WoE Work and Health Think Tank

Table 1: Data

Topic **What we know about local populations in respect of work/worklessness, disabilities and long-term conditions; and what are the data gaps?**

Facilitators Henry Lawes, Education Partnership Manager, West of England LEP

Nick Smith, Strategic Intelligence and JSNA Manager, Bristol City Council

Group Discussion

- We are using a geographical definition of WoE that comprises four local authorities: BANES, Bristol, South Gloucestershire and North Somerset. This matches the data sources and analysis of the WoE Local Enterprise Partnership (LEP). It includes, but is not contiguous with, the footprint of the proposed WoE Mayoral Combined Authority (Devolution: BANES, Bristol and South Glos, which is developing a regional Employment and Skills strategy); and cuts across those for the NHS Sustainability and Transformation Plans (Bristol, South Glos and N Somerset; Bath, Swindon and Wiltshire). This makes it more difficult to amalgamate health and employment data, particularly with respect to developing Work and Health strategy and planning services.
- Nevertheless, we do hold demographic, employment, business and health data for the WoE population: we need to know where the data sets are and to be able to match and analyse them. The local authority **Joint Strategic Needs Assessments (JSNAs**) could be the mechanism to do so.
- We also need to understand challenges from beyond WoE (eg central government policy) as well those within the region.

Employment rate: In 2013 the WoE Employment Rate was 73.7%, well above the UK rate of 71.6%. It is also the highest of all large urban areas in England, including London (70.5%). However, there are wide variations within this rate (see Infographics WoE for Work and Health THinkTank).

The West of England's prosperity has increased in recent years, but there are still a significant number of localities and groups experiencing high levels of deprivation. This includes wards with inter-generational worklessness, leading to poor health and wellbeing for residents. Specific under-represented groups include: ethnic minorities, women, disabled people, young people and older people. The common barriers to employment are: limited education, lack of employability skills, disability, childcare, debt, digital exclusion and lack of English for Speakers of Other Languages (ESOL) skills.

Economic inactivity: in WoE (2016) there were 114,000 economically inactive people (aged 16 – 64). Of these, approximately 50,000 were classified as inactive for reasons of long-term and temporary sickness, discouragement and other reasons. The 2014 figures for WoE show 38,900 unemployed people, of whom 2,364 had been claiming unemployment benefits for over a year.

Skills – more people of working age in WoE are qualified to degree level than the UK average (although, whilst the percentage of graduates is continuing to rise, WoE's advantage is reducing). Future opportunities, and the skills needed: in the WoE, those business sectors with high qualification requirements are growing, so there will be a continuing need for a highly-qualified workforce.

Recruitment of skilled workers – 72% of Bristol employers who responded to a LEP survey said they would prefer to recruit already-skilled and experienced workers (less so in other WoE authorities). In the same survey, only 2% - 5% of employers said they prefer to recruit people who are new to employment. Need to understand employer recruitment practices and reasons for gaps – lack of skills needed, not just technical and job-specific skills but also leadership etc.

Jobs forecast – is generally good but there is a threat from automation. There is a need to link jobs forecasts (and therefore skills needed by WoE employers split by area and sector) with skills/training programmes.

Data on shape of workforce – including part-time jobs. What is the definition of 'in employment' here? Longer term planning needed (eg older people coming back into part-time work). Need joint approach to issues e.g. based on regional data on job retention – data on workforce market – split by private and public sectors.

Core data – benefit claimants – split by groups, including equality groups, also by reason.

Top Three Priorities

1. Use consistent data set/indicators, across the four WoE local authorities, linking the JSNAs with employment, skills, health and business data to enable partnership working. To do this, we will need to map and share data sources across the region.

2. Understand output of local education systems; align education/training outcomes with local employer skills requirements (meeting the skills gap)

3. Profile populations and barriers to employment, so that support services can be appropriately targeted, particularly for those groups who are most-affected by unemployment (ESA claimants) or economic inactivity.

WoE Work and Health Think Tank

Table 2 Discussion

Topic **DWP – national and local ambitions and intentions**

Facilitators Shelley Fuller, Senior Policy Adviser, DWP Work and Health

Yvette Naylor, Senior Partnerships Manager, DWP SW

Top three priorities

1. Integration of key partners (the challenge will be to identify partners and drive positive behaviour at senior levels) with an ability to collaborate (e.g. data sharing)

2. Build a shared definition / understanding of what success looks like (shared outcomes)

3. Develop shared language, built around a social model – in order to ensure that processes are inclusive rather than divisive (not 'them and us').

WoE Work and Health Think Tank

Table 3 Discussion

Topic **Mental health – why the system is currently failing people with mental health conditions and what local organisations can do to improve their work and health outcomes.**

Facilitators Ian Popperwell, Mental Health Commissioner, Bristol CCG

Steve Spiers, South Glos Council

Background from Ian

- In general good quality work contributes to good mental health
- Big inequalities in employment level between general population and those experiencing mental ill health
- The longer people are away from work the more difficult it is for them to re-engage
- Current pressures experienced by many at work can contribute to mental ill health so employers need to be aware of this impact
- Stigma is experienced by many in the workplace so they often will not disclose their struggles until they are at a critical point
- There is a lack of support for people experiencing mental ill heath to stay at work
- Reasonable adjustments and Access to Work are not used a widely as they could be.
- Workplace culture is at least as important as support services in supporting positive wellbeing in the workplace.

Group discussion

- **Employment should not be seen as the end of a process of recovery and sustaining good mental health but a fundamental part of the ongoing process. In practice this means every effort should be made to both sustain people in employment but also get those out of employment back as quickly as possible. However this needs to be backed up by appropriate support. It was felt none of this was the current norm.**
- Flexible working could be used more creatively as part of a reasonable adjustment approach.
- Mental ill health needs to be demystified at the moment it scares employers so they do nothing. The power of simple wellbeing activities is often under estimated with an expectation that clinical support is always needed when in reality this is not the case and there is not capacity to meet need anyway.
- **Institutional stigma in the work place is widespread and needs to be addressed at an organisational wide level. MH Champions at all levels are needed. Time to Change's workplace action plan was seen as a useful tool to achieve positive culture change.**
- Overall there is a lack of support for people with low level needs but where it does not exist it is not always widely known about. Managers often do not feel confident to support or signpost their staff.
- Managers may be defensive if workplaces are cited as the cause of stress and this does not lead to an open culture for change.
- The tension was identified between the need to perform and work hard and the need to keep work life balance and positive wellbeing. Achieving both can be hard and one culture, usually that of high performance, tends to win out.

- The private sector needs a business case to invest in staff wellbeing.

- If was felt while more people may be prepared to disclose anxiety and panic attacks than conditions like psychosis and personality disorder where more taboo.

- **Wellbeing activities giving socially inclusive meaningful activities were seen as very positive so services like wellbeing colleges or wellbeing hubs as well as social prescribing were well received but it was pointed out that many people don't know they exist so access is patchy. It was also added that longer courses for about 8 weeks with an accredited awards of some type were the next stage on from wellbeing activities that otherwise focus mainly on developing networks.**

- Social media was seen as part of the continuum of support for those who were out of work and isolated.

Top three priorities

1. Employment should not be seen as the end of a process of recovery and sustaining good mental health but a fundamental part of the ongoing process. In practice this means every effort should be made to both sustain people in employment but also get those out of employment back as quickly as possible. However this needs to be backed up by appropriate support. It was felt none of this was the current norm.

2. Institutional stigma in the work place is widespread and needs to be addressed at an organisational wide level. MH Champions at all levels are needed. Time to Change's workplace action plan was seen as a useful tool to achieve positive culture change.

3. Wellbeing activities giving socially inclusive meaningful activities were seen as very positive so services like wellbeing colleges or wellbeing hubs as well as social prescribing were well received but it was pointed out that many people don't know they exist so access is patchy. It was also added that longer courses for about 8 weeks with an accredited awards of some type were the next stage on from wellbeing activities that otherwise focus mainly on developing networks.

WoE Work and Health Think Tank

Table 4 Discussion

Topic **Musculo-skeletal conditions – the largest cause of sickness absence. What needs to happen to get people back to work quicker?**

Facilitators Emma Clark, Director BHP Bristol Bones and Joints HIT

Karen Wallace, GPST3 Southmead & Henbury Family Practice

Group Discussion

Current Key Issues

Lack of employer support to help employees manage long-term conditions and sustain employment

Managing cultural expectations – not re-disabling conditions

Lack of education/training for employers

Lack of knowledge/support for GPs to assess who is fit for work

Commissioning and delivering networks

- One Care Consortium pilot project 'Rapid access physiotherapy' offers a rapid-access telephone advice service to patients, seeking to address the acute MSK problem and lack of GP appointments http://onecareconsortium.co.uk/physio
- Social prescribing
- Disability Rights UK – advice to organisations on procurement and commissioning processes
- Job coaches
- 'Help to Help' – 3 tier social care model
- 'Building better opportunities' (Big Lottery/ ESF funding) https://www.biglotteryfund.org.uk/esf https://www.biglotteryfund.org.uk/global-content/programmes/england/building-better-opportunities/west-of-england
- Occupational health
- Wellness guidance by Mencap
- Job Centre
- Working and Health Programme
- Health and Wellbeing Boards

Top Three Priorities

1. Integrating the education system – infiltrating the curriculums 'Health School Programme'. Encouraging self-care, self-limiting illness, mental wellbeing including family education.

2. Health Integration Team on 'Health and Employment

3. Employers' support as a single point of access

WoE Work and Health Think Tank

Table 5 Discussion

Topic **Disability Rights UK – what do employers need to do to recruit and retain disabled people?**

Facilitators Leo Capella }

Anna Denham } Disability Rights UK

Charlotte White}

Group Discussion

The current key issues include:

- Lack of support for disabled people
- Lack of understanding/knowledge amongst employers
- Fear, especially re: employing visually impaired/deaf people – there is a level of ignorance amongst employers
- Competency-based interviews are common and tend to disadvantage young disabled people, who often haven't had opportunities for previous work experience (e.g. paper round)
- Supporting deaf employees can be difficult and expensive for smaller companies
- Potential employees risk feeling a 'burden'
- Inability to claim for Access to work support and lack of help to do so
- These issues continue once in employment e.g. Jane Cordell and lack of funding for signer
- Pressure to make decisions re ESA
- ESA support criteria are too general
- Fit for Work assessments are often ineffective and are not necessarily in agreement with health treatment/advice received by the employee.

Commissioning / delivery networks

- Deaf Plus commissioned to ensure the future of their service
- Deaf Plus have to provide commissioners with reports to retain the service/funding
- Awkward to produce information for commissioners – too bureaucratic and lack of understanding from them
- Funding not necessarily going where it's needed due to lack of understanding
- Targets influencing practice rather than local understanding/insight

Top Three Priorities

1. Improve recruitment/selection processes such that they are more inclusive of disabled people: address the fears of both the employer and the employee
2. Work with grassroots 'bottom-up' approach
3. Make Access to Work scheme easier for employers to access.
4. 'Universal' design/enablement approach to new-build work environments

WoE Work and Health Think Tank

Table 6 Discussion

Topic **Into Work Programme – local practice, employment skills and health**

Facilitators Jane Taylor, Service Manager, Employment & Skills, Bristol City Council

Paul Gaunt, Bristol City Council

Group Discussion

Jane Taylor	Bristol City Council
Paul Gaunt	Bristol City Council
Joanne Payne	New Fosseway School
Justine Jones	Serona
Simon Arnold	N Gage / WTPN
Elaine Flint	Healthy Living Centre
Sue Escourt	Weston College
Frances Brennan	PLUSS
Terinaya Cummings	Southern Brookes
Sam Ponsford	Campbell Page

Notes of general discussion

1	JT	Overview of the employment support initiatives and programmes in Bristol and the wider West of England including: • HYPE West, (a multi-agency collaborative support programme for 18-24 year olds aimed at helping them find and sustain long term employment) • Works, an engagement Hub for young people aged 15-19 to work with them and the people that support them in their career and employment decisions • Adult Education Budget - £20m in devolved funding which is coming to the West of England and how we will have the ability to influence spend • Apprenticeships and Internships – with the introduction of the Levy, there needs to be a plan to explore how we can use it for people with health conditions • Social Value Commissioning and how we can build targets around employment and skills into Council and public sector contracts.
2	FB	Discussion round how there is a struggle to recruit people with construction skills in Somerset and how there is a need to bring partners together to address this
3	EF	Spoke about the Boost programme in the Lawrence Hill area of Bristol and how this small, charitably funded programme can grow through links to the BBO. Elaine felt that the key issue is how we embed individualised support into practice and make the "joins" and partnerships to provide an inclusive collaborative approach to employment, skills, health and disability
4	SP	Sam discussed the need to influence GP's with regards to the issuing of sick notes to make them see work as a health outcome
5	SE	Sue gave an overview of Team North Somerset and how it was established through a pot of money from the local authority and social housing providers and has evolved to a position where they are currently establishing a local hub and are working with a number of organisations who are advocating social prescribing. Furthermore Weston College are currently developing a Wellbeing Academy
6	FB	Frances focussed on the issue of working with employers and how she felt that the SME base was more appropriate in supporting people with health conditions
7	C	Christine outlined how the New Fosseway School helped young people in achieving their health outcomes, through linking them with employers who offered supported work.

8	SA	Simon explained the work of the WTPN who are talking with employers to develop work place mentoring programmes
9	EF	Elaine stated that 40% of a GP's caseload is non-medical. She felt that there was an opportunity to work with them to identify ways in which patients could be triaged to programmes which focus on employment, housing and debt advice etc. The health and social care system should be equipped with general employability information for low level interventions A clear referral route should be developed which embeds the links between health and wellbeing into support services
10	SA	Simon commented that to deal with skills shortages, employers should be informed how to access support to employ people with health conditions. Furthermore there was a need for "job carving" whereby entry level job roles are identified for people with certain conditions
11	PG	There are many different initiatives to support people with health conditions but there is not a comprehensive baseline that catalogues them.
12	JT	Jane felt that there is social disadvantage and isolation of whole communities on the basis of race. This could be addressed through linking education, CCG's the devolved Mayoral Combined Authority, Big Lottery and wellbeing initiatives to bring health and employment provision together through the establishment of local strategic level integration boards.

Top Three Priorities

1. There is a willingness and need to establish an Integration Board / HIT Team composed of strategic level Health and Employment representatives.

2. There is a need to develop a package of support and tools for employers to enable them to feel more confident in providing work experience and employment opportunities for people with health issues.

3. There is a need to develop a package of support tools for health providers which focusses on:
    a. The benefits of social prescribing
    b. Simple referral routes to employment support services
    c. Support packages for individuals with health issues to gain employment.

WoE Work and Health Think Tank

Table 7 Discussion

Topic **WoE Combined Authority – partnerships**

Facilitators Paul Scott Deputy Director, Public Health Bath

Kate Stark BANES Council

Chris Shaw Sheffield Council

Group Discussion

Lots of provision but can it articulate the offer.

Language

Understanding support

WoE boundaries are false for people but impact on access to services

Driven by LA boundaries

Different organisational footprints and different organisation silos are a challenge to overcome

CCG → North Somerset + Bristol + South Glos

Examples in LAs of reduced collaboration – need to build up joint working to make an impact WoE wide

Choose the 'art of the possible'. Don't be afraid to 'tread on toes'

Remember the human scale – what do people and employers need?

Build on:

Bristol work zones

Team North Somerset

→ variety of organisations committing

→ central co-ordination + support + learning structures

BBO Project = VCS led → need to make sure this all links i.e. with Team Nth Somerset

Regional and local points of access needed – connecting system elements

How can examples of good practice influence other strategies eg STPs?

Bottom up organisation of services

Need hand holding for people

Generalising conditions can be a barrier. It is currently difficult to connect at WoE level

Simplification

Recognised points of engagement

Strategic leaders → open forums → need to balance expectations

Service user input into Strategic Plan

Data and shared understanding of key messages → more granular i.e. relationship between employment rate and skills – difference between skilled and non-skilled

Group Discussion cont.

Disabled access to skills development – need more control over this.

Links to ED teams → workplace health agenda preventing people going off work. Increase significance of message re: diverse employment.

Educating employers to look after their assets

Access to soft skills; interview practice; communication.

Benefits for employers of healthy workforce (Westsport research completed on this)

Need set of high level outcomes. Example DCMS

Employer outcome = access to new recruitment market especially for hard to fill vacancies. Pre-employment support + aimed at sectors

Joint clear definitions i.e. DWP definitions include long-term conditions.

Top Three Priorities

1. WoE co-ordination/integration: 'Hiding the wiring' ie integration of services so that people can 'join' and be referred at any point; don't need to know who provides the underlying service
2. Involvement of service users in system design, implementation and evaluation; wide engagement, eg link with housing services
3. Work towards shared outcomes across all sectors: in the first instance, embed work and health outcome requirements in all public sector commissioning. Develop evaluation frameworks to measure work and health outcomes in delivered services.

WoE Work and Health Think Tank

Table 8 Discussion

Topic **Social prescribing/self-care – how can social prescribing support disabled people and people with long-term health conditions (including mental health conditions) to access support?**

Facilitators Ellen Devine, the Care Forum

Colette Bourn, Second Step

Sue Moss, Public Health Bristol

Group Discussion

Social prescribing can support people in work to improve their wellbeing and therefore stay in work. It is not just for people out of work. It could have a role in being an advocate for someone to help them to be listened to in their workplace. Businesses could fund this for their employees.

There are different models of Social Prescribing within and across regions e.g. South Glos and North Somerset have Community Connectors, Bristol has lots of VCSE projects and BANES has DHI. There is a need to raise awareness and create a better understanding of what social prescribing is and how it can be used across WoE. This needs to be wider than GPs. For it to be successful there needs to be a consistency of referral routes and we need to align processes and pathways across regions. It will help to ease pressure on other services.

Note: yellow sticky on this section says 'totally misses the link with routes into work. We need to make this connections'

Social prescribing can be a stepping stone to work but how can this be measured as an outcome? It is difficult to measure as a person's 'journey' into work can be a long one. Social prescribing also supports people to stay in work.

We need to value 'where the person is at'. It is not realistic for everyone to be 'pushed' into work, but many people could do volunteering. For some people 'work' is terrifying because it is seen as a place that is not understanding of certain conditions especially mental health. We need to change the work culture.

GPs don't fully understand Social Prescribing and see it as too many little projects with different criteria. It is too reliant on GPs for referrals and misses other options and opportunities.

Social prescribing relies on there being activities in the community there needs to be funding for VCSE/community development.

Top Three Priorities

1. Have a consistent understanding of the route into and evaluation of social prescribing across WoE.

2. Recognise the value that social prescribing could have in supporting people into work or keeping people in work.

3. We need to value 'where the person is at' work may not be realistic but volunteering may be an option.

WoE Work and Health Think Tank

Table 9 Discussion

Topic	**Addressing financial exclusion and welfare reform: supporting people experiencing changes to their benefits to find work, access training and get other support they may need to improve their situation for the long-term**
Facilitators	Vicki Morris, CEO the Care Forum
	Zoe Trinder-Widdess, Communications Manager Bristol Health Partners

Group Discussion

South Glos backing the trend of mental health figures in terms of ESA claimants

What does 'behavioural' category mean in local data? (Linked with mental health conditions)

Mental health deteriorates over time if you're out of work for too long – data doesn't show if there's an overlap between categories.

Work has to be relatively well paid to replace ESA benefits if it's a disadvantage to enter at a minimum wage job then how do we address the skills gap?

Lack of consistency with job centres. Job centre support is not encouraging, empowering. It's focussed on getting you off the books. If you go off benefits, the pay must be good enough to make it worthwhile. Referrals to services from job centre – claimants feel it's about meeting government requirements, not a benefit to the claimant.

Job centres – are they willing to be flexible?

Don't just have a Job Centre have a 'one stop shop' that also offers support in other areas e.g. mental health.

The structure holds things back. Care leads could help people – multi agency/disciplinary teams bring out the best and bring people together.

Universal credit means in BANES, Job Centres had to bring other agencies in. Job Centres will see the benefit but could central Government stand in the way of that?

Universal credit may force the issue, but DWP support is key.

If you want to get people off long-term benefits you need to invest (*in what?)* but is central Government up for that? This is about cost (timings?) in the end.

Pathways to other support – confidence skills etc. needs investment and local/central initiatives end up derailing things.

An employability passport – how do you make service users move through and out?

Short-termism of investment is an issue. Declaring things like voluntary work causes problems at Job Centres.

Referrals from things that already exist e.g. mental health services making work a health outcome for mental health services.

Fear 'I've got to stay well now'

It's a difficult system to navigate, especially if you have mental health issues. A single point of contact?

Revolving door syndrome – people attending one course after another. Trying to avoid revolving door outcomes.

WoE Community Learning – adult education budget from national pot – fine for next year but then it will be a devolved budget.

BANES – working to build better opportunities – 5 year funding – longevity.

Job retention service doesn't exist and probably should.

KPI driven culture is unhelpful and counter intuitive

Does something need to be done specifically for young people? Better investment as it's more long-term as they have their whole lives ahead.

Education, health, social care – employment needs to be in there.

What about older people? If they want to work or volunteer – can we establish connectivity between workplace, volunteering etc. occupational health for the voluntary sector?

Volunteering – attitudes need to change. It should be an option for people's pathway. Volunteering is important for wellbeing/confidence.

Volunteering – job descriptions etc. needed for parity. But need awareness of lack of resources in smaller charities. Volunteering offers flexibility

Volunteering is used to replace paid posts. If you can only work 6 hours in a voluntary capacity you should be scared of hitting thresholds.

Universal credit should help with the 16 hours threshold – some employers don't support their people with this in mind.

Heath outcome = employment – but some services don't help with that.

Joined up 'hubs' – one stop shops that give benefit, employment, financial advice. Stop people having to repeat themselves. Longer term funding necessary for this – no short-termism!!

Focus on wellbeing and health as being vital for employability – 'work as a health outcome'. Being in sustainable work that is good for your wellbeing. Equality of access to services e.g. IAPT, physio, and bereavement support to improve employability and health outcomes.

Good quality advice – someone to talk to and do your better off calculations. Not just a careers service – whether you're in employment or not.

Top Three Priorities

1. Job Centres as a One-stop Shop that gives benefit, employment, financial advice and offers support in other areas e.g. careers advice, mental health
2. Systematic promotion of referral pathways by statutory services (for example MH providers) into appropriate services for people who need support to help either stay in work or get ready to return to work. This will require specialist services to identify work as a key health outcome.
3. Ensure volunteering is an option for people's pathway to work by establishing connectivity between workplace and volunteering e.g. job descriptions.
4. Establish equality of access to services e.g. IAPT, physio, and bereavement support to improve employability and health outcomes.

WoE Work and Health Think Tank

Table 10 Discussion

Topic	**Fit Notes – how can we ensure good quality conversations about health and work and improve how Fit Notes work?**
Facilitators	Marion Steiner, GP Henbury, Self-care and social prescribing lead @ CCG Strategy
	Lisa King, Programme Manager, Bristol Health Partners

Group Discussion

Q1 what are the current key issues

A: Unhelpful HR policies

A: GPs don't know what is out there

A: Retention

A: There is a clear gap in provision – *did you discuss provision of what?*

Q2 what commissioning and delivery networks exist

A: We don't really know – we need to map this out.

Q3 what are your top 3 priorities?

As a GP, when we changed to writing Fit Notes it felt like a great opportunity and step forward but, there is some tension; GPs are unaware of support mechanisms which are available to support people back in to work

An initiative called Tomorrow's People came into the surgery to assist people (nationally backed) but not sure why this disappeared

Difficult to contact the job centre (unable to get through). Often patients say the job centre has advised them to get a sick note – not sure how to explore alternatives

Some patients have a heavy burden of illness but are very resilient – others not so; GPs are in a difficult position to make the judgement regarding appropriateness of sick notes. Could sometimes be that the person's manager is not understanding and making reasonable adjustments. Reasonable adjustments for mental health issues are poorly understood. There is a disparity between physical and mental health issues. Need to educate employers so that they are able to prevent/respond to problems.

Second Step promote Wellness recovery action plans - one method to tackle this and educate how to manage mental health.

Training around employability pathways. Recovery College (for people using mental health) and also open courses. Pilot being funded at the moment via the Trust – difficult to identify funding for holistic approach.

Policies sometimes work against people – e.g. employees not eligible for phased return unless they have been off sick for 4 months. Need to educate employers about what an appropriate policy looks like and also convincing them of the benefits of being flexible.

Any actions asked of GPs need to be quick and easy because of their time pressures. Would be good to link into social prescribing.

Community resource co-ordinators are located in practices now as part of reception staff – employment services should be within their remit.

Liz – a culture shift is needed – there is a lot of fear. Need to offer genuine support that people are not suspicious of. Could make policies around dismissal in close proximity to sick notes stricter – in order to change culture. Shift focus to retention rather than getting people back to work.

Need to introduce something new in the system – maybe just people working together to provide the resource in a different way. Need to fill the work and health gap somehow.

Could expand the role of OH – so that employers can consult them for advice – this might provide a simple solution but funding might be difficult (this is a private, paid for service currently). There is a business case to be made for an additional service to fill the gap.

People working in job centres need listening skills but they don't always have the time or the knowledge required to do this effectively.

Hospital doctors – need to be able to refer people at the point of diagnosis to someone who can provide the support they need.

Top Three Priorities

1) Need to map what is out there (within our region and outside) in terms of employment advice and support for employers and employees. Could learn from others and build on existing good models

2) Need to focus on retention as well as getting people back into work – crucial to provide advice at the point of diagnosis

3) Need a focussed resource, channelled through Social prescribing initiatives, which looks at retention alongside supporting people in returning to work. Social prescribing provision is variable across the region - flexibility should be retained whilst a framework is also established

4) Need to educate all and change culture – including cost benefit analysis so that employers and staff understand the potential impact