The Association of Directors of Public Health

Improving Lives: The Work, Health and Disability Green Paper

1. Achieving lasting change: investing in innovation

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

Directors of Public Health have reported a number of initiatives to improve health and employment opportunities of which recent examples are given:

- In East Riding, there is a pilot of financial and health road shows designed to support small businesses with health checks to employees.

- In West Sussex, health and wellbeing hubs are working both with employers and towards a workplace charter in local government.

- In Hampshire, a workplace health programme has been integrated as part of the Sustainability and Transformation Plan prevention work stream and linked with an acute provider acting as a pilot site for workplace health.

- In North Lincolnshire there are a variety of schemes delivering health and wellbeing in the workplace. The local social enterprise based community health NHS providers (NAVIGO and Care Plus) offer an employment and health service accompanied by supported employment opportunities for people with mental health, disability and other long term conditions.

- In Cheshire and Merseyside, the Directors of Public Health have undertaken a number of reviews that capture best practice across the region to support people back into work and also to stay in work.

- In Lancashire, the County Council provides a service to support people with disabilities to return back to the workplace linked to the government's 'Work Choice' to support people into employment over 16 hours. It also has a contract with a cancer trust at local hospital for vocational rehabilitation for cancer patients. It provides an employment officer and business administration support to help people referred by the trust back into the workplace. It is hoped that this model can be adopted by local Clinical Commissioning Groups (CCGs) post evaluation.

- A range of activities are also being developed and implemented across London. In Haringey, for example, these include trials on Individual Placement and Support (IPS) for severe mental illness and common mental disorders, interventions aimed at retention in jobs and support from the voluntary and community sector to equip people to get back to job market.

1.2 What evidence gaps have you identified in your local area in relation to supporting disabled people or those with long term health conditions? Are there particular gaps that a Challenge Fund approach could most successfully respond to?

Mental health is a particular concern and extra evidence in this area would be very welcome.

1.3 How should we develop, structure and communicate the evidence base to influence commissioning decisions?

Obtaining evidence of positive outcomes is key to correctly informing the commissioning of services to improve both work and health outcomes. Directors of Public Health play an essential role in both collating and analysing local evidence. Analysis of evidence on local employment should form a major part of the Joint Strategic Needs Assessment (JSNA) process. Local authorities should be further supported by best evidence to take a holistic, place-based approach to work and health, including evidence that helps to assess and understand any skills deficits. The evidence base should always be presented to both Health and Wellbeing Boards and the Clinical Commissioning Groups (CCGs) to influence commissioning.

There are a number of approaches being used to ensure evidence is influencing work and health commissioning, for example:

- In North Lincolnshire an audit of GP-issued fit notes from a number of local surgeries is taking place where the evaluation of each workplace included in the healthy workplaces programme forms part of the evidence gathered. This evidence can then be used to influence commissioning of services aimed towards getting people back into work.

- In Haringey, the public health team evaluated one of the programmes and findings were presented to commissioners of local services who incorporated the recommendations into their contracts.

- In Cheshire and Merseyside, the Directors of Public Health developed an evidence base to support workplace health and address sickness absence.

- Lancashire County Council is developing a JSNA for the working age population, in this case from age 16 to 64 years for ease of accessing the data, although it is recognised that the working age can be, and is, older than this. It will provide an economic breakdown including employment rates, economic activity and inactivity, disability, employment type and occupation and working age population breakdown. It will display indicators on the wider determinants of health, for example, employability skills, health status, income and education across different sections such as working, not working (but looking), not working (and not looking). Consideration is also being given to how the JSNA could include information on stress, sickness, culture, presenteeism (as opposed to absenteeism), flexible working, and carers who work.

2. Work coach capacity

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

Jobcentres could take a more holistic, person-focused approach to clients in order to better identify problems and signpost to appropriate professionals or resources. A results driven culture aimed at

getting people into 'any job' is at odds with this. Obtaining unsuitable employment for those who are disabled or who have long-term conditions can escalate their difficulties and may result in a rapid return to worklessness.

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

Work coaches should be adequately trained in asset based conversation, motivation and goal setting skills to enable them to correctly identify the needs of the individual from the individual's perspective. A plan of action can then be developed based around the individual and their circumstances. At present, conversations are not focusing sufficiently on the individual's health needs and social circumstances. Improvements could be made by shifting the focus, aiming for broader outcomes of health and wellbeing with employment as an integral component. This would require the integration of the work coaching skill set into a multi-agency team supporting the person in primary care. This could be developed as part of a Making Every Contact Count approach, for example, linking health and wellbeing coordinators or health trainers working in primary care or community settings.

Work coaches should be aware of the full range of provision available locally in order to ensure a joined-up approach.

3. Supporting people to stay in work

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

Supporting people in the retention of work requires multifaceted actions. These include:

- Working with individuals to understand their requirements and help them to find flexible employment opportunities that would enable them to sustain work.

- Working with employers to develop and implement a range of policies and procedures allowing managers to exercise flexible working arrangements and tailor specific job descriptions and responsibilities. Smaller businesses need support with occupational health as unlike larger businesses they may lack the capacity to identify and deal with workplace health problems.

- Developing country-wide 'Social Value Checklists' that can be used with employers and all contracts. The Social Value Checklist should incorporate employment opportunities for those with mental ill health, disabilities and dyslexia.

- Promoting a Workplace Wellbeing Charter for the whole public and private sector and implementing and promoting initiatives such as Time to Change in a more sustainable way. This should be seen as mandatory rather than optional.

- Devising a benefit system that allows flexible working and a top-up so that those experiencing illness are incentivised to keep their job (e.g. reduced working hours topped-up by benefits either from the Department of Work and Pensions or their own employers for a longer time period – 6 months). The system currently incentivises people to go off sick as this protects full pay. There is no flexibility to have phased return to work for longer than four weeks where pay is protected.

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

There are a number of strategies which could be adopted to ensure the suitability of employment support for those with mental health conditions:

- Training for staff on the impact of mental health conditions with mentoring and support while in work.
- Flexible employment for those with mental health conditions and robust processes for problematic situations in the workplace.
- Capacity for the support of colleagues with mental health conditions built into the workforce through volunteers or buddies supported by health staff trained in employability related skills. Mental health 'first aid' support should be statutory, with access to talking therapies and mindfulness courses.
- Health at work policies which accommodate for relapsing conditions such as mental health where bad health may be episodic.
- Mental health champions installed in the workplace to suggest the most appropriate support for line managers to provide.
- Job roles designed more flexibly to adapt to the needs of individuals.
- Action to tackle stigma around mental health in the workplace.
- Support services that are fully linked into the full range of provision available locally to ensure a joined-up approach focused around the person

A good example of an initiative to support workplace health is the London Healthy Workplace Charter. This provides clear and easy steps for workplaces to make them happier and healthier, and over 140 organisations have been accredited. More information is available here: https://www.london.gov.uk/sites/default/files/accreditation_guidance_for_workplace_leads_and_verifiers.pdf

It is very important that strategies are in place to prevent work-related stress and employee burnout. Estimates from the Labour Force Survey in 2013-14 suggested that the total number of cases of work-related stress, depression or anxiety accounts for 39% of all cases of work-related illnesses. Occupations with the highest reported rates of work related stress were health professionals, teaching and education professionals and caring personal services.

Burnout is related to workload and time pressure, role conflict and role ambiguity, lack of social support, lack of feedback, lack of autonomy and lack of participation in decision making. A 2016 Public Health England review found that changing aspects of an organisation's culture and working practices might be considered alongside individual level interventions to prevent burnout. Organisational interventions in the workplace may be more effective than individual interventions alone. For example, in Cheshire West and Chester, mindfulness training and Mental Health First Aid training is being delivered to managers to help them spot signs of anxiety, stress or depression to enable early intervention and support.

4. Improving access to employment support

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

No comment.

4.2 What type of support might be most effective and who should provide this?

People with disabilities or long-term health conditions can be supported in employment through:

- Delivery of individually tailored advice and guidance
- Effective management of disabilities and long-term health conditions
- Effective communication between health care professionals, employers and employees
- Adaptations to the workplace and working conditions
- Multidisciplinary interventions including workplace components
- Early engagement with workers to minimise absence
- Provision of financial incentives for job seekers and employers
- Identifying types of intervention that are most relevant for specific impairments. Supported employment schemes are likely to be beneficial for people with severe mental health conditions, people with learning disabilities or young people lacking work experience, for example, whilst older employees are more likely to benefit from initiatives focused on in-work retention and flexibility in the workplace.

Initiatives led from within the Department for Work and Pensions have struggled to address the challenges of people with mental health and other long term conditions. It may be time to shift the culture in which these challenges are addressed.

There needs to be a broader outcomes based approach framed within a health and wellbeing context focusing on independent living and delivered as an integral part in the support of people managing a long term condition. This would ensure better outcomes for individuals and service demand alike and could be a place based process commissioned locally by the Health & Wellbeing Board, irrespective of the footprint of the contributing agencies.

In Lancashire, a Work and Health Forum comprising of local partners including Lancashire County Council and Lancaster University, has begun developing a study which explores the employers' experience of recruiting and supporting workers with long-term conditions or disabilities. It has a number of aims in the study and one of these is specifically around identifying practical guidance and support for line managers and how this should be provided.

4.3 How might the voluntary sector and local partners be able to help this group?

The role of voluntary sector agencies locally is key. With the right competencies and skill set, voluntary agencies could provide and/or support the coaching approach progressing people further towards employment. Engagement with local employers also needs to be integrated with other strands of support and dialogue with employers around the local economy, linking support to increase opportunity

and support in work with efforts in the community.

The voluntary sector can also support return to work by offering volunteering opportunities to help people build confidence in returning to work. However, the issue of whether this will result in people losing benefits or being penalised for not actively seeking work must be addressed to enable this longer term approach.

6. Reforming the assessment process

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

Yes. The focus of the conversations will be very different. Separating the financial assessments from the support assessments could be a good way of promoting the benefits of work outside of a financial framework. People could be financially supported with a range of different work opportunities including phased return to work, part time work, or less financially beneficial work.

7. Assessments for benefits for people with health conditions

7.1 How might we share evidence between assessments, including between Employment Support Allowance/Universal Credit and Personal Independence Payments to help DWP benefit decision makers and reduce burdens on claimants? What benefits and challenges would this bring?

Although sharing evidence is a good way to reduce fraud and can help to base support around the whole set of needs of a person, it is also highly contentious in terms of information and data governance. Despite the need for potential limitations on the sharing of evidence and data it is essential to take a joined-up approach.

8. Embedding good practices and supportive cultures

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

Employers may have concerns about the costs and requirements of being able to support someone with a disability or health condition in the workplace. There may also be concern about lack of delivery due to time off sick and a misunderstanding about the impact of certain health conditions.

It may be that some employers are fearful and misinformed about recruitment and employment of disabled people. It may be of benefit to think of workplaces as communities however small or large and the need for resilience and capacity building within the workforce.

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

The public sector should show leadership in the recruitment of disabled people and those with health conditions. Financial incentives are key for improving recruitment and retention rates.

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

Employers must have a good understanding of the needs of employees with disabilities and those with long term health conditions. They should be helped to understand that those with disabilities do not necessarily have a poor sickness record. There are benefits of implementing targeted schemes for example mentoring programmes and policies that do not penalise the disabled or those with long term

conditions.

There could be benefit in implementing advisory groups at national or local level of people with similar conditions to help shape policies and provide frameworks and advice for employers. Good equality and diversity training is key and concerted action is needed to tackle stigma in the workplace. Employees should have access to advice and financial support if needed.

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

Those with disabilities and long-term conditions have a wealth of talent and can make a vital contribution to both individual businesses and local economies as a whole. There is a need to promote and raise awareness of this and tackle stigma. Local authorities could consider targeted campaigns to raise awareness with local businesses and increase the visibility of those who are able to work and contribute their talent but may need minor adjustments to do so.

9. Moving into work

9.1 How can existing government support be reformed to better support the recruitment and retention of disabled people and people with health conditions?

There could be a requirement for an employee to be the disability 'champion' to ensure the employer and workforce remain vigilant and informed about support available. Employers could be encouraged to offer opportunities for existing staff to volunteer as 'buddies' to support prospective and existing staff with disability or long-term conditions within the workplace.

11. Improving discussions about fitness to work and sickness certification

11.1 How can we bring about better work-focussed conversations between an individual, healthcare professional, employer and Jobcentre Plus work coach, which focus on what work an individual can do, particularly during the early stages of an illness/developing condition?

At present, the fit note conversation does not necessarily focus on assisting people to return to work and serves to 'protect' people staying off work as long as needed. This allows for the protection of the individual's pay and full salary benefits. The system does not account for people requiring a longer-term phased approach to work that is more acceptable and suitable for their health needs.

A multidisciplinary approach would be most appropriate. There is a lack of a shared sense of employment support and respective contributions across different sectors and roles. The ability to generate local initiatives to address this is limited by the extent of local flexibility.

The actions outlined in the green paper to develop the support provided by job coaches look very positive. The signal to coordinate attention to the issue across government is also welcome. However, translating this through to a clear and shared recognition and support of contributions across sectors is a considerable challenge.

11.2 How can we ensure that all healthcare professionals recognise the value of work and consider work during consultations with working-age patients? How can we encourage doctors in hospitals to consider fitness for work and, where appropriate, issue a fit note?

Healthcare professionals recognise that work can contribute to wellbeing but they do not necessarily see themselves as having a role in promoting it and would also recognise the potential for work to compromise wellbeing. They may feel uncomfortable about compulsion to work and would generally

feel unable to identify 'appropriate' work.

Conversations about work and health may also be difficult in clinical settings due to time pressures. Doctors should therefore be expected to have a brief conversation and be more equipped to refer to others who can address work and health issues specifically.

Local areas should consider applying the ethos of Making Every Contact Count to work and health. This would include both NHS and local authority staff being supported and encouraged to have brief conversations about work and health with individuals and suggest sources of support. This would need to be handled sensitively.

All staff, including healthcare professionals, should be informed of the existing range of support offered by the local authority, NHS, and the local voluntary and community sector so that they can share this information with individuals. Local authorities should consider asset-mapping existing work and health resources to gain a picture of the existing landscape, and then sharing this with staff.

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

In reality, GPs may not necessarily be best placed to provide work and health information given that consultations are only 10 minutes long and they are under considerable pressure. This may be better suited to other clinicians who have more regular contact with those with disabilities and long-term conditions, including nurses and therapists. However, if GPs understand the range of support available they will be better equipped to refer people to others and take an asset-based approach.

Further assessment would need to be carried by a multidisciplinary team who can assess people's health needs as well as social circumstances and career expectations. The team could consist of medical professionals, occupational therapists, social prescribers and mental health and musculoskeletal specialists**.**

11.4 Turning to the fit note certificate itself, what information should be captured to best help the individual, work coaches and employers better support a return to work or job retention?

There should be a distinction between fitness to work in clinical terms and information regarding motivation, resources and networks needed to support return to work. The focus of the current fit note is too narrow.

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

It may be useful to mirror the prescribing systems that require accurate information to trigger payment. Taking this approach to record keeping and the fit note may improve available intelligence. Information gathering would benefit from a multi-agency approach using the available tools such as case conferencing to determine where people are on the journey to work, the time frame for progressing to work and who therefore should be the key worker for that individual.

12. Mental health and musculoskeletal services

12.1 How should access to services, assessment, treatment and employment support change for people with mental health or musculoskeletal conditions so that their health and employment needs are met in the best possible way?

There are a range of people who present with and are recorded with these symptoms. Some cases are straightforward and fall within a relatively simple clinical pathway. Other individuals may have complex underlying problems which may only be resolved by addressing their general wellbeing and social circumstances. There should be some caution in interpreting a diagnosis simply in medical terms without putting it in a wider context. This latter group may benefit from a broader coaching approach within a health and social care setting to understand whether there are other issues behind the presentation of these symptoms. There could be a referral process to a single worker or into a case conference type approach with the individual, depending on the complexity.

The whole system needs to create environments which encourage improved mental and musculoskeletal health rather than focussing solely on services for people with these health problems. This will include physical activity programmes linked to the workplace as well as mental health initiatives such as mindfulness.

For people with mental health problems there may need to introduce special programmes to support the take-up and retention of employment as well as programmes to tackle stigma. There needs to be clearer linkage and pathways between employment and health services. One example of an approach could be a 'employment hub' in each borough consisted of multidisciplinary team of professionals providing holistic support. Co-location of Job Centre Plus in Increasing Access to Psychological Therapies (IAPT) services, mental health trusts or primary care would go towards this model.

Another challenge in relation to mental health is often that the individual does not acknowledge an issue and will be reluctant or resistant to support. Developing motivation to work and recognition of barriers (including mental health) is an important step before access to mental health support. Musculoskeletal issues do not carry the same stigma but recognition of the significance of work environments and practices is poor. Medication for musculoskeletal problems is also an important issue. People may have been put on analgesic medication for musculoskeletal pain and may remain on the same medication for many years. It is then the medication itself which may be the most important barrier to improved health and wellbeing. The appropriate services will need to be made available to address this issue.

Feedback from healthcare professionals as well as those delivering employment services to those not in employment suggests that there are a significant number of individuals who have minor mental health conditions often labelled 'low mood' (lack of confidence, family pressures, lack of focus and support to overcome barriers to employment leading to 'drifting', anxiety etc) and which often is not addressed either clinically or by employment support organisations.

'Low mood' as well as depression episodes (sometimes accompanied with prescribed medication but limited clinical, counselling or advocacy support and intervention) is an increasingly occurring condition that manifests itself in short-term absence from the workplace amongst those already in employment as well as longer term disengagement by those who are unemployed, in receipt of Employment Support Allowance and who could be closest to being able to return to work with timely and appropriate support.

There is increased acceptance in the medical community, as well as more widely, that whilst medical interventions are necessary and appropriate in order to treat specific medical conditions or health problems, the importance of strong social networks, access to/ engagement with/ support from friends and family and engagement in an active and healthy lifestyle is often neglected. Such networks can, for example, support individuals to follow- through medical treatment and lifestyle choices such as: actually

taking prescribed medication to treat depression episodes; post treatment exercise and lifestyles programmes provided upon completion of musculoskeletal (MSK) care packages.

Experience suggests that for many individuals there continues to be an anxiety and nervousness of engaging with mainstream services, or at least mainstream services accessed and delivered in traditional settings. For many, engagement with the voluntary and community sector and access to services facilitated by this sector is seen as a better choice and can provide an improved package of integrated support, supporting individuals to identify, and tackle, issues that prevent them from taking the required steps towards employment and sourcing solutions that enable this. There is also an opportunity to utilise and maximise volunteering as a pathway into meaningful day-to-day activity, supporting increased confidence and ambition and leading to healthier lifestyles.

Such an approach fits with the Social Prescribing Model (linked to wider Social Value). As part of this approach, we recognise that removing barriers to progression often has a financial cost; often this is quite low but can make a difference- for example purchasing an additional mattresses or bed to alleviate childcare/ child custody and access issues. This promotes further the concept of self-help, self-management and individuals taking greater responsibility.

We would recommend the following steps:

- That activity to support people into work is done so by adopting the principal that the ultimate destination of participants is paid employment (recognising that some individuals may move quickly into paid employment in a linear manner whilst others will require a wider range of support and interventions and take longer to secure paid employment);
- Putting in place a set of key workers to provide coaching, mentoring and appropriate non-clinical counselling support and advocacy to address issues of: low mood; lack of confidence; limited employment ambitions; lack of purpose and drifting and an inability to identify and remove limiting barriers that prevent 'that next step' on the journey to employment;
- Key workers drawn from/ experience of working across the wider partnerships involving health, social care, employment services and the voluntary and community sector, and will include facilitating access and referral to organisations and delivery that will make a difference. This could include, for example, addressing issues of debt which may be a root cause of low mood/ anxiety/ low to moderate mental health conditions;
- Access to appropriate and timely Information, Advice and Guidance that can be delivered by mainstream National Careers Service providers in voluntary and community settings;
- A personalised budget facility to purchase additional goods and services which is promoted and guided by the key workers; nominally an average of £1,000 per individual has been set aside but we would envisage operating on a flexible basis so that more could be provided if required (e.g. to support an Intermediate Labour Market opportunity); and
- Ensuring that individuals are provided with appropriate welfare benefits counselling as part of removing barriers to employment through facilitating individuals to take the necessary steps and choices.

12.2 How can we help individuals to easily find information about the mental health and musculoskeletal services they can access?

Health improvement programmes and sickness services need to be better integrated into the workplace. Information and resources in both the workplace and in health services is vital.

13. Transforming the landscape of work and health support

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

It may be useful to engage businesses in a dialogue about a local levy to fund a shared occupational service that could be employed through the newly emerging GP federated level organisations or accountable care organisations (ACOs). Delivery through the health service will help engagement with small and medium sized enterprises who do not have the capacity to have their own provision.

13.2 What has been your experience of the Fit for Work service, and how should this inform integrated provision for the future?

Fit for Work and Access to Work services are not being utilised fully, partly because of lack of awareness amongst primary care but also partly due to 'mistrust' as these services are commissioned by the Department for Work and Pensions or national organisations.

The Fit for Work service had noble intentions but may be misunderstood by GPs and misused by employers for staff with long standing problems who are not the intended focus of the service. This seems to be true of NHS and academic organisations. The idea of telephone support as part of a service is a good one, in combination with web based information, but it should be an integral part of the local health system.

13.3 What kind of service design would deliver a position in which everyone who needs occupational health assessment and advice is referred as a matter of course?

Occupational health could be a part of the ACOs and carry out occupational health assessments with some remuneration so that it can be incorporated into the person's health records – creating a single record.

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

14.1 How can we best encourage innovation through local networks, including promoting models of joint working such as co-location, to improve health and work outcomes?

This can be achieved through devolution with clear parameters for innovation. Co-location, particularly the co-location of Job Centre Plus in other services, may result in a more integrated approach with better outcomes for individuals. Commissioning of services to improve work and health outcomes should take a whole-journey approach to an individual, anticipating their likely pathways through the system and providing support at every available point of contact.

It is crucial that small and medium enterprises are considered and included in any programmes since they will find engagement more difficult but make up a large proportion of the workforce.

14.2 How can we encourage the recording of occupational status in all clinical settings and good use of these data?

The best mechanism for ensuring this would be to require it in contracts.

14.3 What should we include in a basket of health and work indicators covering both labour market and health outcomes at local level?

Key components include market data, employment data, health related work absence and conversion to unemployment, the health status of the unemployed, and data on service provision and outcomes.

14.4 How can government and local partners best encourage improved sharing of health and employment data?

There is a need for more established mechanisms both nationally and regionally to facilitate sharing of this data.

14.5 What is the best way to bring together and share existing evidence in one place for commissioners and delivery partners?

A person's ability to work should be considered as an integral part of their overall health and social care needs. There should be a team around the person with the purpose of securing the best health and wellbeing outcome for that individual. For the most complex cases a case conference type approach could be adopted to ensure the right decision in reached and a plan is developed to progress the individual towards an agreed shared outcome.

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

This can be achieved through sharing evidence and ownership of the problem and establishing a clear understanding of the roles of different parts of the system in improving both work and health outcomes. Health and Wellbeing Boards are not mentioned in the green paper yet they play a vital role in bringing together local partners and may represent a good channel for a strategic and joined up approach to work and health.

15. Changing the culture around work and health

15.1 How can we bring about a shift in society's wider attitudes to make progress and achieve long lasting change?

There needs to be a joined-up, integrated approach to work and health which is focused on the person. This should include wrap around services and the adoption of a coaching ethos and needs to be realised at a place-based level.

A commissioning for outcomes approach would be very useful. This would provide an opportunity for all services to own the outcome for an individual and their family, rather than one agency responsible for health, one for securing employment and others for the wider determinants of wellbeing. Leadership is needed for coherence and to support the individual to achieve the outcome of health and wellbeing of which employment is an integral part. It would be helpful if that leadership role was at the local level and recognised by all the contributing agencies.

There is currently a focus on building community capacity and resilience within communities. There should be the same expectation of employers and their 'community' of employees, building capacity to support colleagues with disability to remain and advance in the workplace. There is a need to ensure early access to interventions and preventative measures, encouraged and modelled by leadership and management. In wider society, work needs to be seen as part of a healthy lifestyle. Cultural change is

needed to develop the concept of work for health, and focus on ability not disability.

15.2 What is the role of government in bringing about positive change to our attitudes to disabled people and people with health conditions?

There are a number of ways the government could bring about positive change:

- Remove bureaucratic barriers to employment support for those who are disabled or who have long-term conditions
- Lead by example by employing more people with disabilities and health conditions
- Ensure policies do not imply that people with a disability or health condition are a problem needing to be fixed
- Continue to support access and participation for people with disabilities or health conditions in mainstream activities

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