**Royal College of Occupational Therapists**

**Health is Everyone’s Business –Proposals to reduce ill health related job loss**

**HM Government consultation closed 7th October 2019**

Q1 – strongly agree

Q2 – There are not currently enough incentives for employers to do this. They will need stronger incentives to demonstrate they have intervened early, used good principles for return to work and placed greater emphasis on prevention of ill health in the work place. If they are provided with timely, accurate advice from independent professionals, such as occupational therapists, this would improve the situation. Supporting people to remain in, return to, or obtain work is a key function of occupational therapy. All occupational therapists at the point of qualification are expected to be able to ask the work question. Specifically (RCOT 2016: *Entry Level occupational therapy core knowledge and practice skills,* p8) says that the profession are trained in the following vocational rehabilitation skills:

* Knowledge: of biopsychosocial sciences, current key policies and legislation influencing the work and employability environment and the implications of a range of conditions and impairments that impact on an individual’s occupational performance and ability to remain in, or return to work.
* Skills: in analysing activities and the use of graded occupations in return-to-work settings

Q3 – Yes

Q4 – Any employee who is able to demonstrate a need for workplace modifications on health grounds.

Other……In addition to the right to request workplace modifications our occupational therapy members have the following ideas to reduce ill health related job loss:

* Extension of workplace modifications to those who want to retire and return with shorter hours and amended duties to support the ageing workforce
* Increased use of employment passports that contain detailed workplace adjustments that individuals require which would support employees and employers.
* The ability for employees to buy extra annual leave to support work life balance and different needs during the life course.
* Health time schemes as part of workplace adjustments to allow employees to promote and maintain their health and wellbeing by having a relatively short amount of time over and above their annual leave entitlement, to do health and wellness activities
* Increasing the use of the ability to work from home to support those who would otherwise need to take sickness absence due to fluctuating symptoms, to attend occupational therapy or other appointments or manage ongoing symptoms such as fatigue.

Q5 – 0-4 weeks

Q6 - Yes, Yes -Providing this in writing will make all parties take the request and reasons for declining more seriously. In our occupational therapy members experience, sometimes requests are denied when there has not been thorough and accurate exploration of the possible workplace modifications. Occupational therapists regularly help people back to work because they focus on solutions. In fact, they will often find a solution where one has not been considered previously and can often “think outside the box” when faced with complex and challenging circumstances. They often have contact with the workplace and will often visit the workplace to find solutions in situ. Occupational therapists focus on functional and practical abilities (rather than difficulties/inabilities) and use a biopsychosocial approach rather than a medical model which is beneficial for generating practical solutions. Occupational therapists have the expertise to enable people to work through:

1. Giving a detailed assessment of individual capacity and workplace requirements

2. Teaching the person to manage the ongoing condition and related symptoms such as pain and fatigue;

3. Delivering rehabilitation through agreed goals with the employee and employer.

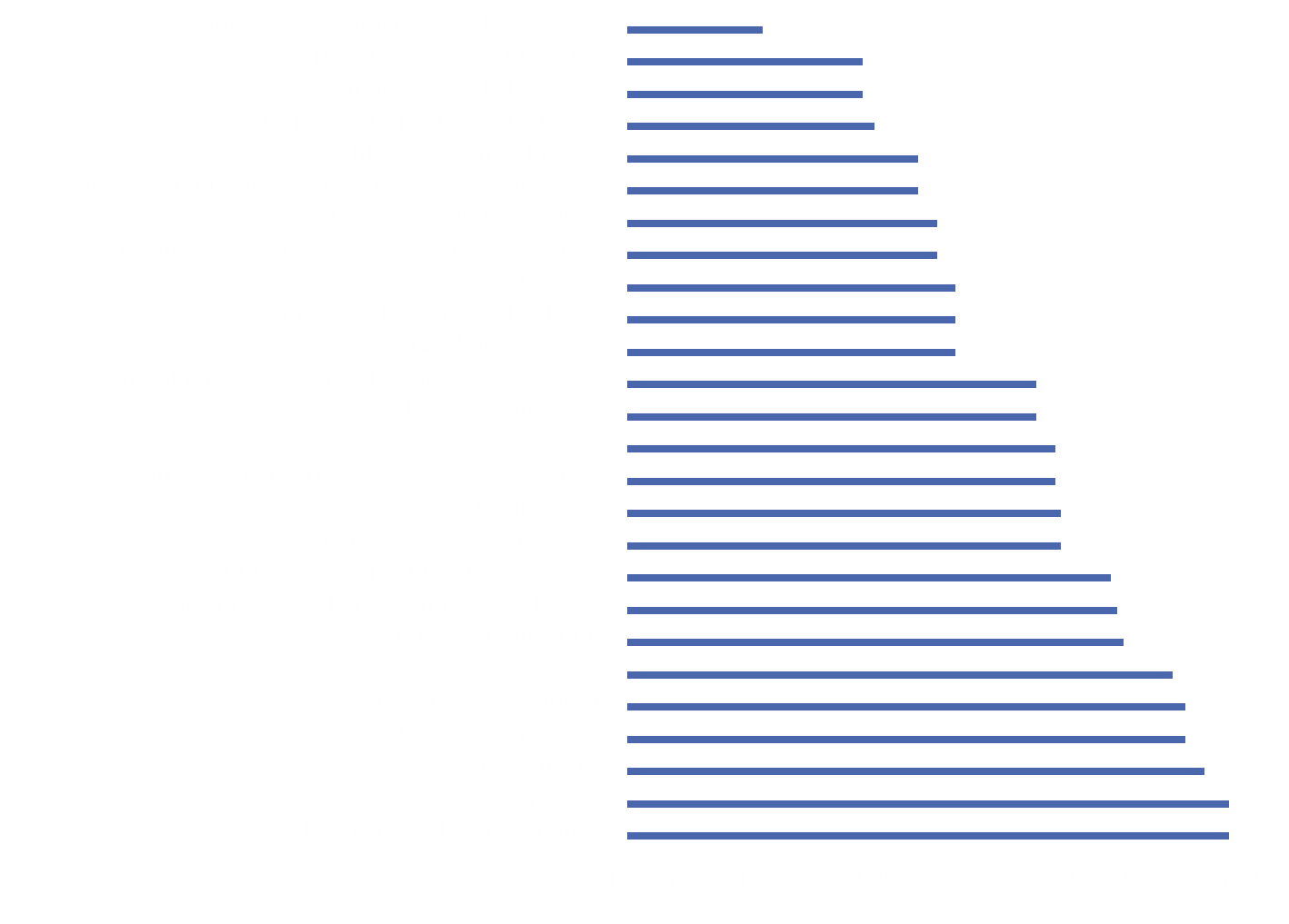
4. Advising on reasonable adjustments to the work place.

Q7 – no answer

Q8 - Yes

Q10 – Guidance should set out more specific actions for employers to take.

Other – Our members believe that both principles-based guidance and more specific actions could be used together. This is because there are a wide range of early, sustained and proportionate actions that could support return to work. For example, when occupational therapists were asked what actions are needed across all types of injury, illness or disability (we are dual trained in both physical and mental health), they listed 26 different categories ranging from cognitive behavioural approaches and pain management advice to seating assessments and workstation modifications.



Q11 - A formal write up using a tool that lists the presenting problems and workplace modifications -very much like the AHP Health and Work Report. The key part of this is an analysis of the presenting problem and a corresponding workplace solution which is the table in the middle of the form. Please contact [Genevieve.smyth@rcot.co.uk](mailto:Genevieve.smyth@rcot.co.uk) if you would like more information about this form.

<https://www.rcot.co.uk/practice-resources/standards-and-ethics/ahp-health-and-work-report>

Q12 – Other - Faster access to independent experts such as occupational therapists who can provide practical advice and problem solve for return to work and if necessary, a work place visit. Occupational therapists work in vocational rehabilitation, occupational health . This means that occupational therapists can work in NHS settings, independent, private and commercial sectors. Interventions can range from those needing minimal interventions to those needing more intensive and joined up support, specialist services, supported employment or vocational rehabilitation.

By using standardised work assessments occupational therapists adhere to recognised and agreed quality assurance in work assessment or reporting. Occupational therapists can make recommendations regarding work ability, in highly specific terms and which always relates to the competitive employment scenarios.

Occupational therapists also work as case managers to co-ordinate input, build rapport and advocate for the individual to ensure they access the required services is also beneficial. There are many successful examples of this often funded by insurance services, where more time and specialist health care delivery is required for complex situations.

Q13 – In our occupational therapy members experience, there is evidence that improved, faster access to expert help in primary care has sped return to work. About 50% of employees and people who are self employed do not have access to any occupational health, so for many people, the first place to go for help is the GP surgery. By placing occupational therapy led vocational clinics in GP surgeries, most patients seen have been able to return to work faster than the medical estimate given on the GP Fit Note. Having employers accept the recommendations and advice from occupational therapists rather than GPs has been crucial to this success. Most employers get very little information on the GP Fit Note and can take better action if they are provided with tailored, specific advice early on.

Q14 - In our occupational therapy members experience, the following support and actions, facilitated by employers can be crucial:

* Providing a breakdown of job task demands, worker role analysis including the physical and psychological demands of work duties
* A description of the work environment conditions and work place limits / strengths including key relationships
* Both of the above allow all parties to look at what parts of the job are currently possible, what parts may need some modification and what are currently not possible.
* Clear and specific written, agreed actions to help all parties and stakeholders in the work place
* Clear and specific return to work plans – immediate / medium term /long term goals
* Clear, specific and costed reasonable adjustment plans and alternatives that are appropriate and proportionate
* Workplace implementation services for employers

Q15 – - In our occupational therapy members experience, the following actions by employees can be crucial: Being able to reflect on and acknowledge their own work ethic / motivation; Engaging in baseline measurement of educational and technical attainment including the person’s skills, stamina and abilities; Being willing to consider their own temperaments and readiness for work – confidence ratings and problem-solving abilities; Being willing to engage in consideration of their personal causation, values, interests, roles, habits of the worker and how they may help or hinder return to work.

Finally, employees need to give consent for health professionals to get in contact with employers to facilitate return to work. Occupational therapists frequently see people at point of injury or soon after so we can give early interventions before HR and medical OH are involved as long as consent is given. Employees often need access to OH in the very early stages of illness/injury and this does not always happen. In complex situations there is often a need to have a workplace visit to meet with the line manager which can only happen of the employee gives consent for this to happen. Phone or clinic-based assessments do not resolve the situation. Our members report that they go into the workplace with the patient and see the manager and together work out an action plan. Managers and HR often comment they do not need to involve OH as the occupational therapy intervention has been more helpful. Traditional medical OH services tend to be unable to provide rehabilitation. Early communication between employee and employer is vital but both parties can find this difficult. Bringing in a third party such as an occupational therapist, to provide practical information to enable agreement about the way forward, can resolve this.

Q16 – No -it is too binary a system at the minute (either off sick or at work) and does not offer any actual prompts about return to work.

Q17 – Other suggestions - All of the above

There is also a need to ensure that all parts of the health and social care systems work in unison to reinforce the message that good work is good for health and are able to have conversations that support people’s work aspirations and return to work. For example, in a joint project with Public Health England, over 95 occupational therapists have become Health and Work Champions. They provide training to colleagues in health and social care to make it routine practice for clinicians to talk to people about their work aspirations. Making these types of conversations more part of everyday practice and being able to provide basic information about whether a return to work would be appropriate would support the government’s aim. The training that Health and Work Champions provide has been shown to improve clinician’s knowledge and confidence to talk about work. In 17 months, they have trained over 1500 health and care professionals. For more information:

https://www.rcot.co.uk/promoting-occupational-therapy/health-and-work-champions-promoting-health

Q18 – Yes

Q19 – Yes

Q20 – Yes

Q21 – No

Q22 – Yes

Q23 - Yes

Q24 – Yes

Q25 – The system should be as simple and quick as possible otherwise it will discourage employers to claim their rebate of SSP.

Q26 – Extension of the 28-week period of SSP would allow those with more serious illness or disability more time to make enough of a recovery to return to work. Currently these people face undue stress and worry because of the 28-week period rule.

Q27 – Yes

Q28 – We believe targeted subsidies or vouchers could be effective particularly for smaller employers who have employees with a complex health problem or disability. Typically, these organisations approach us as they wish to purchase a small amount of private occupational therapy assessment and intervention to get the person back to work. Having access to subsidies or vouchers that were flexible enough to be able to purchase occupational therapy time would promote this.

Q29 – Yes

Q30 – all these could be included

Q31 – We believe occupational therapy should also be included as a category of support. Occupational therapists are trained to degree level and once qualified and registered with the Health and Care Professionals Council are able to support people’s work aspirations including carrying out an independent assessment of the persons needs and abilities, co-producing a return to work plan and offering rehabilitation to improve work skills and make environmental adaptations. Occupational therapists can design and deliver bespoke graded work plans, work modifications and adjustments, and support the patient and employer to deliver this. Occupational therapists are currently employed in the NHS, local authorities and private companies. We would like to see an increase in the numbers of occupational therapists offering return to work advice and believe every OH team should employ an occupational therapist. In countries such as Australia where employers have increased involvement in supporting those with health conditions in the workplace due their insurance system, there are many more occupational therapists providing work advice than in the UK. Occupational therapists can complement OH and should be present in all hospital OH departments.

Q32 – We believe a new accreditation system is needed that is not so medically driven and expensive as the cost of the SEQOHS accreditation is prohibitive for many of our occupational therapy members. SEQOHS which is run by the Royal College of Physicians on behalf of FOM, indicate that average fees over a five-year period are £8000 with annual fees ranging from £2400 - £3300. This will be well beyond the reach of many private occupational therapy providers who are therefore being squeezed out of the market place. An additional problem is that only SEQOHS accredited services can then be part of the NHS Health at Work Network, which then has annual fees of £850. Again, the cost of this means our occupational therapy members are effectively excluded from this system.

Q33 - Yes

Q35 –

Q36 – We believe that your question relates to the fact that for OH physicians, the number of clinical placements in private OH providers has declined rapidly while funding for OH physician training remains paid for by the state. However, to clarify, allied health professionals and nurses do not have funded bursaries in England. Occupational therapists also undergo clinical placements as part of their training and would welcome an expansion of this being offered by any OH provider, private or otherwise.

Q37 – To change the training and development of the OH workforce, a broader participation needs to be consideration using the pyramid workforce model including universal, targeted and specialist parts of the workforce, not just the specialists at the top. More consideration is needed about expanding the middle and lower tier. For example, the Health and Work Champions program is upskilling the current universal part of the workforce to talk more about work in their everyday consultations. See our workforce triangle below which works equally well across the whole health and social care workforce.

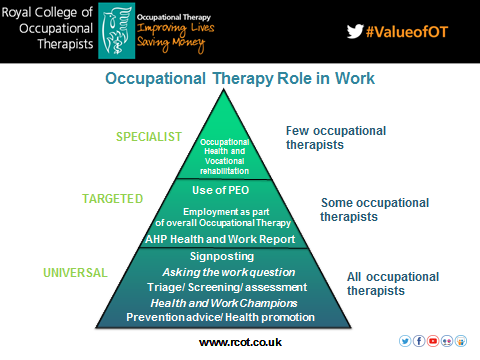
There needs to be inclusion of the contribution NHS services make in this area. Allowing NHS and social services occupational therapists to deliver work-based interventions would be a cost-effective option. Occupational therapists look at three main areas of focus; the person, the environment and their occupations. Occupational therapists consider the relationship between what a person does every day (occupations), how illness or disability impacts upon the person and how a person’s environment supports or hinders their activity (the PEO Model -see below).

In addition, OH is more than doctors and nurses -it must include occupational therapists. Taking immediate action to increase the flow of the workforce must include our workforce and not focus solely on medical colleagues. Many presenting health problems, particularly long-term conditions, cannot be managed only by medical input.

There are currently 39,436 occupational therapists registered with the Health and Care Professions Council. In 2000, there were 21,006 registered occupational therapists so each year has seen a growth in numbers. There is a total of 5734 occupational therapy students in training at presently approximately one third of which qualify each year from across 32 providers in the UK.

Since the termination of HEE commissioning and the removal of student numbers caps, RCOT has seen a significant rise in work in this area. Between 2015/16 and 2019/20:

1. We have seen a 26% increase in the number education providers now offer pre-registration entry routes:
   1. Seven new providers have already been accredited by RCOT.
   2. Another new provider has an accreditation event scheduled in February 2020.
2. We have seen a 26% increase in the number of entry level programmes accredited by RCOT, comprising not only of those programmes offered by new providers, but also new programmes offered by established providers.



Q38 – There should be a single body to coordinate the development of the OH workforce generally across both statutory services and the commercial sector.

Q39 - We are in agreement that clearer leadership is required to steer the workforce to deliver a future model, for better coordination of OH for research and for central information hubs. We do not believe that this rests with the National School of Occupational Health as this has a predominantly medical focus and is tied too closely to the RCP, FOM and SEQOHS which are all medically driven. The pressing need to enable people to remain in or return to employment will not be solved by replicating a purely medical approach. RCOT is a member of the Council for Work and Health and we believe the Council could play more of a coordination role in the future, it could be a broker between government and the wider group and could take on this leadership function although possibly as a sub group of the main which focuses solely on the workforce.

Q40 – Central research networks where smaller organisations could take part in larger scale studies, multi-professional studies.

Q41 – All of these

Q42 – We believe there is more scope to make better use of expert professionals from abroad to increase access to specific, tailored return to work advice for employers. For example, currently occupational therapists are not on the Immigration Priority Occupation Shortage List. The Migration Advisory Committee advised earlier this year that we should be added to help meet pressing workforce demands, particularly in London but we have yet to hear if the current government will accept those recommendations.

Q43 – all of the above plus …The issues of increasing pace of innovation is not unique to OH. There is much to be learnt from other sectors and more cross fertilisation of ideas and approaches is required. The book Range by David Epstein has some excellent ideas about how to improve performance by opening up problem solving to wider groups of stakeholders (see below Q44).

Q44 – We believe an expansion of the traditional networks in this area that have dominated for too long is required in order to embrace wider ideas about what OH is, who and how this can be provided.

Q45 – Other -we are sometimes contacted by employers who have received an OH report and want to understand the professional background, qualification and regulatory body of the individual. For example, it is sometimes unclear if the person who has completed the report is a nurse, doctor or another professional. We believe making this clearer would help employers choose OH providers.

Q46 – We believe having access to occupational therapists should be included as quality indicator.

Q47 –We believe that return to work and remaining in work over a period of time such as one year is a useful metric. For example, findings from the University of Nottingham show that if patients with Traumatic Brain Injury receive vocational rehabilitation from an occupational therapist, that compared with treatment as normal, this group had almost 30% more employment rates one-year post injury and that more carers also returned to work earlier.

Q48 - We support the idea of using more competency-based approaches as it allows better consideration of the whole workforce. There could be greater focus on the use of on-line modules for OH workforce development.

Q49 – Yes

Q50 – All of the above , also self-management advice and more detailed advice about workplace modifications

Q51 – all of the above

Q52 –

Q53 – All of the above

Q54 – Yes

Q55 – Yes

Q56 – As an overall package of measures, there are some excellent ideas that will provide a better balance between supporting employees and supporting employers. In particularly our members have highlighted the introduction of the right to request workplace modifications and graded return to work while on sick pay as ideal as in combination it would allow people to build their skills and confidence while in the workplace.

However, we feel that to implement these excellent changes, employers will need more detailed, specific advice for example, about what workplace modifications may be useful or how to gradually introduce someone back to work while still on sick pay. Some of that advice could come from occupational therapists, yet the mechanics of how to match your intentions with our workforce are not clear and will need further exploration. For example, two thirds of our workforce are in statutory services while this consultation focuses purely on the private OH market.

Genevieve Smyth, Professional Adviser, RCOT.