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1. Executive Summary

Summary of main findings

- 1.1 Vocational rehabilitation is a process whereby those disadvantaged by illness or disability can be enabled to access, maintain or return to employment, or other useful occupation.
- 1.2 In the United Kingdom (UK) it is influenced by:
- Charitable bodies
 - Department for Education & Employment (DfEE),
 - Department of Health (DOH),
 - Department of Social Security (DSS)
 - Department of Trade and Industry (DTI)
 - Employers and their occupational health resources (if any)
- 1.3 Loss of work through accident, illness or disability affects:
- Patients and their families
 - Colleagues
 - Employers
 - Services eg the NHS
 - The state, through the benefits system and loss of taxation
- 1.4 The cost of sickness absence is enormous and includes:
- Direct costs
 - Lost productivity
 - Reduced services
- 1.5 The report reviews:
- Deficiencies within vocational rehabilitation
 - Barriers to return to work
 - Good practice
- and makes recommendations.

Main findings

- 1.6 The commonest medical causes for being in receipt of Incapacity Benefit are:
- Musculoskeletal (predominately spinal pain)
 - Mental health
 - Circulatory disorders
- 1.7 Research conducted for this report surveyed 30 non-governmental organisations and found they regarded:
- Waiting times for NHS services as unacceptable
 - Services as inflexible
 - Understanding about the impact of disease and disability on work lacking
 - Awareness of options to prevent work loss lacking
 - Inter-agency working was notably lacking.
- 1.8 It is recognised that the longer one is off work, the lower the chance of returning to work. After 6 months of back pain, there is about a 50% chance of returning to work, which falls to 25% at one year and 10% at two years. Few individuals return to any form of work after 1-2 years absence, irrespective of further treatment.

- 1.9 The last two decades have seen an increasing separation of employment and health services with detrimental effects eg:
- Ignorance within the NHS of the means of re-integrating individuals into employment
 - Sequential vocational rehabilitation that usually considers employment rehabilitation after completion of health-orientated treatment
 - Little designated responsibility within the NHS to facilitate interagency working
- 1.10 The NHS has largely lost the culture and skills of facilitating employment as a key element of effective health care. Currently, rehabilitation services are predominately focussed on promoting independence in personal daily life and enabling people to leave hospital rather than a return to productive work. Due in part to pressure from other parts of the NHS, the skills of rehabilitation professionals are directed principally to assisting early hospital discharge or maintaining those with disabilities in the community.
- 1.11 A number of important changes have been made in the ways in which both government and non-government organisations try to help disabled people to obtain employment. Information is lacking on the overall impact of these changes but is badly needed.
- 1.12 The Government has acknowledged the need for new forms of assistance within vocational rehabilitation, as in the appointment of advisers under the New Deal for Disabled People. This is an important step in the right direction but currently it is targeted solely at those on incapacity benefits and lacks any involvement from the NHS. Appropriately focussed health care has the potential to prevent the progression of patients on to incapacity benefits. This needs to be developed.
- 1.13 Many Disability Employment Advisors (DEAs) are unable to assist people disabled by complex disabilities into work because:
- They have inadequate access to health professionals
 - They have not been given the specialist skills needed to assist those with complex disabilities into work
 - The support offered by their career structure and continuing professional training is inadequate
- 1.14 The potential value of Occupational Health Services in facilitating employment rehabilitation is poorly recognised by the NHS with uneasy relationships between GPs, hospitals and occupational health practitioners. Provision in the UK is variable and patchy.
- 1.15 General practitioners have a pivotal part to play in vocational rehabilitation. Because they have responsibility for certification for fitness for work they are in a position to trigger access to vocational rehabilitation. The current shortage of resources generally precludes this.
- 1.16 Examples of good practice instigated by both government and non-government organisations are found in the following areas:
- Back pain
 - Mental health
 - Cardiovascular disorders
 - Head injuries.
- These practices need to be spread more widely.
- 1.17 The best practice treatment of work-related upper limb disorders is illustrative of areas in which good organisational management of work tasks can help prevent ill health and disability.
- 1.18 These programmes exemplify the advantages of a multi-professional approach to assessment and treatment from the onset of illness until return to work.
- 1.19 Evidence supports the effectiveness of the case manager approach to assisting unemployed/incapacitated individuals back into employment.
- 1.20 Strategies directed towards job retention are of proven value: they are needed in the first months of sickness absence. These deserve to be widely known, used and further evaluated.
- 1.21 A significant number of people are left with psychological difficulties after accident or illness. Others have mild psychiatric disorders some of which may relate to stress at work. Due to severe pressure on clinical psychology services in the NHS, many people do not receive appropriate treatment and others may have inappropriate care (eg physically-oriented treatments for emotionally distressed patients with back pain).

- 1.22 Countries with successful vocational rehabilitation have invested in:
- Accessible, adequate health and employment services
 - An academic base for research and training programmes
- 1.23 Better, speedier, more focussed management of sickness absence with the aim of job retention and earlier return to work will:
- achieve considerable financial savings for the state and for industry
 - reduce the numbers of those needing incapacity benefits
 - improve the quality of life for those involved.
- 1.24 International experience, where modern vocational rehabilitation services based on case management principles have been developed and introduced, show financial benefits from the second and third years after introduction of such schemes.

Summary of Main Recommendations

- 1.25 The NHS and Employment Services should recognise formally that early, professional and accessible vocational rehabilitation:
- Should be equitably available early following illness or injury
 - Requires a multi-professional team spanning the health and employment services to support patients and employers at a district level
 - Requires one member of the district rehabilitation services to have the responsibility and skills to lead vocational rehabilitation in the health service and liaise with the Disability Employment Adviser
 - Requires close liaison with occupational health services
 - Requires an enhanced role for the Disability Employment Adviser who needs access to district rehabilitation services
- 1.26 The precise relationship between these services and NHSplus needs further investigation.
- 1.27 Case management should be adopted formally as the means to assist individuals with complex disabilities back into work.
- 1.28 A National Service Framework for vocational rehabilitation would ensure national standards across the UK and should be developed by the Department of Health.
- 1.29 Universities and Colleges of Further and Higher Education should be encouraged to develop training programmes for health professionals, DEAs and case managers which will be accredited by a National Institute.
- 1.30 A new Institute for Vocational Rehabilitation Research should be set up to promote multi-professional research into vocational aspects of rehabilitation and accredit training programmes.
- 1.31 This institute should have responsibility for working with the undergraduate schools of health professionals to ensure:
- Awareness of the importance of employment to good health
 - Need to reduce sickness absence and to promote vocational rehabilitation

A systematic assessment of the current status and need for change would be worthy of study by an independent body.

2. Introduction

- 2.1 For most people, work is central to their lives and to the way that they think of themselves. Indeed, Roosevelt said in 1903 "Far and away the best prize that life has to offer is the chance to work hard at work worth doing". Recently, both the public and politicians have become acutely aware of the difficulties faced by societies and individuals as a result of unemployment. The current Health Secretary, Alan Milburn, has challenged conventional orthodoxy that "health spending is a debit" and argues, "that health is not only a good in its own right, but that good health care is an imperative for improved productivity and national economic success"³.
- 2.2 The British Society of Rehabilitation Medicine (BSRM) shares this view. It represents doctors committed to supporting people with physical disabilities in all aspects of their life and work. This document has been produced in the hope that it will contribute to the debate on work (within government, the health professions and other interested bodies) and lead to improvement in services for those for whom accident, illness or disability has led to temporary or permanent loss of work. Better practice within the National Health Service (NHS) and liaison with other agencies can prevent unnecessary sickness absence and job loss in view of the number of bodies involved in vocational rehabilitation. This report is wide-ranging in the hope that it may act as a resource for those entering the field without detailed knowledge of all the agencies involved.
- 2.3 The BSRM has convened a number of working groups to contribute to and facilitate the development of knowledge and good practice by producing reports on services and on specific medical issues that may be helpful to the health professions and other interested parties. The field of vocational rehabilitation seems, from the health perspective, to have been largely ignored in the last two decades, in spite of its economic importance. Consequently the BSRM decided to devote its winter scientific meeting in Glasgow, November 2000 to this topic and to convene a working group derived from relevant bodies to report by that date. This report highlights the need to expand and improve the provision of vocational rehabilitation services.
- 2.4 The membership of the working party, and the bodies that they represent, are given in Appendix 1. We appreciate that the topic is broad and this report focuses predominately on the early management of disability due to illness or injury. The issues relevant to vocational rehabilitation encompass the work of at least 4 government departments: for Education & Employment (DfEE), Health (DOH), Social Security (DSS) and Trade and Industry (DTI). From a health perspective, they embrace areas as disparate as back pain, coronary rehabilitation, learning disabilities, sensory impairment and trauma (eg acquired brain injury). From an industrial perspective, attitudes of employers to their employees and their health can influence outcome in terms of workers retaining their jobs in spite of ill health or injury.
- 2.5 The working party has been derived from professional bodies involved in the area. Appropriate government departments have assisted from the beginning and have been unstinting in supporting the efforts of the group. As it is not possible for a group of functional size to cover all the appropriate interests, 100 non-governmental bodies were invited to respond to a questionnaire designed to elicit their views about vocational rehabilitation in the United Kingdom (UK). The working group agreed the broad thrust of the report and its recommendations, but some parts of the report reflect a majority view.
- 2.6 The objectives of the working group were to identify those aspects of current practice within the NHS, Employment Service or industry which may impede the return to employment of those with a recent injury, illness or disability; to consider options for change and to make recommendations.

Summary

- 2.7 Vocational rehabilitation is addressed from the perspectives of the National Health Service, the Employment Service, the employer and the employee.

3. Background To Vocational Rehabilitation

3.1 By “vocational rehabilitation” the Working Party embrace the concept of enabling individuals with either temporary or permanent disability to access, return to, or remain in, employment. The term is not meant to be restrictive - see Glossary.

The health context

3.2 Disability may be congenital or caused by injury or illness. However, any incapacity may affect an individual’s ability to carry out their normal duties and assistance, or rehabilitation, may be required to enable a return to work. Vocational rehabilitation is required both for people who become incapacitated during their working life (job retention) and also for those with congenital or early onset disabilities who require assistance initially to enter the employment market. This report is concerned primarily with the former group. It focuses on the importance of keeping individuals within work. Vocational rehabilitation embraces schemes to support those with disabilities or illness whilst in employment as well as schemes for those out of work into employment. Such schemes may be relevant for some claiming benefits who have acquired physical problems (eg back pain) whilst unemployed and who therefore have additional problems when trying to return to physically demanding work.

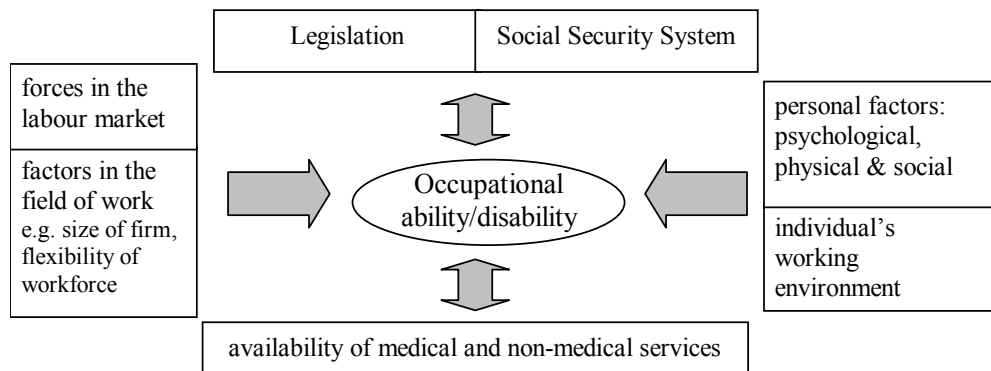


Fig 1 - A schematic view of vocational rehabilitation (from ¹)

3.3 Figure 1 considers the relationships between personal and environmental factors, availability of services and the legislative/benefit framework on a worker’s occupational ability or disability. A paucity of rehabilitation services will reduce the individual’s capacity to return to work, while a punitive social security system may increase the pressures of premature return to work. The inter-relationship between social security and the availability of health services with regard to employability was recognised by Beveridge in 1942 ⁴.

3.4 The NHS was formed to prevent and cure disease and disability by medical treatment, rehabilitation and fitting for employment; which would result in a reduced number of people claiming state benefits. By paying for disease and accident openly and directly in the form of insurance benefits, the cost to the nation should be emphasised, giving stimulus to illness prevention ⁴.

Rehabilitation

3.5 Rehabilitation has many different definitions, but following injury or illness it is a process of active change arriving at an improvement in functional ability and greater participation in society - see Glossary. In the present context, it is usually a process whereby an individual engages in an active partnership with health professionals to achieve desired goals.

- 3.6 Vocational rehabilitation aims to maximize the ability of an individual to return to meaningful employment. Best rehabilitation practice:
- improves work and activity tolerance
 - avoids illness behaviour*
 - prevents deconditioning*
 - prevents chronicity*
 - and reduces pain and the effects of illness or disability.
- (* see Glossary)
- 3.7 Effective rehabilitation of work related illness/injury enables employees to return to work more quickly. For maximum effect, medical, social and vocational rehabilitation should occur concurrently rather than sequentially.
- 3.8 The adverse effects of unemployment on physical disability and mental health are well known. It is also known that the ability of individuals to cope with these effects varies considerably with significant numbers of unemployed people moving on to sickness and disability benefits. Within this group obstacles to reemployment can develop quickly eg
- deterioration in physical and mental health
 - adaptation to life on benefits
 - financial gain from returning to work feels unacceptably small
 - satisfaction with the life style out of work which allows pursuit of other interests
- 3.9 Once on sickness and disability benefits it can become easy for those with physical and mental health problems to continue with sickness certification when a return to work might otherwise improve their physical, mental and socio-economic well being.
- 3.10 For many who are unemployed and on sickness benefits the critical window of opportunity for return to work is within the first few weeks of becoming unemployed or sick. After 12 weeks of unemployment the prevalence of physical and mental illness increases considerably and problems become more difficult to resolve. If Government wishes to address this issue government departments or other organisations must become more proactive within the first few weeks of unemployment. At this stage, liaison with the occupational health service, if present, can greatly facilitate job retention.
- 3.11 Successfully rehabilitated individuals feel confident about their work abilities and general well being⁵. Physical and biomechanical approaches should be complemented with organisational management policy and psychosocial factors such as participation, job discretion and social interaction⁶. Attention to risk factors and workstation design require ergonomic assessment. Rehabilitation programmes that do not address changes to those conditions that have contributed to the development of the disorder are unlikely to produce positive health outcomes⁶.
- 3.12 Rehabilitation after acute illness or injury requires a continuum from a health-orientated specific programme, which may be wholly hospital-based, to working full-time in the work environment (see cardiac rehabilitation model - section 11). Initial therapy often requires a full multidisciplinary hospital team and the use of facilities (eg workshops and hydrotherapy) to help regain confidence and normal physical function^{7,8}. This team should be in early contact with employers, occupational health services and / or the Employment Service early to facilitate a return to work at an appropriate time and with appropriate environmental or temporal modifications.
- 3.13 Best practice considers the employment requirements of individuals as well as their health and social rehabilitation needs. Occupational Therapists have an important role to play in this. Currently very few posts exist designated to consider the needs of patients on returning to employment. Skilled in activity analysis, they can assist employers and trainers in devising reasonable adjustments to work tasks to enable those with disabilities to be valued employees⁹.
- 3.14 Rehabilitation in the USA has shifted from work hardening programmes (see Glossary), based away from the work site, to the delivery of services on site. This has the advantage of maintaining the employee in a worker role, even if on modified duties. This is better for employers, health services and society. For the individual it may avoid low self-esteem and lack of confidence in (or even actual decline of) ability.

- 3.15 Support from supervisors and managers is essential to securing the best outcome for injured workers. They should be involved in prevention and rehabilitation programmes and be encouraged to facilitate early return to work ^{5,6}.
- 3.16 In the field of chronic pain management, a growing body of evidence is challenging the biomedical model, traditionally adopted by health professionals, in the management of pain ¹⁰⁻¹².

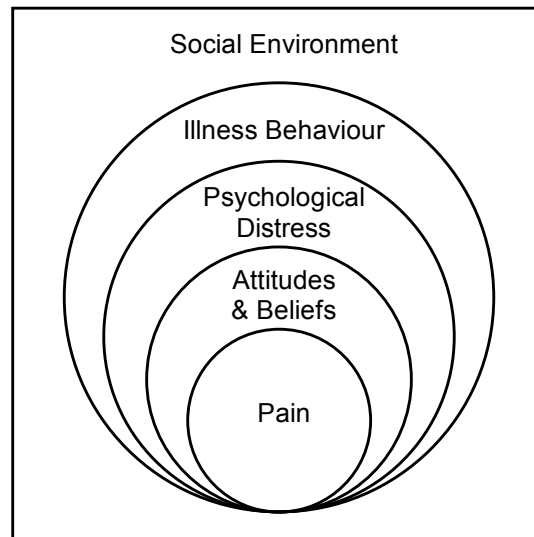


Fig 2 - Biopsychosocial model of illness (after CSAG 2)

- 3.17 This shift in philosophy provides individuals with ways of dealing with their pain thereby reducing the risk of chronicity and subsequent disability (see Section 11 - low back pain).
- 3.18 Problems for society arise when the estimated costs of the consequences of illness may exceed the estimated sums spent by health services on treatment (see Section 11 - low back pain). Rehabilitation contributes to an economical solution for the problems of occupational ill health eg in Sweden back pain accounts for 30% of all sick leave. Nachemson argues that the introduction of a comprehensive rehabilitation programme would result in socio-economic gains which could be as high as \$600 million ¹³.
- 3.19 Modified work programmes facilitate return to work for temporarily and permanently disabled workers. Injured workers who are offered modified work can return to work about twice as often as those who are not. Modified work programmes can cut the number of workdays by 50% ¹⁴.
- 3.20 Many charities are actively involved in vocational rehabilitation eg Royal National Institute for the Blind (RNIB), National Association for Mental Health (MIND), Scope and many others (the list in Appendix 6 includes many such organizations but is not exclusive). Rehab Scotland, in Glasgow, has demonstrated (in those with brain injuries) the potential of health teams and employment expertise to work together.
- 3.21 Good models of rehabilitation include the following elements:
- appropriate multiprofessional staffing and other resources
 - staff access to continuing professional development and lifelong learning
 - good interprofessional and interagency relationships
 - clear lines of professional and managerial responsibility/accountability
 - local ownership of change through close staff involvement
- 3.22 These elements hold true whether those involved are employed within the Employment Service, industry or the NHS.

Personal factors

- 3.23 Work is an important determinant of well-being ¹⁵ and helps to inform our identity. When a person is not at work other aspects of their life may become strained eg their family relationships.

- 3.24 Following injury or illness some have no difficulty accommodating their disabilities and altered body image and are happy and competent to make or negotiate any adjustments needed to allow a return to work. However, many do have difficulty in accepting their new disabilities, continuing to hope, and wait, for a full recovery ('return to normal'). They may equate limitations in ability to "sickness" and an inability to work. Many have difficulty in accepting alternative ways of functioning in either personal care or work tasks, whereas others automatically adjust and work out alternatives.
- 3.25 The history of vocational rehabilitation in the UK, and its social context are outlined in Appendix 2; the complex background to the Employment Service initiatives in Appendix 3. The full range of government policy and recent initiatives in the employment field are given in Appendix 4, but the pace of change driven by government currently is enormous and some elements are outlined below.

New government initiatives

- 3.26 'Welfare to Work' was announced by the Government in 1998 and forms one element of policy aimed at addressing social exclusion. Welfare to Work will reshape the benefits system and welfare provision with a view to providing work for those who can and security for those who cannot. One element is the New Deal for Disabled People which targets the 2.5 million people of working age with a disability or long-term illness who receive Incapacity Benefit, Income Support/Housing Benefit/Council Tax Benefit or Severe Disablement Allowance. Of these 2.5 million, only 5% leave benefit for work each year.
- 3.27 Whilst supporting the aspirations behind the government's approach in the New Deal for Disabled People, the working party has strong reservations about the way that the pilot studies have been implemented. Within the complex field of vocational rehabilitation, pilot studies, sometimes of only one year's duration, are unlikely to produce the concrete results needed to put the future developments within the Employment Service on a sound footing. Convincing results are more likely to be achieved if the evaluation of future pilots is built in to the initial proposals. Examples of evaluation being tied to a project initiative and providing cost-effective outcomes in other areas of rehabilitation can be found ¹⁶.
- 3.28 The Government have announced that the Joint Investment Programmes (JIPs) will be extended to cover Welfare to Work for disabled people ¹⁷. These may demand that health and social services develop closer working relationships with employment, education and careers services to maximise opportunities for individuals with disabilities to access employment.
- 3.29 The Welfare to Work agenda demands that the health professions review their roles in vocational rehabilitation. This new emphasis on the value of work may require the development of skills and new models of service delivery eg to assist individuals who are seeking to enter (or re-enter) the employment market, to find and sustain appropriate work.
- 3.30 The working party welcomes the "personal adviser" initiatives but develops in this report the need for professionally trained case managers (see section 13).
- 3.31 The Working Group also welcomes the recognition by the DOH that there are health implications for the development of employment opportunities for those with disabilities. The Joint Investment Plans (JIPs) recognise that partnerships need to be developed between the NHS and the Employment Service ¹⁷. The document seemed vague as to who would be involved from NHS trusts and how such initial work would be funded.

Summary

- 3.32 In the last 20 years unacceptable gaps have developed between the employment and health agencies in the services available to facilitate employment opportunities. Pre-existing disabilities, injuries and sickness can all reduce chances of successful employment, but overcoming these disadvantages appears to have increasingly become the unique province of the Employment Service. Patients with acquired injury or sickness are usually assisted by this service only at the conclusion of NHS treatment.
- 3.33 Effective rehabilitation involves early involvement of the multidisciplinary team with close liaison with employers and the Employment Service. Good employment practice can do much to facilitate job retention.

4. Deficiencies in Current Provision

Health Service

- 4.1 The NHS was formed to prevent and cure disease and disability by medical treatment. It was also to provide rehabilitation with a view to fitting for employment, although many would now not recognise this aim. It was thought this would ultimately result in reduced numbers of people claiming state benefits. It was hoped that by paying for disease and accident directly in the form of insurance benefits, rather than indirectly, the cost to the nation would be understood and reduced, ultimately giving stimulus to prevention⁴.
- 4.2 Illich argues that the NHS was created on the basis that in every population there is a limited amount of morbidity, which if treated under conditions of equity will eventually decline¹⁸. Beveridge had calculated that the annual cost of the health service would fall as therapy reduced the rate of illness. Health planners and welfare economists did not anticipate the vast expansion of health care such that only budgetary restrictions would prevent from expanding indefinitely.
- 4.3 Over two decades, efforts to contain the cost of the NHS to the nation, have meant that services have been rationed (eg number of outpatient therapy treatment sessions restricted; certain facilities, including those for vocational rehabilitation withdrawn). Thus meeting an occupational therapy standard to see all inpatients within 3 days of referral may only be achieved at the expense of ongoing treatment of outpatients.
- 4.4 Access to healthcare is therefore a real issue - figures for the end of April 2000 showed that there were 1.054 million patients in England waiting for NHS treatment¹⁹. The existence of waiting lists within the NHS has stimulated the growth of private healthcare; especially evident in the musculoskeletal field eg sports injury clinics. A number of employers also recognise the value of providing quick and easy access to healthcare for their workers; often provided outside the NHS.
- 4.5 Historically a variety of health professionals have been available to help people with injuries and disabilities, but funding for such positions is variable around the country with variable access. In recent years, the pressure within every NHS Trust to facilitate early discharge has resulted in patients who are admitted (even with major disabilities such as head injury, or following orthopaedic operations such as joint replacement) receiving treatment and therapy only to a point where they would be safe at home. Much subsequent outpatient treatment tends to be focussed on patients 'struggling' to maintain independence in the community. The result has been that fewer resources have been focussed on the less disabled patient with the aim of returning them to work.
- 4.6 Excessive waiting times are commonplace for hospital outpatient appointments, investigations requested by hospital staff and for physiotherapy. Waiting times for physiotherapy in 1 acute hospital trust reached 1 year before management decided this was unacceptable. However, waits in that trust now range from 4-8 months to see a consultant orthopaedic surgeon or rheumatologist, 3-4 months for a scan (CT or MRI) and a further 4 months to see a physiotherapist. At the same time practice within Job Centres usually requires this process to be concluded before employment assessments can begin. Delays in returning to work may be months and may prevent any return to work.
- 4.7 Of the 10 Medical Rehabilitation Centres listed by Stephen Mattingly in 1981²⁰, only 5 now remain. Of those closed in the past 20 years (Camden Road, Garston Manor, Farnham Park, Passmore Edwards and 1 Combined Services Unit) it is often not clear what services have been put in their place. These centres were specifically aimed at creating a level of fitness compatible with work. Few have been replaced by comparable facilities within acute trusts²¹.
- 4.8 There has been a considerable loss of therapy commitment to vocational rehabilitation reflecting the need to divert scarce therapy resources to the acute sector. The staff side evidence to the pay review body shows the vacancy rate for all Professions Allied to Medicine across the country is 9%. Surveys show that staff are feeling increasingly overworked and not properly rewarded; factors which contribute to their loss of morale. These factors have a direct impact on the nature and extent of vocational rehabilitation available to the public. Loss of morale has also been felt to be a factor contributing to the shortage of Occupational Therapists.
- 4.9 These deficiencies are also noted from the occupational health perspective (Section 8)

Views from stakeholders

- 4.10 The Working Party is not alone in seeing vocational rehabilitation in the UK as impoverished. The TUC²² has described rehabilitation in the NHS as “starved of resources to deal effectively with any but the most serious of rehabilitation needs, and isolated from occupational health both at the point of injury and at the point of return to work, existing provision is patchy (geographically and in terms of quality) and often ineffective”. It goes on to describe the record of rehabilitation in Great Britain as “lamentable”²².
- 4.11 The Association of British Insurers²³, in its second bodily injury award study, recognises that the NHS “spends more on caring for and supporting individuals with serious long-term injuries than many other countries, but with less effect”. It believes that the reasons for the “UK’s poor record on rehabilitation” (related to work) “run deep... the relevant skills and resources are deployed in a fragmented way. The various agencies are poorly co-ordinated and sometimes have conflicting agendas. It is rare that any one organisation has an overall responsibility for an individual’s well-being”. Their 1997 study²³ found that, “although the UK has a good record when it comes to saving lives, its record once accident victims are out of the acute phase of injury lags behind those of many other western countries. Someone left paraplegic as a result of injury, for example, had a 50% chance of returning to full-time employment in Scandinavia, a 30% chance in the US, and a 15% chance in the UK”.
- 4.12 Disabled people perceive current services as remote, inadequate, fragmented and designed more for the convenience of providers than recipients²⁴. The working party’s survey (Appendix 5), derived from a wide range of bodies (Appendix 6) echoes these anxieties. The responses from the circulated bodies representing disabled people emphasise the frustrations and difficulties, and indeed job loss, that relate to waits throughout the NHS. They also point out the lack of awareness within the service of the urgent need of the patient to return to, or remain in, work. More information, more flexibility and more emphasis on the financial and vocational needs of the users of the service are required.

Summary

- 4.13 Major deficiencies in health service provision have been identified in this review, by the Trades Union Congress and the Association of British Insurers. Excessive waiting times for hospital assessment, further waits for investigations and prolonged waits for therapy all militate against reducing sickness absence and job retention. Units that previously performed vocational rehabilitation have been closed, apparently without adequate services to replace them.
- 4.14 Research conducted for this report surveyed 30 non-governmental organisations and found they regarded:
- Waiting times for NHS services as unacceptable
 - Services as inflexible
 - Understanding about the impact of disease and disability on work lacking
 - Lack of options to prevent work loss as unacceptable
 - Inter-agency working poor.

Recommendations

- 4.15 Government waiting list initiatives must tackle excessive waits for radiology and therapy services in addition to consultant appointments.
- 4.16 The DOH needs to urgently review the resources committed to the vocational rehabilitation of sick and disabled individuals. Some of the increase in doctors and therapists intended within the National Plan needs to be committed to vocational rehabilitation.
- 4.17 Consideration should be given to the development of a National Service Framework for services to those of working age.

5. Disincentives to Return to Work

Compensation

- 5.1 Some people are injured or suffer other health problems in circumstances which allow them to proceed with claims for compensation because the injury suffered is attributable to the negligence of a third party. Personal injury compensation claims most frequently arise from road traffic and workplace accidents, but not exclusively so. Such claims are normally managed by insurance companies acting for insured Defendants or by trade unions although some large 'self insured' organisations may act independently. The wide spread of Defendant insurers, each keeping their own records, has resulted in a dearth of pooled information about the volume of personal injury claims: there is no centralised statistical record. Consequently, information about not only the numbers involved but also related personal and medical data is hard to obtain.
- 5.2 Literature on compensation claimants has tended to highlight 'compensation neurosis', 'compensationitis', malingering, 'functional overlay' and 'secondary gain'. These are all terms which refer to the exaggeration or prolongation of health problems or disability in pursuit of enhanced compensation. It is understandably true that a proportion of compensation claims are characterised by such responses - or even fraudulent claims - but probably not to the extent suggested by previous literature. A review of that literature for example, highlighted sources of bias and methodological shortcomings²⁵. Other surveys of insurance company records of persons of working age injured at work or in road traffic accidents have suggested that, within samples of more severely injured claimants, attempts to inflate claims were suspected in less than a tenth of all cases^{26,27}.
- 5.3 In contrast, the same survey research also indicated that a majority of personal injury claimants returned to work before claims were settled, with most of those who did so achieving that outcome within a year of injury. Medical examiners were of the opinion that only around one in twenty claimants were likely to be totally and permanently unemployable. Research therefore revealed a sizeable subgroup comprising between a quarter and a third of the samples studied who, while deemed medically capable of returning to work, did not do so. Examination of records on these cases indicated that few had any contact with services which might have assisted with vocational aspects of their rehabilitation including occupational therapy and specialist Employment Service provision^{26,27}.
- 5.4 Subsequent efforts to direct eligible claimants to vocational rehabilitation services have encountered numerous stumbling blocks eg:
- employers who have been quick to implement medical retirement procedures rather than action to 'accommodate' employees who could return to work after illness or injury
 - trades union organisations and their legal representatives (and, indeed, other lawyers) who continue to place a high premium on maximising cash compensation at the expense of rehabilitation
 - government specialist services for people with disabilities which have demonstrated a reluctance to become involved with persons who are pursuing compensation claims.
- 5.5 Some New Deal Retention Pilots are working with insurance companies in helping people back to work who are claiming compensation.
- 5.6 There are also issues concerning the efficiency and effectiveness of service delivery and resourcing in the UK. The underlying model of service delivery has tended to be 'sequential', with an expectation that medical, social and vocational phases are discrete and can therefore be dealt with in turn. This elongates timescales and poses problems of continuity and coordination in individual cases which have been addressed by numerous official committees and working parties over the years.
- 5.7 Other countries which have addressed this problem have used an alternative model based on principles of early intervention and 'concurrent' attention to medical, social and vocational aspects of rehabilitation, using occupational therapists and other professionals (eg vocational rehabilitation counsellors) in a co-ordinating case management role. The effectiveness of this alternative approach has been assessed in various ways, including:
- reduced time between injury and return to work
 - lower average sickness absence rates
 - reductions in state benefit payments

- lower outlays on the past and future wage loss aspects of personal injury compensation claims.
- 5.8 Countries like Australia, New Zealand and Canada (all of which inherited - but have now abandoned - the post-war legislative and administration framework which continues to guide UK policy and practice), and also some Scandinavian countries, have needed to overhaul and re-orientate resources and attitudes. They have encouraged employers and unions to be more receptive to vocational rehabilitation goals and to become actively involved in the rehabilitation process. They have made a quite different use of social security and workmen's compensation scheme funding. They have actively promoted the development of occupational health, therapy and other vocational rehabilitation professional services and have also helped to develop a market for such services. The net effect of reorganisation along those lines is illustrated by the case of the State of Western Australia. There, referral to rehabilitation services after four weeks absence from work was made mandatory and resulted, in halving the State's sickness absence rate (Western Australia Workman's Compensation Board - personal communication).
- 5.9 It is doubtful whether that degree of success could be achieved in the UK without a major overhaul of resources. Compared to the theoretical volume of potential need for assistance with return to work after illness or injury, the level of support available (eg through DfEE services) is disproportionately low even after the introduction of Welfare to Work.
- 5.10 Until recently, compared to its counterparts in other countries, the British insurance industry showed little interest in vocational rehabilitation. It did, however, support a research and development programme at the University of Edinburgh from the early 1980s onwards. Outcomes of that programme included a 'mapping out' of the field, providing for the first time a description of the demographic, medical, social and occupational characteristics of persons involved in pursuit of personal injury claims. The research also recorded their pattern of involvement with rehabilitation services and return to work outcomes and analysed factors associated with a return to work^{28,29}.
- 5.11 Around the same time, providers of 'first party' insurance (eg personal accident and permanent health insurance policies) also examined rehabilitation. Their difficulty in linking policy holders to needed services prompted a growing number to promote their own in-house services, often employing nurses to undertake disability counsellor or other case co-ordination or case management roles. From those early beginnings, has grown a substantial cadre of professionally trained personnel, drawn mainly from nursing and occupational therapy, but increasingly from other fields, who are working either in-house or in private practice to assist with the rehabilitation of insurance claimants.
- 5.12 Hand-in-hand with that development has been the emergence of a network of other, mainly institutionally-based, multiprofessional services providing occupational assessment and in-house rehabilitation and vocational training courses. Although current examples are mainly found in the field of acquired brain injury (Section 11), that model could easily be adapted for persons with other types of illness or injury. Through those developments, the private sector has provided foundations for the emergence of professional vocational rehabilitation services in the UK.
- 5.13 Recognition of the need for these recently introduced services and for future investment is clearly acknowledged in the report of the Rehabilitation Working Party of the UK Bodily injury Awards Study²³. This not only confirms the low priority previously accorded to rehabilitation by UK insurers, but also makes a case for:
- greater participation of the industry in the development and provision of rehabilitation services
 - outlines a code of best practice on rehabilitation, early intervention and medical treatment in personal injury claims
 - identifies the need to make good a shortage of case managers, possibly by the establishment of a suitable university programme to develop the discipline and provide professional training.

Income replacement payments

- 5.14 Broadly speaking there are two competing social goals underpinning the concept of income replacement for sick and disabled workers, to:
- provide economic security to disabled people
 - ensure that as many people (of working age) as possible remain in the workforce or are rehabilitated back to work as quickly as possible.
- 5.15 A person who is sick or disabled and unable to work may receive income replacement from one or more of a number of sources including: employer sickness benefits, state benefits, private insurance benefits or a

pension and personal savings. But there are disincentives created by the presence of income maintenance payments of this sort:

- the availability of income replacement benefits may act as an incentive for workers with marginal disabilities to drop out of the workforce and seek these benefits instead - particularly where there is relatively loose control of the gateway on to such benefits
- the receipt, or potential receipt, of disability benefits may act as a disincentive to rehabilitation
- the level of income replacement benefits may act as a financial barrier – to be financially better off the wage (plus any ‘in-work benefits’) must exceed the level of income from out of work benefits³⁰.

5.16 The latter may be characterised by the so-called ‘benefit trap’ - where a disabled person finds themselves unable to get a job, particularly part time work, which will pay more than their out of work income.

Summary

5.17 There needs to be agreement by the insurance industry and the TUC that it is in the best interests of clients that assessment and treatment is obtained by an appropriate rehabilitation service as early as possible in the legal process and that delays for the advantage of either side in the legal process would not be good practice as long-term recovery would be compromised with increased costs to both the state and private sectors.

5.18 The Working Party share the conclusions of the Association of British Insurers (ABI) and the Trades Union Congress (TUC) who have independently identified the need for a new vocational rehabilitation case management role to provide, in individual cases (or caseloads), general oversight, co-ordination and practical assistance for persons returning to work after illness or injury.

5.19 The ABI and the TUC are major stakeholders in the personal injury field and thus might be expected to have a significant involvement in the establishment of a National Institute and the education and training of case managers. The Working Party considers that there is also a strong case for public sector investment and involvement in such developments. The potential benefits are to individuals and to society as a whole as the service would transform recipients of compensation or state benefits into wage-earners and tax payers.

5.20 Currently, within the state sector, that task is the responsibility of a small cadre of Disability Employment Advisers, whilst in the private sector (mainly insurance) or private practice, an even smaller but growing number of vocational rehabilitation specialists fill that role. This report has identified significant mismatches between the number of persons providing those services and the number of potential beneficiaries; and between the type of help needed and type of help available.

Recommendation

5.21 Both the scale and scope of current (disability employment adviser and private sector) provision is reviewed urgently bearing in mind (a) that similar changes in other countries (eg New Zealand and Australia) have already been achieved on the basis of re-allocation of existing funding (eg Workmen’s Compensation schemes) rather than new money and (b) that the essential requirement is likely to be for development of a new professional role (of case manager) rather than an expansion of existing DfEE resources.

6. Health and Employment - The Scale of the Problem

- 6.1 Consequences of work loss through ill-health has social as well as economic consequences for:
- individuals
 - their families
 - employers
 - the state
- 6.2 Strategies for reducing sickness absence can only be established when the nature of those conditions influencing time off work are understood. Sickness absence / working days lost before state benefits are paid (i.e. Statutory Sick Pay or employers sick scheme coverage) are given by ranked diagnosis, starting with most common condition:
- musculoskeletal / connective tissue
 - respiratory
 - injuries and trauma
 - mental disorders
 - ill defined symptoms
 - circulatory
 - digestive
- 6.3 Conditions which give rise to the need for Incapacity Benefit (Table 1) are broadly similar. The following areas are given particular consideration in this report as they illustrate different aspects of vocational rehabilitation (Section 11).

Musculoskeletal disorders

- 6.4 The prevalence of self-reported musculoskeletal disorders was estimated to be 1.2 million workers in 1995, of which over half stated that it affected their back. Estimated prevalence amongst workers were ³¹:
- back pain 642,000
 - neck and upper limbs 512,000
 - lower limbs in about 212,000
 - more than one affected site 178,000
- 6.5 These disorders also represent the biggest group (28%) of the 1,718,400 people awarded Incapacity Benefit (Table 1).
- 6.6 Many of this group on state benefits and not in work have problems of the back and neck; 21% of the total of 2,607,000 noted by the Labour Force Survey of spring 1999 ³². A further 19% have problems of the arms, hands, legs and feet, most of which will be musculoskeletal. Musculoskeletal disorders constitute the commonest reason for ill-health retirement from the NHS ³³.
- 6.7 Low back pain is experienced by 50-85% of the adult population in the UK at some time in their lives ³⁴. A National Back Pain Association survey ³⁵ stated that of the 117.6 million days of certified incapacity in 1995-6, 30,715 were due to work-related back injuries. The highest incidence was among agriculture, construction, food, nursing, retail and water industries. During the same period, there were 33,000 work-related back accidents and 500,000 work-related back illnesses. The "back pain epidemic" ³⁶ is of enormous economic proportions, costing the NHS £481-1061 million with indirect costs possibly exceeding £5-10 billion ^{2,37,38}. It also makes demands on the private sector ^{2,38}. The DSS estimate that in 1997/8 about 90 million days were lost to the British economy through spinal disorders - Fig 3 (figures kindly provided by the DSS).

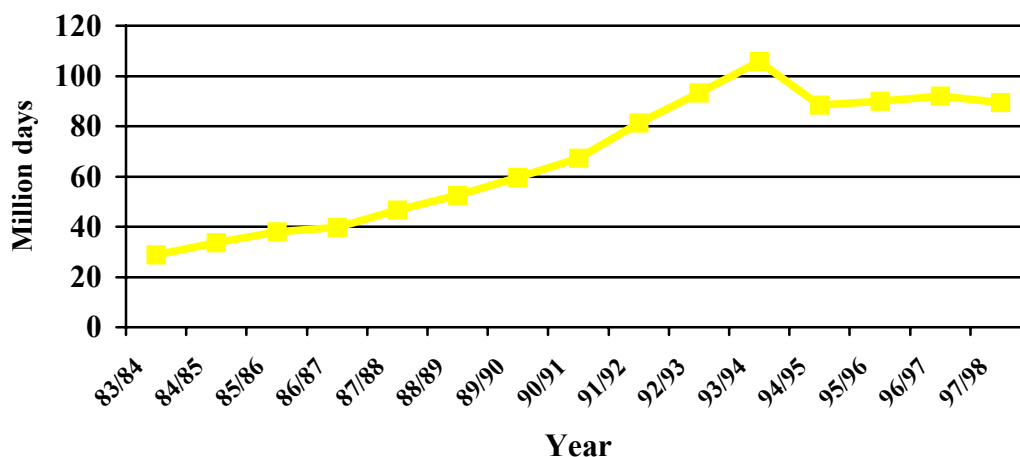


Fig 3 - Sickness absence from back pain (from DSS)

- 6.8 The economic consequences of back pain reflect partly the costs of many small episodes of sickness absence, but mostly the costs of those with severe and disabling pain. Thus a recent study in a rheumatology clinic showed patients to have had a mean duration of the current episode of pain of over 2 years. Fifty four percent of those patients, of working age, were in receipt of state benefits³⁹.
- 6.9 Neck pain also has considerable economic importance. It has been estimated that neck pain cost the Netherlands economy \$686 million in 1996, reflecting about 1% of health care expenditure and 0.1% of their gross domestic product⁴⁰. Only some of this pain will relate to repetitive sedentary upper limb work.
- 6.10 Estimates of several reports on back pain indicate that the total cost of back pain corresponds to 1-2% on the GNP in several countries⁴¹.
- 6.11 The exact prevalence of work-related upper limb disorders (WRULDs) is unclear for a number of reasons, including under-reporting and misdiagnosis. However, the Health and Safety Executive Labour Force Survey of self-reported ill health³¹ highlighted that over 1% of all workers or ex-workers are affected by WRULDs. The survey also identified four occupational groups in which WRULDs were particularly prevalent: armed forces, construction workers, textile processing workers and other processing workers. These results indicate that 2% of all workers in these occupations were affected³¹.

Mental health

- 6.12 Mental and behavioural disorders are the second commonest reason for being awarded Incapacity Benefit, being 20% of the 1,718,400 in receipt of the benefit. In London it is now the biggest reason for the award of Incapacity Benefit, with 26% of the 97, 280 recipients having these disorders (figures kindly provided by the DSS). It is clear that most clients in this group suffer from minor mental illness (eg anxiety and depression) and not major psychiatric disorders⁴²⁻⁴⁴. It is postulated that this reflects partly the pressures of the workplace (stress)^{45,46}. The second biggest cause for ill-health retirement from the NHS is minor mental illness³³.
- 6.13 The Mental Health Foundation believes that 1 in 4 adults in Great Britain will experience a mental health problem during any one year. Stress-related illness now accounts for more than 500 000 working days lost every year. Unemployed people are twice as likely to have depression as people in work and people with physical illnesses have twice the rate of mental health problems compared to the general population⁴⁷. Mental illness costs approximately £32 billion in England each year: this includes almost £12 billion in lost employment and approaching £8 billion in benefits payments⁴⁷.

Coronary artery disease

- 6.14 Diseases of the circulatory system now comprise 13% of all Incapacity Benefit recipients and represent the third largest group.

Further economic considerations

- 6.15 Consider a person of working age who becomes ill or suffers an injury which prevents work and which is likely to last more than a few weeks. Failure to restore this person's functional capacity so that they may return to work can have a clear human cost in terms of suffering and financial hardship for the individual and their family. There is also a wider cost to industry and to the state.
- 6.16 Costs to employers include those of:
- sick leave / lost production
 - recruitment and retraining
 - compensation, and litigation and insurance
 - property damage (sometimes)
 - medical treatment (sometimes)
 - early retirement on health grounds
- 6.17 Costs to the state (NHS/Social Services) include:
- managing long term treatment/disability
 - state benefits for people of working age who are economically inactive
 - loss of revenue from taxation.
- 6.18 Of the thirty five million people of working age across Britain (men aged 16–64, woman aged 16–59); 2.8 million (8%) are economically inactive and receiving state benefits on the grounds of medical incapacity for work at a cost of £7 billion/year. Every week some 3,000 people of working age move on to state Incapacity Benefit (either directly from work or from Statutory Sick Pay) of whom 2,700 will never return to work (figures from the DSS).
- 6.19 Injuries and illness at work are estimated to cost up to £10 billion (95/96) (Figures from Health & Safety Executive) with the economic costs borne by the employees, their employers, insurers and the rest of society.
- 6.20 Effective vocational rehabilitation also has much to contribute to the Government's objectives on combating social exclusion and poverty.
- 6.21 Research findings indicate that vocational rehabilitation schemes have the potential to produce a return on costs of between 2 and 10 fold⁴⁸⁻⁵⁰. Economic benefits can be measured in terms of:
- reduced sickness absence
 - reduced early retirement
 - increased productivity
 - continued payment of taxes
 - reduced payment of state benefits

and this is further explored in Section 11.

Economic efficiency of rehabilitation schemes

- 6.22 A key factor is the timing of intervention in order to avoid intensive input to people who would have recovered and returned to work without such help. Much more research is required to identify better those people / groups who are at greatest risk of long term disability. More research is also required to identify what interventions in the field of rehabilitation and job-retention actually work, particularly for common conditions (back pain, mental disablement) and those of gradual onset (certain musculoskeletal and neurological conditions)

Work-related illnesses

- 6.23 The Health and Safety Executive (HSE)³¹ estimated that there were two million self-reported work-related illnesses in Great Britain in 1995. Back, neck or limb problems represented almost 60% of all the work-related illness reported in this study. The HSE estimates that around 3.7 million working days are lost each year as a result of back pain alone (excluding those with back pain related to other musculoskeletal conditions), with about 10 days being lost per employee with a back problem.

- 6.24 The latest labour force survey of disabled people taken in winter 98/99 identified over 6.4 million people with a current long term disability or health problem, that is 18% of the working age population in private households⁵¹.
- 6.25 Eighty five percent of non-disabled people are currently economically active compared with only 51% of those declaring a disability⁵¹. Two thirds of unemployed disabled people said getting a job was important to them and over a quarter who had left work because of their disability said they could have stayed if adaptations had been made, though only 20% had changes offered⁵¹. Industrial injury and chronic illness both can effect work performance. For the individual this includes their ability to work, their call on the health benefits system and the potential need for medical retirement⁵². For society it also includes the impact on organisational productivity and wider socio-economic costs⁵³.
- 6.26 The cost to employers of workplace injuries and work-related ill health is estimated to be around £2.5 billion a year (1995/6 prices): about £0.9 billion for injuries and £1.6 billion for illness⁵⁴. Human costs reflect:
- loss of quality of life
 - pain and suffering
 - worry and grief to family and friends
 - financial loss due to temporary or permanent incapacity
 - financial loss due to other people having to take time off work to provide care
 - loss of income if forced to change job to one with lower wages
 - additional costs associated with incapacity⁵⁴
- 6.27 The survey⁵⁴ showed that over 2 million people in Britain were estimated to have an illness caused by work, 4.8% of all adults who have ever worked. Of 105,000 people forced to change job the previous year because of illness, 48% of these became economically inactive.
- 6.28 As the length of time off work increases the probability of return to work decreases^{2,55}. Most work-injured employees with back or neck pain return rapidly to productivity. However they are more likely to become disabled by their symptoms than patients with similar symptoms and underlying pathology which are not work related⁵. Once patients lose their jobs, the deleterious health consequences of unemployment have been well documented⁵⁶⁻⁵⁸. Those consequences are well documented even amongst those with no predisposing physical or mental health problem. For those with such predisposing problems the health consequences are yet more serious.
- 6.29 There are important relationships between employees' mental health and the nature of their employment. Whilst this is outside the remit of this review, recent work highlights the importance of a stable work milieu in which employees can function. Stress cannot be eliminated from the marketplace^{45,46}, but good employment practice can help employees feel valued which minimises additional stress.
- 6.30 The key inter-relationships lie in the nature of an individual's disabilities, the nature of their previous work experience and the employment market.

Summary

- 6.31 Musculoskeletal conditions, minor mental illnesses and coronary heart disease, in that order, are the conditions with the greatest impact on the workforce through sickness absence and the need for Incapacity Benefit.
- 6.32 The economic costs are enormous. The costs of spinal pain alone, estimated at between £5-10 billion, are born more by industry and the benefits system than by the NHS.
- 6.33 There is a dynamic relationship between the risks of employment, which may give rise to both accidents and ill health, and the risks of unemployment-related illness. Although industry is a major cause of both accidents and ill-health, there is now recognition that, with appropriate advice about work-related issues and individual support, many more people could be assisted back into employment. The role of the NHS and the health professions will be fundamental to this and will require prioritisation to facilitate redeployment and expansion of rehabilitation teams.

Recommendations

- 6.34 Much more research is required to identify better those people or groups of people who are at greatest risk of long-term disability. More research is also required to identify what interventions in the field of rehabilitation and job-retention actually work - this is particularly the case for 'common' conditions (back pain, mental disablement) and those of gradual onset (certain musculoskeletal and neurological conditions).

Table 1

Number of beneficiaries of Incapacity Benefit at 31 August 1997 - n=1,718,400

By primary diagnostic group	%
Musculoskeletal (and connective tissue)	28
Mental and behavioural disorders	20
Symptoms, signs and abnormal laboratory findings not classified elsewhere	14
Circulatory	13
Injury, poisoning and other external causes	6
Nervous system	5
Respiratory	4
Endocrine, nutritional and metabolic	2
Digestive	1.7
Neoplasms	1.2
All others < 1%	4.3
Claimants without any diagnostic code	0.5

Source DSS

7. Implications for Employers

- 7.1 Concern has been expressed by Government and industry about the levels of sickness absence within both private and public sectors and the higher levels of sickness absence in the public sector. The 1999 annual CBI survey covering the 1998 calendar year recorded the average sickness absence for employees in the private sector as 7.5 days per year compared with 9.2 days in the public sector. These figures represent levels of 3.3% and 4% respectively based on the 228 day working year used in the survey. The cost of sickness absence is enormous (Sections 6, 11) eg the estimated notional cost to Wandsworth Borough Council in 1998/99 was in the order of £3 million.
- 7.2 The Government has called on the public sector to reduce sickness absence by 30% by the year 2003. Days lost through sickness absence are to be used as an indicator to measure the performance of local authorities when the Best Value regimen is introduced in 2003
- 7.3 Causes of sickness absence vary and it is difficult to know how much of the absence is avoidable. There are clear medical reasons for which absence is necessary, e.g: heart attacks, fractures, severe injuries, etc. There are also medical reasons for which the need for absence from work is less clear. Examples might include minor respiratory infections, stomach upsets, toothache and backache. There are also non medical reasons for perceived sickness absence including domestic problems, children, sick dependants and a dislike of the job. Workplace issues eg perceived harassment may also contribute to stress and ill-health. Not all employers have appropriate family-friendly policies that address these issues.

Management of sickness absence

- 7.4 Effective management of sickness absence is of crucial importance⁵⁹. As part of the process of achieving this each company should have an explicit sickness policy and code. Some of the elements of such a scheme are listed in box A. However, such a scheme is only one element within a wider policy of:
- optimising job design
 - optimising working conditions
 - implementing occupational health policies
 - operating appropriate Health and Safety procedures
 - improving job satisfaction

Box A Some elements of a sickness absence scheme

Written company policy and codes

Recruitment policy for those with poor sickness records

Probationary period (6 to 12 months)

Sickness targets

Medical certificates

Monitoring system (Records and monitors cause of sickness, frequency and duration)

Audit system (Analyses data)

Trigger points (To implement necessary action)

Return to work certificates (Completed by employee on return to work)

Return to work interviews

Appropriate action by managers

An appeals scheme

- 7.5 Organisations have evaluated and implemented a variety of schemes in attempts to reduce sickness absence. Some companies do not pay employees for the first three days of sickness absence. In others the annual incremental progression of pay is modified. Organisations are experimenting with new ways of trying to reduce sickness absence, e.g: Wandsworth Borough Council. This Council is exploring a work/payback scheme. This requires staff who trigger certain levels of absence to work or ‘payback’ a proportion of the hours lost through sickness absence. This might be achieved by staff working additional hours, by trading in equivalent annual leave entitlement, or, where these options are not practical, by staff reducing pay by an equivalent amount.
- 7.6 The introduction of the scheme in certain areas of work within Wandsworth Borough Council has reduced sickness absence by some 56%. However, the operation of such a scheme needs to take into account workers previous work record and to be sympathetic to special circumstances.
- 7.7 In any organisation a certain number of staff may routinely or from time to time work beyond their basic hours without seeking recompense. It is important when operating a work/payback scheme not to alienate such goodwill and to take it into account when making decisions. This can be achieved by taking into account the hours worked during the preceding twelve months.
- 7.8 There are special circumstances and considerations to be taken into account when operating sickness absence schemes. Amongst these are serious illness (eg cancer and heart attacks), long term and chronic illness (eg rheumatoid arthritis and Crohn’s disease), pregnancy, industrial injuries and other exceptional circumstances. Moreover, a quicker return to work might be facilitated by encouraging a progressive return to work by allowing reduced levels of productivity in therapeutic work. This in turn might be made easier by making changes to the official medical statement of incapacity for work (Med 3).
- 7.9 It is also essential that any sickness absence scheme takes full account of employment, antidiscrimination and any other relevant legislation including the Disability Discrimination Act of 1995.
- 7.10 Organisations might reduce sickness absence by implementing ‘prevention’ policies. Such action can be arranged through an in house or contracted occupational health department and might include advice on health and safety at work; the self-management of every day simple illnesses; and health promotion schemes on stress, alcohol abuse, drug addiction and healthy life styles.

Employment of sick or disabled people

- 7.11 A range of special considerations needs to be taken into account when employing sick and disabled people and when people who have become disabled return to work. These are outlined in box B. Usually major alterations are rarely needed and minor adjustments to work duties, equipment used and hours worked are all that is needed.

Box B Considerations to be taken into account when employing sick and disabled people

<p>Access</p> <ul style="list-style-type: none"> To site (Disabled parking) To buildings (Ramps and lifts) To rooms and facilities in building (Canteen, toilets, managers office, work place) <p>Job design</p> <p>Working conditions (The working environment: temperature, noise, comfort)</p> <p>Adaptations</p> <ul style="list-style-type: none"> To furniture (tables, chairs) To machines and equipment <p>Flexible hours (including: part time work, therapeutic work, hospital time and rehabilitation time)</p> <p>Access to occupational health facilities</p>

Summary

- 7.12 Concern has been expressed by government and industry about the levels of sickness absence in both the private and public sectors. The cost of sickness absence in terms of direct costs, lost productivity, reduced services and corporate image is enormous. A range of medical conditions, social problems and work related issues account for much of the absence. The effective management of sickness absence is of crucial importance and a number of organisations are experimenting with ways to reduce absence and to facilitate early return to work. Employers should give special consideration to how they might best facilitate the employment and the return to work of sick and disabled people.

Recommendations

- 7.13 Employers should have:
- strategies for the prevention of work-related illness and the support for employees who become sick.
 - explicit policies to facilitate the employment of sick and disabled individuals.

8. Occupational Health Services

Introduction

- 8.1 Occupational medicine is that branch of medicine that considers the effects of work on health and the effects of health on work. Increasingly it is the latter that forms the main component of occupational health practice with significant levels of sickness absence and associated financial costs driving business agendas. The 1999 annual CBI survey (1998 calendar year) recorded the average sickness absence for employees in the private sector as 7.5 days per year compared with 9.2 days in the public sector. These figures represent levels of 3.3% and 4% respectively based on the 228 day working year used in the survey.
- 8.2 In the past the public sector has paid relatively little attention to such problems but it is increasingly being recognised that high levels of absence in parts of the civil service, police and fire services and the NHS have a significant impact on the ability to deliver services effectively and economically. Many factors influence the levels of sickness absence but the availability of rehabilitation services or otherwise will influence the return to work.

Absence patterns

- 8.3 Numerous causes are given on medical certificates for sickness absence but in most sectors musculoskeletal and psychiatric problems head the list, the latter including the term 'stress'.
- 8.4 The length of absence has a clear influence on the likelihood of a return to work. The longer the absence continues for whatever cause the less likely is a return to come about. If therefore the length of absence can be reduced by whatever means then a return to work is more likely. Increased productivity, reduced costs, reduced ill-health retirement, reduced state benefits and increased personal well-being will all result.
- 8.5 One of the most significant reasons for long term sickness absence is the length of NHS waiting lists, particularly for musculoskeletal conditions. It is arguable that many people on such waiting list do not in reality need to be there if recommended guidelines for management were followed eg back pain². The waiting lists are not, however, only for initial consultation or admission but are often for further investigation and subsequent treatment such as physiotherapy.
- 8.6 Even if hospital admission has been necessary follow-up rehabilitation is not available quickly and is often only provided following subsequent re-referral when problems continue.
- 8.7 Effective management in primary and secondary care providing early rehabilitation would reduce or avoid:
- Sickness absence
 - NHS waiting lists
 - long term sequelae of often relatively minor conditions

Examples of waiting list management are given in Section 12.

Relationship with the NHS

- 8.8 The provision of occupational health services in the UK is patchy. The UK has signed up to the European requirements on the provision of occupational health services by saying that the NHS provides a comprehensive medical service and thus all requirements are covered by this. In reality the NHS does not always provide comprehensive occupational health cover even for its own employees. Where it is provided for its staff it is not always a consultant led service. NHS trusts with occupational health services may see them as an opportunity for income generation with the risk that their primary function is poorly provided.
- 8.9 Traditionally large firms have provided in house occupational health services which may include consultant occupational physicians, part-time and sessional doctors, occupational health trained nurses, other nurses, occupational hygienists, physiotherapists, dentists, and complementary practitioners. Also there may be welfare advisers or other counsellors. There may be fitness facilities. Such services are becoming fewer as firms concentrate on their core activities.

- 8.10 Many occupational health services are nurse led and occupational health nurses provide a significant level of care in this field. To do so, however, they have to rely frequently on information from GPs and hospital specialists to enable them to provide proper advice.
- 8.11 Additionally there is often the feeling that there should be no need to provide health facilities as the NHS should be doing so. (See below).
- 8.12 Some public sector services have developed the rehabilitative component of occupational health teams. West Midlands Police now offer physiotherapy to any officer who needs it, and Merseyside Police are trying to reduce their £12 million annual sickness absence bill through using physiotherapy. Surrey police used a physiotherapist to alter procedures in riot control training, which had been identified as a source of a number of musculoskeletal injuries, leading to a successful reduction (personal communication, Chartered Society of Physiotherapy).
- 8.13 Increasingly, businesses are buying in occupational health services from a commercial provider who may be an NHS trust seeking external income. The range of services bought varies with perceived need but is usually accompanied by the requirement to reduce costs and increase value for money. Businesses who go down this line often do so following outsourcing reviews or restructuring to concentrate on core business activities. Such activities may of themselves be stressful⁴⁵. Depending on the resulting contract often they may lose full time access to those providing the service.
- 8.14 Many companies, particularly smaller ones, contract a doctor to provide a service which is often limited to their perceived needs. There is a small number of providers specifically designed for small firms. The HSE provides the Employment Medical Advisory Service, one of whose tasks is specifically to help small firms. This service has, however, been considerably reduced and it is much more difficult for such firms to receive advice.
- 8.15 Occupational health departments or occupational therapists can, as part of an employee's rehabilitation, arrange duties fit for some (rather than alternative) work. When employees are transferred to alternative duties there is often no link back to their previous duties: the quickest way to achieve a return to normal duties has been found to allow individuals to return doing as much as possible of their normal job, gradually resuming additional tasks as they are able²¹.
- 8.16 The qualifications of doctors offering an occupational medicine service vary from fully accredited consultants holding Membership of the Faculty of Occupational Medicine (MFOM) or Fellowship (FFOM); through trainees holding Associateship of the Faculty (AFOM) and in approved training posts; to GPs with the Diploma of the Faculty. There are those practising occupational medicine with no qualifications in the speciality at all. Whether revalidation of doctors will address this question is unclear as it appears that it will be up to individual doctors to declare themselves in what fields they are working and to demonstrate adequate training for their roles.
- 8.17 The Faculty has this year introduced a Diploma in Disability Assessment Medicine which is aimed at Benefits Agency doctors and GPs involved in disability assessment.
- 8.18 There is often an uneasy relationship between occupational physicians and the NHS even including those occupational physicians who work for the NHS. It is often perceived that occupational physicians are working on behalf of the business rather than the individual. This can be a barrier to managing a return to work, an activity which, in itself, may lead to a speedier recovery of the health of the individual.
- 8.19 The patient and practitioner may initially feel that sickness absence is justified but the longer it continues the more difficult it becomes to bring it to an end. Much sickness absence continues while waiting for referrals or investigation to take place, a period during which there may be no actual bar to work - merely the perception that such referrals or investigations must be completed first.
- 8.20 Many individuals and employers assisted by some doctors feel that treatments such as physiotherapy or counselling should be successfully completed before a resumption of work can be contemplated. In reality a return while such support is in place will result in a more rapid and effective recovery.
- 8.21 Occupational health departments are able to arrange with employers rehabilitation duties allowing alteration in activities or hours to allow a gradual resumption of work. There is thus a clear distinction between being fit for normal work and being fit for alternative work.
- 8.22 Despite the advice of the DSS Chief Medical Adviser to certifying practitioners⁶⁰ this distinction is often not appreciated by GPs when completing certificates. Therefore a conflict can develop between occupational

health departments and other practitioners. Such conflicts can best be overcome by effective communication between all health professionals seeking to improve the welfare of patients.

- 8.23 Despite having signed consent of patients and offering to pay significant sums for reports from GPs and hospital specialists there is often difficulty in obtaining useful information or indeed any information at all. This is made more difficult in many instances by hospital administrators requiring payment for getting clinical notes from the files for a consultant to prepare a report and requiring a signed indemnity that no legal action is being contemplated. This displays a woeful ignorance of the role of occupational medicine. The sums being asked for even simple reports are sometimes very high, several hundred pounds on occasion. Even then clinical information is often lacking. Occupational physicians in such instances are seeking clinical information, investigation results and plans for treatment. Often what is provided is opinion on the merits of medical retirement instead. This is the province of the occupational physician who will be aware of the retirement and pension rules.
- 8.24 There is a lack of appreciation by many practitioners that repeated or prolonged sickness absence can lead to termination of employment. There are those who believe that if a certificate is provided then an employee cannot be dismissed for non-attendance at work or cannot be dismissed while a certificate is in force. Sadly this is not so. Employment law is clear that non-attendance at work for whatever reason can be grounds for lawful dismissal. Practitioners need to be aware that prolonged absence can and does lead to dismissal whereas an effective joint rehabilitation programme can lead to early recovery and continued employment. It is the maintenance of such employment that is a key role of occupational physicians in conjunction with other health professionals.
- 8.25 Additionally some practitioners fail to appreciate that the issuing of sickness absence certificates not only results in the payment of statutory sick pay but also significant sums of company or employers' sick pay. It needs to be considered whether the payment of such considerable sums is justified if rehabilitation programmes are available at work.

Rehabilitation (as viewed from an occupational health perspective)

- 8.26 The availability of rehabilitation services within the NHS is patchy both in terms of the existence of such services and their accessibility. Most soft tissue injuries or mechanical musculoskeletal problems will resolve or improve sufficiently with early physiotherapy thereby allowing an early return to work. For those who have needed surgical intervention, physiotherapy or other rehabilitation services if provided early will lead to earlier recovery and return to work. If delayed, mobilisation becomes more difficult and is sometimes impossible (Sections 8, 9). Some consultants believe patients can rehabilitate themselves and do not need therapy, thus referring only when they have been proved wrong and the condition has become chronic. Self-motivated patients who do not require rehabilitation can soon be discharged from therapy with advice.
- 8.27 There is certainly the perception that current NHS emphasis on waiting lists means that all efforts are directed towards admitting and subsequently early discharge of patients. The target is then met but the patient's condition may not have been fully dealt with and recovery may not be complete. Outcome is not the measure whereas throughput is. All the effort is put into measurable narrow targets rather than wider outcomes including a return to work. Indeed a return to work is not considered a target at all!
- 8.28 The shortfall in effective rehabilitation services is met sometimes by companies and organisations such as the fire services by the provision of in-house facilities or direct payment for or payment of private health insurance. Even where such facilities are available there still needs to be a degree of co-operation between all practitioners in order to bring about recovery, which must after all be in the interests of the patient. For reasons outlined above this is not always easy. Where it works it works very well.
- 8.29 There is often reluctance for businesses or the public sector to provide such facilities as it is felt that the NHS should be doing so. There is a perception that medicine is 'free' and that therefore paying for rehabilitation should not be necessary. Additionally, particularly in the public sector, there may be political (with a small 'P') objections to supporting private medicine. This is not the case in countries with different healthcare provisions where employers recognise that provision of healthcare products such as rehabilitation services is of direct benefit to employees and employer alike.
- 8.30 The employer has responsibilities, both moral and legal, towards rehabilitating employees back to work. The Disability Discrimination Act (1995) lays down clear duties on employers in respect of those with disabilities. The definition of 'disabled' is now laid down in the Act and encompasses a far wider spectrum of the population than previously. Reasonable adjustments are required by law to enable disabled individuals to

continue in employment. It may be necessary to move from rehabilitation to redeployment in some instances when occupational health advisers have a clear role.

Recent developments

- 8.31 The Government issued “Revitalising Health and Safety, Strategy Statement” in June 2000⁶¹. This addresses the question of Occupational Health and Rehabilitation and draws attention to a new occupational health strategy for Great Britain (see below).
- “The government will encourage better access to occupational health support and promote coverage of occupational health in local Health Improvement Programmes and Primary Care Group strategies in England” (Action point 29).
 - “As part of the next stage of the New Deal for Disabled People, the Government is considering how best to strengthen retention and rehabilitation services for people in work who become disabled or have persistent sickness” (Action point 30).
 - “The Health and Safety Commission will consult on whether the duty on employers under health and safety law to ensure the continuing health of employees at work, including action to rehabilitate where appropriate, can usefully be clarified or strengthened eg organisations might be required to set out their approach to rehabilitation within their health and safety policy” (Action point 31).
- 8.32 Additionally there may well be taxation implications for individuals if the business pays for health care provision. If they are to be taxed, individuals and trades unions are often reluctant to take up such benefits. The Inland Revenue announced on 19 November 1999 that the Government is to exempt general welfare counselling provided by an employer from tax and National Insurance contributions. Other rehabilitation services are exempt from tax if they relate directly to something that has happened in carrying out employment.
- 8.33 As indicated in “Revitalising Health and Safety”⁶¹ a new strategy for Occupational Health, “Securing Health Together”, was launched on 4 July 2000 by the Health and Safety Commission⁶². The targets of this strategy include:
- 20% reduction in incidence of work-related ill health
 - 30% reduction in the number of days lost due to work-related ill health
 - Those off work through ill health or disability to be made aware, where appropriate, of opportunities for rehabilitation
- 8.34 The strategy links with other government programmes including Welfare to Work, The New Deal, New Deal for Disabled People and public health initiatives in England, Scotland and Wales.

NHSplus

- 8.35 The NHS plan envisages provision of “an occupational health service to thousands of employers as well as NHS staff themselves”. There is no indication how this is to be resourced in either manpower or financial terms. This is particularly important as current provision to NHS staff is itself very patchy. The pool of trained occupational physicians is small as is that of those in training.
- 8.36 Those NHS trusts that do have a consultant-led occupational health service often do provide services to other public sector organisations and some businesses. To be expanded it will need resourcing. It is a matter of speculation as to whether the thousands of employers mentioned in the NHS Plan would be prepared to pay for such a service or would expect it to be provided as part of an NHS free at the point of delivery.

Summary

- 8.37 Occupational Health provision in the UK is variable and patchy. Those involved in its delivery have varying qualifications or sometimes none.
- 8.38 The relationship between Occupational Health practitioners and hospitals and GPs is often uneasy. The place of Occupational Health services in facilitating rehabilitation back to work is often not appreciated. Rehabilitation services are currently predominately focussed on the relief of symptoms and treatment of the illness rather than a return to productive work.
- 8.39 Absences are often longer than they need be due in part to the length of NHS waiting lists and the lack of easy and early access to rehabilitation facilities.

- 8.40 Whereas some organisations and businesses provide their own rehabilitation facilities there is often reluctance to do so as it is felt that the NHS should make such provision particularly when the need follows on from the provision of acute services. Additionally there may be tax implications if a business provides facilities.

Recommendations

- 8.41 Rehabilitation services should be focussed on achieving a return to work.
- 8.42 Rehabilitation services should include employment, medical, psychological and therapeutic components.
- 8.43 The taxation implications of business providing rehabilitation support should be reviewed.
- 8.44 Communication between hospital, GP and employer (or Occupational Health on their behalf) needs to be improved with all agencies being aware of the needs of the other.
- 8.45 There is scope for improving the understanding by health professionals (particularly doctors) of employment issues and of employers to understand the role and availability of Disability Employment Advisers.

9. General Practitioner Services

- 9.1 General practitioners (GPs) can help those with injury, illness and disability to return to work. It is often the GP who has an overview of an individual's condition and progress and is the person who is best placed to harness, monitor and progress chase the components of vocational rehabilitation. However it appears it may be difficult to do so effectively.
- 9.2 GPs in the NHS frequently encounter individuals unable to work because of injury, disability or illness. They present in a variety of ways and at different times during their injury or illness. Some approach the family doctor directly; others are referred by an occupational physician; and others are seen after treatment at a casualty department or other hospital facility. Individuals can present with an acute injury requiring urgent diagnosis and treatment or may have been diagnosed and treated elsewhere and be recovering before attending their GP.
- 9.3 They may have a straight forward, simple condition or a more complex problem. Amongst the spectrum of conditions seen are the following: small and large soft tissue injuries; fractures; osteoarthritis; back and neck problems; work-related upper limb disorders; deafness; eye injuries and other visual problems; cardiac and respiratory problems including hypertension, angina, myocardial infarction and pneumoconiosis; strokes; epilepsy; and mental health problems including anxiety, depression, stress, substance abuse etc. Some are short-lived and trivial whilst others are of major importance. It is not easy to sort out these differing aetiologies.
- 9.4 Helping those with injury, illness or disability to recover and return to work as quickly as possible also requires GPs to access and harness many resources in addition to their medical skills. The underlying principles are those of diagnosis, treatment and rehabilitation. Traditionally these are viewed as sequential steps. However, the processes involved are closely interrelated and should take place in parallel. Even accessory services to aid diagnosis may be time-consuming.
- 9.5 The GP needs to understand the interaction between work demands and the impairment under consideration, both its causation and recovery. Recovery may be assisted if individuals can return on a graded programme of restricted (may only do some of their normal) or adjusted (implies some modification to the way they are done, eg changes made to equipment, seating, etc) duties.
- 9.6 Often GPs can make a diagnosis after a clinical examination and with the help of a number of tests which can be conducted in the surgery (eg an electrocardiogram). As our understanding of injury, illness and disability advances and medico-legal considerations feature more prominently, the demand for special diagnostic procedures increases. The time taken to access these varies enormously. Delays in diagnosis can significantly delay treatment and lengthen the time a patient is off work.
- 9.7 GPs will refer a number of patients to secondary care to establish a diagnosis or for specialised treatment. Long waiting times for outpatient appointments, X Rays and other investigations; and further long waiting times for surgical and other treatments can significantly delay definitive treatment. These delays may result in:
- a decline in mental well being with anxiety and depression
 - decreased physical fitness (deconditioning) to levels that make a return to work difficult or impossible
 - delay and making return to work more difficult
 - strained family economic situation with increased family worry
- 9.8 Within the NHS limited manpower (doctors, therapists, technicians); financial constraints; and shortages of equipment significantly delay diagnosis, treatment and rehabilitation of a significant number of those who have suffered injury or illness at work.
- 9.9 Where an individual has sustained a severe disability eg a spinal cord injury, GPs may liaise with a wide range of agencies to rehabilitate the person back into their home, community and work e.g:
- housing authorities to secure appropriate accommodation
 - social services and voluntary organisations for adaptations to the home and for personal support
 - local authorities to secure reserved parking facilities

- employers and occupational physicians about an appropriate programme for returning to work
- employment services for financial assistance.

9.10 Advice is also needed with:

- driving by helping the person to attend a driving assessment centre
- vocational assessment, retraining and access to work
- job adjustments and modifications to the working environment
- financial benefits.

Habilitation

9.11 Occasionally GPs initiate and facilitate the process of vocational 'habilitation' for those born with disabilities or those who acquire disabilities in early life. The family doctor will work closely with a range of employment, educational, health, social and voluntary services to facilitate entry into the world of work.

Prevention

9.12 Primary care has a major part to play in prevention. The GP, along with occupational physicians, health and safety workers and employers also helps to prevent illness and bad practice which might contribute to industrial injuries or illness. Advice on diet, alcohol consumption, weight, physical fitness, lifting heavy objects, protection from noise and fumes and how to cope with stress in the workplace may prevent injury and illness at work and help reduce the demand for vocational rehabilitation.

Return to work

9.13 GPs are well placed to facilitate the early return to work of sick and disabled individuals. However, the necessary time, support services and the facilities required to properly undertake this work are not available (eg counselling, psychology, physiotherapy, occupational therapy, rehabilitation, retraining). Moreover, many GPs would be reluctant to become further involved in a certification role, especially one that might result in conflict with their patients over fitness for their own work or fitness for other work. It is recognised that primary care services are under great pressure currently which might militate against expanding their role eg to follow a certification process which led to assessment for rehabilitation after a fixed period of sickness certification.

9.14 The relationship between unemployment, sickness and disability and the benefits system has been reviewed recently⁴³.

Reports & certification

9.15 Providing advice on fitness for work is part of the management of those with injury, disability or illness. The advice might variously focus on consideration of the:

- time an individual is likely to remain unfit for work
- date on which it would be appropriate to return to work
- fitness or unfitness to return to their previous work
- alternative employment
- therapeutic work
- adjustment of machinery, the working environment and working practices

9.16 In these contexts, doctors regularly provide reports for use in litigation and insurance matters; medical certificates to support claims for financial benefit from the Benefits Agency (and for the use of employers) and statements to secure information and help from the Employment Service. All documents must be completed with meticulous attention to accuracy.

9.17 It is the duty of the doctor who has clinical responsibility for an individual to provide free of charge certain 'official' medical statements (certificates) recording the advice given to the individual on their ability to undertake their own occupation. These statements are then used by individuals to support claims for financial benefit from the Benefits Agency. The increasing pressures of clinical practice, changing employment situation, economic pressures within society, and changing attitudes of a number of individuals can, at times,

make this an unappealing task. However, there is an obligation on doctors to undertake the work with due diligence. Details are given in Appendix 7.

Summary

- 9.18 General practitioners have a statutory obligation to provide fitness for work certification and are pivotal in deciding on fitness to work. It is often the GP who has the best overview of an individual's condition and progress; is best placed to harness the necessary resources; to monitor progress and to progress-chase the treatments, rehabilitation and other services which may result in an individual's speedy and satisfactory return to their previous or other employment.
- 9.19 The known limitations of the NHS, limited manpower, financial constraints, shortage of equipment and facilities significantly constrain the ability of GPs to provide fast, accurate diagnosis and treatment so as to return individuals to work with minimal delay.
- 9.20 Links between primary care and occupational health services are often poor.

Recommendation

- 9.21 Better liaison between occupational health services and primary care, and speedier access to secondary care with enhancement of secondary care services (eg radiology, therapy services) would promote job retention.

10. Rehabilitation Resources

- 10.1 This section considers those rehabilitation resources that are needed by GPs. To enable the individual to maintain their place in employment and speedily return to work, treatments should be designed to meet the needs of the individual from the “menu” of rehabilitation services. Some individuals with more complex needs, however, will require intervention from more than one profession (for both assessment and treatment). For simplicity, these skills are described separately, even though significant numbers of individuals will benefit from a multiprofessional approach^{24,63,64} (Section 11).

Consultant Physician in Rehabilitation Medicine

- 10.2 Rehabilitation Medicine is concerned with the prevention and reduction of disability and handicap arising from impairments and the medical management of disability from a physical, psychosocial and vocational point of view.
- 10.3 The role of the Rehabilitation Medicine consultant varies widely from but can involve:
- community rehabilitation
 - musculoskeletal rehabilitation
 - neurological rehabilitation
 - prosthetics and orthotics
 - spinal injuries rehabilitation
 - any combination of these together with other specialist services^{24,63,64}.
- 10.4 Pressures within acute NHS trusts have resulted in many consultants and other members of the rehabilitation team being involved in facilitating early discharge from hospital and a return to independent living. Following discharge (or for those who are seen in outpatients, once the diagnosis has been established and appropriate treatment implemented), the vast majority of individuals can return to work. Problems arise for those who have lost their job whilst waiting for their outpatient appointment or who have been discharged from hospital in an early stage of their recovery eg head injury. These individuals need vocational assessment, work hardening and sometimes retraining. These facilities are now rarely available to the NHS.
- 10.5 The current training curriculum for Rehabilitation Medicine includes an optional module in vocational rehabilitation but this is not considered part of the “core curriculum”. Obtaining adequate training in this area is difficult mainly because of the lack of potential trainers involved in this area. Consequently many specialist registrars do not acquire appropriate training in vocational rehabilitation.
- 10.6 Consultants in the neurosciences, orthopaedics, pain management, rheumatology and to a lesser extent other specialties are also involved intermittently in facilitating a return to work. They are under similar pressures to those described above and rarely have formal training in this area of medicine. Again the main referral route is to the therapist and for those who fail to improve satisfactorily a referral is made to the disability employment adviser. Often a decision on fitness to work is left to the GP.

Occupational therapy

- 10.7 Occupational therapists (OTs) use their core skills (activity analysis) to enable and empower people to make choices and to achieve a personally acceptable lifestyle, with the goal of maximising health and function. In the early stages of recovery the aim is to reduce the impairment, but the ultimate goal is always to return the individual as near as possible to their previous occupational level of functioning. They restore health using purposeful occupation as the process and as the ultimate goal.
- 10.8 Occupational therapy was founded in the early part of this century largely to help disabled war veterans back into useful employment after the two world wars. More recently it has been used primarily to assess personal care needs to allow for a safe discharge from hospital. However, the core skills remain the same. Occupational therapists assess a person's ability to safely manage whatever activities they need to do, and they also use activities therapeutically to improve ability. Because activity is their core skill, they are ideal professionals to analyse work tasks and compare these to worker abilities, especially when these have been affected by illness or injury, and to make recommendations regarding suitable adjustments.

- 10.9 Occupational therapists are employed in many different settings including hospital and rehabilitation departments run by the NHS or private or voluntary sectors; they also work for local authority social services departments. Others work for insurance companies or medico legal organisations or in private practice, covering a range of activities. A few are employed as part of occupational health schemes.
- 10.10 In the acute sector occupational therapists can provide:
- continuity of care from the time of initial illness or injury (for example in the provision of thermoplastic splinting) until the person has returned to work - previous job, a modified job or alternative work
 - care manager or key worker roles to provide advice about help available from other agencies such as the disability service team, social security benefits (eg disability living allowance) and the health and safety executive (eg where an accident was caused by unsafe working practices)
 - craft and specific work-related activities to regain their former or maximum functional capacity in a protected and structured environment⁸
 - worksite visits to help plan a return to work, if necessary on a graded basis doing restricted duties⁶⁵. Such visits provide an opportunity to instruct the employer in disability awareness issues so that the employee is accepted for his/her abilities but not put under undue pressure in areas of difficulty.
 - explore alternative employment opportunities - for those unemployed at the time of treatment or with no possibility to return to their previous work. Some will only need advice to find or return to work, but others will need to be supported through every stage of the process. For some it will be a single injury from which they can easily recover, but for others it may be an illness or injury that follows a series of earlier problems so that return to work may require a complex solving of numerous difficulties.
- 10.11 Disability Employment Advisers may work closely with occupational therapists as they hold the Access to Work budget which may need to be used to help fund modifications. However, usually the only modification required is a restriction of duties and hours at the time of initial return to work. It has been demonstrated regularly that most workers will achieve their maximum or former functional level more quickly if they are allowed to return on a graded basis, trying out difficult duties as they are able, but with the opportunity to decline, and encouragement to ask for help when it is needed.
- 10.12 Recommended adjustments, or grading of duties, must be strictly implemented by employers if the recovery process is not to be halted or reversed due to over-use. Staff shortages must not be allowed to compromise the health of any worker, particularly one who is currently still undergoing rehabilitation. This may require a change of culture in some organisations. Workers have individual capacities which must not be surpassed if their health is not to be put at risk. Thus it is important that staff working in the vocational rehabilitation are well qualified, otherwise complex problems will not be unravelled and failure is more likely. The more failures experienced by an individual the harder it is likely to be, and the longer it will take to achieve a successful return to employment. Physical and mental health are closely interlinked (Fig 2) and many people experiencing a physical injury or illness will have difficulties returning to work due to associated psychosocial problems.
- 10.13 A flow diagram of the Return to Work Occupational Therapy service offered at Wexham Park Hospital, Slough is appended as an example (Fig 4).

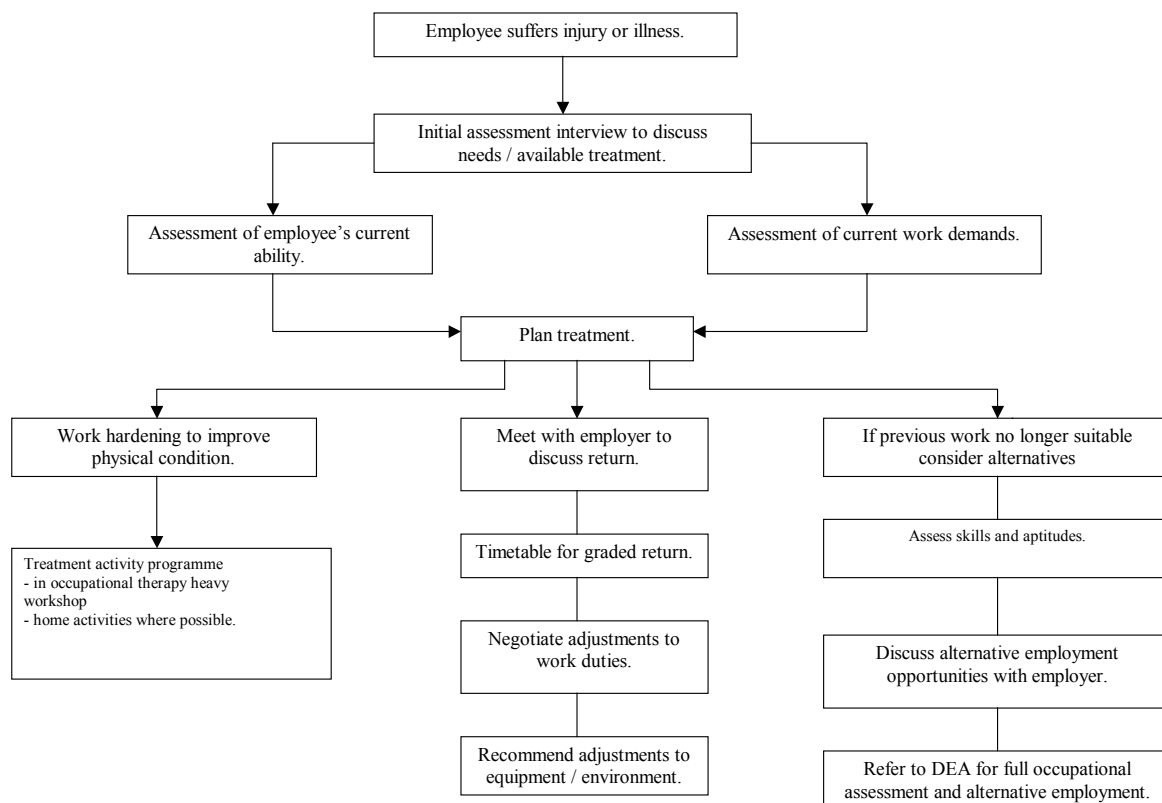


Fig 4 - Schematic view of an Occupational Therapy Vocational Rehabilitation Service

Physiotherapy

10.14 Chartered physiotherapists have expertise in the analysis of human movement and in the rehabilitation of individuals with musculoskeletal, neurological or respiratory disorders. They appreciate the challenge of effective management of chronicity and are increasingly using cognitive behavioural techniques to ensure maximal physical rehabilitation. Physiotherapy has a key role to play in the rehabilitation of the workforce and should form an integral part of any occupational health service.

10.15 Physiotherapists specialising in occupational health have developed expertise in:

- functional capacity evaluation
- manual handling
- pre-employment screening
- rehabilitation of workers who have sustained injury at work
- risk assessment related to workers and their work activities
- work hardening/work conditioning
- workforce health promotion

10.16 Given the complex needs of individuals whose working environment may have a negative impact on their well-being, an interprofessional, multifaceted approach to rehabilitation is necessary. An integrated physiotherapeutic approach which includes vocational training and general education, combined with job placement efforts tends to increase the likelihood of return to work⁶⁶.

Psychology

10.17 Vocational rehabilitation has never been a primary focus for the professional activities of psychologists in the UK. In the past, Occupational Psychologists were core members of the staff in Employment Rehabilitation Centres. Since the demise of the Employment Rehabilitation Centres during the 1980s, DfEE Employment

Occupational Psychologists have continued to make similar contributions in conjunction with the disability service teams. However, those Occupational Psychologists, who are estimated to number about 70 currently (DfEE personal communication) together with a smaller number who are now in private practice eg as employment consultants (providing reports for medicolegal purposes), comprise just a small minority of all persons in that branch of Psychology.

- 10.18 The position of Clinical Psychologists is broadly similar. Although there has been a significant increase in the number of graduates entering that branch of the profession, the primary areas of recruitment have been in services for persons with learning disabilities, child and adolescent psychology and services for the elderly. Where adults of working age are concerned, Clinical Psychologists and Neuropsychologists contribute to a range of specialised services for acquired brain injury, cardiac rehabilitation, neurodisability, pain management and spinal cord injury. Apart from some programmes for acquired brain injury however, the primary roles of those services are mainly directed to other therapeutic aims, with vocational rehabilitation of secondary concern. Whilst GPs are already able to refer patients of working age to clinical psychology services, in practice the number of such referrals is comparatively low compared to the scale of need. These individuals are not accorded any priority and waiting times for referrals can be prolonged. To overcome these problems, it may be necessary to consider provision of a specialised fast-track clinical psychology service for those of working age whose return to work may be unduly delayed.
- 10.19 It is widely recognised that the emotional components of ill-health require similar attention to that normally accorded to physical aspects. That interlinking is clearly acknowledged in those countries which have supported the development of rehabilitation counselling services. In a UK context, the primary potential source for such specialised assistance would be clinical and / or counselling psychologists. The Working Party has been unable to identify any information that would provide an accurate estimate of demand for such professional assistance and would recommend early investment is made in researching the extent of unmet need; and the availability of treatment modalities eg cognitive behavioural therapy (CBT) which are known to be particularly helpful^{67,68} (see below). However we note the view that, as a basic principle of good rehabilitation practice, emotional agendas need resolution before physical goals can be achieved⁶⁹.
- 10.20 There is a growing awareness that, in practice, the emotional and the physical are inseparable⁷⁰⁻⁷² (Fig 2). In the fields of spinal pain (Section 11), fibromyalgia and chronic fatigue, the incorporation of psychological principles into clinical practice have improved outcomes⁷³. Psychological illness per se (eg work-related stress) is also recognised as an increasingly important reason for illness absence (Sections 3,6,8,9,11).
- 10.21 In contrast with developments in other countries, psychological services in the UK have not provided a springboard for the emergence of a more vocational rehabilitation-oriented branch of professional activity, such as rehabilitation psychology or vocational rehabilitation counselling, drawing upon clinical, occupational and counselling psychology roots and focussed on the rehabilitation and return to work of adults with health problems or disabilities. The situation in the UK therefore stands in strong contrast with that in the USA where, for example, the activities of psychologists employed in that field are backed by their own Division of the American Psychological Association.

Summary

- 10.22 Rehabilitation teams (including Consultants in Rehabilitation Medicine) are primarily focussed on the rehabilitation of acute and severe disability with little time for vocational rehabilitation. Training facilities in vocational rehabilitation are poor and access to appropriate vocational rehabilitation facilities is sparse. Few occupational therapists appear to continue to work in this field.
- 10.23 There is increasing evidence of the value of psychological treatments such as cognitive behavioural therapy. There appears to be a mismatch between the number of people needing psychological help after disease or injury and the availability of appropriate services, not only for those with physical problems but also for the increasing number of those suffering from the effects of stress at work or similar mental disorders.

Recommendations

- 10.24 Early investment should be made in researching the extent of unmet need for psychological help; and the availability of treatment modalities eg cognitive behavioural therapy.
- 10.25 Training of specialist registrars in Rehabilitation Medicine, therapists and psychologists should include exposure to good vocational rehabilitation practice.

- 10.26 Expansion in vocational rehabilitation will demand doctors, psychologists and therapists with dedicated sessions.
- 10.27 Return to work should be an outcome measure of treatment provided by the NHS much more frequently.
- 10.28 Stronger links are needed between health and employment services.
- 10.29 Consideration needs to be given to providing consultant sessions dedicated to supporting vocational rehabilitation activities by hospital or community rehabilitation teams.
- 10.30 Creation of a course in vocational rehabilitation together with encouragement to involve trainees in specialties other than Rehabilitation Medicine in vocational rehabilitation is urgently needed. This will need to be jointly planned between the Employment Service and the NHS.

11. Specific Areas of Service Delivery

- 11.1 This section examines illustrative areas of service delivery to show where evidence demonstrates the value of good practice, often crossing the barriers of employment and health. Musculoskeletal disorders are discussed in some detail as they cause so much sickness absence and disability.

Musculoskeletal disorders

- 11.2 The epidemiology of these conditions has been given in Section 4. The ageing workforce will have specific health needs due to their increased risk of musculoskeletal disorders eg osteoarthritis and osteoporosis (as well as arterial disease and an increasing prevalence of inflammatory joint disease).

Back pain

- 11.3 Primary prevention of low back pain is the elimination or minimisation of risks to health or well being. It is an attempt to determine factors that cause disabling low back disability and then to create programmes to prevent those situations from occurring⁷⁴. Prior significant episodes of back pain (previous job changes due to back pain) are associated with an increased risk of future episodes of pain^{75,76}.
- 11.4 Corporate stress management programmes at three high risk work sites have reduced the number of accidents (including those to the spine) and related costs⁷⁷. This was achieved through stress reduction (which included organisational change as well as employee education) and the identification of high risk sites and groups.
- 11.5 The introduction of ergonomics in railroad industry in the USA has controlled costs through the reduction of accidents and injuries. In one company, management took a participatory approach and encouraged workers to configure their own tools and material handling devices⁷⁸. By:
- storing tools and materials off the ground - between knee and shoulder height
 - storing the heaviest items at knuckle height
 - devising winches to lift and handle heavy equipment
 - using worktables, dollies and carts to handle heavy car parts and tools
- companies are noting productivity improvements, reduced costs and increased job satisfaction⁷⁸.
- 11.6 In California, a one year back injury prevention programme (costing \$90,000) combining education, training, physical fitness and ergonomic improvement showed a net benefit of the programme to be \$161,108 with an investment return of 179%⁷⁹. Factors included reduced:
- medical claims
 - sickness absence
- 11.7 A new coal mine in Queensland, Australia was established with a back programme that included workforce education with orthopaedic input, acute back care by first aid officers, early referral to a GP and facilitation of an early return to work⁸⁰. Management and supervisors took care of the worker who returned to work early. The workers were made to feel an important part of the team. Usually no light duty was available after the worker returned to work. This resulted in a mean return to work in 10 days and no worker was off work longer than 60 days during a 6 year period. There were significant reductions in the number of claims and in the costs per claim compared to another similar mine. The authors felt that an enlightened management and altered workplace perceptions may have contributed to the good results⁸⁰.
- 11.8 There is little evidence to support education by itself⁸¹. Evidence supports initiatives that include participation of the workforce and organisational change.
- 11.9 The longer a person is off work with back pain, the lower their chance of returning to work. After 6 months there is about a 50% chance, which falls to 25% at one year and 10% at two years². It is now thought unlikely that individuals will return to any form of work after 1-2 years absence, irrespective of further treatment⁸².
- 11.10 Early, but relatively simple, physiotherapy intervention including education and activity for acute episodes of back pain (seen within three days instead of ten) has shown that 57% of individuals returned to work within

ten days compared with 36% of the control group⁸³. The risk of developing chronic pain was 8 times lower for individuals in the early intervention group, with only 2% remaining out of work at 7 month follow-up compared with 15% in the other group⁸³. A study of 14,000 US postal workers using an early treatment protocol implemented if the worker was off work for more than 7 days, reduced costs by 55% and days lost by 60%⁸⁴.

- 11.11 The Rover motor company's Back Care programme reduced absenteeism from back pain amongst 17,500 employees by some 6 000 days⁸⁵. The programme offered prompt access to physiotherapy, advice on manual handling issues and self-help and remedial exercises on site.
- 11.12 Specific education leaflets based on evidence of effective approaches in the management of acute back pain, specifically advocating early activity, were shown to reduce extended sick leave by 70%, compared to 20% in individuals receiving non-specific advice leaflets. This was based in light industrial settings and has been confirmed with use of the Back Book⁸⁶.

Obstacles to a return to work

- 11.13 The commonest physical finding in those with chronic low back pain is deconditioning⁸⁷. Physical reconditioning is usually addressed by a general exercise and stretch programme taught by a physiotherapist. Its aim will be to build muscle, bone and collagen strength, improve general fitness, stamina, aerobic and local circulatory capacity and joint lubrication and to reduce stiffness and enhance flexibility⁸⁸. Conditioning exercise programmes together with ergonomic and other improvements at the workplace have been shown to decrease sick leave episodes associated with back pain⁸⁹. Co-morbidity is an important element in determining whether an individual will return to work³⁹.
- 11.14 Depression has long been recognised as a major complication of chronic pain and particularly chronic low back pain⁹⁰⁻⁹⁹. It is particularly likely to impede a return to work when occupational mental stress is involved⁹⁸. The perception that physical methods of treatment alone will overcome the problem of chronic low back pain has been a major impediment to services for this large group of individuals. Post-traumatic distress (with some or all of the features of post-traumatic stress disorder) is often missed^{69,100,101}. Involvement of clinical psychologists and occupational therapists are needed to facilitate appropriate multi-professional management of low back pain that the evidence now shows is needed.
- 11.15 Job dissatisfaction is well recognised. So-called "blue flags" are perceived features of work generally associated with higher rates of symptoms and include:
- job demands
 - job content (including repetitiveness)
 - job control
 - lack of support from supervisor / colleagues
 - role factors (e.g job future and career issues)
 - technology issues
 - Organisational / management issues¹⁰²
- 11.16 So-called "black flags" are obstacles to recovery that affect all workers equally and relate to nationally established policy and working conditions eg pay rates or benefits. Local issues may include sickness policy, management style and organisational issues¹⁰².
- 11.17 Physiotherapists have integrated cognitive behavioural therapy approaches into practice. A randomised controlled comparison⁶⁸ of an exercise programme with a cognitive behavioural approach (which shifted emphasis away from a disease model towards a model of normal human behaviour) and conventional GP management showed a positive effect on the participants' ability to cope with the pain in the long term. It did not influence the intensity of the pain, but participants reported fewer days off work and used fewer healthcare resources than the control group.
- 11.18 Although much evidence into the effectiveness of back pain treatment has confined itself to symptom control, evidence on effective ways of helping individuals back into employment has recently been reviewed⁸². There is moderate evidence that, for those having difficulties in returning to normal activities at 4-12 weeks:
- changing the focus from symptomatic treatment to a back school approach to rehabilitation can produce faster return to work, less chronic disability and less sickness absence
 - temporary provision of lighter or modified duties facilitates return to work and reduces time off work

- a rehabilitation programme and organisational interventions designed to assist workers with back pain to return to work is more effective than single elements alone ⁸².
- 11.19 Intensive rehabilitation programmes involve ⁸²:
- multi-professional physical, psycho-social, educational and vocational components
 - learning to function in spite of pain
 - cognitive behavioural therapy
 - developing physical tolerance in both fitness ¹⁰³ and vocational areas ^{87,104-107}.
- 11.20 These programmes embrace the concepts of:
- back school education
 - work hardening ⁸⁷
 - sports injury approach ^{108,109}
 - functional restoration ¹¹⁰⁻¹¹²
- 11.21 Traditional comparisons between inpatient and outpatient programmes favour inpatients ^{105,113} but non-hospital-based residential programmes have not been evaluated.
- 11.22 Such programmes definitely reduce sickness absence ^{105,108,109}. Whether they are cost-effective has not been established in the UK. The Canadian studies, however, showed savings in terms of:
- days lost from work
 - wage-loss benefits costs
 - total costs of treatment
 - less costly permanent disability awards
 - less pensions awarded to the intervention group ¹⁰⁸
- 11.23 Similar results were not found in Finland ¹⁰⁷. One explanation could be that the social security background of the country doing the study can influence outcome (see Fig 1 and Section 5 - income replacement payments). Regrettably, randomised controlled trials have been inhibited in the USA by such issues as denial of treatment liability, but comparison studies have looked at work return, health care utilisation and recurrent injury. Even post-surgery rehabilitation has been studied, showing that individuals given intensive rehabilitation post-fusion had a return to work incidence of 85% and work retention at one year of 83%, being higher than either discectomy or control groups ¹¹¹.
- 11.24 The limited evidence of the cost-effectiveness of back pain interventions has been summarised elsewhere ¹¹⁴. Cost-effectiveness was mostly described in terms of reduced sickness absence.
- 11.25 The Working Party welcomes the government's recent "back in work" campaign as evidence that it realises that there is a major problem in the rehabilitation of individuals with back pain into employment.

Work-related upper limb disorders (WRULDs)

- 11.26 These disorders reflect another area of practice where the physical, emotional and work environments interact with major consequences for health with resulting terminological imprecision ^{115,116}. WRULDs are usually related to repetitive, forceful work and are preventable usually through:
- comprehensive, regular work station risk assessments conducted by fully trained competent risk assessors
 - changes to workstations based on ergonomic principles
 - changes to job tasks to include greater task variety or job rotation
 - regular breaks from repetitive and/or fast-paced work
 - training about posture, exercise and breaks
- 11.27 Prevention has been frequently inadequate, resulting in many workers having this condition, requiring treatment and rehabilitation. Best practice requires early and accurate diagnosis ¹¹⁷, along with referral to physiotherapy.
- 11.28 There are many physiotherapists with expertise in the treatment of WRULDs working in industry and private practice, in addition to those working in the NHS. However, many people with WRULDs work in small firms where an occupational health service is not available. They are often low paid and may have lost their jobs as a result of the condition. It is therefore vital that the NHS can respond to their needs.

- 11.29 Current barriers to effective treatment of WRULDs include:
- problems with early, accurate diagnosis
 - delayed referral to appropriate agencies eg physiotherapy
 - long waiting lists for, and /or rationing of physiotherapy in some areas - eg people may receive 4 - 8 sessions when a longer and more flexible course is necessary
 - resultant development of chronicity while awaiting treatment
 - vacant posts and pressure of work render it difficult for physiotherapists to have time off for continuing professional development

Mental health

- 11.30 Mental health is a priority on the health agenda¹⁷. The Mental Health National Service Framework⁴⁷ highlights the need for mental health promotion and the need to target workplaces as well as those at risk eg those who are unemployed. Mental health problems associated with work include depression and anxiety, alcohol misuse and sickness absence. Work overload, monotony and pressure of work are key factors, as are lack of control over work and exclusion from decision-making⁴⁷.
- 11.31 Many of the mental health problems seen in primary care are below the thresholds for pure “psychiatric classification” (including alcohol and drug abuse) and require careful medical and social assessment⁴².
- 11.32 The framework recognises that exercise, relaxation and stress management have a beneficial effect on mental health⁴⁷. Evidence highlights the value of exercise training and increased physical activity in improving cognitive function and an individual’s physical status; and that those with increased levels of physical activity have a level of protection from the more common mental disorders of depression and anxiety. Some firms have recognised this link and have installed gyms or offer free membership of local gyms to employees. In the on-site gym a physiotherapist is often on hand to supervise these activities and to design individually tailored fitness programmes.
- 11.33 Loss of work has been postulated to increase alcohol abuse and re-employment may reduce it¹¹⁸. It is important to note that alcohol abuse can increase the rate of injuries¹¹⁹. Even severely affected alcohol dependent sufferers eg those with Schizophrenia, can be helped into supported employment¹²⁰.

Cardiac rehabilitation

- 11.34 Our Healthier Nation lists coronary heart disease and stroke as a target - aiming to reduce deaths in people under 75 by 40% within the next 10 years. Lifestyle risk factors include smoking, poor nutrition, obesity, physical inactivity and high blood pressure¹²¹. The report cites that levels of physical activity vary by social group and occupation; people in unskilled occupations being more physically active at work but less so in their leisure time than people in professional occupations¹²¹.
- 11.35 The National Service Framework for Coronary Heart Disease (CHD) has set national standards and defined service models for health promotion, disease prevention, diagnosis, treatment, rehabilitation and care¹²².
- 11.36 Cardiac rehabilitation is a multidisciplinary approach which should consist of exercise training, educational, psychological and psychosocial interventions¹²². These programmes aim to::
- Enable individuals to return to everyday activities (including work) as far as their health permits
 - increase confidence
 - reduce anxiety, depression and tiredness.
- 11.37 The Audit Commission¹²³ noted that cardiac rehabilitation has received increased recognition from both clinicians and service managers and is relatively inexpensive. Two non randomised trials examining the medium to long term implications of cardiac rehabilitation demonstrate a significant reduction in the cost of readmission to hospital and treatment coupled with savings resulting from earlier return to work¹²².
- 11.38 Exercise prescribed by physiotherapists can reduce the symptoms of angina in people with CHD⁸⁵. Physiotherapists providing the exercise element of cardiac rehabilitation programme improve exercise tolerance in people with CHD and heart failure¹²⁴. There is a need to offer a variety of exercise options, including home-based, community-based and hospital-based programmes, to fit not only the individual’s medical condition, but also their lifestyle¹²⁵.

- 11.39 The Coronary Heart Disease National Service Framework included health promotion as a target. GPs are already using exercise prescription as a preventive measure for those at high risk or with chronic conditions. It is vital that physiotherapists advise on appropriate individual exercise programmes for such client groups¹²⁶ so that the risk of sudden death with low-moderate intensity training can be minimised¹²⁷.
- 11.40 Factors impacting on return to work after a cardiac event are complex and include:
- individual - age, clinical status, perceptions
 - societal - family attitude, labour market
 - employment - career stage, job satisfaction, work stress, type of work, financial and employer attitude.
- 11.41 The cardiac rehabilitation team should work closely with the patient's primary physician to provide a comprehensive assessment of all the factors that may influence a successful return to work and the potential for improvement while on the programme. Vocational counselling should form an integral component of cardiac rehabilitation¹²⁶.

Head injuries

- 11.42 The management of traumatic brain injury (TBI) is often extremely complex. Factors complicating management¹²⁸ include:
- extent of the neurological involvement with consequent severe physical disability
 - cognitive losses
 - protracted course of recovery
 - effects of co-morbid trauma¹²⁹
 - high rate of unemployment pre-injury (sometimes related to substance abuse)¹³⁰
 - devastating effect on the family
- 11.43 Even mild head injuries can result in persisting symptoms after a return to work with resultant inefficiencies at work¹²⁸ and the potential for costly litigation¹³¹. These persisting symptoms are often not recognised by the patients or their professional advisers.
- 11.44 In spite of these difficulties, considerable numbers of patients can be returned to employment^{130,132-134}. Factors that have been felt to be important include:
- work-site visits
 - individualised return to work plan¹³⁰
 - dialogue with employers¹³²
 - unpaid training in the work setting^{130,135,136}
 - placement assistance¹³⁰ which may include a trial at work¹³⁶
 - coaching after the job has been obtained¹³⁰
 - restructuring at work¹³⁰; assistive devices provision at work¹³⁰
 - client advocacy¹³⁰
 - educational support¹³⁶
 - social support¹³⁶
 - legal support¹³⁶
 - primary care support¹³⁶
 - financial support¹³⁶
- 11.45 These interventions include the concepts of work adjustment and supported employment (Appendices 3,4).

Summary

- 11.46 Musculoskeletal disorders (predominately spinal pain) are the commonest reason for needing Incapacity Benefit, followed by mental health problems and circulatory disorders. Musculoskeletal disorders lack significant government priority except in so far as there are excessive waiting times to be seen in hospital outpatient clinics.
- 11.47 Secondary services for those with chronic or intractable¹³⁷ low back pain are poorly developed in the UK and lack the appropriate multi-professional intensive rehabilitation and pain management. There is a grave

shortage of psychological support and a lack of emphasis on the need to obtain a return to work rather than symptom relief. Without such programmes it is impossible to envisage those with chronic back pain coming off the incapacity benefits and into work.

- 11.48 Good management in industry has been shown to reduce back injuries and sickness absence through organisational change, particularly when the work force have been involved in its planning. Work-related upper limb disorder exemplifies an area in which good organisational management of work tasks can minimise risks of ill-health and disability.
- 11.49 Cardiac (or coronary) rehabilitation has been shown to be effective with the process of assisting individuals back to work being initiated by the cardiology team in hospital and implemented by the rehabilitation team in collaboration with the medical team after discharge.
- 11.50 Cardiac rehabilitation highlights the advantages of a multiprofessional approach to:
- assessment
 - treatment from the day of admission until return to work, or adjustment to the level of residual capability.
- 11.51 The management of traumatic brain injury is very difficult. Nevertheless significant numbers with severe and complex disability have been returned to work using extensive multi-agency collaboration with particular assistance in:
- planning assessment for work
 - work-site visits
 - support after re-employment in the workplace
 - support in many aspects of their lives.
- 11.52 These needs are highly appropriate for case management.
- 11.53 Only when resources (including staff) are in place will we be able to repeat the benefits (in terms of return to work) which have been shown to be achievable in disparate conditions eg back pain, myocardial infarction and brain injury.

Recommendations

- 11.54 The evidence presented in these diverse conditions should be widely applied in clinical practice.
- 11.55 Musculoskeletal disorders should be given government priority to develop fast track assessment, investigation and treatment where indicated for those off sick with musculoskeletal problems.
- 11.56 The shortage of clinical psychologists working specifically in back pain management, but also throughout the acute sector, needs to be addressed urgently. Some psychologists may have appropriate training and experience in occupational assessment and vocational guidance.

12. Models of Practice

- 12.1 The current rehabilitation situation in the UK focuses on symptoms and solutions, and is not targeted at the workplace. The majority of care (when available) takes place in the acute setting and to a lesser degree in primary care. Future service delivery needs to take a more integrated approach, building bridges between the public and private sectors of health care and industry. This requires professionals to work together across organisational boundaries. What can be learned by looking at proven models of good practice?
- 12.2 The value of multiprofessional approaches to disabling symptoms eg pain, has recently been recognised although the recent CSAG report made little reference to the challenge of rehabilitating individuals disabled by their pain back into employment¹³⁸. This is essential if people are to be helped from welfare to work.
- 12.3 Lessons from Scandinavia and the USA have highlighted the benefits of multiprofessional work-based programmes, placing a greater emphasis on prevention and rehabilitation and the responsibility to employers to create the right environment, supporting workers on return to work¹⁴.

Local models of vocational rehabilitation

- 12.4 Local models of vocational rehabilitation include:

Day Centre Rehabilitation

- 12.5 The "early discharge" policy from in patient care to the acute NHS trust has highlighted the need for intensive out patient care. This is probably best delivered in a day care facility with an employment focus.
- 12.6 Such specialist facilities do exist (not always NHS facilities) eg Icanho at Stowmarket and Oliver Zangwill Centre at Ely. The Talygarn Rehabilitation Centre originally offered vocational rehabilitation to the mining community of South Wales. The decline of heavy industry in the area has meant that the centre has changed its focus. Individuals are referred to the centre by local consultants for advanced intensive rehabilitation for a range of conditions eg post-operative orthopaedics, post-trauma or rheumatological conditions. Such centres do need specialist facilities such as hydrotherapy and workshop facilities.

Community rehabilitation teams

- 12.7 Discharge from hospital to a community rehabilitation team (where such a team exists) may facilitate the transition from hospital to home and thence back to work. In a number of areas the community multidisciplinary team has been set up to deal with a specific disability such as stroke and head injury. The teams usually comprise occupational and physiotherapists with or without speech therapists, psychologists, social workers and doctors. The teams rarely have any relationship with the employment services and are not focussed on older patients. When teams communicate closely with acute trusts the potential for continued relevant treatment and support for individuals for months or years is possible, eg after a severe head injury where the opportunity to facilitate a return to work is increased¹³⁵.

Local occupational therapy services

- 12.8 Those wanting to return to work are assessed regarding their:
- referring injury or illness and to any other conditions which may affect their ability to return to work.
 - work requirements²¹
- 12.9 A number of measurable, achievable objectives are set, agreement to comply with the programme obtained and treatment plan is designed to meet the objectives set. Therapeutic objectives may relate to:
- medical improvement eg increasing the range of joint movement or improving balance or stamina
 - specific work needs, such as the ability to lift and/or carry certain weights or push, pull or otherwise manoeuvre certain objects
 - address specific concerns regarding work activities (which are replicated where possible) and practised in the safety of the occupational therapy department under professional supervision
 - Work site visits may be carried out to target therapy more precisely to work needs and to demonstrate to the employer both their abilities and restrictions

- Specific adjustments may be recommended to tasks or equipment; usually only a reduction of hours and / or some heavy tasks are needed to return to work
- Woodwork is used as the main therapeutic activity including the use of bicycle fretsaws, treadle lathes, benchwork activities and decoration²¹

Regional/supra-regional intensive vocational rehabilitation

- 12.10 For those individuals who fail to get fit enough for work or still feel unable to work after outpatient / day case rehabilitation a period of residential vocational rehabilitation can be appropriate. The Vocational Rehabilitation Unit at Papworth provides a suitable model¹³⁵. This comprises a residential facility, a full rehabilitation team and appropriate facilities. Individuals undergo a day assessment followed by a short 3-week assessment; if appropriate they proceed to a longer stay. The major difficulties with this type of rehabilitation are both the scarcity of resources and the difficulties with funding. Its residential vocational rehabilitation programmes have been shown to get up to 75% of patients who complete the course back into some employment; although significant numbers fulfilling admission criteria for this type of rehabilitation are unable or choose not to undergo such programmes (Karen Speare, personal communication).
- 12.11 The Papworth rehabilitation unit is a good example of a ‘hub’ unit. The service provides users with access to specialist multiprofessional assessment and therapeutic intervention that can be integrated into the workplace. In order for carry-over to continue post-discharge from the hub, close links are developed with local services (the spokes). Whilst the need for regional neurorehabilitation services is generally recognised and agreed, regional services for non-neurological complex disability are few and far between (Bath, Oswestry and Royal National Orthopaedic Hospital excepted). If we are to attempt to rehabilitate into employment individuals who have been in receipt of incapacity benefits for many years, such regional services will be required by virtue of:
- complexity of need
 - scarce human resources (eg psychologists)
 - appropriate rehabilitation facilities
- 12.12 Such hub services do not need to be strongly ‘hospitalised’; the hostel model worked very effectively in Salisbury for many years²⁰ as a part of the gradual progression towards independent living.
- 12.13 The BSRM have previously recommended the ‘hub and spoke’ model for the provision of equipment needed by disabled people^{139,140} and this recommendation has been accepted by the Audit Commission¹⁴¹. Given the scarcity of rehabilitation professionals and facilities (eg hydrotherapy, workshops) it seems clear that the assessment, provision of equipment, and therapeutic components of the rehabilitation process should be co-located and a similar model developed.

Waiting list management

- 12.14 In some parts of the country there are waits of many months to see an orthopaedic surgeon; waits of more months to have a MRI scan, and waits of even many more months before undergoing orthopaedic operations or physiotherapy.
- 12.15 There are a growing number of services which are developing innovations to reduce the length of waiting lists to see hospital consultants. One such is the use of chartered physiotherapists who work as extended scope practitioners (see glossary). They are trained to perform a clinical examination, order appropriate investigations, make a provisional diagnosis and arrange appropriate management and treatment interventions within guidelines. Other models have used clinical specialists in nursing, occupational therapy and physiotherapy to take patients off waiting lists, do follow-up clinics and provide specialist advice in the musculoskeletal field alone. These schemes¹⁴²⁻¹⁴⁴ have been shown to:
- reduce consultations with consultants while maintaining patient satisfaction
 - reduce length of wait
 - provide a cost effective service.
- 12.16 The recent modernisation action teams have been considering a number of issues of relevance to this debate - we welcome the Government’s recent investment in attempting to reduce current waiting times.

Summary

- 12.17 Models exist whereby:

- waiting times to see hospital specialists can be greatly reduced by using appropriately trained nurses or therapists
- multiprofessional vocational rehabilitation programmes can be provided both locally and regionally

Recommendations

- 12.18 Research is needed to evaluate the cost-effectiveness of the models described.
- 12.19 Until better evidence is available, vocational rehabilitation should be provided using a ‘hub and spoke’ model of regional and local services to complement this model which is being developed in other areas of rehabilitation practice ^{139,140}.

13. Vocational Rehabilitation Case Management

- 13.1 The Working Party is not alone in identifying poor co-ordination between health and employment services as a major issue: this persisting problem has been addressed by numerous official policy reviews and research reports (Appendix 2). The Working Party is also not alone in identifying the importance of a new case management/case co-ordination role to ensure that disabled individuals undergoing rehabilitation have a single figure to whom they can turn for advice, information and practical assistance.

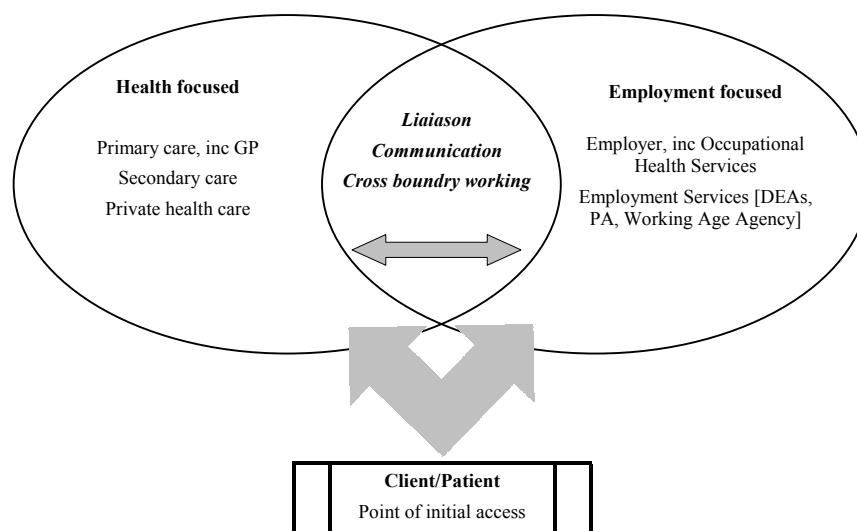


Fig 5 - Vocational Rehabilitation Case Management

- 13.2 Vocational rehabilitation case management implies a service with similar professional responsibilities to its clientele as health or social services workers already exercise with respect to their patients or clients. In consultation with all relevant bodies:
- employer and/or occupational health service and the Employment Service
 - GP and other members of the primary health care team
 - community based health teams or hospital
 - charities eg Headway
- Case managers would coordinate and oversee, from the early stages of recovery (from illness or injury), the overall programme of rehabilitation and return to work activities planned for each individual. Primary duties would include:
- conduct or arrangement of an initial assessment of the individual's needs
 - preparation and agreement of a rehabilitation plan incorporating clearly formulated aims, timescales, and outcome criteria (exit point)
 - implementation of those plans including liaison with other services (health, employment, education, charities) and employers
 - practical assistance with job search, job development, job modification or other related placement activities.
- 13.3 These duties should be undertaken in the context of a system of management which would be expected to foster:
- keeping of confidential case records
 - setting and maintenance of both quality assurance and professional standards
 - ongoing professional development of its case managers

- 13.4 The need for such a role in the context of employment rehabilitation centres was identified by the research carried out at the Employment Rehabilitation Research Centre¹⁴⁵, but never acted on. Research undertaken by the Disability Management Research Group at the University of Edinburgh identified the need for a similar case co-ordinating function to assist the rehabilitation and return to work of personal injury claimants and led on to the implementation and evaluation of a controlled trial of that role¹⁴⁶.
- 13.5 That pioneering service has provided a model for the development of in-house vocational rehabilitation services subsequently developed by many insurance companies in the UK. The importance of the case-management approach has also been recognised in other countries including Australia whose model of service delivery has recently received a strong endorsement by the TUC in its consultation document on rehabilitation²².
- 13.6 The Working Party subscribes to the view that the case management model is appropriate for a much wider range of people returning to work after illness or injury.
- The range of potential beneficiaries of such a service is very broad ranging from those with low back pain to spinal cord injury, facial disfigurement to brain damage, upper limb fractures to amputation.
- 13.7 It is recognised that there are possible areas of overlap between the proposed role of case managers and tasks already undertaken by eg Disability Employment Advisers. Indeed, when operating most effectively, Disability Employment Advisers undoubtedly provide a form of ‘case management assistance’. However, they are frequently hampered from doing more by lack of resources; their inability to perform the role to the professional standards established in other settings and the fact that circumstances often mean that they are called upon to provide help at too late-a-stage. The Working Party also believe that Disability Employment Advisers may lack empowerment to maintain timely delivery of resources eg arranging physiotherapy. They are also organisationally and professionally isolated from other relevant services.
- 13.8 The Working Party does not propose the creation of a new profession. It makes the case for the implementation of a more professional role that could be undertaken by persons from different professional backgrounds eg nursing, personnel management, psychology, social sciences and the therapy professions. Appropriately trained Disability Employment Advisers could perform this role. Persons from all of these backgrounds have practical experience and relevant skills to contribute although, to date, vocational rehabilitation has been of secondary consideration in their basic training programmes.
- 13.9 To enhance their effectiveness as case managers we believe that they would benefit from additional postgraduate or post-professional training covering the wide range of information and practical skills needed to underpin the effective performance of case management roles. A training programme could become part of the remit of the proposed National Institute for Disability and Rehabilitation.
- 13.10 The Working Party has not been able to conduct an exhaustive review of case management. Further, much evaluation has been of whole systems of vocational rehabilitation rather than each of its component parts (in common with many other areas of care⁸²). The compelling arguments come from:
- experience from other countries eg Australia
 - use in the insurance industry suggesting their experience is cost-effective
 - literature cited throughout this report, but with additional studies in various fields¹⁴⁶⁻¹⁵². In the back pain field, the need for research in this area has been identified^{82,153}.

Recommendation

- 13.11 Case management needs to be much more widely developed in the UK.

14. International Perspectives

14.1 Vocational rehabilitation has been taken very seriously in many other countries in contrast to the UK.

United States of America (USA)

14.2 UK practice stands in very striking contrast to that in the USA. There both assessment and rehabilitation have been, for many years, more systematic and sophisticated processes.

14.3 Work samples and computerised occupational information are used extensively (Appendix 3). There are several 'systems' of work samples, of which Valpar and the Key system are perhaps the most widely used in the UK. Valpar is rarely used against the standardised employment information of the American system. However, Valpar equipment remains useful assessment and treatment equipment albeit very expensive.

14.4 Rehabilitation, or work preparation as it is now being called in the UK, is also more systematic in the USA. There it is called work adjustment and an important part of the assessment (evaluation) process is to identify the 'critical work behaviours' which an individual may need to achieve their vocational aspirations, and to determine whether there is a 'shortfall' with regard to any of these.

14.5 What is more significant than this technological superiority, is the much greater extent of proper professional training. Both rehabilitation counsellors and vocational evaluators have their own professional body, each with its own rigorous procedures for accreditation. There are over one hundred Masters programmes on offer, with each state having at least one programme. The Rehabilitation Services Agency (RSA), a part of the federal government, has a budget of nearly \$50 million to support these programmes.

14.6 It is worth noting that another US government agency, the National Institute on Disability and Rehabilitation Research (NIDRR), has a budget of over \$100 million. Much of this goes to Research and Training Centres, which receive five year grants, to research and develop new approaches in medical, social and vocational rehabilitation, of around \$1 million a year.

14.7 Another key aspect of services in the US is the accreditation of rehabilitation facilities themselves. This is done by the Commission for the Accreditation of Rehabilitation Facilities (CARF). Much of the funding provided by the RSA (\$2 billion/year) is contingent on meeting CARF standards.

14.8 A recent related development that is also very relevant in the context of UK services, is the drawing up of 'evaluation standards and performance indicators for the State Vocational Rehabilitation Services Programme'. Amongst other things these will seek to reflect the importance of not just placing the clients of rehabilitation programmes in work, but also in work that is matched to their abilities.

Australia and New Zealand

14.9 Vocational rehabilitation services in both Australia and New Zealand are also based on a strong emphasis on professional training of staff. Each Australian state has a university-based, postgraduate training programme in rehabilitation counselling. These receive financial support from the Commonwealth (federal) Rehabilitation Service, which has also commissioned from one university (Sydney), a distance-learning version of their programme.

14.10 Until comparatively recently, services in both Australia and New Zealand bore a strong resemblance to those in the UK. In terms of both policy and staffing they were based on Beveridge-type assumptions. As in the UK, by the mid 1980s there were strong indications that services were not meeting their proclaimed objectives. However, unlike the UK which settled for a bit of fine-tuning of the old system and no significant increase in funding, that conservative approach to reform was rejected in both Australia and New Zealand where more radical changes were implemented.

14.11 The New Zealand solution was based on the introduction of a "no-fault" compensation scheme, one aim of which was to ensure cost containment through the earliest possible referral to rehabilitation (all types of medical, social and employment rehabilitation). To implement that policy and programme, rehabilitation

councillors were recruited and trained with a continuing commitment to the expansion and academic underpinning of research and development. In Australia, similar decisions were reached to replace the inherited UK model by more professional services. Workers Compensation Fund Money was used to finance the development of new services.

- 14.12 In recognising that the old system was encouraging longer than necessary absence from work (and unduly delayed referral for rehabilitation) a review of policy and services recognised the need for a radically different approach based on alternative principles. Early intervention to ensure earliest possible resumption of work after illness or injury required the timely availability of relevant services and their funding as well as an effective system of referral. To that end, new initiatives included the early review of all sickness absence, ensuring (in certain circumstances) mandatory referral for rehabilitation. To support that aim, it was necessary to:
- invest significantly in the training of therapists and other relevant professions who would be involved in the provision of such services
 - stimulate a market in which those services were provided on a “fee for item” basis
 - create a new role for persons to work along-side patients in order to ensure proper assessment of need and delivery of services and to liaise with employers over return to work – the “case manager role”
- 14.13 As a general indication of the effectiveness of these changes, sickness absence rates were reduced by one half in Western Australia.
- 14.14 Australia has also examined the feasibility of developing an occupational data-base, similar to that of the US, but so far resources for this have not been forthcoming.

Germany

- 14.15 There is remarkably little information on the way in which assessment and rehabilitation are carried out in European countries. In Germany rehabilitation tends to be equated with vocational training. A countrywide network of centres exist and they are extremely well resourced. Courses usually last eighteen months and lead to a vocational qualification which is the same, in all respects, to that obtained by non-disabled people completing a more traditional apprenticeship training.
- 14.16 There are, to our knowledge, no professional associations in Europe and no post-graduate professional training programmes, comparable to those in the US, Australia and New Zealand, apart from the City University (Appendix 3) and a similar programme at University College, Dublin. The City University course is closing due to lack of financial support from the Higher Education Funding Council and to the difficulties of students in funding themselves.

Sweden

- 14.17 The Scandinavian countries – especially Sweden and Norway – have for some time pursued more ‘active labour market’ policies, directed at getting disabled people back to work. More recently new legislation has been introduced requiring employers ‘to submit a rehabilitation enquiry to the local insurance office within eight weeks (of sickness absence). It is also responsible for initiating and financing interventions aimed at work resumption, while the social security agency is responsible for the co-ordination and supervision of rehabilitation measures’¹⁵⁴.
- 14.18 Sickness absence in Sweden is certified by an occupational physician.
- 14.19 A paper, comparing policy in a number of different countries¹⁵⁵ notes that the legislation mandates ‘firms to provide commensurate work to employees who have become disabled in their current jobs. These mandates in principle are more far-reaching than the more modest mandates imposed on firms by the Americans with Disabilities Act in the United States’.
- 14.20 Disability organisations in the UK have, for a long time now, advocated the introduction of a partial disability benefit, arguing that this would overcome many of the problems associated with the ‘benefits trap’. The paper cited above however concludes that ‘regardless of the administrative structure in which disability transfer programmes operate, partial benefits have only a limited impact. It is unclear to what extent factors such as labour market consideration or assessment problems make gate-keepers reluctant to award partial benefits’¹⁵⁵.

The Netherlands

- 14.21 There are a number of similarities between Sweden and Holland, including the provision of a partial disability benefit, which is however seldom realised in practice.
- 14.22 For many years though the very high numbers of people receiving disability benefits led to talk of the ‘Dutch Disease’, with the authors cited above even editing a book ‘Curing the Dutch Disease’¹⁵⁶. Over the last ten years or so the government have gradually tightened up their system and now reference is sometimes made to the ‘Dutch miracle’. A recent international study, carried out under the auspices of the International Social Security Association, found that over four-fifths of disabled people who had gone on to disability benefits eventually returned to work. This was the highest of all the countries studied¹⁵⁷.
- 14.23 One particularly interesting feature of Dutch provision is the system, developed by the Joint Medical Service for matching job requirements to individual functional abilities and disabilities. The Joint Medical Service maintains an occupational database of around 10,000 jobs and this is used to assess the extent of an individual’s disability – i.e. the loss of earnings arising from their disability – and thus the level of partial benefit needed. The data-base can also be used to help identify redeployment opportunities or new career possibilities.

Summary

- 14.24 There are many countries with more effective services than the UK.
- 14.25 Countries with successful vocational rehabilitation have invested resources into:
- creating well-developed services
 - assessment of the scale of demand for vocational rehabilitation services
 - staff with professional qualifications
 - supported by an academic base for research, and the development of appropriate training programmes (as recommended by the ABI).

Recommendation

- 14.26 Discussions (involving both governmental and non-governmental bodies) should begin to apply to UK practice the lessons learned by countries successful in vocational rehabilitation.

15. Education, Research and Training

- 15.1 If we wish for better understanding of the work-related problems of patients (with a vast variety of medical and surgical conditions - some acute, some chronic, some requiring surgery, some requiring difficult, expensive and protracted medical treatment) then it is essential that the whole NHS workforce is 'work aware'. This is not an easy task. It can be achieved only by identifying and training key professionals.
- 15.2 The first requirement is for a cadre of well-informed and well-educated staff to produce continuing training for themselves and others. This is probably best located within the rehabilitation professions. It is essential that a group of doctors is also highly trained: these include those in rehabilitation medicine, in occupational health and public health. As the primary purchasing power will lie with general practice, expertise (or at least considerable awareness) must lie here.
- 15.3 As work awareness is required in all NHS professions it needs to be part of the undergraduate training of all NHS staff. Those who need a greater input are undergraduate doctors, occupational therapists and physiotherapists.
- 15.4 To produce proper training, a national training unit and regular training course are required along the lines developed by Professor J Ekholm of the Karolinska Hospital in Sweden. Such knowledge cannot be static and uninformed by research: a research institute, with long-term funding needs to be established alongside the training unit.
- 15.5 Currently effective interagency working largely fails because there is neither designated interagency sessional commitments in the job description nor a common body of knowledge across individuals from different disciplines. The second of these is best addressed by the employment of staff from disciplines relevant to, but outwith, the NHS in the teaching and research units. Multidisciplinary teaching by the unit will also address the problem.
- 15.6 A national training unit will need to link with training and research establishments within each region which are capable of more local teaching and research which co-ordinate with the national agenda and ensure the spread of knowledge into the areas of the NHS to which they relate. They will also aim to provide better interagency working and knowledge exchange in a similar manner to the national centre. Such a 'hub and spoke' arrangement would probably be an effective and cost-effective method of enhancing practice across the country.

16. Potential Ways Ahead

- 16.1 The development of local rehabilitation services, enhancement of the roles of the Disability Employment Adviser and the development of case managers will create the necessary inter-agency co-operation to enable rehabilitation into work to take place at a much earlier stage than at present.
- 16.2 A National Service Framework for the UK would ensure:
- a high quality vocational rehabilitation service
 - equity of access
 - common auditable standards and practice
 - interagency working locally and nationally eg NHS - Working Age Agency
- 16.3 The formation of a National Institute to promote and monitor training and research into vocational rehabilitation will complement the National Service Framework.
- 16.4 This strategy will provide much needed rehabilitation and support to those with newly acquired illness or disability with a consequent reduction of the emotional and financial burden on their partners and families. It will reduce both sickness absence and the numbers of those needing incapacity benefits.

17. Summary of Findings

- 17.1 Vocational rehabilitation is addressed from the perspectives of the National Health Service (NHS), the Employment Service, the employer and the employee. (Section 2).
- 17.2 With a background of rapidly evolving employment and social change, unacceptable gaps have developed between the employment and health agencies in the services available to facilitate employment opportunities. Pre-existing disabilities, injuries and sickness can all reduce chances of successful employment, but overcoming these disadvantages appears to have increasingly become the unique province of the Employment Service. Individuals with acquired injury or sickness are usually assisted by this service only at the conclusion of NHS treatment (Sections 3,4,5,8,9, Appendix 2).
- 17.3 Effective vocational rehabilitation involves early involvement of the multidisciplinary team with greatly improved co-ordination between employers, the Employment Service and health services. Good employment practice can do much to facilitate job retention for those off work due to illness or disability (Section 3, Appendix 2).
- 17.4 There is poor co-ordination between the NHS and the Employment Service. From the NHS there is a low appreciation of employment aspects and vice versa. The Disability Employment Adviser fulfils only part of the requirement for help. The Disability Employment Adviser is inadequately:
- resourced compared to the scale of need
 - skilled to meet the full range of requirements (Sections 3,13, Appendices 2-3)
- 17.5 A number of important changes have been made in the ways in which both government and non- government organisations try to help disabled people to obtain employment. Information is lacking on the overall impact of these changes. Very little is known about which rehabilitation measures, and in what circumstances, are effective (Section 3, Appendix 3).
- 17.6 Services offered to disabled people (from employment and health agencies) need to be more professional and competency-based. Those providing these services need to be better trained (Section 3, Appendix 3).
- 17.7 Major deficiencies in health service provision have been identified in this review, by the Trades Union Congress and the Association of British Insurers. Excessive waiting times for hospital assessment, further waits for investigations and prolonged waits for therapy all militate against reducing sickness absence and job retention. Units that previously performed vocational rehabilitation have been closed, often apparently without adequate services to replace them (Section 4, Appendix 5).
- 17.8 Research conducted for this report surveyed 30 non-governmental organisations and found they regarded:
- waiting times for NHS services as unacceptable
 - services as inflexible
 - understanding about the impact of disease and disability on work lacking
 - awareness of options to prevent work loss lacking
 - inter-agency working poor (Section 4, Appendix 5)
- 17.9 There needs to be agreement by the insurance industry and the TUC that it is in the best interests of individuals that early assessment and treatment is obtained by an appropriate rehabilitation service as soon as possible in the legal process. Delays for the advantage of either side in the legal process would not be good practice as individuals' long-term recovery would be compromised with increased costs to both the state and private sectors (Section 5).
- 17.10 The Working Party share the conclusions of the Association of British Insurers (ABI) and the Trades Union Congress (TUC) who independently identified the need for a new vocational rehabilitation case management role to provide, in individual cases (or caseloads), general oversight, co-ordination and practical assistance for persons returning to work after illness or injury (Section 5).
- 17.11 The ABI and the TUC are major stakeholders in the personal injury field and thus might be expected to have a significant involvement in the establishment of a National Institute for Vocational Rehabilitation that might oversee the education and training of case managers. The Working Party considers that there is also a strong

case for public sector investment and involvement in such developments. The potential benefits are to individuals and to society as a whole as the service would transform recipients of compensation or state benefits into wage-earners and tax payers (Section 5).

- 17.12 Currently, within the state sector, that task is the responsibility of a small cadre of Disability Employment Advisers; whilst in the private sector (mainly insurance) or private practice, an even smaller but growing number of vocational rehabilitation specialists fill that role. This report has identified significant mismatches between the number of persons providing those services and the number of potential beneficiaries; and between the type of help needed and type of help available (Section 5).
- 17.13 Musculoskeletal conditions, minor mental illnesses and coronary heart disease, in that order, are the conditions with the greatest impact on the workforce through sickness absence and the need for Incapacity Benefit (Section 6).
- 17.14 These economic costs are enormous - the costs of spinal pain alone going into billions of pounds, born more by industry and the benefits system than by the NHS (Section 6).
- 17.15 Vocational rehabilitation could help to reduce the total number of working days lost due to work related injury and ill health. Effective vocational rehabilitation also has much to contribute to combating social exclusion and poverty (Sections 6,11).
- 17.16 There is a dynamic relationship between the risks of employment, which may give rise to both accidents and ill health, and the risks of unemployment-related illness. Although industry is a major cause of both accidents and ill-health, there is now recognition that, with appropriate advice about work-related issues and individual support, many more people could be assisted back into employment. The role of the NHS and the health professions will be fundamental to this and will require prioritisation to facilitate redeployment and expansion of rehabilitation teams (Section 6).
- 17.17 A range of medical conditions, social problems and work related issues account for much of sickness absence. The effective management by employers of sickness absence is of crucial importance and a number of organisations are experimenting with ways to reduce absence and to facilitate early return to work. Employers should give special consideration to how they might best facilitate the employment and the return to work of sick and disabled people (Section 7).
- 17.18 Occupational Health provision in the UK is variable and patchy. Those involved in its delivery have varying qualifications or sometimes none (Section 8).
- 17.19 The relationship between Occupational Health practitioners, hospitals and GPs is often uneasy. The place of Occupational Health services in facilitating rehabilitation back to work is often not appreciated. Rehabilitation services are currently predominately focussed on the relief of symptoms and treatment of the illness rather than a return to productive work (Section 8).
- 17.20 Factors which may contribute to delayed return to work after sickness include:
- length of NHS waiting lists (Sections 8,9, Appendix 5).
 - lack of easy and early access to rehabilitation staff & facilities (Sections 8,9, Appendix 5).
 - employment-based obstacles (Sections 7, 8,9,11, Appendix 5).
- 17.21 Whereas some organisations and businesses do provide their own rehabilitation facilities there is in many cases a reluctance to do as it is felt that the NHS should make such provision particularly when the need follows on from the provision of acute services. Additionally there may be tax implications if a business provides facilities (Section 8).
- 17.22 General practitioners (GPs) have a statutory obligation to provide fitness for work certification and are pivotal in deciding on fitness to work (Section 9).
- 17.23 Within the NHS, limited manpower, financial constraints, shortage of equipment and facilities significantly delay the diagnosis, treatment and rehabilitation of a significant number of those within the workforce experiencing illness or injury (Section 9).
- 17.24 Rehabilitation teams (including consultants in Rehabilitation Medicine) are primarily focussed on the rehabilitation of acute and severe disability with little time for vocational rehabilitation. Training facilities in vocational rehabilitation are poor and access to appropriate vocational rehabilitation facilities is sparse. Few occupational therapists appear to continue to work in this field (Section 10).

- 17.25 There is increasing evidence of the value of psychological treatments such as cognitive behavioural therapy. There appears to be a mismatch between the number of people needing psychological help after disease or injury and the availability of appropriate services. Psychological services are needed not only for those with physical problems but also for the increasing number of those suffering from the effects of stress at work or similar mental disorders (Section 11).
- 17.26 Musculoskeletal disorders lack significant government priority, except in so far as there are excessive waiting times to be seen in hospital outpatient clinics, in spite of their economic importance (Section 11).
- 17.27 Secondary services for those with chronic or intractable low back pain are poorly developed in the UK and lack the appropriate multi-professional intensive rehabilitation and pain management. There is a grave shortage of psychological support for rehabilitation services. Without such programmes it is impossible to envisage those with chronic back pain coming off Incapacity Benefit and into work (Section 11).
- 17.28 Good management in industry can reduce back injuries and sickness absence through organisational change, particularly when the work force have been involved in its planning. Back pain and work-related upper limb disorder exemplify areas in which good organisational management can minimise risks of ill-health and disability (Section 11).
- 17.29 Cardiac rehabilitation highlights the advantages of multiprofessional approaches to:
- assessment
 - treatment from the day of admission until return to work, or adjustment to the level of residual capability.
- 17.30 The management of traumatic brain injury is very difficult. Nevertheless significant numbers with severe and complex disability have been returned to work using extensive multi-agency collaboration with particular assistance in:
- planning assessment for work
 - work-site visits
 - support after re-employment in the workplace
 - support in many aspects of their lives.
- These needs are highly appropriate for case management.
- 17.31 Only when resources (including staff) are in place will we be able to repeat the benefits (in terms of return to work) which have been shown to be achievable in disparate conditions eg back pain, myocardial infarction and brain injury (Section 11).
- 17.32 Models exist whereby:
- waiting times to see hospital specialists can be greatly reduced by using appropriately trained nurses or therapists
 - multiprofessional vocational rehabilitation programmes can be provided both locally and regionally (Section 12).
- 17.33 Case managers in the private sector already coordinate and oversee from the early stages of recovery (from illness or injury) the overall programme of rehabilitation and return to work activities planned for each individual and this system works well (Section 13).
- 17.34 Countries with successful vocational rehabilitation have invested resources into:
- creating well-developed services
 - assessment of the scale of demand for vocational rehabilitation services
 - staff with professional qualifications
 - supported by an academic base for research, and the development of appropriate training programmes as recommended by the ABI (Section 14).

18. Summary of Recommendations

- 18.1 The development of long-term initiatives in vocational rehabilitation by a partnership between the Employment Service and appropriate university departments to ensure that satisfactory evaluation of vocational rehabilitation initiatives is achieved (Section 3, Appendix 3).
- 18.2 The DOH needs to urgently review the resources committed to the vocational rehabilitation of sick and disabled individuals. Some of the increase in doctors and therapists intended within the National Plan needs to be committed to vocational rehabilitation (Section 4).
- 18.3 Government waiting list initiatives must tackle excessive waits for radiology and therapy services in addition to consultant outpatient appointments (Sections 4, 8,9,11, Appendix 5).
- 18.4 Consideration should be given to the development of a National Service Framework for services to those of working age (Section 4).
- 18.5 Both the scale and scope of current (Disability Employment Adviser and private sector) provision is reviewed urgently recognising that:
- similar changes in other countries (eg New Zealand and Australia) have already been achieved on the basis of re-allocation of existing funding (eg Workmen's Compensation schemes) rather than new money
 - the essential requirement is likely to be for the development of a new professional role rather than an expansion of existing DfEE resources (Section 5)
- 18.6 More research is required to identify:
- those people/groups who are at greatest risk of long-term disability
 - what interventions in the field of rehabilitation and job-retention actually work - this is particularly for 'common' conditions (back pain, mental disablement) and those of gradual onset (certain musculoskeletal and neurological conditions).
- 18.7 All employers should have strategies for:
- prevention of work-related illness (Sections 6,11)
 - support for employees who become sick (Section 7,11)
 - return to work after sickness absence (Section 7,11)
- 18.8 Rehabilitation services should:
- focus on achieving a return to work (Sections 8,11)
 - include employment, medical, psychological and therapeutic components (Sections 8,10,11)
 - develop using the 'hub and spoke' of local and regional services to complement the model being developed in other areas of rehabilitation practice^{139,140}. These services will often be associated with the research and education developments which also require a 'hub and spoke' model (Sections 12, 15)
- 18.9 Industry should be more aware of the role and availability of Disability Employment Advisers (Section 8).
- 18.10 The taxation implications of business providing rehabilitation support should be reviewed (Section 8).
- 18.11 Communication between employer (or Occupational Health on their behalf), GP and hospital needs to be improved with all agencies being aware of the needs of the other (Sections 4,8,9).
- 18.12 There is scope for improving the understanding by health professionals (particularly doctors) of employment issues (Sections 4,8,15).
- 18.13 Early investment should be made in researching the extent of unmet need for psychological help; and the availability of treatment modalities eg cognitive behavioural therapy (Section 10).
- 18.14 Any expansion in vocational rehabilitation will demand dedicated sessions from doctors, psychologists and therapists (Section 10).

- 18.15 The shortage of clinical psychologists working specifically in back pain management, but also throughout the acute sector, needs to be addressed urgently. Some psychologists may have appropriate training and experience in occupational assessment and vocational guidance (Section 11).
- 18.16 Return to work should be an outcome measure of treatment provided by the NHS much more frequently (Sections 8,10).
- 18.17 Stronger links are needed between health and employment services (Sections 4,8,9,10).
- 18.18 Creation of a course in vocational rehabilitation is needed. This will be needed by trainees in specialties other than rehabilitation. This will need to be jointly planned between the Employment Service and the NHS (Section 10)
- 18.19 Musculoskeletal disorders require priority to develop fast track assessment, investigation and treatment where indicated for those (particularly recently) off sick with musculoskeletal problems (Section 11).
- 18.20 Programmes of intensive rehabilitation and pain management need evaluation in the UK (Section 11).
- 18.21 Case management needs to be developed in the UK (Section 13).
- 18.22 Investment in research and development in vocational rehabilitation is badly needed with appropriate working relationships developed between the Employment Service, the NHS and the universities to evaluate new services as they develop (Sections 14,15, Appendix 3).
- 18.23 There needs to be further investment in the development of staff in this field, with accredited courses for staff of the NHS and the Employment Service (Sections 14,15).
- 18.24 A new Institute for Rehabilitation Research should be set up to promote multi-professional research into vocational aspects of rehabilitation. Such research should:
- define the vocational needs of those with chronic illness or disabilities
 - define appropriate means of reducing sickness absence
 - evaluate measures designed to minimise the effects of sickness absence and loss of employment - in terms of their effects on individuals, their families, colleagues at work, employers and society at large
 - liaise with provider services to improve data collection for the monitoring of inputs, activities and outputs
 - accredit postgraduate programmes designed to train professionals in the field of vocational rehabilitation.
 - liaise with the undergraduate schools of health professionals to ensure the development of an appropriate awareness of the importance of employment to the maintenance of good health and minimising sickness absence (Section 15).
- 18.25 Discussions (involving both governmental and non-governmental bodies) should begin to apply to UK practice the lessons learned by countries successful in vocational rehabilitation (Section 14).

19. Vocational rehabilitation: the way forward

Three years on

Introduction

- 19.1 The first edition of the British Society of Rehabilitation Medicine report “Vocational Rehabilitation: the way forward” (hereafter referred to as ‘the report’) stimulated interest throughout Government, the insurance industry, the voluntary sector and the health professions. It seems to have been instrumental in drawing together the various strands, which together comprise vocational rehabilitation. These include health & safety at work (including the importance of good employer/employee relations), primary care (including the vital sickness certification), and appropriate rehabilitation back into work; combined with an increasing combination of government incentives and appreciation of the need to avoid disincentives.

Initial responses

- 19.2 The report stimulated interest in various bodies that combined to host a conference in 2001 of representatives of the health professions, charitable bodies and the insurance and business sectors¹⁷¹, when the Executive Summary and recommendations of the first edition of the report were circulated to participants. Many of the conference conclusions confirmed those of the report including the importance of:
- early intervention
 - case management
 - rehabilitation in occupational settings
 - potential national multidisciplinary institute of rehabilitation¹⁷².
- 19.3 The report stimulated a number of editorials^{173 174 175 176}. The BMJ¹⁷⁴ joined the Journal of the Royal Society of Medicine¹⁷³ in recognising the need for improved rehabilitation services in the UK whilst doubting the government’s commitment to fund what is needed. However, Disler and Palant pointed out that
- “whilst this (rehabilitation) is not a cheap option, a community with unemployed, disabled ex-workers is likely to be even more costly”¹⁷⁴.*
- 19.4 Rehabilitation professionals also commented on research in progress¹⁷⁷ and the model of vocational rehabilitation successfully followed by the armed services, where vocational rehabilitation is integrated into intensive rehabilitation programmes that successfully keep service personnel working^{178 179}.
- 19.5 Other important publications covered the implications for:
- benefit provision following withdrawal of rehabilitation facilities¹⁸⁰
 - communication between health professionals^{181 182}
 - early intervention¹⁸³
 - future rehabilitation developments¹⁸⁴
 - sickness certification (see Appendix 7)^{185 186 187}
 - supporting those with musculoskeletal conditions in work¹⁷⁵

Royal College of Psychiatrists and vocational rehabilitation

- 19.6 The Royal College of Psychiatrists (RCPsych) has newly published “Employment opportunities and psychiatric disability” in which they state:
- “The BSRM report on vocational rehabilitation examined all areas of disability. Inevitably they examined the issues of mental health disorders and work. Their report covers some of the ground of the present report but did not consider severe mental illness specifically. The conclusions and recommendations of the present report overlap with those of the BSRM and it is worth referring to that document in conjunction with the present report”¹⁸⁸.*
- 19.7 Amongst a galaxy of recommendations the RCPsych report called for:

- review of the organisation of psychiatric rehabilitation services including vocational rehabilitation
 - interdepartmental working group to monitor the cumulative impact of employment policies and initiatives on people with mental health problems
 - psychiatric rehabilitation services to focus on getting people back into work or other meaningful activity
 - improved communication between general practitioners (GPs), employers and mental health services
 - improved working relationships between local employment agencies and mental health teams
 - vocational and welfare specialists in community mental health teams¹⁸⁸
- 19.8 Thus two different multiprofessional groups with voluntary sector involvement have reached very similar conclusions!

The voluntary sector

- 19.9 The voluntary sector contributed to the report¹⁸⁹ and subsequently was very supportive:
- Depression Alliance - importance of the workplace in the genesis and rehabilitation of those with mental health problems¹⁹⁰
 - National Vocational Rehabilitation Association (NVRA) - need for a “co-ordinated approach to supporting disabled people to gain or retain work¹⁹¹”
 - NVRA - proposal for a national vocational rehabilitation institute¹⁹²
 - Royal National Institute for the Blind - lack of NHS support for job retention¹⁹³.

Occupational health

- 19.10 Relationships have developed between the BSRM and the Society of Occupational Medicine. This has resulted in a consensus statement on “Rehabilitation and retention in the workplace - the interaction between GPs and occupational health professionals”¹⁸¹ with subsequent editorials^{194 182} and correspondence^{179 195}.

General rehabilitation

- 19.11 In 2002 the BSRM responded to “Getting back to work: a rehabilitation discussion paper” published by the Association of British Insurers. In its detailed response the BSRM strongly supported their statement:

“Ultimately the Working Group would wish to see the UK operate a system whereby all those injured and off work, regardless of the cause, could benefit from a rehabilitation programme”.

- 19.12 A wider group of stakeholders have identified similar obstacles to rehabilitation, and have set out a convincing case for reform^{196 197 198}. The report recognised the impact of psychological factors on ill health and sickness absence. This view has been supported by the impact of psychological illness as the largest single cause of individuals needing incapacity benefits in the UK¹⁹⁹. The Third UK bodily injury awards study noted:

“There are too few specialists. Doctors and specialists are usually inadequately trained in the recognition and management of psychological/social factors”¹⁹⁸.

Case management

- 19.13 The report strongly recommended the role of case management. The BSRM welcomes the newly formed Case Management Association of the UK (CMSUK) – details available from Deborah Edwards, 78 Alexandra Road, Wimbledon, SW19 7LE (tel: 020 8715 4919).

Government action - DWP

- 19.14 The government has been active in vocational rehabilitation. This has been greatly facilitated by the restructuring of the Departments of Education and Employment and Social Security. Their employment functions were combined within the new Department for Work and Pensions (DWP), thus linking the worlds of work and benefits. The DWP has been given the lead role in improving services in vocational rehabilitation.
- 19.15 The need for better accredited training programmes for those working in the field of vocational rehabilitation has been validated by the HOST report last year which stated a clear need for a:

“sustainable strategy that takes a determined and progressive approach to tackling long-standing concerns about staff training/development – particularly in the area of staff in supported employment”²⁰⁰.

- 19.16 The HOST report also clearly recognised the role of research in meeting the UK needs discussing the contributions of:
- evidence-based practice
 - one or a number of centres of excellence
 - demonstrator projects
 - evaluation strategy.
- 19.17 The government recognises that health issues (amongst others) remain a major barrier to many individuals returning to work. The job retention and rehabilitation pilot was launched in April 2003²⁰¹ to test the effectiveness of helping individuals, off work because of sickness, injury or disability to return to, or remain in, employment (see Appendix 4).
- 19.18 ‘Pathways to work: helping people into employment’¹⁹⁹ was published in 2002 and well received in many quarters, including the BSRM. The government’s response to the submissions was published this year¹⁸⁷, and included a quote from the BSRM submission:

“There is a clear need for training of all health professionals in understanding the importance of work to health, and the interrelationships between employment and health. There is also a clear need for experts in the area of vocational rehabilitation”²⁰².

- 19.19 As well as improving job retention, the action following ‘Pathways to Work’ included piloting:
- staff development within Jobcentre Plus
 - enhancing the roles of Personal Advisers
 - changing work-focussed interviews
 - linking work-focussed interviews with personal capability assessments
 - improved information to service users
 - linking DWP and local NHS providers to facilitate vocational rehabilitation
 - evaluation of these pilot programmes¹⁸⁷.

Government action – Department of Health

- 19.20 The BSRM welcomes initiatives from the perspectives of Health & Safety at work 203 and Occupational Health. The reality, however, is that many needing help to return to work will not have work-related injuries, nor the assistance of an occupational health scheme. For these individuals, it is the psychological, psychiatric and general rehabilitation services that are needed and it is here that further investment is required.
- 19.21 The BSRM welcomes the emphasis on vocational rehabilitation being developed by the National Service Framework for chronic neurological conditions.

Conclusions

- 19.22 Since the publication of “Vocational rehabilitation: the way forward” there have been developments in many of the areas covered by the report, specifically in the areas of occupational health, primary care and sickness certification and the need for collaboration between employment and health provision. The importance of early intervention is widely supported^{176 183}, with clear implications for collaboration between local NHS providers, local DWP services and employers.
- 19.23 There continues to be a growing realisation that, within the generality, NHS rehabilitation services are not meeting the needs of the working population in facilitating work for those with long-term illness or disability

The BSRM believes that further consideration should be given to the following:

- 19.24 The DWP/DOH contact the Department of Education and Science to inform them of a change in health strategy viz the need for work-awareness in all training programmes (medical, nursing, therapy).

- 19.25 Financial incentives to get vocational rehabilitation on to postgraduate training programmes with:
- bursaries for MSc students
 - grants towards courses – contacting specialist societies
- 19.26 Consideration should still be given to the creation of a National Institute for Vocational Rehabilitation. Linked to an appropriate university, it would embrace employment issues from the roles of good management in industry to the detailed rehabilitation into employment of those with work-related health issues. It is the interface between the worlds of work and health that are complex, and not well understood in either sector.
- 19.27 The role of a potential ‘Standing Committee’ of leaders in the field promoted by the ABI/TUC conference needs further examination. Such a body would provide leadership across all the boundary areas covered in Pathways to Work.
- 19.28 Either of these bodies would have the stature to tackle the enormous problem of mental ill health (anxiety, depression, stress etc) that now causes the greatest numbers of individuals to go on to incapacity benefits.
- 19.29 The BSRM supports efforts being made collaboratively to define the responsibilities of doctors to assist their patients in gaining or remaining in employment¹⁷⁶, but also recognises that these responsibilities are shared with all health professionals.

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Glossary

Acute back pain: back pain of less than 7-10 days duration ¹³⁷ - NB the term does not imply severity of pain.

Case management: see vocational rehabilitation case management

Chronicity (chronic): a term used to reflect an established pattern, usually duration of illness. Chronic pain is usually considered to be pain which persists past the normal time of healing ¹⁵⁸. Chronic low back pain is normally considered to have been present for 3 months. NB the term does not imply severity of pain.

Deconditioning: general decline in an individual's general physical condition following a period of relative inactivity and absence from work for a mild condition resulting in a reduction in the ability to function physically - often found in those with chronic low back pain ⁸⁷.

Extended scope practitioners: clinical physiotherapy specialists, with an extended scope of practice, who see patients referred for assessment, clinical diagnosis and management of neuro-musculoskeletal disorders.

Illness behaviour: includes all acts and conduct that we commonly understand to suggest the presence of illness eg pain behaviours include talking, moaning, facial expressions, limping, taking pain killers, seeking health care and stopping work. NB illness behaviour is a form of communication. It is not conscious or intended. Most pain behaviour is completely unconscious ¹⁵⁹.

National Service Frameworks (NSFs): set national standards and define service models (including workforce planning and training/educational needs of staff) for a specific care group, establish programmes to support implementation and set targets against which services can be measured. They are being introduced as part of the Government's reform of the NHS in an attempt to reduce the current variations in service provision and quality of care across the country.

Occupational therapy promotes and restores health and well-being in people of all ages through using purposeful occupation as the process or as the ultimate goal (taken from the COT core skills document).

Physiotherapy is a healthcare profession which emphasises the use of physical approaches in the promotion, maintenance and restoration of an individual's physical, psychological and social well-being, encompassing variations in health status ¹⁶⁰.

Rehabilitation

- a) An active process by which people disabled by injury or disease regain their former abilities or, if full recovery is impossible, achieve their optimum physical, mental, social and vocational capacity and are integrated into the most appropriate environment of their choice ¹⁶¹.
- b) The use of all means aimed at reducing the impact of disabling and handicapping conditions and at enabling disabled people to achieve optimal social integration ¹⁶², quoted in ²⁴.
- c) A process of active change by which a person who has become disabled acquires the knowledge and skills needed for optimal physical, psychological and social function ¹²⁸.

Subacute back pain: back pain of more than 7-10 days duration but less than 3 months duration ¹³⁷

Vocational rehabilitation case management: a service with similar professional responsibility to its clientele as health or social services workers already exercise with respect to their patients or clients. In consultation with all relevant bodies in each case (GP, hospital, employer, Employment Service), case managers would be expected to coordinate and oversee from the early stages of recovery from illness or injury the overall programmes of rehabilitation and return to work activities planned for each client. Primary duties in each case would include:- conduct or arrangement of an initial assessment, preparation and agreement of a rehabilitation plan incorporating clearly formulated aims, timescales, and outcome criteria; and implementation of those plans including liaison with other services (health, employment, education) and employers and/or practical assistance with job search, job development, job modification or other related placement activities. Those duties to be undertaken in the context of a system of management which would be expected to foster the keeping of confidential case record; the setting and maintenance of both quality assurance and professional standards and the ongoing professional development of its case managers.

Work conditioning comprises a single discipline intervention focussed on physical conditioning and functional activities related to work. This approach has been successful in producing a higher percentage of return to work and an earlier return to work in a group off work for at least 2 months ¹⁶³.

Work hardening is an interprofessional, highly structured, goal-oriented and individualised approach to rehabilitation that has been shown to increase the rate of return to work by 52% in patients off work for more than 4 months¹⁶³.

Work-related Upper Limb Disorder is a term commonly used to describe a range of conditions (usually but not invariably occupational in origin) that are characterised by pain and dysfunction, often of an incapacitating nature, of the upper limb. While such conditions are not a new phenomenon (having been documented for 300 years in jobs such as clerical work and telegraphy), there has been an increase in prevalence over the past 20 years¹¹⁶.

Abbreviations

ADC(s)	Ability Development Centre(s)
AtW	Access to Work programme
BSRM	British Society of Rehabilitation Medicine
CARF	Commission of Rehabilitation Facilities
CHD	Coronary Heart Disease
CT	Computerised tomography
DfEE	Department for Education & Employment
DOH	Department of Health
DSS	Department of Social Security
DTI	Department of Trade and Industry
ERC(s)	Employment Rehabilitation Centre(s)
ES	Employment Service
ESP	Extended scope practice (practitioner)
GP(s)	General practitioner(s)
MRI	Magnetic Resonance Imaging
NIDDR	National Institute on Disability and Rehabilitation Research
NVQ	National Vocational Qualification
NHS	National Health Service
ONE	The ONE Project
OT(s)	Occupational therapist(s)
PA(s)	Personal Advisers
PACT(s)	Placing, Assessment and Counselling Team(s)
PCA	Personal Capability Assessment
RSA	Rehabilitation Services Agency
SEP	Supported Employment Programme
SSP	Statutory Sick Pay
TBI	Traumatic brain injury
WRULDs	Work-related upper limb disorders
UK	United Kingdom
USA	United States of America

Appendix 1 - Membership of the Working Party

Membership of the Working Party (body represented)

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Appendix 2 - Historical and Social Context

1. Government and professional interest in vocational rehabilitation started during the First World War with the emergence of interest in rehabilitation, moves to retrain disabled ex-servicemen and the establishment of remedial work. Interest lapsed after the war but returned during the Second World War as attempts were made to reduce disability, retrain disabled servicemen and to employ disabled civilians in occupations from which workers had been called up for the forces. In 1943 the Miners Welfare Commission (recognising that miners away from work for more than a limited period underwent a decline in general physical fitness which further delayed their return to work or made them permanently unfit to return to their previous job) established seven rehabilitation centres for miners and the first industrial rehabilitation unit was established. Also during the war the RAF established several rehabilitation centres.
2. Government has highlighted the importance of rehabilitation and vocational rehabilitation in a number of reports. In 1942 the Beveridge Report commented on 'a national health service for prevention and cure of disease and disability by medical treatment' - a National Health and Rehabilitation Service⁴. Rehabilitation was envisaged as being a pillar of the new NHS 'fitting for employment by treatment which will be both medical and post medical'. The need for co-operation between government departments was noted. In 1943 the Tomlinson Report focussed on 'proposals for the introduction at the earliest possible date of a scheme for the rehabilitation and training for employment of disabled persons'¹⁶⁴. In 1956 the Piercy Report addressed the provision for the rehabilitation, training and resettlement of disabled people¹⁶⁵.
3. Reports from other bodies have also addressed the importance of rehabilitation. In 1962 a Report from a Committee of the Sheffield Regional Hospital Board recommended the establishment of comprehensive medical and industrial rehabilitation centres near district general hospitals. The centres were not built. In 1972 the Tunbridge Report was published by the Department of Health and Social Security and Welsh Office¹⁶⁶. It gave reasons for the failure of provision and focussed on the 'future provision of rehabilitation services, their organisation and development'. The Mair Report on Rehabilitation Services in Scotland was also published in 1972 by the Scottish Home and Health Department¹⁶⁷. This report also considered deficiencies in services and made recommendations for the future.
4. Consistent themes through these reports were the lack of provision, the lack of co-ordination and the division of responsibility between government departments and other agencies. Moreover, the implementation of recommendations from the reports was sparse. Many changes in the NHS, employment services and society have exacerbated the divisions between the health and employment agencies in recent years. Attempts to develop links between health and employment were made with development of the NHS/Department of Employment facilities at Garston Medical Rehabilitation Unit/ERC²⁰ and the industrially based Port Talbot unit. Hospital Disablement Resettlement Officers were appointed but effects were limited to the achievements of the individuals concerned. However, by the late 1970s and early 1980s there existed a diverse range of rehabilitation and vocational rehabilitation facilities, for example: hospital rehabilitation departments; RAF rehabilitation units; miners rehabilitation centres; medical rehabilitation centres (eg employment rehabilitation centres); special training centres, demonstration centres and centres established by voluntary organisations.
5. Recent years have seen the demise of many of these facilities and initiatives which, had they been given sufficient government and professional support, might have served to develop vocational rehabilitation facilities much needed today. Indeed, looking back at the development of vocational rehabilitation from the time of the first world war, (soon approaching 100 years), it is concluded that the development of services has been piecemeal, unco-ordinated, lacked adequate investment and been inadequate for society's needs. Moreover, looking at today's depleted services, it can only be concluded that they are woefully inadequate in the scope, content and standards which might reasonably be considered appropriate for the beginning of the twenty first century.

Changing social background

6. Services are needed for people in different socio-economic settings and cultural environments; with different life styles and educational backgrounds; with a wide spectrum of skills and occupations; and with a diverse range of injuries, illnesses and disabilities. Differences in any of these variables can affect both the process and the outcome of vocational rehabilitation.

7. Social and economic changes occur in both urban and rural communities. In urban areas heavy industry has declined as high technology and service industries have expanded. In rural areas changes in farming practice and village life have changed the character of country living. Changes in the working environment and practice have brought about changes in employment prospects, personal wealth and levels of unemployment. Significant social changes in families include an increase in one-parent families, in the number of wives and mothers who choose to work outside the home and the large number of people taking early retirement. Amongst the changes taking place in society are an increase in the consumption of alcohol and the taking of illicit drugs. Alongside considerations of employment and unemployment are questions about wages; financial benefits provided by the state and the adequacy of family incomes. To varying degrees these changes affect people's aptitude, capacity and motivation for work (Fig 1).
8. The British Isles is increasingly becoming a multi-ethnic and multi-cultural society. Family traditions, expectations, working practices and family support systems vary widely. Individuals' education and achievements vary from the most modest to the most sophisticated. The links between education, job skills and employment flexibility cannot be ignored in the context of vocational rehabilitation (Fig 1).
9. Individual life styles vary extensively. On the one hand there are still those who consume high fat diets, smoke heavily, consume excessive alcohol and lead a sedentary existence. These may contribute to premature disease, illness or injury. On the other hand there are those who indulge in regular exercise, consume special diets and pursue physical fitness. Links between physical and mental health and a predisposition to occupational injury and illness are well established. There are also strong links between health, a commitment to vocational rehabilitation and prospects of a successful return to employment. Psychological issues need not preclude successful rehabilitation if appropriate psychological or psychiatric support is included in the rehabilitation programme ¹⁶⁸.
10. With the changes in society and industry have come changes in the nature of employment. Heavy manual work has declined and lighter industries have taken their place. Employers are placing demands on individuals for increased productivity. With new working practices have come new illnesses such as the work-related upper limb disorders and occupational stress. Common conditions such as back pain have developed new perspectives: in addition to back pain caused by heavy manual work we now have back problems related to sitting posture and the sedentary nature of some employment. More employers are thinking of a person's fitness to work in the context of Health and Safety Legislation. The Disability Discrimination Act is beginning also to have a significant impact on both recruitment to work and retention in work.
11. In communities where old industries have declined and where new industries are developing there is frequently a mismatch between skills available in the local workforce and the skills required by the new industries. It is often difficult, even if training and other facilities are available, for those in the middle of their lives and previously employed in heavy manual work to retrain and acquire new skills.
12. These social and economic changes may affect people's physical and psychological fitness for work; motivation to work; chances of experiencing work and non work-related accidents or illness; enthusiasm and suitability for vocational rehabilitation and the likelihood of a successful outcome.

Appendix 3 – Background to Employment Services

Introduction

1. In 1987 the National Audit Office published a report on the services provided for disabled people by the Department of Employment ¹⁶⁹. The report was very critical and following a thorough and comprehensive review of its services the Department published a Consultative Document ¹⁷⁰, which proposed a number of major changes in the services embracing:
 - closure of most Employment Rehabilitation Centres (ERCs)
 - contracting out of rehabilitation to outside agencies
 - establishment of Ability Development Centres located in what had been ERCs in each of the nine regions
 - ‘re-balancing’ of sheltered employment in favour of sheltered placements, whereby disabled people work in an ordinary employment setting, but are employed by a ‘sponsoring’ organisation, while the ‘host organisations’ pay only a proportion of their wages, the difference being made up by government.
2. Setting up of what came to be known as Placing, Assessment and Counselling Teams (PACTs) - recently re-named Disability Service Teams (DSTs). There are over 50 of these, each serving a population of around one million people and staffed mainly by Disability Employment Advisers.
3. The Consultative Document acknowledged that ‘the training of Disabled People Resettlement Officers (DROs) (needed) to be strengthened and the possibilities of developing a stronger specialist career structure (needs) to be examined’. The possibility of DROs acting as case managers was also proposed. This idea was not pursued. The DROs subsequently evolved into Disability Employment Advisers.

Disability Service Teams (DSTs)

4. There has been no in-depth research into the effectiveness of these teams and no comparison can be made with the ERCs as they are broader in scope. There has certainly been a much higher throughput but there is very little information on whether the quality of the service, or the outcomes achieved, have improved. Most of this appears impressionistic and anecdotal.
5. Research by a City University M.Sc. student – and ex-PACT manager - indicates that most assessments of clients are relatively informal and less use is now made of more formal, objective approaches using psychometric tests and work samples. This more sophisticated technology was introduced in the eighties, following a very critical evaluation of the ERCs by the Employment Rehabilitation Research Centre ¹⁴⁵. Each ERC – and ASSET Centre – was equipped with a variety of Valpar work samples, imported from the United States.
6. These work samples were however designed to be used in conjunction with a very comprehensive set of occupational information, developed by the US Department of Labour and widely available in the form of computerised data-bases . A few centres such as Queens Park Hospital’s Vocational Rehabilitation Department and Enham’s Resource Centre, did attempt to use the American information but none of the ERCs did so.
7. Currently it is mainly the occupational psychologists, who are attached to the Disability Service Teams, who use the Valpar work samples, although a small number of Disability Employment Advisers are trained to do so.

Rehabilitation

8. It is difficult to assess whether the contracting out of the service has resulted in an improvement. A number of City University M.Sc. students, themselves Disability Employment Advisers, have carried out qualitative studies of the work done by agencies with which they have worked. It is not possible though to draw firm conclusions regarding the quality of the service, and how it compares with that provided by the ERCs.
9. What can be said though is that the Employment Service has failed to draw up proper criteria for evaluating the service they provide.

The Supported Employment Programme

10. In 1994 the Employment Service re-named their sheltered employment programme and, at the same time, changed the funding arrangements so as to facilitate the movement from sheltered workshops to sheltered placements. At around the same time Remploy initiated its Interwork scheme and it now employs nearly 4000 disabled people in what are essentially sheltered placements.
11. 'Re-balancing' has not however occurred to the extent envisaged in the Consultative Document and there are still 13,000 disabled people working in sheltered workshops.
12. The government is currently focusing on the small proportion of people who move out of supported employment into open employment. In 1998 the Government announced an additional £30 m for disability services spread over three years, around half of which was for supported employment. Much of this will go to fund development projects testing alternative approaches to supporting individuals, with the aim of improving the "transition" rate, currently only 2% a year. Further developments in this programme are planned and details are given in Appendix 4.

The Ability Development Centres (ADCs)

13. In 1997 the ADCs were closed. The functions of ADCs remain and are carried out by Regional Disability Services and the National Disability Development Initiative.
14. For some time previous to this they had been becoming less and less relevant and the closure of these centres lies at the heart of the problems surrounding vocational rehabilitation in the UK.
15. The Consultative Document had proposed that the ADCs would focus 'particularly on the development of new technologies' but would 'assist where appropriate in the training and development of agency staff'. They would directly provide services to a number of clients and, by doing so, be able to adopt a 'teaching hospital' 'style of operation'. The ADCs could, of course, also have played a key role in improving the training of the Disability Employment Advisers but, sadly, none of these encouraging ambitions were realised.
16. In the past there seems to have been a deep-seated reluctance, within the Employment Service, to consider the possibility of becoming a more professional, and appropriately trained, group of staff (see section 12 and Appendix 4). Now there appears to be a growing recognition within the Employment Service of the need for better training for their staff. A report has recently been published¹⁴⁶ with fairly detailed proposals for all Personal Advisers (PAs) becoming more professional and receiving much more training. In the meantime the Employment Service is going to require Disability Employment Advisers and other staff, who become PAs, to acquire a National Vocational Qualification (NVQ) in Guidance. They were also examining the possibility of developing an NVQ in Disability and had drawn up a list of the disability-related competencies required by Disability Employment Advisers. Four NVQ style units of competence have been developed to complement existing NVQ units in the Level 3 qualification. Two are for Disability Employment Advisers and two for New Deal for Disabled People PAs.
17. It is particularly disappointing that the New Deal for Disabled People (NDDP), with a budget of £195 million, is failing to address this need for professional training. Virtually none of this funding is being spent on staff training. Similarly the National Disability Development Initiative was too narrow in scope to support any development of this kind. It seems unlikely that the new Supported Employment Programme will be any different in this respect.
18. The setting of targets and audit criteria could assist this changing culture and some are suggested in Appendix 8.

Incapacity Benefit

19. Mention should be made of the major changes that have taken place with regard to entitlement to state incapacity benefits including Incapacity Benefit, Severe Disablement Allowance and the Disability Premium for Income Support. The Incapacity for Work Act 1994 set the legal framework for entitlement on the grounds of 'incapacity for work' which could only be considered on those grounds arising from 'a specific bodily disease or disablement.' The Act introduced a new assessment process, the All Work Test which involved ill or disabled clients being asked to complete a questionnaire to describe the functional limitations arising from their medical condition or disability. A benefit decision maker determined whether the test

criteria were met and could refer the client to an 'approved' doctor for a medical examination to obtain further evidence.

20. The Incapacity for Work Act 1994 and the All Work Test were strongly criticised by the disability organisations because the law did not allow the assessment procedures to take account of the individual's education, skills or the local labour market. The view was expressed that an individual could be assessed as 'fit' for some work but their chance of actually securing local employment may be very low.
21. The government committed itself to a 'fundamental reform' of Incapacity Benefit (Department of Social Security, 1998) and to a radical revision of the All Work Test, so that it 'focuses on what disabled people can do, not on what they cannot' and recognises that 'capacity for work is a continuum'.
22. The All Work Test was replaced from 3 April 2000 by the Personal Capability Assessment. The change in name is intended to correct the impression that people who meet the qualifying conditions for incapacity benefits are unable to do any work.
23. Under the new arrangements the Personal Capability Assessment will set a threshold of incapacity which people must meet in order to get state incapacity benefits. The incapacity threshold and the method of assessment, which looks at the effect of an illness or disability on a person's ability to perform a range of functions related to capacity to work, are not changing.
24. Twelve pilot areas have been established. In these the examining doctor will compile two reports on an individual; an Incapacity Report to go to the benefit decision maker and a Capability Report which can go to the Personal Adviser. The Capability Report will contain advice on the way in which the person's medical condition affects their work prospects. It will provide positive and constructive information, which Personal Advisers can use to give their clients effective help to improve their employability and plan to start work or return to work.

Long term unemployment → long-term incapacity

25. In the decade from 1979 onwards, against a background of rapidly increasing unemployment, over 20 changes were made to definitions of eligibility for inclusion in national unemployment counts. One significant change was a switch-over for a large number of people over 50 years old, particularly males, from receipt of unemployment benefit to the marginally higher rate of long-term invalidity benefits. Those persons were excused from further participation in the labour market. Those affected came to regard themselves as undergoing early retirement on medical grounds, thereby avoiding the stigma of being unemployed.
26. The growing pool of persons who left the labour market by that route is reflected in the rapid and significant increase in the number of persons claiming Incapacity Benefit, over which successive governments have expressed concern. As a result, recent reviews have identified that pool of older persons of working age as one of the target groups for the government's New Deal Programmes, to be implemented alongside other measures to overcome "age discrimination", by persuading employers to look more favourably on applications from job-seekers in older age bands.

Appendix 4 – DWP Services for People with Disabilities (Review kindly provided by DWP)

There is a range of well-established employment and training measures to help disabled people into employment. Working from the premise that some 70% of unemployed disabled people are helped through the mainstream activities and programmes of Jobcentre Plus, that leaves the remainder requiring help through specialist disability support run by Jobcentre Plus. These are detailed below.

Existing Measures

Disability Employment Advisers aim to provide coherent employment advice and assessment for employers and disabled people. Their services are accessed through the local jobcentre or Jobcentre Plus office.

The function of Disability Employment Advisers is to help disabled people select, obtain and keep jobs and help employers develop good recruitment policies. This includes offering support to employers to retain employees who become disabled, or for whom a worsening disability poses a threat to continued employment.

Disability Employment Advisers have access to the full range of Jobcentre Plus disability and mainstream programmes. These are detailed below.

- i) For those disabled people who are not yet ready for work, **Work Preparation** (formerly Employment Rehabilitation) provides a tailor-made package of help designed to help them return to work. The purpose of the programme is to help jobseekers to:
- understand the effects of their disability on work related activities
 - build their confidence to pursue work opportunities effectively
 - make an effective occupational choice
 - improve interpersonal skills at work
 - re-learn basic skills

Around 9,000 people a year are helped by Work Preparation.

- ii) Vocational Training is also available for those disabled people who need it. Most will take their place alongside non -disabled people but where no suitable local provision is available, residential training may be offered at 14 colleges or providers.

Residential training providers (RTPs) have become specialist providers of training for disabled people. These are more likely to be able to cater for the (often complex) needs of disabled people than mainstream provision. The client group includes those with: a physical and/or sensory disability; a deteriorating medical condition; mental disabilities; and behavioural and learning difficulties (and frequently a combination of the four).

The providers enable trainees to move towards social inclusion through an inclusive approach to meeting their individual training, support and caring needs. This includes: psychological and counselling support; specialist medical facilities and expertise; therapeutic support; technical support; assessment and employment preparation advice and guidance; enhanced staff expertise; and specially designed buildings and facilities.

The providers consist of 4 large and 3 small residential training providers catering for all disabilities, 1 specialist residential training adviser for people with hearing impairments and 6 for adults with visual impairment.

- iii) The **Access to Work (AtW) programme** delivered by Jobcentre Plus aims to provide support to overcome the effects of disability at work, so that disabled people can participate in mainstream employment. Disabled people apply through their local Disability Employment Adviser or by going directly to an AtW Adviser at a regional AtW business centre.

The AtW programme provides support tailored to the needs of individual disabled people to enable them to overcome the effects of their disability in the work place. Applicants must be in, or about to enter, paid work. Support can take the form of help with the cost of getting to work, help with the cost of aids and adaptations to equipment, computers or the work place and with the cost of a support worker. The latter can take many forms, eg carer, driver, jobcoach, advocate, job-aide, counsellor, travel buddy, communicator/note-taker for deaf people, personal reader/helper for those with a visual impairment and job designer. Jobcentre Plus expects to help around 18,000 new applicants a year with this programme.

An AtW Adviser will work together with the applicant and the employer to arrive at the most effective solution to meet the needs of the disabled person in the work place. The support agreed by Jobcentre Plus continues for a maximum of 3 years, when it is reviewed. If continuing help (eg support worker) is still needed, then further grants will be for less than 100% of the cost, as detailed in the following paragraphs.

Access to Work pays 100% of the approved costs for anyone entering paid employment from unemployment or who has been in paid employment for less than six weeks. Unemployed people do not have to be on Job Seekers Allowance. People who change jobs get 100% funding. AtW can also meet 100% of approved costs for help with fares to work and with communicator support for deaf people at a job interview whatever the employment status of the disabled applicant.

For all other **employed** people, (including cases reviewed at the three year stage) a system of **cost sharing** applies under which AtW does not pay the first £300 in any 3 year period; it meets 80% of costs between £300 and £10,000; and it pays for all costs over £10,000. Self-employed people are not asked to contribute towards the cost of their support.

- iv) The **Job Introduction Scheme** provides a weekly grant of £75 towards the cost of employing people with disabilities for a trial period of employment. This is usually 6 weeks but may be extended to a total of 13 weeks. The scheme is for use at the discretion of Jobcentre Plus staff in situations where a disabled applicant is considered suitable, but the employer has genuine doubts about the individual's ability to cope with the proposed job or place of work. It is expected that 3000 people a year will be helped by this measure.
- v) Jobcentre Plus also manages WORKSTEP, the government's **supported employment programme**. The programme was introduced in April 2001 and provides support for around 25,650 people. The aim of WORKSTEP is to provide tailored support to find, secure and retain jobs for people with disabilities who have more complex barriers to finding work and keeping work. WORKSTEP provides the support and opportunity for people to progress to open employment where this is the right option for the individual. The programme also retains its role in providing longer-term support for people who need it.

WORKSTEP provides a wide range of supported work opportunities that meet the differing needs of disabled people. Supported employees work in jobs or in supported factories and businesses.

The programme is delivered in partnership with over 240 local authority, private sector, voluntary organisations and Remploy Ltd

Jobcentre Plus has adopted the Business Excellence Model to continuously improve its services including work preparation/ employment rehabilitation; for example there is an expectation of 50% positive outcomes (into jobs, training or education) from work preparation/employment rehabilitation contracts.

New Deal for Disabled People (NDDP) is the first programme specifically designed to support people on disability and health-related benefits into employment. Participation in NDDP is entirely voluntary.

NDDP pilots ran from September 1998 to June 2001 and helped over 8,000 people into work. Based on this success, and building on the best practice from those pilots, NDDP was extended from July 2001 across England, Scotland and Wales with the introduction of a network of Job Brokers from private, voluntary and public sector organisations or combinations of these in partnership who:

- help customers understand and compete in the labour market;
- agree with each customer the most appropriate route into employment for them;
- support customers in finding and keeping paid employment;
- work closely with providers of training and other provision where a customer needs additional support;
- work with local employers to identify their needs and match them with the skills of their customers; and
- support customers during their first six months in employment.

NDDP focuses on achieving sustained employment and Job Brokers are paid on an outcome-related basis, receiving payments for registering customers, job entries and achieving sustained employment. From July 2001 to the end of June 2003, 50,876 people had registered with an NDDP Job Broker and 16,715 had found jobs.

A New Deal for people aged 50 and over began in April 2000. The New Deal 50plus is an important package of back to work help comprising: an employment credit; help with training; personal advice; and jobsearch help was introduced in nine pathfinder areas on 25 October. It will be delivered by the ES, building where possible on existing provision. The budget for the New Deal was £270m for the three years 1999-2000 to 2001-2002. The programme is aimed at unemployed and economically inactive people, including those with disabilities, in receipt of benefit for six months or more and their dependent partners.

The programme is voluntary and offers:

- a guaranteed minimum take home income of £170 a week or £9,000 a year for those taking up full-time employment
- flexible support for part-time and full-time work and self-employment
- a tax and national insurance free Employment Credit (paid to the individual) of £60 a week for up to 12 months (£40 for part-time work)
- personal advice
- In-work Training Grant of up to £750
- jobsearch Help

vi) Job Retention and Rehabilitation Pilot

The new and innovative Job Retention and Rehabilitation Pilot may give advisers an additional tool in giving practical advice to customers who are off work due to sickness, injury or disability. The pilot is delivered in partnership with external providers in Birmingham, Glasgow, Sheffield, Tyneside, Teesside and West Kent, under brand names: WorkCare; HealthyReturn; and Routeback. The results from this research study will be used to inform future government policy.

The pilot was launched on 1st April 2003 by the Department for Work and Pensions, together with the Department of Health and assisted by the Health and Safety Executive, Scottish Executive and Welsh Assembly. The pilot aims to test the effectiveness of three different types of help for those who are off work because of sickness, injury or a disability to get back to, and remain in work.

The pilot is open to employed/self-employed volunteers who:

- Live and work in one of the pilot areas;
- Have been off work because of sickness, injury or disability, for between 6 and 26 weeks.
- Feel at risk of losing their job.

This pilot has already helped people to get back to and remain in work. For example:

A mechanic, suffering from a degenerative disc disease had been off work for over 3 months due to illness and was also becoming depressed about the prospect of incapacity. Following liaison between the pilot caseworker and the employer, the volunteer was offered relocation to a non-manual job within the company. The volunteer has also started an IT course and is being supported by a disability employment adviser.

A civil servant sustained a knee injury whilst playing football. The volunteer was concerned that this injury would keep him off work for so long that he would be at risk of losing his job. Through taking part in the pilot, he received an MRI scan within a week, therapy commenced and the volunteer has returned to work 2 months earlier than anticipated.

If volunteers are eligible and willing to participate, they will be randomly assigned to one of four groups. Three groups offer a person-centred management approach and a boosted range of treatments to those currently available in the local area. Those in the workplace group receive workplace-focussed care, those in the healthcare group receive boosted healthcare help and advice, and those in the third group receive a combination of the two.

The fourth group is the control group. This group is necessary so that the experiences of those who receive a boosted range of treatments can be compared with the experiences of those who receive only existing services. From this comparison we will be able to see which types of help are most effective at returning to work.

Participation in this pilot is free and does not affect any rights to any benefits or other forms of healthcare/assistance participants may be entitled to.

If you would like more information, or know someone who might benefit from this pilot, please call the appropriate helpline number:

HealthyReturn: Glasgow: 0800 052 1012 (healthyreturn.org)

WorkCare: Sheffield: 0800 052 6528 (workcare.org.uk)

WorkCare: Birmingham and West Kent: 0800 052 1659 (workcare.co.uk)

Routeback: Tyneside and Teesside: 0800 052 4038 (routeback.co.uk)

Appendix 5 - Survey of non-governmental organisations

Survey of non-governmental organisations (commissioned by the group)

INTRODUCTION

No. of organisations circulated	100
No. of organisations replying	30
No of organisations declined to fill in (some gave their information)	6
No. of organisations replying and filling in questionnaire:	24
Some gave their information:	
Concerned with sensory impairment	2
Concerned with ethnic minority view	1
Concerned with skins	2

Thus, replies are not representative and should not be seen as such. Furthermore, this appendix is a distillation of these responses, not a scientific study. We were grateful for the information given about work of the various organisations but it was probably significant that not one gave us any lead into research being undertaken nor quoted references to work done (we asked “can you point to any models of good practice. Please give details. We are very interested in research papers and information on costing/cost benefits.”)

SECTION A: About those trying to stay in work

Rationale

With a temporary or new disability it is important that a job is not lost unnecessarily. It is easier to reinstate a person in his/her job (with or without modification) or at least in their own workplace (where their value is known) than to present a person newly disabled to a new employer.

Factors in the Health Service which make it difficult for people to stay in work

(“list up to 5 factors related to Health Services and elsewhere”)

1. WAITS* for assessment, consultation, rehabilitation, treatment
2. Lack of understanding of impact of disease/disability on work
3. Lack of awareness of options to prevent work loss (aids, access to work, ergonomic and vocational input.

Other subjects listed by those replying (these were usually single responses whereas the factors listed above were given by several responders). WAITS* in various guises was a response given by many.

Poor physical access and transport; inflexibility of services; that there is no intermediate position between sickness and fitness on sickness certificates. Lack of effective interagency working, vocational assessment, rehabilitation, preventive fitness advice, national occupational health advisory service.

Factors external to the Health Service which make it difficult for people to remain in work:

1. Physical barriers, access and transport problems
2. Lack of flexibility on part of management or in working practice
3. Lack of information on disability, help required or equipment
4. Lack of knowledge of Disability Discrimination Act
5. Lack of understanding of disease/disability by employer, discrimination by them and workers

Other subjects mentioned by respondents

- Poor communication
- Low self-confidence of disabled employee
- Discrimination by employers and other workers
- Lack of stability in employment contracts

SECTION B: About those who have recently lost work (in last 6 months)**Factors making it difficult for people to return to work**

("list up to 5 factors related to the Health Service")

Factors related to the Health Service

1. WAITING times, delays, long gaps between appointments
2. Lack of vocational aspects to rehabilitation policy + inadequate provision of rehabilitation

Other subjects included

- Lack of case management, appropriate expertise and advice (including in primary care).
- Medical focus on impairment.
- Too slow in recognising deteriorating health, and slow in bringing disease under control.
- Ignorance, lack of flexibility in provision, negative attitudes, access.

Factors external to the Health Service

("list up to 5 factors related to factors external to the Health Service")

1. Low self-esteem and confidence of person who has lost work
2. Flexibility (and part-time/flexible return to work)
3. Employer needs support when employee has returned to work

Other subjects included

- Late access to work assessment; restricted access to 'Access to work' Scheme
- Attitudes
- Poor knowledge of disease/disability
- Lack of career posts for disabled people
- Difficulties with benefits/lack of knowledge
- Lack of initiatives to prevent adoption of sick role

SECTION C: Factors which would make it easier for people to remain in work**Suggestion for the NHS**

1. Shorter waits
2. Better rehabilitation (including counselling, guidance, access to employment advice and vocational assessment within the NHS)

Other responses:

In the main these mirror the problems. Interesting additions include financial support for vocational rehabilitation, “disability leave”, speed up referral to agencies outside the NHS and speed up legal process for personal injury cases.

Outwith the NHS

Flexibility is required of the employer in terms of adjusting work to the person, even temporarily, **of the benefits system and of the NHS** (delivering services in a timely manner to help retain work, near or at work and at sufficient speed and intensity)

Other responses:

In the main these mirror the problems. Other interesting suggestions include improvement of attitudes, workplace education on healthy lifestyle, on disease and disability, speed of response to difficulties, compliance with Disability Discrimination Act, access.

Factors which would make it easier for people to regain recently lost work

Suggestions for the NHS

1. Better cross agency working
2. Speedy, flexible HS responses
3. Better rehabilitation services (including vocational rehabilitation)

Other suggestions mirrored the problems viz flexibility, professionals better informed of the work of patients, and partnerships to support patients returning to work.

Suggestions related to factors external to the NHS

1. Flexible response
2. Early identification and resolution of work-related problems

Other suggestions mirrored the problem except for the following:

- Well publicised retention policies
- Improved attitudes and knowledge of managers, especially on the capabilities of persons returning to work
- Access to new technology
- Government commitment to any changes and new policy

In summary respondents required of the NHS that waits were reduced such that initial consultation, effective treatment, focussed, intense and vocationally orientated rehabilitation could be regularly delivered rapidly. This would underpin job retention and early job return. Vocational assessment and rehabilitation are needed to start concurrently with rehabilitation (not **after** NHS involvement) even though vocational rehabilitation may continue outside the NHS. Better interagency working needs to become part of the routine NHS practice. Staff need to be trained, not only to be ‘disability aware’ but also ‘job aware’. The NHS needs to be much more responsive to what is happening in the patient’s workplace.

Appendix 6 - Organisations Surveyed

Organisations Surveyed by the Working Group (* organisations which replied to the survey)

<p>(Adult) Dyslexia Organisation Access to Communication and Technology Action for Dysphasic Adults (ADA) * Arthritis Care Asian People with Disabilities Alliance * Association for Spina Bifida and Hydrocephalus Association of Disabled Professionals Association of Muslims with Disabilities Ataxia Backcare * Black Business Association Black Training and Enterprise Group British Council of Organisations of Disabled People British Diabetic Association * British Dyslexia Association British Epilepsy Association * British Heart Foundation * British Polio Fellowship (BPF) * British Psychological Society British Stammering Association * Careers Service National Association Cleft Lip and Palate Association (CLAPA) Cystic Fibrosis Trust Deafblind UK Depression Alliance Disabilities Coalition Disability Action (Northern Ireland) Disability Alliance * Disability Law Service Disability Scotland Disability Wales/Anabledd Gymru Disabled Employment Aid Foundation * Disablement Income Group (DIG) Dyslexia Institute Employment Committee Equal Opportunities - Institute of Personnel & Development Equal Opportunities Commission Foundation for Communication for the Disabled Haemophilia Society Head of Employment Advice and Equalities - Local Government Management Board Headway National Head Injuries Association Huntington's Disease Association Irwin Mitchell, Solicitors Leonard Cheshire Foundation * Limbless Association Living with Disability Action Group ME Association Meniere's Society * Migraine Trust Motor Neurone Disease Association * Multiple Sclerosis Society Muscular Dystrophy Group of Great Britain and Northern Ireland * NASE National Secretary National Advisory Council for Careers and Educational Guidance</p>	<p>National Association for Colitis and Crohn's Disease National Association for Mental Health (MIND) National Asthma Campaign National Autistic Society National Centre for Independent Living * National Eczema Society * National Federation of Black Women Business Owners National Kidney Federation National Organisation of Asian Business National Schizophrenia Fellowship * National Vocational Rehabilitation Association Neurofibromatosis Association * Neurological Alliance Opportunities for People with Disabilities Parkinson's Disease Society Psoriasis Association * Rehab UK REMAP GB * REMPLOY Ltd Restricted Growth Association * Royal College of Nursing, Work Injured Nurses - Group (WING) Royal College of Speech and Language Therapists Royal National Institute for the Blind (RNIB) * Royal Society for Mentally Handicapped Children and Adults (MENCAP) Royal Society of Health SCOPE Sense (The National Deafblind and Rubella Assoc.) Sickle Cell Society Skill Spinal Injuries Association * Stroke Association Swiss Re, Re-insurance company * Talent to Work Thalidomide Society * The Bar Council Disability Panel The Dystonia Society The Industrial Society * The Local Government Association Social Services The Papworth Trust * The Royal National Institute for Deaf People (RNID) The Training Standards Council TUDA (Trade Union Disability Alliance) UK Coalition of People Living with Aids & HIV Unum Ltd * Women Returners Network</p>
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Appendix 7 - Sickness certification

Sickness certification - a brief summary ⁶⁰

1. For the first seven days of incapacity individuals certify their own incapacity for work using form SC1 (if unemployed or self employed) or SC2 (if employed). After the seven-day period an official medical statement can be used by a registered medical practitioner to record the advice given to the patient in relation to their fitness for their regular occupation. Such statements are usually accepted as medical evidence by employers (who pay Statutory Sick Pay or the employer's equivalent) and by the Department for Work and Pensions (DWP) who administer state incapacity benefits.
2. Medical statements are official documents and it is very important that they are completed in accordance with official guidance issued to all doctors by the DWP. Under the current legislation [Social Security (Medical Evidence) Regulations 1976, as amended] only registered medical practitioners can issue the official statements. NHS general practitioners are required to issue (or refuse to issue) statements to patients as an integral part of their clinical management of working age patients. NHS GPs are also required to provide factual information on a patient who subsequently claims a state incapacity benefit to a DWP medical officer.
3. Form Med 3 is a statement of incapacity for work based on a medical examination of the patient on the day, or the day before, the certificate is issued. Within the first six months of incapacity the certificate can only be given for a period of up to six months or less. Certificates issued after the first six months can be issued for longer periods. Provision is made on the Med 3 to specify a date for return to work provided it does not exceed 14 days from the day after the certificate is issued.
4. On occasions a doctor may wish to provide a statement of incapacity for work based on an examination he performed prior to the time requirements specified for issuing a Med 3 or based on a report from another doctor. In these circumstances, and providing certain detailed requirements are met, it might be appropriate to issue a Form Med 5.
5. Where the patient is claiming a state incapacity benefit the certifying doctor may be required to provide the patient with Form Med 4 on the first occasion that the Personal Capability Assessment is applied. The information provided by the doctor on this form supplements that provided by the patient about how their health condition or disability impacts on their everyday life.
6. The DWP Chief Medical Adviser issues guidance to all doctors which makes clear that they should always consider carefully whether advising a patient to refrain from work is the most appropriate clinical management. Doctors may often best help a patient of working age by taking action which will encourage and support work retention and rehabilitation. When advising a patient about fitness for work the DWP guidance to doctors advises them to consider the following factors:
 - nature of the patient's medical condition and how long it is expected to last
 - functional limitations which result from the patient's condition, particularly in relation to the type of tasks they perform at work
 - any reasonable adjustments which might enable the patient to continue working. Noting that under the Disability Discrimination Act 1995 an employer may be required to make reasonable adjustments to the workplace for an employee with a long-term disability
 - any appropriate clinical guidelines, for example the Royal College of General Practitioners has produced clinical guidelines on the management of acute low back pain which emphasises the importance of remaining active
 - clinical management of the condition which is in the patient's best interest regarding work fitness, including managing the patient's expectations in relation to their ability to continue working.

7. Form Med 3 may also be used to record advice that a patient need not refrain from work. A doctor may use the 'Doctor's remarks' section to record, for example, that certain workplace adjustments may be appropriate or desirable in the light of the patient's medical condition or disability.

8. Full details on the medical evidence for Statutory Sick Pay, Statutory Maternity Pay and Social Security Incapacity Benefit, can be found in 'A Guide For Registered Medical Practitioners - revised with effect from 3 April 2000'⁶⁰ available at http://www.dwp.gov.uk/medical/guides_detailed.asp#IB204. The DWP medical website also contains updates, guidance and desk aids related to fitness for work certification.

Appendix 8 - Audit considerations

There are two broad ways of approaching possible audit criteria

Patient/employee centred outcomes:

- functional ability/residual functional capacity
- independence /stamina to hold on to job
- return to work rate
- participation in workplace/ degree of adaptation required
- income
- other quality of life measures
- retirement rates on health grounds

Process audit allows service development to be audited in terms of:

- manpower
- facilities
- component of service
- access/waiting times
- use of protocols/algorhythms

Service orientated outcomes:

- employment uptake in target population/decrease in benefit spend
- health costs/resource utilisation
- service occupancy
- subsequent service use

Business outcomes

All businesses above a certain size should have a vocational rehabilitation policy.

The Working Party has no wish to be prescriptive, but possible actions that could be taken within a year of publication of this report include:

- Establishment of a partnership between appropriate government and non-government bodies (charities, business/insurance sectors) to:
 - define appropriate rehabilitation policies, embracing both health and employment, locally, regionally and nationally
 - develop funding partnerships as appropriate (capital development and research agendas)
- Publication of minimal staffing to be dedicated to vocational rehabilitation locally, regionally and nationally
- Publication of a research agenda, particularly into the cost-effectiveness of rehabilitation both within industry and the state sectors