

**NEWSTATESMAN**



Does getting  
**back to work**  
have to be a pain?



2 March 2009

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First published as a supplement to the New Statesman issue of  
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# Working towards a healthier nation

Work is good for you. It meets psychosocial needs, provides a framework for identity and social status, reduces poverty, and promotes rehabilitation and health.

With more than 2.6 million people in the UK dependent on incapacity benefits, the government is looking for ways to help people return to the workplace. The development of the new Employment and Support Allowance that is replacing Incapacity Benefit and Income Support focuses on what people can do, rather than on what they can't.

One of the most common reasons for incapacity and time off work is pain. On page 4 Ingrid Torjesen provides an overview of how chronic pain is currently managed (or not) in the UK.

With a view to improving work and life opportunities, participants of our round table discussion considered:

- How we can improve the way pain is assessed and treated
- How we can better identify people with problems and support them before they need to take time off work
- How we can help people suffering from chronic pain back to work, when they may have residual health issues
- How we can join up services to ensure that no one falls between the responsibilities of the Department of Work and Pensions and the Department of Health

This and the other reports in the long-running series of *New Statesman* and Pfizer joint-sponsored round table discussions are available at: [www.policyforum.co.uk](http://www.policyforum.co.uk).



# Cost

## of chronic pain in money and misery

With no physical test to diagnose or measure the severity of pain, no guidelines for GPs on how to manage its chronic stage and no incentives to treat it, it is hardly surprising pain costs us so dearly, writes *Ingrid Torjesen*

Chronic pain is a significant burden on the UK economy, not just on the NHS. Around 7.8 million people in the UK live with it. For most, it substantially reduces quality of life and requires time off work. For some, it turns the activities of daily living into a daily struggle, so they do not work and instead rely on benefits.

The total cost to the economy is very difficult to calculate. However, according to the Pain in Europe survey in 2003, three-quarters of people affected by chronic pain in the UK are of working age.

The cost of benefits alone for people unable to work because of chronic pain comes to £3.8bn per year. Figures from the Department for Work and Pensions suggest that 2.4 per cent of incapacity benefit claims were for pain-related problems. Around 22 per cent of people in chronic pain go on to develop mental-health issues in the form of depression.

For those who continue to work, pain increases absenteeism and reduces

productivity. Around one-quarter of people diagnosed with chronic pain will eventually go on to lose their jobs – and the longer people have to take off work, the less likely they are to return.

Of those who have been off work for six months with chronic pain, only 50 per cent will go back.

In October 2008, incapacity benefit was abolished and replaced by Employment and Support Allowance, as part of government plans to rid the UK of its “sick-note culture”. Health Secretary Alan Johnson said he wanted to see a “well-note culture” instead and the new allowance sets out an individual’s capabilities for work rather than their incapacity.

He quoted figures indicating that nine out of ten people who begin claiming incapacity benefit expect to return to work. But he added: “In too many cases, what starts off as a short-term health issue slowly develops into a much deeper problem that prevents someone from ever working again.”

In the case of pain, this is when it becomes a chronic problem. Pain is termed chronic when it is not linked to an identifiable cause that can be healed or when it continues beyond the expected healing time of the condition with which it is linked. This is generally accepted to be three months. Any pain that persists for more than three months generally becomes chronic, highlighting the need for people with pain to be seen and treated quickly.

To date, neither politicians nor the health sector have given pain the priority it deserves. It is a “silent epidemic” and the large tranche of population affected by it is mostly managed by general practitioners (GPs).

One reason for this is that there is no physical test to diagnose or measure the severity of pain. Its assessment relies on patients grading what they feel using visual analogues or verbal-rating scales. This is unreliable because it is inconsistent and re-





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lies on patients recalling the intensity of the pain that they felt. As a result, it is difficult to get a clear picture of what proportion of the population is affected by pain and how badly. Estimates put the proportion at between 10 per cent and 50 per cent, with a degree of consensus at around 20 per cent.

About one-quarter of the time that GPs spend managing chronic conditions is focused on pain. But the question is whether ordinary GPs are equipped to manage pain effectively and whether they are the best health professionals to do so.

There are no primary-care guidelines on managing chronic pain for GPs to refer to. The British Pain Society and the Royal College of General Practitioners (RCGP) are currently developing guidance but, at present, GPs only have the British Pharmacological Society (BPS) and RCGP guidelines on neuropathic (nerve) pain and the National Institute for Clinical Excellence (NICE) guidelines on osteoarthritis to guide them.

Unlike treatment of other chronic problems, GPs are not incentivised to manage pain. The quality and outcomes framework (QOF), which rewards practices that demonstrate improved care and outcomes for patients with long-term conditions, such as asthma, hypertension and diabetes, does not include chronic pain, even though chronic pain takes up a much larger amount of GPs'

## Provision of specialist pain services is patchy to say the least and, where good services exist, there are often long waits

time than some of the other conditions.

Every year there are 4.6 million GP appointments for pain, but these consultations rarely resolve the problem and patients will return. GPs usually treat pain with a prescription for painkillers and some patients will end up taking several different kinds.

In 2005, 66 million National Health Service analgesic prescriptions were dispensed in England at a cost of £510m. In addition to this, a massive amount was spent on over-the-counter pain relief. Some GPs also still advise rest, whereas what patients actually need to do is exercise under the advice of a physiotherapist.

GPs have little choice but to attempt to manage chronic pain in the best way that they can. Provision of specialist pain services is patchy to say the least and, where good services exist, there are often long waits. A survey by the RCGP in 2004 found that nearly one-quarter of patients waited more than one year to be seen by a secondary-care pain-management service and that only 13 per cent of these clinics had waiting times of three months or less. That same year, a report by Dr Foster, the healthcare information provider, found that only 36 per cent of primary-care organisations had allocated any specific funding for pain-management services and just one in five provided a formal or structured chronic pain service.

Ignoring pain is a financial mistake. Long waiting lists for specialist services and physiotherapy make it more likely that pain will become chronic. What is needed is a multidisciplinary approach.

A great deal of pain management can take place in primary care but, where it does so, the patient's GP needs to work in collaboration with other health professionals, such as physiotherapists and specialist pain nurses. What is needed is early assessment, either in hospital or in the community, by a specialist team. Most patients can then be managed, either by their own GP or by a community pain clinic, involving GPs with a special interest in pain management working in tandem with a pain consultant.

Where such approaches have been put in place, the evidence is that waiting lists have been cut drastically, ensuring that people with pain are seen and start receiving appropriate treatment before their pain becomes chronic.

*Ingrid Torjesen is a medical writer and health journalist*

# Round table: what we need to get back to work

**Branwen Jeffreys** We know that the overall cost to the UK economy of sick leave or unemployment through ill health has been estimated at around £100bn. Last year, Dame Carol Black produced a government report *Working for a Healthier Tomorrow*, on the health of Britain's working-age population. She described that cost as "an historical failure of healthcare and employment support for the workless stretching back generations".

Around 2.6 million people are still on the old incapacity benefit, although that figure has been going down. Incapacity Benefit (IB) is being replaced by Employment and Support Allowance (ESA) under the welfare changes being brought in by the government. However, unemployment is rising – approaching two million. The last two recessions have left a legacy of people on benefits and out of work, many of whom have then struggled to get back into employment. So, if the fit and well are losing their jobs, where does that leave those in poor health and those suffering from chronic pain?

Minister, in the context of difficult economic circumstances, how easy will it be for you to deliver on your promise to get more people who are suffering from ill health back into the world of work?

**Tony McNulty** The move from IB to ESA is hugely important. We will see over the coming weeks quite what the change in nature and shape of the first cohort of ESA is, compared with IB, including the numbers of people who get through and whether



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**Paul Watson**

they go into the 'support' group or the 'work' group.

It is hugely important because it shifts things to what people can do and how we can help. There will be a number of people (we think about 20 per cent) in the support group, for whom, unless they voluntarily want help and assistance to stay close to the labour market or to get back into work, debilitation is the norm. If they want to get back into work, we will help them, but they should get as full a support as possible. We think the rest of the people we can work with.

I do take to heart what you said about previous recessions. However, I do not think we should leave people behind in that context, either in terms of the narrow focus on the new people on ESA or what we are trying to do with Welfare to Work and the longer-term unemployed. There is a contraction of the available vacancies. There are now about 500,000 or so. Even with that, many of those jobs may not be appropriate jobs for people in this particular area. It may well be that, for a time, it becomes more about helping people and focusing on them being as ready as possible to get into work and as close to the labour market as possible, rather than actually getting them into jobs. However, it is not appropriate that we forego that effort and deal with those far more work-ready (because they have been in jobs for 20 years or whatever and have sadly fallen out of employment). It is not a civilised way of going about things or politically the way we should go about things.

**Branwen Jeffreys** I would like to talk a little bit about pain itself. It is a very complex physical and emotional mixture. Heather Wallace, you are chair of the charity Pain Concern. You deal with many hundreds of people through your helplines. You also have experience of being out of work through chronic pain. Can you just describe what very severe pain is like?

**Heather Wallace** Pain varies and even one person in pain is going to have different intensities of pain from time to time. That fluctuation is one of the challenges of getting people back to work.

Quite commonly, people are in a situation where every fractional move brings wave after wave of shooting pain. People say that you cannot even speak or even cry out for help. You are just speechless and engulfed by this pain. That is about as bad as it does get. A lot of women say it is much worse than childbirth.

It encompasses experience of aches and pains, which can be really quite distressing, right the way through to

something where you cannot even get to the loo.

You cannot even describe pain to yourself, partly because you are so bewildered by it. I had pain as a child but I did not recognise some of the sensations as pain. It was only years later when a doctor put me on a drug, amitriptyline, that I suddenly realised, "Oh, that was pain."

**Branwen Jeffreys** I would like to draw on some of the doctors around the table to talk about what we know about pain. Is there any simple way of relating pain and how you measure it to how people confront it and their capability?

**Paul Watson** The relationship between pain and function is very weak. That is one of the problems that we have. The longer the pain goes on, particularly with chronic pain, the more difficult or tenuous that relationship is. In acute pain, for example, when somebody has a recent injury, the relationship between pain and function tends to be stronger.

Chronic pain waxes and wanes and so does the function associated with it. Some people with chronic pain have a remarkable level of function, despite their chronic pain, so it is quite difficult to have a direct link because pain is extremely personal, very variable and changes over time.

Pain is always seen as directly proportional to the amount of injury, which it is not. Some things that are supposedly quite trivial can be very, very painful.

**Branwen Jeffreys** Dr Collett, how much does people's capacity to deal with pain, and to function with it, vary according to other factors?

**Beverly Collett** One of the most important factors is the person in pain understanding why they have got pain, because many people in pain do not understand why they have it. They have had an injury or an operation and the pain has persisted. We doctors are still looking for this sort of Cartesian model where the amount of tissue damage you have equals the amount of pain and yet we know now that there are many changes that go on in the spinal cord that perpetuate the pain message.

It is really important for people in pain to understand what is going on in their bodies and also to understand, in the terms of mechanical lower back pain, that actual hurt does not mean harm. A lot of people get what we call fear avoidance. They are very concerned about doing activity because it makes the pain worse.

There are also some differences that we are aware of relating to genetics. Some people do have different pain susceptibility. We also know that there are some gender differences in the amount of pain complaints. We know that hormones affect our perception of pain. Testosterone protects against pain; female hormones may make us more susceptible. There are cultural influences on girls and boys growing up and how your mum and dad related to you when you had pain. It is a complex experience.

When we talk about measuring pain, we do not

## I remember looking after chronic angina patients for whom you could not explain the chronic pain by the physiology **Berkeley Phillips**



just want to measure pain intensity; we also want to measure the impact that pain has on quality of life, on sleep and on the ability to do things.

**Paul Watson** There are also differences in responses to pain as well. Women tend to be slightly quicker to become depressed as a result of their pain, probably because of the way their role changes, whereas men tend to express a different type of distress. Depression in women is often more acute and more common, particularly with chronic pain.

**Branwen Jeffreys** Dr Phillips, what do we know about how prescribing relating to pain has changed?

**Berkeley Phillips** The points raised about the importance of diagnosis are crucial because people with pain can present in so many different ways to healthcare professionals.

As a cardiologist, I used to find that managing the uncomplicated patient with angina was reasonably straightforward because you know that the arteries are narrowing and that causes the pain. You can prescribe something that opens up the arteries and relieves the pain.

However, I remember looking after chronic angina patients for whom you could not explain the chronic pain by the physiology. It was much more difficult to understand how to treat that patient. I think that will delay the diagnosis. Once you get into the realms of chronic pain, it is really crucial that that specialist identifies that a patient has chronic pain. The cardiologist in this example might not be the best specialist to look after that patient.

**Branwen Jeffreys** How do we interface that with a system that wants to test whether or not people suffering from chronic pain are able to get back to work? I would like to talk a little bit about pre-incapacity and at what point we should be identifying people who are going to develop chronic problems. Dr Duckworth, at what point should we begin to assess people or begin to intervene?

**Stephen Duckworth** I think intervening early is a danger because, with all due respect to the doctors around this table – and I was once one of them – doctors make you sick. If you look historically at the experience of pain over the ages, pain has become more common as there have been increases in medical advances and diagnostic techniques, such as MRI scanning. As soon as a patient with pain has a MRI scan, it confirms in their own mind that it is a serious thing.

I would like to see employers adopt an approach that creates a more healthy working environment so that anybody whose function and capacity to follow the requirements set out in their employment contract are provided with the necessary tools to do the job. That could be an ergonomically designed chair that allows them to sit more comfortably. They could have a workplace assessment or a risk assessment to ensure they have the right-sized keyboard or that, if they are left-handed, they have a left-handed mouse. Those things can be done as standard practice in a large organisation.

What we do not have at the moment (Carol Black has spoken about this) is the need to have that sort of service available. Perhaps it should be through primary care trusts (PCTs) working in partnership with the local authorities to deliver an occupational health service to the small- and medium-sized enterprise (SME) sector, so they can provide an ongoing service to people who are vulnerable to absences from work.

The later we medicalise the problem, the better. That should only happen once you have explored all the potential adjustments to alleviate the symptoms that a person might be feeling. Carol Black said that signing someone off sick is a major clinical intervention in its own right. However, many GPs operate in such a way that the easiest thing to do, maybe, if a patient has complained many times, is to sign them off sick.

We do not have a triangular relationship, with a GP being able to get back to the employer and say, “We need to get this sorted out otherwise we are going to have somebody with long-term pain.”



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**Phil Gray**

**Branwen Jeffreys** Phil Gray, as a physiotherapist, you often advocate catching people earlier.

**Phil Gray** Very much so. I fully respect what Stephen is saying in terms of over-medicalisation. Perhaps we need to distinguish between intervening and letting people who have a particular problem think that their situation is irrecoverable, which is the point that he is making rightly.

Early intervention is a crucial part of what has been missing. The second recommendation in Carol Black's report is early intervention – rapid access and early intervention. The role of the National Health Service (NHS) in this is still missing.

International research shows very clearly that the earlier you can give people access to specialist advice or treatment, the better, and the greater the chance that they will get back to work quickly.

Psychologically they will not get into a position of thinking, “This pain is so terrible that I cannot possibly do what I was doing before.”

The statistics show that, if you can intervene in the first six weeks, the odds for people going back to work are excellent. After ten weeks, you get an increasing likelihood that they will not go back to work. As the Department for Work and Pensions (DWP) knows very well, after six months, the odds are that, once you are on IB, you will be on it for a minimum of eight years and you will more likely die than you will return to work. Early intervention really matters and, if we miss that out, we are condemning many people to going on to IB and into further chronic conditions.

In the middle of a recession, it is more important than ever that people have the chance to retain their jobs and those people who are at risk of going off ill are those who are more vulnerable to being selected for redundancy when times get tough.

I was very bitterly disappointed by what came out of the joint DWP and Department of Health (DH) response to Carol Black's report. On page 65 of the lengthy report, it has three paragraphs with the heading “Ensuring the NHS supports people to work”. In other words, the vast majority of this appears to have let the NHS off the hook.

The NHS has been completely unwilling to make early intervention one of its priorities. Even now, although physiotherapy self-referral is on the new operating plan from next April, the return-to-work focus is not there.

**Branwen Jeffreys** Tony McNulty, this problem does involve cross-departmental working. What do you have to say to that?

**Tony McNulty** It surely does. For that part of our responsible action, I would say, “More to follow.” In the longer term, we need to make sure that we educate people about work and the potential downfalls of work in terms of your own personal health. The health dimension to work is never referred to other than in problematic times.

Equally, I am concerned about the psychological

and other impacts on people from failure to get into work. That is a huge issue. The DWP is certainly very clear that, if this is not done across the board by government, including the health and prevention aspects, then it will be a missed opportunity.

**Hugh Robertson** There is far more presenteeism than absenteeism. Far too many people go to work when they probably should not be there in the initial acute stages. As a result, because a lot of these conditions are either caused or made worse by work, they are not doing themselves any good. An acute condition can become chronic if people do not seek help.

Good work can be good for you, but 2.2 million people reckon that their health has suffered because of their work. People are rushing back to work before they are ready and a lot of people with chronic pain conditions are not being given the opportunity to properly recover. If your back pain is being caused by long-term heavy lifting, going back into the same working environment is not going to do you any good. It is not always employers or doctors who are rushing people back; it is often the individuals themselves.

**Paul Watson** I would agree with that for particular very heavy-duty jobs but, for the vast majority of people, there is very little evidence that there is ongoing damage. Early return to work is connected with symptoms improving.

We have been working on an international collaboration looking at the evidence and we are finding that an early return to work is actually beneficial. That is taking into account workplace adjustments. You should be able to adjust the workplace to allow people to return to work quickly. There is a sackload of evidence for that. If we can get people back to work with modified duties so that they do not lose the attitude of getting up in the morning and going to work, we actually do them a favour. The employer does not lose contact with them and they do not lose contact with the employer. I do agree that we do not get people back to work if they are doing heavy lifting, but a lot of that is declining.

We have come up with a strategy for the employer, for healthcare and for government and other people to try to facilitate early return to work. We try to break it down to the development of disability stage, which is mainly due to psychosocial factors, and then the rehabilitative stage.

I think we can learn a lot from what has been done in other countries. What we are missing is that there is nobody coordinating any of this.

**Michelle Mahdon** To start at the very beginning, when people start to notice symptoms, it sounds like common sense to be able to have a culture in the workplace where you can raise issues.

If you are starting to have symptoms, whether they are physical or psychological, you should be in a safe environment with your employer so you can start to discuss the issue. You can then talk about your situation, and adjustments you might need without

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**Hugh Robertson**



needing to medicalise it. Equally you could get treatment very quickly and have time off work to talk to doctors or access occupational health in a positive way.

Some employers are making good progress, but there is some way to go. Often, what comes up is the conversations that we have with our line managers and the ability to train line managers so that they can have these conversations.

We do have a lot of presenteeism in this country and this might mask some of the symptoms where there are underlying causes. Sometimes absence is a symptom of something to do with workplace culture and issues people have. If you have an increase in presenteeism because people are scared about going off sick, you might then find that you are building up longer-term problems.

**Mark Platt** I used to work for the Federation of Small Businesses and after that the Confederation of British Industry, so I visited discussions around stress and the difficulty for small businesses as opposed to large businesses. There is a difficulty about companies being able to embrace the fact that employees cannot be healthy and well all of the time. They do need to take time off to recover and to cope with illness. Occupational health departments in big companies are great but they will probably start to downsize those because you can get rid of those types of things without damaging your core business.

With SMEs, if you are only a three-man company and one person goes off, you could go under. The pressure on someone to turn up for work and the pressure from the people who run the company for them to be in work is immense. The recession is going to make that even worse.

The vast majority of people in the UK work with keyboards and are looking at monitor screens. Work-related upper-limb disorders, such as repetitive strain injury (RSI), are ill-defined and poorly diagnosed. People find they are forced to go back into the workplace to do the same kind of job that caused them injury in the first place and over which there is still dispute as to whether it is a real injury, whether

there is actually any pain. The issue about subjective versus objective measures and pain definition places employers and employees in a difficult situation.

I think that this dialogue is one that the NHS or the state can facilitate, by creating the space where people feel comfortable saying, "I have a problem. I do not want this to affect my work, but I want my workplace to accommodate me. I am committed, but I also have my health to look after." There is the old mantra, "A healthy workforce is a good workforce is a productive workforce."

**Michelle Mahdon** We talk about how you have to have different equipment, but there is a real lack of skills among employers being imaginative around how to redesign jobs. You can make the most of the capacity that people still have to do things, either until they get better or permanently, so they do not go back into a job that is making things worse.

**Phil Gray** Regarding levels of support being available, recognising that SMEs do have difficulties, I would say that that is where the health service, with others, has a part to play. In the Heart of England NHS Trust in Birmingham, there is an excellent occupational health physiotherapy service available for staff. It has been running for seven years. There is a similar one in Gloucester hospital that has been running for over ten years. They have reduced sickness absence by 30 per cent because people are able to self-refer, as well as being referred by line managers and others if they are concerned about them. It puts the individual in charge and gives them permission to talk about it and to get it resolved. Getting it resolved might be by just good advice or it might be advice and treatment, or a range of things. The Post Office is doing similar things. The Metropolitan Police also uses internal occupational health services. It is that kind of imagination that you need to apply.

**Hugh Robertson** I do not disagree with Paul. However, when 2 per cent of the population have access to comprehensive occupational health advice



**There is a real lack of skills among employers being imaginative around how to redesign jobs**  
**Michelle Mahdon**

and only 30 per cent have access to any at all, it is irrelevant. Most people go their GPs. GPs do not understand adjustments. GPs are wonderful, but it is not their job. People just see the GP and get signed off for a while and then go back to work or they get a referral which, for a specialist or physiotherapist, takes a minimum of six weeks and often takes closer to three months.

People without a sick-pay scheme will have gone back to work by then because they cannot afford to be off any longer, so they are at risk of making their condition worse.

**Branwen Jeffreys** Tony McNulty, is it not right that GPs are the first port of call for most people? How on earth do you get them to join up with the other pathway factors and all the efforts that are going on?

**Tony McNulty** I agree that it has to be joined up and it is my job, among others, to make sure that that back-wiring is there and not complicating things for the individual who wants help and support.

Things are changing. For example, in most of the public sector you will have the right chairs, meaning you are not doing your back in by hunching over a screen. I think RSI has been recognised a little bit more. However, it is all slow, it is not universal and it is not everywhere. The long game must be to join up all these things. If all that happens over the next five years is that we bring in ESA, everyone gets it, it works very well, but the necessary help and support is not there in other fields, I do not think it will be such a great success.

The earlier there is access to the safe space among employers, the better. It will transform things if we can talk about what people can do and how we can help them, rather than being dismissive.

The GP has to understand that the process should be transformative. From, "How sick are you?" to "How fit are you?", from "What can't you do?" to "What can you do?" There is a shift of emphasis. A core of people will be debilitated to the point where we will not force any conditions on them to work unless they volunteer but, for the remaining 80 per cent or so (we are thinking it will come out about 80:20), the bar will be lifted. For some, it will probably be dropped as well and it really does depend on where they fit into that 80 per cent subset. That puts a lot of emphasis on the capability assessment. It will be interesting to see how that has gone for the first cohort since October. We should be getting the reports on that soon.

The new emphasis is about saying, "As a society, we cannot afford to dismiss the efforts and potential of 80 per cent of the 2.6 million in such a cavalier fashion." About one million of them probably can do some form of work or get ready for work. How can we just leave that rich potential to one side?

**Stephen Duckworth** Hugh said that this is not the GP's job. GPs recognise that. We have done three different research projects with GPs. They are the patient's advocate. They will advocate on behalf of

their patient. Sometimes that may be to the detriment of their health if we agree that going back to work is more likely to be therapeutically beneficial.

If you are absent from work, what you have is a lot of time to think about your pain. The more time we have to think about something, the bigger it becomes in our minds. Unfortunately, that is exactly the way the chronic pain syndrome can develop.

A new and emerging profession is developing through the Chartered Society of Physiotherapy, College of Occupational Therapy and I think the UK Rehabilitation Council. There will be a body to establish through Lord Mackenzie (Tony's colleague), a standard for people working in vocational rehabilitation. They may come from a nursing-/physiotherapy-/occupational therapy-/psychology-type background to provide a peripatetic service in GPs' practices.

So, a GP will know that, every Tuesday morning, they will have a specialist in their workplace that they can refer patients to. The specialist will be someone who can act on behalf of the patient with their employer about creating, as Michelle said, a healthy working environment for them to go back to.

**Mark Platt** Some of my members have been concerned about this and have raised concerns about what it will do to their ability to get benefits and also to be integrated into the workplace. They feel they are being penalised. That may or may not be the case but they feel they have not been involved in the process, that patients with the conditions have been excluded from developing some of these protocols. So there is a sense that it has been done to them and not with them. As we move to a health service that is supposed to be more about personalisation and engagement with patients, that is sowing a bad seed.

**Tony McNulty** I accept that to the extent that, once we know how the first cohorts of ESA rather than IB have gone through that process, I think it does behove us to make sure that we get all perspectives. So, I might be knocking on your door once we have got that information to say, "This is roughly the shape of it, after the first cohort of ESA people have gone through. What do you think that tells us?" I want to hear that voice once we have got the first cohort of active, sort of live, research, of people going through the process.

**Branwen Jeffreys** Heather, Stephen Duckworth was saying that, when people are off work and in pain, they can get sucked into that and feel very isolated. What was your own experience?

**Heather Wallace** You are very frightened because pain does involve loss of control. If you have had to stop working, everything you spent years training for is suddenly falling apart. You have let colleagues down. When you leave work, if you do not have focus and structure to your day, somehow your brain just fills up with the pain. So, it is much better to be able to be involved in some kind of work. Generally,

**If you are absent from work, you have a lot of time to think about your pain. The more time we have to think about something, the bigger it becomes in our minds**  
**Stephen Duckworth**



the people who can work seem to suffer a lot less than those who are at home with their pain, probably with the rest of the family out working.

You lose self-confidence. If you stop functioning with the pain, you lose muscle tone. So, as soon as you start to do something again, you are in pain very quickly and it becomes a vicious circle. It is very difficult to break out. You have to do it in baby steps, which is where you come to things like pain-management programmes.

**Beverly Collett** Of the patients I see, probably two-thirds are not working. Of those two-thirds, more than 50 per cent have symptoms of depression or anxiety. Whether they had those before the pain or before they lost their job is impossible to say. If you look at most of the research, it would seem that it follows the pain and that these people were previously functioning well and were fine. We need to pick that up quicker. I do not want to medicalise people, but we should be assessing people better so that, if they have or are developing a mental-health problem as well, it is addressed by a mental-health professional. We do have counsellors in GP surgeries but the quality of counselling can be very variable.

**Paul Watson** The relative risk of people not improving or being likely to have persistent work loss is mostly due to psychological factors: fear avoidance, people tending to catastrophise things, feeling that they will never get better, that they are bound to lose their jobs and cannot cope. Certainly, by this magical six-week mark when people have been struggling with pain or are unable to work, we can identify some of these things – such as fear of activity, not coping well, passive coping, tending to avoid activity, avoid work and taking lots of medication quickly. With the right type of treatment we can address these.

There has been some interesting work done in training physiotherapists to identify some of these factors and address them early, to help line managers identify when people are not coping. We need to give these people the right skills – whether they are an

occupational health nurse, a physiotherapist, a line manager or whoever – to put something in place when things are going wrong. I would like to see it as part of something like PCT commissioning, so these services are available. There should be people who are trained in vocational management. I would like to see every physiotherapy department having somebody there. At the moment we have no way of giving these people any status or remuneration. I do not really care which profession takes it up as long as it is there and available quite quickly in primary care.

**Branwen Jeffreys** Phil Gray, are physiotherapists going to be stepping up to this?

**Phil Gray** It is already happening to quite a significant extent. One of the positives to come out of Carol Black's report is that getting people back to work and talking about their work life should be crucial for every healthcare practitioner who deals with those people. Good, early intervention gives back self-confidence and hope. Restoring that self-confidence enables people to risk dealing with the pain and going back to work.

There are twice as many people off ill at any one time with a musculoskeletal condition as there are with stress and mental health, although the media would have you believe it is the other way round. Many people with musculoskeletal conditions actually recover quite quickly. Historically, we have failed many of the 2.6 billion people on IB by failing to provide them with the help they need.

**Mark Platt** It has to be supportive and not coercive, though. People have to want to do it and feel they are being enabled to do it, not forced to do it because it is good for everyone else or that just compounds the issue.

**Phil Gray** I agree.

**Tony McNulty** The difficulty with where we are at the moment is that people's default is to have an apocalyptic view of events that might actually be



**It is about getting to a stage where there is a wraparound package of help and support for individuals that goes far, far beyond just the DWP**  
**Tony McNulty**

overcome. IB has almost formalised that – “Well, you are on IB now so no one needs to bother you again,” which is not helpful. That is why we will take up, starting in pilot form, the Fit for Work service that Black talks about with employment, health and broader social elements to help people on that pathway back. The approach starts with the premise that we do not give up on hardly anyone.

**Branwen Jeffreys** I saw that you have put out a call for expressions of interest in Fit for Work today, asking for organisations to come forward. Are you going to have many takers?

**Tony McNulty** The sands have shifted. There is likely to be a wider pool of unemployed than we anticipated when we put the contracts out. That may mean that bidders need to change their model. It may mean that we have to move to an activity-based payment model rather than a model that is simply payment by results – job or no job. That is an example of mature reflectivity by government and recognition of the shifting sands that we have at the moment.

**Branwen Jeffreys** There is quite a lot of consensus about the kinds of things that can help people, but what do you do to rehabilitate all those people who have been out of work for an incredibly long time?

**Tony McNulty** That is an interesting but very different challenge – to try to bed in ESA, to try to embed Black's recommendations. I am very clear that it will be a huge challenge. Flexibility has to be the absolute key to the transfer from IB to ESA, putting people into a support group or a work-related group. In the work-related group, there is a whole host of different packages that people need to get on the path and journey back to work, if not straight into work.

I have said the same about what we are trying to do with problematic drug users, that it is about getting to a stage where there is a wraparound package of help and support for individuals that goes far, far beyond just the DWP. It would involve housing, local government and all those other elements, to take each individual person along the path; otherwise we shall surely fail.

**Branwen Jeffreys** Hugh, come in on this point about the backlog of people who have been on benefits for a very long time, and what can or should be done to help them.

**Hugh Robertson** The reality is that, if someone has been on benefit for a very long time, the physical reason for them being on IB is not probably the main issue. The main issue is the psychosocial reasons and their own issues, the belief that employers will be unsupportive, have poor attitudes towards disability and workplace adjustment. You can get them physically better, you can put the bits back together perhaps, but that will not get them back into the workplace unless there is proper support.

DWP has done some very good stuff, and I do not

think it gets enough credit for a lot of the stuff it did with Pathways for Work and so on. However, there is some pretty varying evidence over what was effective. It was effective on the physical side but not as effective in the psychosocial aspect. We need a package that is available for everyone with a view to encouraging them and supporting them back into the workplace, not coercing them back into the workplace. If you coerce people, they will automatically make up all sorts of reasons why it is not possible because they have genuine fears – and they are genuine. A lot of it is about our attitude towards physical and mental disability and mental illness.

**Heather Wallace** When you go back to work, it is quite risky. There will be setbacks that may go on for some time. Many people go back to work and get a series of flare-ups and then just give up again. People need to understand pain and how it works, from the GP to the employer. They need support through the flare-ups that I suspect are almost inevitable as you explore new physical states, so that they do not just feel they have failed but that they can overcome the flare-ups and make progress. In the long term, you suffer less, but it is difficult going back. For some it can take months. Some people who have done pain-management programmes have gone back to work part time and then, maybe five years later, they have gone back to work full time. It is not a quick fix.

**Mark Platt** Still, many workplaces find it hard to cope with someone who has a mental-health problem. It is something that many workplaces are not comfortable with doing or are capable of doing. For many people with long-term conditions, their mental health suffers too. Getting people back into the workplace is multi-faceted and very complicated.

**Tony McNulty** You cannot blame DWP for this apocalyptic view that we have as a society on mental health but the notion that it takes time and a pathway to get back into work is a fair one.

**Stephen Duckworth** I work with a provider that is delivering six of the Pathways programmes at the moment. The thing to be clear about is that these programmes are only being used by people who are new entrants to the benefit system. They are not being used by what we now refer to as “legacy clients”. However, those legacy clients can voluntarily engage in the process and about 7-8 per cent are doing so currently. We have only just started to see what are referred to in the contract as the “mandated clients” come through onto the programme.

A key element of the programme is the condition-management element of it, whereby people learn how to manage their conditions. Some great stuff on heart conditions came out of Glasgow with the heart manual, and the angina toolkit from Leeds. There is mindfulness-based cognitive therapy for people with mental-health experiences, and there are similar products that are more specialised.

**Some people who have done pain management programmes have gone back to work part time and then, maybe five years later, they have gone back to work full time. It is not a quick fix.**

**Heather Wallace**



**Beverly Collett** One of the things we could be doing is offering people pain-management programmes earlier, rather than when people have had their pain for two years or whatever, and also integrating that into the things that are going on in the vocational areas. We have pain-management programmes that are medical, and then we have other condition-management programmes that are run with very little medical input. I think we need to integrate these.

**Paul Watson** One of the problems is that pain management is likely to be recommended earlier. I do not know what the National Institute for Health and Clinical Excellence (NICE) guidelines will come out with but NICE is not actually looking at the entirety of cost. NICE looks at the cost to the health service.

**Branwen Jeffreys** Is that not an example of unjoined-up, unravelling thinking, Tony McNulty?

**Tony McNulty** It is very, very easy to go on and on about the mantra of being joined up but it is much more difficult to deal with in reality. Of course there should be some cross-over.

**Branwen Jeffreys** Michelle, on the 7-8 per cent who are the legacy clients who have volunteered to come forward, what do we know about the long-term success of getting people who have been off work for a very long time back into the world of work?

**Michelle Mahdon** It can work but there are not that many great examples, unfortunately. I wanted to pick up on what employers can do, rather than just the state. Some employers will always shun wanting to do this, but there is a huge section of employers who would be open to some of the possibilities but they do not know how to do it. There may be a need to have employers who are champions of this to show how it can work positively and set an example for employees.

**Mark Platt** The NHS is probably one of the best examples you could use. It is a huge employer,

supporting its staff. The Expert Patient Programme, which we get from the community interest company is designed to help patients manage their condition but also manage the other things around it, and perhaps gives some consideration to the work element. That might be a way forward, in helping people think how they can get back into work, continue in work or make work fit them better.

**Paul Watson** It would be very nice if the NHS was mandated to do a lot of the things we have talked about. As a practitioner, one of the biggest difficulties is having an NHS employee who has only been called in to occupational health after about six months off work for the employer to then ask, “When are you coming back?” or, “Have we got to start proceedings to get rid of you?” If the government thinks this is important, it could probably tell the NHS that it needs to start doing something. It would be very nice if we could start setting good practice.

We seem to have skirted around the employers’ responsibilities in all of this. I wonder if there is a way that we could start to look at trying to encourage employers by using a carrot-and-stick approach to actually implement some of the things that we have been talking about.

**Phil Gray** The United States, Australia and Scandinavian countries all have systems that have obligations on employers to take rehabilitation seriously, whatever the form of that rehabilitation. We tried lobbying but we were told flatly, “No moral obligations on the employers.” The consequence of that is that employers are not playing their part. The DWP is now seriously looking at that.

Coming back to Paul’s point about what the heck is going on with the NHS, I have two frustrations. One is the Pathways to Work pilots. Those pilots were turned into very good things but the problem was that it was largely dealing with people who were newly coming on to IB, rather than people who had been on it for quite some time. Physiotherapists do not just deal with people with newly diagnosed



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**Beverly Collett**

conditions. Now we are having a Fitness for Work system, new occupational-health systems across multi-disciplinary ones, but again we are running pilots. Why? We have tons of evidence, including lots of evidence produced by the DWP as part of this exercise, that shows very clearly the evidence is, “Get on with it.” The pilots will take until 2013 to be assessed. That is a scandal.

**Tony McNulty** In the end, I think it will be more a phased implementation rather than pilots.

**Hugh Robertson** Most employers genuinely would like to know what to do, but they have not got a clue because there is no national occupational health service and they will not put money into it. They think their people have paid their National Insurance and so it is up to the state to do it. So, having a national occupational health system that the employers will have to pay into will not work. SMEs are just not interested. Insurers are not interested in forcing it. They just want to take the money.

There has been a lot of attention paid to try to get insurers to do some of the schemes that exist in other countries. It is not just a question of resources but if there is investment into a national occupational health scheme that is free, we are never going to make the huge savings we could make. It is about prevention. If you can get that right, the rest flows from it.

**Branwen Jeffreys** What does success look like?

**Paul Watson** I think we measure success in reducing absence from work and reducing the number of people going on to long-term benefits, and reduce the cost to the UK.

**Beverly Collett** I would agree, but also we want more people to have a better quality of life whether they are working or not working.

**Phil Gray** In terms of what success looks like, Carol Black’s report comes up with a total cost to the economy of £100bn. Real success would be the NHS making work issues and return to work a real priority, and putting the resources into it, alongside the common availability of rapid access into early services, such as physiotherapy self-referral, and decent pharmaceutical systems that go with it.

**Mark Platt** I agree. Also, people who want to get back into work should be able to get back into work in a way that they feel comfortable with. For me, success would be the Health and Safety Executive being empowered to prevent people from becoming unwell; the DWP and the DH combined so people get the care they want and are supported through that with financing. I do not think that will come cheap.

**Berkeley Phillips** I think success would be when patients feel they know where to go, the point of contact. We talked about GPs often being the first

port of call, but I think that, quite often for patients, it is their own family members and friends who are the first port of call. So a big part of this is educating the whole community around where to seek help for chronic pain.

**Michelle Mahdon** I would like to see a change at national-debate level to focus on quality of life, and that is part of an employer debate as well, so that our working regimes are looking at trying to improve quality of working life.

**Heather Wallace** I am going to come in where I feel there has been a gap in this conversation. Non-specialist GPs and other doctors need to be educated in pain. They need to be able to take the fear of the pain away from the person, reassuring them, explaining what is going on with their body, explaining that the drugs are not so toxic and help stop the pain becoming chronic. We need to give GPs the confidence to not say to the patient, "I can only prescribe co-codamol. If that is not working, tough."

**Stephen Duckworth** For me, it is about learning from what some of the larger employers are doing in a very positive way – to promote an employment environment that is conducive to disclosing and talking about things. It is about encouraging those businesses to engage with their supply chain so that the messages get cascaded down to the SMEs.

**Tony McNulty** First, we need to persuade people that there is not an inevitability to the journey from work to sickness and, therefore, being off work. Breaking that up is the key. That means greater health awareness and education for those in work. It means early intervention by a GP or someone else before we even get into people being in a long-term position.

Second, we need to provide more and more work, help and support for the work-related group of the emerging ESA cohort of clients. Yes, I am afraid, with that conditionality – I will not call it coercion. It may well be that it is the preparedness for work and the activity around that preparedness that is the measure, rather than simply getting into a job.

Third, as we go through those who are already on incapacity benefit, we should be helping as many of them get much much closer to a journey that ends up with work than where they started from. That is enormously difficult. There is not much research elsewhere because there is not a whole lot of other developed countries that have that same stock – it is an ugly word, but it will do – of people who have been thrown to one side on IB. The Americans do not have it; many of the Scandinavians and Europeans do not. They have not let the situation get to that sort of state.

**Branwen Jeffreys** That seems like a good place to stop. A peculiarly British problem, then, which may take some years to resolve. Thank you all very much for coming.

## Participants' policy suggestions

**Join up services so that people do not fall between the responsibilities of the Department of Work and Pensions and the Department of Health**

**Develop a national occupational health service that can be delivered by PCTs to support businesses that are unable to provide their own, such as SMEs, and build vocational rehabilitation into primary care services. Allow people to self-refer to this service**

**Provide training for GPs on options available for patients with long-term pain conditions so they do not feel compelled to sign people off sick. Provide a mechanism to triangulate engagement between pain patients, their GP and their employer. Make GPs aware of all the prescribing options for pain**

**Train and support employers, managers and line managers to develop the knowledge to spot the problems arising in the workplace earlier. Show them how to redesign jobs around the health needs of their employees**

**Involve patients with conditions such as pain in further developing the ESA and in developing capacity testing so that their needs and experiences inform the service**

**Create a package that encourages and supports, but does not coerce, those who are already on benefits back to work by empowering them. Integrate pain and condition management so that patients receive both medical and non-medical support at the same time – for example, include the issue of "getting back to work" in the Expert Patient Programme**

**Help people better understand their pain, as well as gain better awareness of their overall personal health. Identify patients most at risk of "catastrophising" their situation and ensure that mental-health support is available to them**

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