain a customarily effective independent existence;
  - Cognitive independence – the individual's ability to sustain a customary level of independence without need of assistance;
  - Mobility – the individual's ability to move about effectively in his/her surroundings;
  - Occupation – the individual's ability to occupy time in the manner customary to that person's sex, age and culture;

- Social integration – the individual's ability to participate in and maintain customary social relationships; and
- Economic self-sufficiency – the individual's ability to sustain customary socio-economic activity and independence.

- The Australian Job Capacity Assessment (JCA), is a comprehensive assessment of an individual's level of functional impairment and work capacity, usually conducted to assist in determining qualification for a Disability Support Pension. The assessment identifies a person's:
  - Level of functional impairment resulting from any permanent medical conditions;
  - Current and future work capacity (in hour bandwidths); and
  - Barriers to finding and maintaining employment and any interventions/assistance that may be required to help improve their current work capacity.

  JCAs are conducted by job capacity assessors. As part of the assessment process, assessors have access to relevant available information about the person, including details about current and past medical conditions and disabilities, and prior participation and employment history. Assessors can also liaise with treating doctors and other relevant health professionals as required.

Whilst Jersey may not wish to adopt these methods wholesale, they would offer good evidence for the efficacy and aims of an assessment method which considers the effect on the claimant of the illness or disability in terms of making it more difficult for them to remain in work.

3.1.2 Functional Assessment

We echo the recommendations of previous expert consultants employed by the Government of Jersey, and strongly recommend that the Barema scale "loss of faculty" assessment model is replaced by an alternative that looks at the effects of the condition on the claimant's ability to function. This is likely to provide a fair and objective method of assessing entitlement to a benefit based on relationship to working ability.

Functional assessments take the approach of assessing an individual's capabilities to undertake domestic or workplace activities both physically and cognitively. Such assessments can be designed to focus on specific abilities which may be relevant to current employment, wider workplace needs, daily living activities or very specific requirements.

Therefore we suggest that the needs of Jersey's longer-term support system may be best met using the recommendations in this report to adopt a system of benefit award based on a functional assessment.

3.2 Designing an assessment appropriate to Jersey

A move away from the current system of assessing LTIA offers the opportunity to create a method of assessment tailored to Jersey's unique economy and society. This could make

the benefit genuinely responsive to the loss of opportunity and/or associated impacts on earning capacity that arise from long-term incapacity.

An assessment aligned to functional capability, which is more closely related to the everyday requirements of employment, can offer a more direct link to the needs of the workplace. It would be able to assist, and be assisted by, occupational health considerations and the realities of the Jersey labour market. It could assist claimants in considering return to (or remaining in) work by offering a more objective view of their situation. The assessment would inform health care professionals and identify areas where support could offer immediate returns.

Adopting such an assessment, which is already widely used in many administrations, would be able to make use of existing knowledge and experience in this field. Elements of the test could be devised which would be able to assess applicants against the real world of their employment and alternatives. This ‘real-world’ / functional based assessment could make use of a wider range of factors, when considering the support needs and the potential for full or partial work. While a direct match of functions against the specific requirements for each type of real-life job is attractive, the practical difficulties are substantial, requiring a detailed understanding of the actual requirements of every type of employment (or potentially self-employment) in Jersey.

Alternatively, elements of ‘real-world’ assessment could be imported from the individually tailored return to work activity and occupational health assessments, both of which consider employability and barriers that would be already considered during STIA. An exhaustive database of potential jobs need not then be required as the use of these OH-type assessments can enrich the framework of a standardised functional assessment.

However, there already exists a functional test used in Income Support (IS) that is used to provide access to extra components related to living costs and mobility needs. Although our work did not include an assessment of the use of this loss of function test within a means-tested benefit, this common assessment system could be readily adapted as a basis for a new LTIA test, thereby developing a solution for Jersey more efficiently and at less cost.

This should not be a simple reproduction of the existing Income Support test but could usefully review the descriptors of each function for the two benefits at the same time. This would benefit from advancements and refinements to the fundamental principles that the Income Support test was originally based on, for example utilising contemporary knowledge about the limitations of the UK’s Work Capability Assessment (WCA), which has similar origins to the IS functional assessment. This could involve consideration of the extent to which the test meets the ongoing requirements of Income Support, although that exercise is likely to be a significant piece of work.

The possibility of aligning the assessments for IS and LTIA could deliver significant advantages in cost, consistency, capacity and training. While the IS test is a functional assessment, it is not focused on the work environment and capability. Nonetheless a

small number of additional work-related indicators could help to extend this, while some indicators used for IS could be de-emphasised for LTIA purposes.

More usefully, the emphases for common descriptors could potentially change between benefits, by retaining the same indicators but varying the points awarded in respect of each indicator, if appropriate, for each benefit. This would enable the in-work relevance to be better reflected. Although it might diminish the mutuality of the assessment, a distinct viewing of the indicators 'as applying to the workplace or the demands of regular work' might be useful.

The IS use of the assessment is focused on identifying the level of assistance that may be needed in order to safely and constantly carry out everyday activities. This is then used as a proxy for the effects of disability on home life. It awards a lower level where, for example, a small number of everyday tasks may need help to complete and a medium level where more activities require support at a higher level. The highest level of support is for those who are significantly impaired and require assistance with many daily activities.

In LTIA, the emphasis could therefore be placed more on the claimant's capabilities and imitations, and how they affect the ability to function in the workplace or when engaged in regular work. This could be assessed together with associated practical issues such as access.

Additional indicators might include, as noted by Baumberg and others:

- Physical and intellectual characteristics which would be required to perform any work (or 'an occupation in which a person might reasonably be expected to be employed');
- Ability to re-skill into a different occupation within a specified length of time; and/ or
- Whether someone is unable to work for a particular number of hours a week, and whether this will last for a specified length of time.

3.2.1 Outputs of a new functional assessment

Our recommendation is that the outputs of the new functional assessment are streamlined in a similar way to the outputs from the comparable test in Income Support. It is likely that existing claimants could be fairly mapped across to produce levels of loss of function that correspond to substantial, serious and severe. While additional bands might be superficially attractive to address the edge cases, this must be balanced against the additional complexity this adds to assessment and public understanding of the benefit. We make further detailed recommendations below as to how this test could function in such a way to fairly address variability, unexpected outcomes or outliers in assessments.

Given these principles we recommend a 3-level banding system to determine the amount of benefit awarded, with a minimum point requirement to enter the benefit, which would free the benefit from examining levels of reduced functionality which are low enough as to have little effect on the ability to work. These lower impact assessments are likely to include the current 'lump sum' levels of LTIA, and potentially some claimants who

currently get an award for a condition which does not create a significant loss of function or impairment on daily living.

These bands would be designed to include:

- Substantial band – moderate loss of function and effect on one or more activities of daily living. In terms of work this may not have caused the claimant to leave employment, but they may require assistance through partial return to work, or supported work preparation, search or training;
- Serious band – moderate to significant loss of function and effect on multiple activities of daily living, or high loss of function in one area. In terms of work is likely to have significant effect on general ability to work, although depending on actual area of employment the person may remain employed. Likely to require assistance with preparation for work, work related activities, work trials, training; and
- Severe band – very high loss of function in multiple areas or total loss of function in one or more key areas, less likely to be able to maintain employment without significant support, although some people with significant physical disabilities will nonetheless have adapted to less physical jobs.

It is not proposed to introduce work conditionality, so the reference to work ability within each band would not be a formal condition of award, but a reference that would inform support for the claimant and aid understanding.

Unlike the current system, an assessment based on loss of function coupled with occupational health support is more likely to see people with treatable conditions be re-assessed with lower awards over time – as timely interventions will help some claimants manage the effects of health conditions. Reviews could be driven by a mix of calendar-based reviews and those instigated by a change of circumstance, or by a case worker or health professional request. They might be preceded by a light-touch internal check with information held, RTW activity, GP or support workers, to see if the anticipated improvement has occurred – in order to avoid wasting resources on re-assessment “for the sake of it,” to protect vulnerable claimants and to avoid causing harm.

The introduction of a minimum point for qualification would not disadvantage those who have been assessed on the lower percentages of the current LTIA scheme as they will already have received a lump sum payment. Those receiving ongoing payment could be migrated to the appropriate band of the new system. At some point, their cases would need to be reviewed under the new rules. This would be a political decision for the Government of Jersey but must take into account the potential downsides of running a new system in parallel to a less-efficient older system that can in some cases lead to inappropriately-high levels of financial award. There will also be some, mostly lower, awards currently qualifying for a regular weekly payment which would not get an award under the new system as the condition will not have a measurable loss of function. A decision may be taken not to transition these awards.

In developing a test, it will be possible for additional indicators to identify the point at which partial return to work may be appropriate and should be encouraged and/or

supported in many cases, particularly as the return to work principle and early interventions become an established part of the new system. This would not be a condition of benefit receipt.

3.2.2 Options for wider and future change

A more bespoke assessment, focusing on the patterns of employment in Jersey, might be produced in a co-design manner engaging with stakeholders and those with lived experience in particular. Integrating such a process with a review of the appropriateness of the assessment as a proxy for care needs and mobility needs in IS might offer wider benefits. However, this would of necessity be a lengthy and complex process with likely impact on timescales and budgets.

Due to the small size of Jersey, it is however likely that a new benefit model with any occupational health involvement could make use of the ability of caseworker staff to develop strong knowledge of local employment patterns. This is already a feature of Jersey's Back to Work system and employment services in the voluntary sector. This is an acknowledged strength of Jersey's current system and we recommend that this is built upon where possible.

3.3 Designing a new administrative system to deliver high-quality functional assessments

The infrastructure required for a new system of assessing longer-term support need not be created as a stand-alone organisation. Unlike the UK system, it need not be based on a medicalised face to face assessment in all cases, with the costs, concerns and delays that have been characteristic of that experience. An expanded occupational health capability, with knowledge and experience of local circumstances, would fit well with a changed assessment process. While medical and health care expertise will be core for assessing STIA, it is also possible to move much of the LTIA assessment, in particular continuing compliance or reviews, to a more standardised process with administrative support.

Functional assessments do not require a high level of medical expertise but instead the ability to interpret the claimant's evidence about the effects on day-to-day living. While no assessment should be a purely mechanical process, it can be carried out by a broader range of staff than at present and can benefit from a working team with diverse practical knowledge. The team would still rely on evidence from GPs and other health professionals, for example in complex cases where multiple factors need to be taken into account. The engagement of the claimant's GP in treatment and support of return-to-work measures will be key. A wide range of evidence may be available to inform the person carrying out the functional assessment. In most cases, a Decision Maker can review all the evidence, look to medically approved guidance, call on OH / medical support around consistency with the impacts of a stated medical situation and make a robust decision without the need for a face-to-face assessment in every case.

The UK experience for many stakeholders is that over reliance on highly-standardised and even rigid assessments has not led to reliable or robust results. Assessments and especially appeals have been drawn out and expensive and caused concerns around harms to claimants.

An alternative approach will be used in the near future when Scotland takes over responsibility for its own disability benefits; it aims to minimise the need for face-to-face medical assessments. The intention is to make use of existing supporting information, where possible. This might include:

- A social care needs assessment;
- A report from a community psychiatric nurse; and/ or
- Information from a carer.

The aim is to undertake a face-to-face assessment only when it is the sole practicable way to make a decision.

The confidence of the Scottish proposals indicates that adoption of a functional assessment need not be accompanied by an expensive, over-medicalised snapshot. Common sense, weighing up all the evidence, giving some weight to the claimant's own evidence (if consistent and plausible) can mean that a functional assessment can operate with "dignity, fairness and respect" rather than being perceived somehow as a "hostile environment". This will require well trained and skilled assessors in post. We note that Income Support assessments already utilise a self-reporting form, backed up by guidelines and clinical / social evidence, with a face-to-face assessment just used in complex cases.

A long-term assessment must also be seen as a part of a wider process of support for the claimant, focused on the assessment being used as an indicator of support needs rather than solely a gatekeeper for entitlement to financial support. A clear message came out from consultation events that claimants must be encouraged to feel a degree of ownership over the processes that offer support for their long-term health conditions.

To bridge the areas of health-related and administrative processes delivery may be made by named caseworkers with a responsibility for a group of claimants, able to develop a relationship which could include awareness of the longer term, and possibly variable, situation of each claimant, which will not be captured at a snapshot assessment. The caseworker would also be the link to occupational health services and assessments.

Our recommendation is that Jersey consider that the new assessment model is supported by a caseworker model, where a specialist administrative team collates appropriate information to help deliver a functional assessment and support the individual applicant. The caseworker would also be the key coordinator in any return to work support, as detailed elsewhere in this report.

3.3.1 Addressing variability, unexpected outcomes or outliers in assessments

It will also be necessary to have clear guidance for those making decisions to recognise that in any points-based system there will be situations that require special attention, or where the standard assessment process is not suited to the complexity of the individual case. This may be easier in practice in a smaller jurisdiction than in a larger one. Cases where this guidance would be needed include terminal illness, severe disabilities and those outliers which sometimes occur where conditions are rare or their effects far from the typical prognosis.

Additionally, there is a danger in all assessment processes that the assessment is a snapshot of the circumstances and conditions at a single point in time. This may not reflect the 'normal' situation and is unlikely to capture the worst or best conditions over time. The evidence or opinion of the claimant themselves, GPs, other health care professionals, employers or family could also be considered when evaluating the longer-term situation of the claimant. Guidance would indicate how the weight of such material should factor into the final assessment, again taking into account the likely demands and routines of daily activity, including if appropriate employment. Evidence could be sought before the assessment takes place so that the indicative determination could take account of these factors and seek to prevent unexpected or contradictory assessment results as sometimes occur in other systems. Longer-term caseworker involvement would inform this usefully and sympathetically.

The guidance would be linked to the policy intentions of the new scheme and the mechanisms that would allow for its application to be challenged (taking into account the existing legal structures of Jersey's benefit system) would again be a political decision.

Within each band there may be a reasonable period set for re-assessment, with some people being marked for no reassessment need (little chance of recovery or variability of condition) or only light-touch periodic reviews.

3.4 Future cash value of benefit

Currently LTIA is the maximum rate equivalent of STIA multiplied by percentage loss of faculty. Only where assessment of loss is 100% does the benefit reach the cash level of full STIA. However, this is balanced by the ability of claimants to also work and receive earnings. The amount paid is based solely on the assessment of the impairment, there is no means-test involved.

A future rate of benefit would depend upon many factors. This has required a fundamental consideration of the function of financial payments, we considered whether it should be:

- A compensation for loss of faculty;
- An insurance against the occurrence of health-related work interruptions and the associated costs;
- An earnings-related benefit;

- Related to the financial need of the applicant and family; and/ or
- A continuation of STIA.

In the context of the historical and policy intents of support for longer term incapacity of workers in Jersey, and the outputs from our local consultation, it would seem appropriate to retain LTIA as an insurance against the impact of a health-related interruption to work.

The aim is compensatory and not directly related to financial, or other need. Rather, it reflects a potential loss which would be difficult to quantify but may involve loss of earnings capability, either across time or through changes in activity.

The changed system should retain the non-means-tested characteristics of the current system. This would reflect the insurance-based scheme underpinning it but also offers offer a clearer incentive across the system for sick or disabled people to be supported into employment. We have considered whether this provides a perverse incentive to claim benefit whilst continuing to work, but the likelihood of a combination of LTIA in any of the bands (together with reduced earnings) being in total greater than previous full-time earnings does not appear to have been an issue under the existing scheme.

Our recommendation is therefore that levels of longer-term financial support are tied to the distinct levels of loss of function suggested earlier in this section; we do not recommend that support is means-tested, related to current earnings, or related to household financial need. Consultation indicated a strong support for Jersey's insurance model, where people who have "paid into the system" will "get something out of it." Income Support exists to support lower-income households on a fully means-tested basis.

We recommend that it is made clear that ongoing longer-term cash payments are designed to respond to an assessment that looks at loss of function, potentially taking into account other real-world measurements, as this best measures how a health condition affects the ability to support yourself through work. We believe a fair and consistent functional assessment can be achieved without adopting complex forms of assessment that may not be appropriate for Jersey's size and employment market.

We recommend designing the new assessment from the principle that the most severely impaired people are likely to receive the same amount of cash payment as at present (i.e. full-rate LTIA), with proportional decreases below that as existing levels are mapped across to the new system. However, a shift to a more appropriate test will not result in all existing claimants getting the same approximate level of payment. Jersey must consider that some lower level awards might be worth less in cash terms but greatly enhanced by the added value of occupational health support which should maximise the ability to support themselves through earnings. The change to the new system should not financially disadvantage those existing claimants who genuinely need support because of a loss of function. This would be a policy decision for Jersey, as would any transition of existing claimants to the new system.

The introduction of health care / case manager approval before work during a long term benefit claim being permitted should be considered, although this may not need to be applied to the lowest band of the new benefit The intent is not to push people into

returning to work but to ensure that they only return when it is safe and appropriate. This has not proven necessary under the current scheme so a firm recommendation has not been provided allowing the opportunity for further investigation.

3.5 Relationship with other benefits

This section clarifies how a new system for long-term support would interact with Jersey's other benefits.

Short Term Incapacity Allowance

One of the reasons why LTIA is claimed before STIA entitlement runs out is that it enables people to work while receiving the benefit. Work, even voluntary, is not permitted under the current STIA rules. If as we suggest this exclusion is removed in STIA then it will be expected that many people will no longer feel that they need to follow this route, although could still be subject to any return to work negotiation as outlined above. It may then be appropriate to create a more formal pathway to bring forward the start of LTIA in appropriate cases. For example, for cases identified as particularly severe under STIA to be moved immediately to the highest band of a new LTIA.

Income Support

If a functional assessment is more similar to the functional assessment in Income Support, then there are strong advantages in having a common assessment structure that is utilised across both benefits. This is discussed in detail above. This offers a significant operational improvement to Customer & Local Services, but would also be useful for claimants in situations where they are in receipt of LTIA and are required to also apply for a means-tested benefit to meet their daily living costs. They would have less need to undertake a new, different assessment in order to qualify for the disability element of Income Support. It will however be important to make it clear where the two assessments are employed differently, as per recommendations that the outcomes are different depending on the degree to which they are used to assessed function limitation on employment.

Incapacity Pension and Invalidity Benefit

There are a very small number of recipients of Incapacity Pension and a functional assessment more focussed on levels of incapacity will remove the need for this as a separate benefit as it can be replaced by the highest LTIA band.

Although Invalidity Benefit ceased to be awarded in 2004, there are still a number of recipients, as they are yet to reach pension age. Potentially these could also be transferred to a new form of LTIA. Some of these, who are currently not permitted to work, might be able to return to employment with appropriate support.

3.6 UK experience of conditionality and sanctions

We note that some degree of conditionality is a feature of Jersey's Income Support system, although this is designed and administered to take into account the limitations of illness and disability on the ability to look for work.

In delivering any new benefit there will be questions about participation in activities, such as preparing for returning to work, where non-participation might need to be addressed. There tends to be a public perception of higher levels of fraud in sickness and disability benefits, although there is little reliable evidence that this is the case.

Increased intervention or financial penalties are possible solutions to this question, but are not recommended at this stage. In a situation where financial consequences were considered, care would need to be taken so that financial difficulties are not too severe; protection would be in place where hardship is likely; and that reasons for non-participation were fully understood.

Studies of the effects of sanctions internationally have been limited and their conclusions uncertain. Griggs and Evans, in their Joseph Rowntree report *Sanctions within conditional benefit systems - A review of evidence*[3], said

> *"While sanctions may be efficient in terms of shortening unemployment spells, consideration of longer-term sanction impacts … in particular the negative effects of sanctions on job and earnings progression, demonstrates the problems of such efficiency arguments. Furthermore, while cutting caseloads is an efficient way of reducing expenditure, other factors, such as spillover effects on crime rates, along with higher spending on in-work benefits, offset savings."*

Taking this into account, we would highlight that the UK experience shows an absence of evidence that financial sanctions are effective in practice when applied to the conditions for disability or sickness benefits. This more confrontational approach to assessment, and a lack of robust safeguarding, has resulted in people with serious health problems and vulnerabilities experiencing severe distress and worsening health issues.

[3] Griggs, J. and Evans, M. (2010) *Sanctions within Chapter heading conditional benefit systems A review of evidence*, Joseph Rowntree Foundation

4 Occupational health and rehabilitation support

4.1 Key findings from review process

For this review we have examined models of OH and vocational rehabilitation (VR) support internationally, as well as taking evidence from experts in Jersey who have a stake in ensuring that such provision is contemporary, responsive, evidence-based, effective and efficient. This chapter discusses the options for the development of such a service and the way it might support the work of primary care professionals and employers.

This chapter focuses specifically on the provision of wider OH services and the options for developing specialist OH and VR provision for the whole island – so it builds on the proposals in chapter 2 for a lighter touch (but specialist) 'early intervention' service and in chapter 3 for reforms to the assessment and provision of financial support for long-term absence.

Broadly, we define Occupational Health as the range of disciplines and services that aim to keep people well at work and support returns to work; while Vocational Rehabilitation refers to interventions intended to help overcome barriers that may prevent job retention and/ or re-entry (often involving multi-disciplinary teams and approaches).

4.1.1 The design of health-related support for those out of work

Building OH capacity and capability in Jersey will be central to realising the benefits of a new system of support for those living with ill health, injury or impairment. Countries that do this well have invested in effective OH and vocational rehabilitation services, and these occupy a central place in linking Primary Care, in-work and out-of-work support. Key features of the most effective models internationally are that they:

- Emphasise prevention, risk assessment and early intervention;
- Adopt a biopsychosocial approach which, where possible, avoids over-medicalising issues of physical and cognitive strain or impairment;
- Prioritise (good quality) work as a clinical outcome of care, recognising that work can have therapeutic benefits for most working age adults, even those with multiple and complex heath needs;
- Adopt a patient-focused approach to case management, which places weight on the work preferences and aspirations of the individual and is flexible enough to offer 'stepped care' interventions in response to the changing circumstances of individuals (for example fluctuating conditions, co-morbidities, setbacks and exacerbations);

- Recognise that OH and VR services can be delivered by multi-disciplinary teams including OH doctors and nurses, physiotherapists, occupational therapists and clinical psychologists, whose efforts require planning and coordination;
- Support employers to go beyond their legal duty of care and statutory obligations, engage in evidence-based health promotion activity and make workplace adjustments that facilitate both job retention and return to work.

In most countries, the 'market' for OH provision is characterised by a combination of:

- Medium- to large-sized private providers that offer outsourced services to employers, usually focused on statutory provision (risk assessment and reporting), absence management and case management;
- In-house provision within larger employers; and
- Specialist services offered through public health services – for example pain clinics, clinical psychology/ talking therapies, and functional restoration programmes/ physiotherapy.

This mixed market, and market failures, means that it is often the case that employees of small- and medium-sized employers have no access to mainstream OH services. Some countries, like the Netherlands (as referenced in Chapter 2) and Japan, have responded to these market failures by requiring employers by law to retain OH expertise in order to manage job retention and return to work, while others require employers to conduct annual health risk assessments.

As noted in chapter 2 there was strong support for being clearer about the requirements and responsibilities that employers have now, and around trying to encourage better practices by firms. This is also set out in more detail in chapter 5. There was also significant support for developing occupational health capacity and capability within health services and employers themselves, and a strong view that given the specific and fairly unique nature of Jersey's institutions and labour market, as far as possible the emphasis should be on developing 'on-island' provision (with off-island services only used where specialist capability or capacity cannot be met locally).

4.1.2 Core occupational health functions

OH provision can cover a number of core services or domains, which are set out in Table 4.1 below. Within the UK, the best services will also align with a set of 'best practice' standards for Safe, Effective, Quality Occupational Health Services (SEQOHS).

Table 4.1: Core occupational health functions and examples

Occupational Health function	Examples
Prevention Services to minimise the risk of staff or patients acquiring illness or injury. Compliance with statutory requirements.	Infectious diseases (screening and immunisations) Musculoskeletal risk assessment; ergonomic advice Mental health risk assessment; job design Workplace risk assessment; hazard identification Risk exposure – surveillance, long latency PPE
Early Intervention Services to provide speedy access to treatment of major work-related conditions with a return to work focus	Infectious diseases (blood exposures, TB, MRSA) Musculoskeletal assessment and management of acute conditions Mental health – assessment and management of acute mental health issues; counselling support; drug/ alcohol services; liaison psychiatry
Employment Services Services that address HR & employment issues by accepting referrals and providing data/reports & strategic oversight of workforce health	Fitness for work reports; case management coordination Statutory reporting of injuries, diseases and dangerous events
Rehabilitation Services to maximise return to work based on the biopsychosocial model	Functional assessment and job modification Work preparation (e.g. phased return to work plans) Return to work support (mentors/ buddies, monitoring)
Health Promotion Services which improve the health and wellbeing of working age adults/ employees	Physical activity; obesity/ weight management; diet/ nutrition; smoking cessation; alcohol, mental wellbeing/ resilience
Education and Training Instruction, resources, advice and guidance to managers, GPs, Allied Health Professionals, employers, Trades Unions etc on topical and statutory aspects of workforce health and wellbeing	Managing sickness absence and presenteeism Mental health awareness MSK health, posture and workstation design Conducting risk assessments Job design/ redesign for health and productivity

Source: Institute for Employment Studies

However within these categories, in reality many employers tend to prioritise absence management, treatment of work-limiting conditions and return to work support – with less emphasis often placed on prevention and health promotion.

4.1.3 Employment services for disabled people and those with health conditions

Alongside core OH support, this review has also considered the evidence and approach around delivery of employment services for disabled people and those with significant health conditions, most of which fall within the scope of 'vocational rehabilitation' services. For those out of work, these models tend to combine condition- and health-management support with jobsearch, job matching and employer brokerage, vocational training, and help in addressing wider barriers to employment. Services have also historically focused on supporting work retention, for example through workplace subsidies and support/ adaptations, and 'sheltered employment' schemes.

The literature points to three key elements in successful programmes that unsurprisingly are along similar lines to 'what works' in wider OH services:

- **The role of the caseworker or adviser** – with the evidence strongest where there is specialist, one-to-one support from a caseworker working with small caseloads (e.g. 1:20) and who can provide early, forward-looking, capability-based support; co-ordinate provision and onward referral to meet health and wider needs (see below); and who can deliver employment-related support including job preparation, job search and brokerage.
- **Multi-disciplinary support** – building on the caseworker model, with support built around the individual and addressing both specialist health needs (including condition management, self-management, psychosocial interventions) and wider social needs which could include training, housing, careers, budgeting/financial and family/caring support.
- **Workplace and employer engagement** – to support employees whose ability to work is temporarily reduced, to help employers with job re-design, job brokerage, workplace adjustments, and in the provision of in-work transitional support.

There are a number of well evidenced models that combine the above elements and are increasingly delivered in health service contexts, including Supported Employment; Individual Placement and Support; integrating employment advisers within physical and psychological therapies; and group based, peer-to-peer support.

Within Jersey, similar services are currently delivered through the Jersey Employment Trust, which supports over 500 disabled people each year in job seeking, job preparation, training and in-work support; as well as offering training and advice to employers. We have not sought to assess these services as part of this review, but in our view there would likely be significant value in looking to join up and align this support and other services with the new model for work and health proposed below. There may also be a case for extending and investing further in these services, for example to offer specific

and well-evidenced interventions for those out of work like Individual Placement and Support for those with mental health conditions.

4.1.4 A 'work and health centre' approach

Drawing this together, our view is that there is a very strong case for investing in a dedicated, specialist and (ideally) on-island occupational health and vocational rehabilitation service for Jersey. Based on our evidence review and feedback, we believe that this should be positioned in a way that:

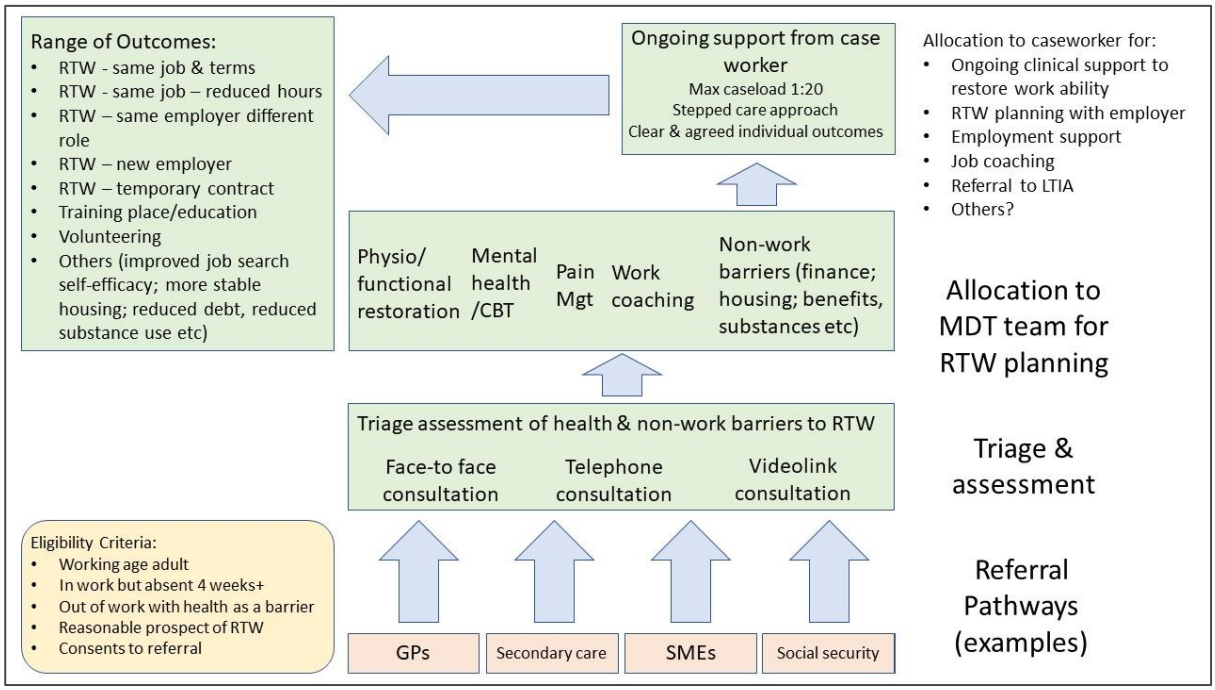
- **Complements and supports the role of GPs** – it is common to find that, beyond an initial, binary, assessment of fitness for work (often aligned to sickness certification) most GPs do not feel equipped or empowered to offer job retention or return to work advice to their patients and even less to employers. GPs can also feel that any role they might have in acting as a 'gateway to benefits' can conflict with their role as 'patient's advocate'. As set out in Chapter 2, we found similar evidence in Jersey and have set out proposals for improving GPs' awareness of OH principles and practice, and engagement with any new services and support.
- **Is 'patient-centred' and tailored** – functional and cognitive impairment can be highly individual and can vary widely even among those with the same diagnosis. Some patients have strong motivations to return to work promptly, others have more complex needs or comorbidities. Interventions that start with the work aspirations and needs of the patient and which work with them to achieve these goals are widely thought to result in better and more sustained work outcomes.
- **De-emphasises 'assessment' or 'benefit conditionality'** – as discussed in Chapter 3, international experience is that a binary or 'pass/ fail' approach to functional capacity assessment frequently results in negative engagement and low trust from individuals; concerns over presumptions of malingering; and a missed opportunity to put in place a positive, supportive and outcomes-focused case management/ support worker model. Interestingly the UK government is now reaching the same conclusion, with the forthcoming Work and Health Green Paper due to include proposals for a full separation of benefit entitlement assessment, conditionality and return-to-work support. Similar arguments also increasingly apply to employer-based OH – with OH professionals in the UK now arguing that the term 'occupational health' itself should be dropped, because for many people with experience of employer-based OH this is increasingly seen as a punitive function working on behalf of employers.
- **Offers a choice of 'modalities'** – the Covid-19 pandemic has led to a step change in the use of online consulting and health support, with concern in the UK that this has in turn increased the number of GP Fit Notes being renewed online (like a repeat prescription) at the request of patients and without re-examination or regular follow-up by GPs. Nonetheless, there is also now much more openness to OH or VR consultations happening either face-to-face or via telephone or video link, including triage and RTW planning, and strong evidence on the effectiveness of remote delivery of services particularly for mental health. So on balance, our view is that services that

offer greater flexibility of access are likely to attract greater take-up and to reduce waiting times and achieve similar or better results to solely in-person delivery.

- **Can support all of those who have reached the point of claiming the new longer-term incapacity benefit, while also available to those who need earlier referral** – our starting point is that all individuals who reach the assessment point for the new longer-term benefit would be able to access specialist health and work support and that this would be non-conditional and separate from the benefit assessment process. However as set out in Chapter 2, there is a strong case for earlier intervention and so we are also proposing that the model incorporates an 'early intervention' service with the scope for onward referral to more intensive and specialist support based on clinical need. In time and if successful, this should mean that far fewer people who are capable of returning to work reach six months of absence, and that the large majority of those that do so will already be receiving OH support.
- **Work in partnership with existing health services, and with wider social supports** – as noted in Chapter 2, there are a range of existing health services that provide rehabilitation, health management and health promotion support that can facilitate returns to work, most notably through the Pain Management Centre and Jersey Talking Therapies. The evidence also points to the importance of aligning with wider services where these are needed, including on issues like household finances, family, jobsearch and retraining. So any new service should complement and work in partnership with these services, including through multi-disciplinary teams. Finally, there would also be value in establishing mechanisms for employer engagement, input and co-design – both to ensure that support and services complement workplace OH provision where this is available, but also to encourage wider adoption of good practices (for example through employer/ industry forums).

A service model which, on the face of it, may satisfy all of these criteria is currently being designed in advance of trialling in the UK and may provide a model that Jersey could learn from (Table 4.2 below). The proposed model in England would establish a number of regional 'Work and Health Centres' staffed by multi-disciplinary teams of OH and VR professionals. Patients would be referred in using a 'work and health pathway' where they will be assessed and triaged, provided with a caseworker and given access to clinical support (using a stepped care model), vocational or employment support, coaching and advice tailored to their needs (for example those out of work as a result of a health challenge, those 'struggling' and vulnerable to job loss, those at risk of moving onto long-term sickness, those with additional non-health needs). Multiple referral pathways will be allowed – via GPs, employers, via pain clinics and first contact practitioners (for example physiotherapists). The work and health centres may offer support for a fixed period of time or until the patient is at work and stable, depending on need.

Table 4.2: The Multi-disciplinary Work and Health Centre Model



Source: Institute for Employment Studies

In our view, Jersey would be very well placed to establish and commission an equivalent centre, building on some of Jersey's unique characteristics (size, connectivity, existing expertise in pain clinics and a strong third sector with specialist expertise). However the model would also need to be designed differently – particularly given the existing landscape of services and the needs of the island; but also the specific objectives for these reforms, which as set out in section 1.4 are around improving outcomes and fiscal sustainability of the incapacity benefits system. Specifically then, we would propose:

- The early intervention service proposed in chapter 2 would be located within the Work and Health Centre model. As set out there, the referral route would be GPs, and the service would provide triage and assessment alongside light-touch (but specialist) advice and case management to the individual and employer.
- All of those assessed as eligible for the new longer-term incapacity benefit would be automatically referred for triage and assessment in the work and health centre, on a voluntary basis – so the referral route for this would be via Customer and Local Services.
- Intensive case management support would be available, delivered by OH and vocational rehabilitation specialists, and with dedicated (new) funding.
- Key stakeholders in existing health and voluntary services (in particular, the Pain Management Centre, Jersey Talking Therapies and Jersey Employment Trust) should be engaged to co-design the approach to intensive case management and multi-disciplinary working – but with an assumption that there would be intensive case

managed support (with ratios of 1:20) based on clinical need, and that multi-disciplinary teams and working should be supported as far as possible.

- Decisions on referral to the intensive caseworker/ multi-disciplinary support would be based on clinical need, but with a presumption that where demand is greater than supply (which is likely to be the case while benefit caseloads remain high), those who have been out of work for longer would be prioritised for support.

If such a model could be commissioned and successfully implemented, then in our view it would also in time be able to become a wider source of expertise and support to primary care, employers (mainly small and medium enterprises) and to the Social Security system – so establishing itself as a centre of expertise and evidence-based practice and driving wider system change across the island (which is covered in more detail in chapter 5).

4.1.5 Commissioning and delivery

A key area for debate during the review has been the role of different state and non-state actors in delivering OH and vocational rehabilitation services. Within Jersey there is already a mixed economy for work and health related support, with private GP services; public health services; an active voluntary sector delivering support and services for those with health conditions and impairments; and some use of contracted-out provision (predominantly by large employers).

There are different arguments for commissioning and funding a new work and health service through public service employment, health services, the voluntary sector or contracted out provision; although the evidence does not suggest that any one sector or model is inherently more effective than another. Overall, our review work suggests that there is significant capacity across the wider 'system' to deliver the constituent parts of the suggested Work and Health Centre model, but that there would not be existing capacity within any one part of it to deliver it all. It is also our view that to realise the benefits of driving system change among public and health services, employers and wider society, there would be significant advantages to developing the model in a way that draws on different sectors and strengths. So we would recommend that Jersey seek to commission a consortium of organisations to collaborate to design and deliver this model.

It is also our view that it is unlikely that this model would need substantial off-island resource to operate, aside from occasional inputs from clinical specialists and training/ staff development support during the set-up phase.

In terms of the costs of a new service, we would anticipate that ballpark costs for a new Work and Health Centre might be in the order of £200-300,000 for every 100 residents that are provided with intensive caseloaded support (over and above the costs of the early intervention service set out in chapter 2). Given that currently around 400 residents make claims for LTIA each year, of whom around a fifth receive awards of 15% or less, it seems likely that a service able to support up to 500 people a year would be sufficient to provide specialist support to all of those making claims for the new longer-term benefit as well as many of those referred from the early intervention service.

4.2 Proposed approach

To summarise, we are proposing that the government invests in developing a new 'Work and Health Centre' model to extend and join up services and support around work retention and re-entry, to drive improvements in work and health outcomes, to provide early intervention support for those leaving work and at risk of longer-term absence and to deliver specialist, caseloaded and multi-disciplinary support for those out of work and in need of more intensive help to manage a return to work.

We would recommend that the government works with partners to finalise the proposed model, drawing on the learning set out above, and with a view to then commissioning a consortium of organisations across health services, the voluntary and private sectors to develop and implement it.

The wider Centre would include the early intervention model proposed in Chapter 2, with the specialist assessment, caseloading and multi-disciplinary support focused on those with the most significant clinical needs. We would suggest that the initial priority should be to ensure that all of those reaching eligibility for the new longer term benefit would be referred for assessment and (where appropriate) support, but that there should also be routes for early referral (via the early intervention service) for those identified as at greatest risk of long-term absence.

The new service will also need to work in close partnership with existing provision, in particular the Pain Management Centre, Jersey Talking Therapies and the Jersey Employment Trust, and so more work will be needed to develop those referral pathways and protocols and ensure that provision is complementary and additive.

If this can be successfully implemented, then we are certain that the service will improve outcomes for individuals and employers, and lead to significant reductions in social security expenditure and wider fiscal benefits – which in turn should support an expansion of the service so that it can intervene earlier and at greater intensity, and so achieve more positive results. We also believe that a successful model would drive system change across wider health services, employers and society.

5 Supporting healthy work

So far this report has focused on changes to certification of ill health, social security benefits and work- and health-related support for workers experiencing ill health or injury. However, a strong theme throughout the review has been the importance of wider system change to support good health at work and good work as a 'health outcome'. This points to the broader importance of workplace and employer practice and of health services in supporting healthy work.

5.1 The role of employers in supporting health at work

As set out in section 1.4, key aims of a reformed incapacity benefits system should be to support retention in work, returns to work and improvements in work and health. Employers are central to achieving this, in creating healthy workplaces, minimising risks of ill health or injury at work, effectively managing sickness absence and supporting returns to work where necessary.

Previous reviews however, by Professor Bruce Stafford and Dr Les Smith, have identified employer engagement and their involvement in managing sickness absence as specific areas for improvement in Jersey. Our findings from interviews and workshops conducted for this review, alongside evidence from other countries' approaches to supporting health at work, points to three key areas where the government should focus attention.

5.1.1 Improving and supporting employer understanding of health and work

A key enabler of effective employer practice is employers having a good understanding of the benefits of healthy and safe working; the potential drivers of ill-health at work; and what steps may help to mitigate the impacts of ill health or help to support reasonable adjustments for individuals with specific conditions. Our review work raised specific concerns around the needs of the many small and medium sized employers, where it was reported that awareness of good practices around health at work was low; but that across all employers there was room for improvement, for example in managing work-related stress, and in improving absence management policies.

The Health and Safety Inspectorate has lead responsibility within Jersey for ensuring both that employers comply with their legal responsibilities around health and safety at work, and for promoting good practices by employers. Inevitably, the bulk of the HSI's work is focused on safety rather than health, with inspection and compliance activity focused on high-risk industries like construction and hospitality; but the Inspectorate also produces good practice resources and guidance, has a range of useful material on its website, and

in its most recent annual report makes clear that improving health is an "increasing focus" of its work.

The HSI website in particular draws on resources produced by the UK Health and Safety Executive (HSE), which has a range of employer-facing material on issues related to health management and protection, including on health surveillance, risk management, OH guidance, effective absence management, managing stress at work, control of infectious diseases and so on. The HSE's Management Standards on stress at work are a particularly good example, setting out for firms the rationale for intervention, straightforward tools to self-assess risks, and resources to support action (these are particularly relevant for Jersey, as the HSI annual report suggests that fully 70% of health-related exits from work are due to stress).

However, the UK HSE is also among the worst resourced inspectorates in the developed world, having seen its budget halved since 2010, and has fallen far behind the International Labour Organisation recommended standard of having one inspector for every 10,000 workers (with the UK figure now closer to one inspector for every 30,000 workers[4]). As a consequence, despite a range of excellent resources on workplace health, the HSE has become increasingly targeted on workplace safety and relatively passive on supporting improvements in health.

In a number of countries there is a far stronger regulatory focus on workplace health (covered in chapter 4 above), with a number of these linking these requirements directly to occupational health assessment and support (for example in Japan and the Netherlands). Within the UK, in Scotland and Wales we also see a greater emphasis on health at work through their (devolved) public health departments. In Scotland for example, the Healthy Working Lives centre provides a range of resources and support to Scottish employers, including through:

- Workplace visits, to share best practice and identify areas for improvement;
- Training courses on health, safety and wellbeing, both in person and through virtual learning;
- A Healthy Working Lives National Award programme; and
- An advice line for employers and website resources (www.healthyworkinglives.scot), including advice on supporting retention and returns to work.

Healthy Working Wales has a similar focus, including advice services and a Small Employer Award programme.

While proactive employer engagement has not been a focus in England's public health system, there are notable examples in English local government (like the 'Working Well' campaign in Greater Manchester), as well as a range of business led approaches which have been backed by government, including Business in the Community resources on health and wellbeing at work and (since 2010) an Investors in People accreditation for

[4] The equivalent figure for Jersey is around one inspector per 15,000 workers.

wellbeing. It should also be noted that the UK Government's Disability Confident campaign has seen more than 20,000 employers sign up to standards around inclusive recruitment, employee support and adjustments at work.

5.1.2 Getting the incentives and requirements right

In many cases, there is a direct business case for firms in supporting good health at work, retention and rapid returns for those who leave work due to ill health – i.e. the costs of presenteeism and of sickness absence outweigh the costs of effective intervention. However, these benefits can often be hard to articulate or may be relatively weak, particularly where the direct salary or compensation costs for sickness absence are met by social security (as is the case in Jersey and many other economies).

For these reasons, a number of countries make use of any or all of taxes/ levies/ charges on employers, financial subsidies and/ or regulatory requirements to try to encourage or compel good practices.

Taxes, levies and charges are the most common way that other states try to rebalance incentives within sickness benefit systems. As noted in chapter 4, in most countries including the UK employers have to pay sickness benefits for the first period of absence, which can last from a few weeks (in for example Norway and Sweden) up to a couple of years (for example in the Netherlands and Switzerland). It is also fairly common for states to use employer 'experience ratings' to set social security payments (in for example Germany, France, Italy, and the Netherlands) – i.e. firms that manage sickness absence less well pay higher contributions. Finally, some countries use levies on employers to fund worker compensation – most notably in Australia and New Zealand.

Financial subsidies are also fairly well used in other countries, although their nature varies. The use of incentives or subsidies for occupational health through public insurance systems is fairly common in Europe (in countries including Germany, France, Italy and Poland), although tax rebates are less so. The evidence suggests that incentives can be most effective where they are focused on future behaviour (not past performance), are straightforward to claim and paid quickly. A number of countries also use wage subsidies to support employment of those with health conditions and/ or disabled people, although these are often linked to new hiring rather than returns to work.

The UK Access to Work model is a good example of an effective subsidy scheme, and enables employers to claim funding for specific additional costs that may be required in supporting disabled people or those with health conditions in work – this can include costs of workplace adaptations, specialist equipment, or travel and support costs. The scheme has been consistently praised in independent reviews of disability employment in the UK, although it has also faced criticism for its relatively low awareness among employers and the administrative burdens in applying for and accessing funding. Jersey has an equivalent Access to Work grant, albeit capped at a maximum of £5,000 (compared with £63,000 in the UK) and only covering aids and equipment.

Finally on **regulatory requirements**, these again vary significantly across countries but typically include obligations to support those who become ill or are injured at work; and/ or to employ/ re-employ of people with health conditions or impairments. In a number of Scandinavian and northern European countries for example, there are varying degrees of requirements to provide appropriate rehabilitation support within public/ social insurance models for those off work due to ill health. In other countries, there are specific targets or thresholds around employment of disabled people so as to encourage more inclusive employer practice – for example in Poland, if fewer than 6% of employees have an impairment an employer can face a fine.

Within Jersey, our consultations (and previous reviews) suggested that incentives and requirements on employers around work and health were relatively light. Employer social security contributions are low by international standards; they are not varied according to risk; employers do not contribute to sick pay; and there are no incentives nor requirements to support retention or returns to work following absence. At the same time however, we also heard that the often limited pool of qualified employees within sectors meant that many (although not all) employers offered comparatively generous sick pay arrangements and had strong incentives to reduce turnover and recruitment costs by supporting retention and health at work.

Overall, in our consultations we found limited support for increasing direct obligations on employers in the short term, but strong support for improving engagement, placing greater expectations around health and work, and being clearer about existing responsibilities and how these could and should be met. In the longer term, there may also be a case for strengthening the obligations on employers to engage with and/ or provide access to occupational health services – for example by requiring employers to work with 'return to work' services, to put return to work plans in place, and to operate healthy workplaces. We understand that there may be scope to introduce measures along these lines under existing health and safety legislation (as Approved Codes of Practice). As noted in Chapter 2 however, we found very little support for moving to an 'employer pays' model for sick pay nor for putting in place requirements to co-fund support or additional regulatory or tax burdens on firms.

5.1.3 Having the right support and services available

If we can improve employer understanding of health and work, and get the incentives and obligations right, then the third key priority is to ensure that firms are able to access the support and services that they need in order to support good health at work. Broadly, we would consider that good employer practice can be thought of in three parts:

- **Supporting healthy and safe working across the workforce**. This goes beyond just compliance with health and safety law, to also considering the extent to which employers are willing and able to support good physical and mental health for employees, address potential stressors, and have effective systems in place to respond to potential signs of ill health/ risk.

- **Effective assistance for those with poor health or at risk of absence**. This can include access to OH services; employee assistance programmes; and effective absence management policies. As noted in chapter 4, OH services (usually outsourced) are fairly common among larger firms in the UK; however, this is often mainly focused on absence management rather than on risk assessment, surveillance and early intervention.
- **Tailored interventions to support work retention**. Examples of these could include workplace adaptations, job re-design/ job carving, and/ or support with addressing wider barriers to work which could include debt, family, transport and so on.

Critically, as NICE guidance on workplace health management makes clear, good employer practice is about issues related to leadership, organisational commitment, line management, trust and participation as much as it is about the physical working environment, job design and health-related support.

It is also important to recognise that effective workplace health management relies on employee disclosure where any health conditions or impairments may affect their ability to be productive in work and/ or to stay in work. Having the right mechanisms for disclosure is a prerequisite for this, but workplace culture arguably matters more – so that employees feel able to talk about their needs and say when they need help and/ or are not well. Senior ownership within organisations, leading by example, and effective line management and HR practices are all key to this, while initiatives like Time to Talk in the UK, and World Mental Health Day, can also provide means for social partners, employers and government to try to drive culture change.

So good employer practice needs to be supported across a range of areas and needs to be supported by a wider work and health 'ecosystem' that can encourage good practice – including within firms, in contracted-out services, in publicly funded employment services, public health and mainstream health services.

As set out in chapter 4, our view is that there are the constituent parts of this system within the island, and that there is scope to bring this together through a new Work and Health Centre model in order to support individuals and to act as a centre of expertise, advice and resources for employers.

5.1.4 Proposed approach

Drawing this together, our view is that a key priority for the new system – and a pre-requisite for achieving the objectives set out in section 1.4 – should be to try to achieve a step change in employer practice around supporting health and work.

Reflecting on the feedback received during this review, we believe that this step change can be achieved without resorting to measures that would increase the direct costs to employers of managing ill health at work – for example by requiring employers to pay for part of any sickness absence or making social security contributions experience-based. But we also note that the financial costs of health-related absence are not felt by employers to the same extent as they are in many other countries, and so if the step

change cannot be achieved through the measures below then the government may want to reconsider how costs and incentives are shared between employers, employees and wider society.

In the meantime we would propose, that:

- The new Health and Work Centre should have a specific remit for health promotion, awareness raising and good practice sharing – building on the models in Scotland and Wales. This could include an advice service and visits; sharing of resources (much of which already exist in UK nations); and an awards scheme. This would include showcasing and modelling the business, economic and social benefits of employer investment in health and wellbeing.
- Specific efforts should be made to promote: the adoption by employers of NICE guidance on health management, the HSE stress management standards, and employer engagement in initiatives like the Investors in People wellbeing standard. These steps would also support the ambition of achieving equivalence between mental and physical health.
- The government should consider the resourcing of the HSI, and in particular the scope to increase resourcing in order to fund a specific 'occupational health officer' post that could support proactive and joined-up working with employers and the new health and work centre around improving workplace health; as well as supporting firms with needs assessment and with development and evaluation of workplace health interventions.
- The government should consider extending its Access to Work scheme, to provide specific advice and financial support to employers around reasonable adjustments, aids, adaptations and support for disabled workers and those with health conditions.

5.2 (Good) work as a health outcome

Finally, this report has set out the critical role that occupational health and return to work services can play in reducing health-related absence and improving health and wellbeing. However we also found, and have described, a range of good practices in wider health services and in particular the Pain Management Centre and Jersey Talking Therapies. At the same time, the new Jersey Care Model emphasises that "it isn't just Health services that keep people healthy", and that "community services, education, employment and housing are fundamental" too.

Recognising the importance of these so-called social determinants of health has grown in significance in health systems across the world, with decent work seen as one of the key social determinants of good health. We argue in chapter 4 that it will be imperative for any new commissioned service to work effectively with existing health services and wider partners, and by the same token – building on the Jersey Care Model – it will be essential that health services can recognise the benefits that decent work can have on our physical and mental health, self-esteem, income, relationships and wider wellbeing.

One important way that the NHS in England and the three devolved nations have sought to drive change in healthcare practice around health and work has been by embedding

the idea of (good) work as a clinical outcome. This has been intended to enshrine consideration of employment in health services commissioning, referral, decision making tools and clinical pathways.

So in taking forward the Jersey Care Model, and in implementing the proposed new Health and Work Centre, we would also recommend convening stakeholders across the wider health system to explore how we can embed good work as a health outcome within Jersey health services.

6 Conclusions and next steps

6.1 Summary of recommendations

This report makes 22 recommendations, as follows:

6.1.1 Managing short-term absence from work

1. A programme of awareness raising and training for GPs, including key principles of OH assessment, return to work planning, work adaptation and onward referral; and to raise awareness and encourage engagement with the proposed reforms and new services;
2. Development of a 'Fit Note' approach to certification – to allow GPs (and, potentially, allied health professionals working in the new early intervention service) to set out what work people *may be able* to do, and advice for patients and employers on how to support effective returns to work;
3. A shortening of the maximum duration of STIA to six months;
4. Co-design and then commissioning of a specialist early intervention service, as part of a wider Work and Health Centre model described in Chapter 4, but with the early intervention model accessed via primary care and providing return to work assessment, advice and support to those out of work for around four weeks; and
5. Extension of STIA to support phased returns to work, where this is agreed/ recommended by the new early intervention service and time limited for up to two months. The level of payment should be reviewed annually in order to minimise any risks of unintended consequences.

6.1.2 Financial support for longer term absence

6. Move from the current loss of faculty assessment for long term support to a system of functional assessment based on the practical effects of illness or disability.
7. Consider the potential for closer alignment with the assessment system in use in Income Support.
8. Introduce a 3-level banding system for substantial, serious and severe loss of faculty, with associated levels of benefit payment.
9. Build a caseworker model to link more closely the benefit's assessment and operation with occupational health and employment support for claimants.
10. Maintain the basis of the benefit as an insurance against the impact of health-related interruption to work, rather than linked to any assessment of financial need.
11. Retain the levels of financial support for the most severe loss of faculty at the highest levels of award under the current scheme.

12. Consider the ending of the Incapacity Pension and Invalidity Benefit schemes, with transfer of recipients onto the new scheme, where appropriate.

6.1.3 Occupational health and rehabilitation support

13. Invest in developing a new 'Work and Health Centre' model to extend and join up services and support around work retention and re-entry, to drive improvements in work and health outcomes, to provide early intervention support for those leaving work and at risk of longer-term absence and to deliver specialist, caseloaded and multi-disciplinary support for those out of work and in need of more intensive help to manage a return to work.
14. Work with partners to finalise the proposed model, drawing on the learning set out above, and with a view to then commissioning a consortium of organisations across health services, the voluntary and private sectors to develop and implement it.
15. As an initial priority, ensure that all of those reaching eligibility for the new longer term benefit would be referred for assessment and (where appropriate) support, but that there should also be routes for early referral (via the early intervention service) for those identified as at greatest risk of long-term absence.
16. Ensure that the new service can work in close partnership with existing provision, in particular the Pain Management Centre, Jersey Talking Therapies and the Jersey Employment Trust, with clear referral pathways and protocols to ensure that provision is complementary and additive.

6.1.4 Supporting healthy work

17. Give the new Health and Work Centre a specific remit for health promotion, awareness raising and good practice sharing – building on the models in Scotland and Wales. This could include an advice service and visits; sharing of resources (much of which already exist in UK nations); and an awards scheme.
18. Promote the adoption by employers of NICE guidance on health management, the HSE stress management standards, and employer engagement in initiatives like the Investors in People wellbeing standard.
19. Consider the resourcing of the HSI, and in particular the scope to increase resourcing in order to fund a specific 'occupational health officer' post that could support proactive and joined-up working with employers and the new health and work centre around improving workplace health.
20. Consider extending its Access to Work scheme, to provide specific advice and financial support to employers around reasonable adjustments, aids, adaptations and support for disabled workers and those with health conditions.
21. If a step-change in employer practice cannot be achieved, then consider again how costs and incentives are shared between employers, employees and wider society – for example the scope for requiring employers to pay for part of any sickness absence, or for making social security contributions experience-based.

22. In taking forward the Jersey Care Model and the proposed new Health and Work Centre, convene stakeholders across the wider health system to explore how we can embed good work as a health outcome within Jersey health services.

6.2 Taking forward these proposals

Given the breadth and interdependence of the proposals, taking them forward is likely to take a number of years and will require careful planning, partnership working and testing. There is also a risk that piecemeal or partial reform could lead to the potential benefits – for individuals, the economy and employers – taking longer to be realised or not being realised at all.

The first priority will clearly be for the States of Jersey to decide whether or not it accepts these proposals; and then in taking this work forward, we would suggest that there are four broad areas that need to be considered and that there are clear **immediate** (next 12 to 18 months) and **longer-term** priorities.

6.2.1 Benefit changes

In the **immediate** term, priorities will be to finalise proposals for fitness for work certification, STIA and the new longer-term benefit, including:

- The assessment criteria, assessment approach, banding and benefit rates for the longer-term benefit;
- The closure of new claims to LTIA;
- The proposed shortening of STIA and the extension of STIA to support phased returns to work; and
- The introduction of a new Fit Note to replace the current sick note certification.

Clearly the detailed and legislative design of the new longer term benefit will be the most significant of these three tasks and would require engagement with Jersey residents and stakeholders.

In the **longer term**, then, ideally legislative changes would be achieved over the next two years and implemented as soon as possible after this point. The timing and phasing of the rollout of changes would then need particularly careful consideration, given in particular the potential impacts for residents currently on LTIA. Broadly, we would recommend:

- Implementing the proposed changes to short-term absence and STIA as soon as is practicable. There is no dependency between these and other legislative reforms in putting these changes in place, and shortening the maximum duration of STIA will likely lead to some modest savings.
- Trialling the assessment model for the new benefit for a period of time before its full rollout – so that the assessment approach can be tested and improved, potential future volumes and costs can be modelled, and any implementation challenges can be ironed out.

- Ending LTIA to new claims as soon as soon as this trialling has been successfully completed and the new benefit is ready to be rolled out.
- Once the new benefit is safely established for new claimants, starting a managed migration of current LTIA claimants. We would suggest phasing this by their percentage award, so that those with lower percentage awards are assessed first and those with the highest awards assessed last.

6.2.2 Access to support and services

The **immediate** priority should be to start the process of engagement and co-design with health services, GPs, wider voluntary and community services and employers on the proposed new Work and Health Centre. This should then lead on to a co-design process to start to work through and seek support for:

- The case for change in Jersey;
- How the new service should be designed in detail to meet this;
- What existing support and services could be integrated *within* the service, what would be aligned *alongside* it, and how these would together;
- How the service would be commissioned and managed;
- What agreements and protocols would need to be developed or changed in order to support its implementation;
- A plan for its mobilisation; and
- Arrangements for partnership, collaboration and continuous improvement.

In addition to this, we would also suggest three further immediate co-design and engagement workstreams, with:

- GPs, to identify the scope and develop proposals for awareness raising, capability building/ training, and future changes to certification process and assessment of fitness for work;
- Employers, focusing on industry-level engagement (both larger and smaller firms) and direct engagement with key large employers, in order to start a conversation around the employer role in occupational health and health management; and
- The HSI, to explore the scope for resourcing a more proactive, health- and prevention-focused approach to employer engagement and regulation.

If possible, this work should be completed over the next twelve months so that in the **longer term**, and certainly by the end of 2022, new services can start to be commissioned and reforms put in place.

We would suggest that the priority should be to build the proposed new work and health centre, so that it can start to take ‘early intervention’ referrals from GPs alongside the

rollout of changes to certification and STIA; with capability and capacity for the fuller, more specialist case management support being built alongside this.

Overall, these reforms will take a number of years to come to fruition and the full benefits will likely take a decade or more to be felt. However we believe that taken together, these proposals could transform health and work in Jersey.