**Improving Lives, the Work, Health and Disability Green paper**

***Response from the College of Occupational Therapists***

**APPENDIX 1: THE ROLE OF OCCUPATIONAL THERAPY AND EMPLOYMENT**

Supporting people to remain in, return to, or obtain work is a key function of occupational therapy. Occupational therapists are one of the key allied health professions involved in this work agenda. Occupational therapists focus on an individual’s functional abilities and the work task requirements to achieve a match between the two areas. They also address the constraints or opportunities afforded by the environment. Occupational therapists work in both vocational rehabilitation and occupational health services. This means that occupational therapists can work in NHS settings, independent, private and commercial sectors.

Occupational therapists can support people into occupation across a spectrum of physical and mental health related conditions and disabilities. Occupational therapists have unparalleled experience and expertise to work with individuals and the environments they work within, supporting them into employment. Occupational therapists are dual trained across both physical and mental health and so can consider the totality of an individual’s needs. They are also skilled in prevention of ill health, the assessment of an individual abilities and work tasks in relation to specific job and skill requirements. Because of their dual training they are able to consider physical, cognitive, mental health and social needs in the workplace whether for a new job or returning to an existing job. Occupational therapists are solution focused believing that good work is good for you, so work with both the employee and employer to reach the desired outcome of employment.

Interventions can range from those needing minimal interventions to those needing more intensive and joined up support, specialist services, supported employment or vocational rehabilitation. All occupational therapists offering interventions to working age adults ask the “work” question. Other occupational therapists specialize in vocational rehabilitation or occupational health services. They are trained to assess individuals’ abilities and job tasks and then to make adjustments to existing equipment and environmental circumstances, recommending specialist equipment based on individual needs where needed. Occupational therapists 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. This may take the form of liaising with organisations and employers to mediate, advocate and discuss the implementation of recommendations.

Work is an essential occupation to ensure good health and wellbeing. 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.

Occupational therapists working in this area have the necessary skills, competence and expertise to:

1. Complete the Allied Health Professional Advisory Fitness for Work Report
2. Carry out a range of vocational, cognitive and occupation based assessments
3. Offer specific interventions in vocational rehabilitation including providing education and advice to the employee and employer about managing the employee’s health and wellbeing in relation to their job and adapting the environment to support performance.

Occupational therapists can work at an early intervention and preventative level in primary care and occupational health services to help people stay in or return to work. Occupational therapists also work in public health and train other staff about the benefits of work to health. Recent projects show that at a population level occupational therapists can optimise health and address health inequalities by equipping health staff with basic knowledge about employability or vocational rehabilitation. This not only helps health and wellbeing but also helps the economy moving people from benefits to employment.

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. The involvement of occupational therapists allows standardized in depth functional capacity assessments or ergonomic assessments which may be required for some health conditions. This helps establish what physical and psychological demands are appropriate in a particular work role and to establish current functional level. The detailed information collected includes analysis of the organizational response to health needs and the human resources available to potentially support the person with ill health.

The involvement of occupational therapist 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.

**APPENDIX 2: EXAMPLES OF SMALL SCALE PROJECTS THAT COULD BE SCALED UP**

**Example: Solent Neurological Rehabilitation Service, Solent NHS Trust**

This small NHS vocational rehabilitation service is led by one specialist occupational therapist and two support staff in Southampton. The Vocational Rehabilitation Service (VRS) is based on a non-NHS site, where the facilities include a workshop, computer suite and office space, in order to replicate various work-based environments and skills. This site provides a unique and valuable resource, allowing people to attend a setting outside of a medical context, practicing the vocational skills of arriving on time and focusing on specific tasks for a designated length of time. Assessment and treatment can also take place in a person’s home or workplace, as appropriate.

The Vocational Rehabilitation Service sees approximately 80 clients per year. The people seen within the service are predominantly living in their own homes and are seen either in the workshop setting (as outpatients) or within their home or work environment. Some of the clients seen by the service will have on-going care needs. For some, these needs will be met by a formal package of care, for others their needs may be met by a family member or informal carer.

Overall, 52% of people who use the service have a positive vocational outcome and a further 10% are equipped with the potential to return to work. The total cost of the service is £179,815 while the cost of 42 people claiming benefits for one year would be £395,304. Therefore there is a potential net saving of £215,489 per year. Positive comments are regularly received from people such as:

*"I truly believe without the help and support, not only from the staff but other people with similar problems, I would not be heading back to work so soon, if ever"*

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**Example: NHS Lothian Work Support Services**

NHS Lothian’s Work Support Services provides a five day service, fifty-two weeks a year with an established team of 4 occupational therapists and one physiotherapist (and other staff) that delivers on work outcomes**,** providing quick self-referral / GP access to patients with any health condition - mild to severe. The objective of the service is about shifting from a single model of work support to one that is tailored to individual need and uses valid and reliable measures of work fitness.

**Benefits**

* The service has proven clinical benefits to NHS Lothian patients and in addition is highly regarded by General Practitioners and business enterprises in Lothian. Circa 5000 patients passed through service to date.
* It is a 360 degree service in the sense it is less about the diagnosis and what the patient/employee cannot do and more than what they can do. It deals with physical and mental health conditions (and the functional overlay) equally well.
* It offers a service to both simple and complex cases and takes an occupational therapy case management approach. It significantly assists NHS Lothian in meeting health inequality targets and is cost effective: = Cost per case <£365 (i.e. less than four weeks Statutory Sick Pay). Many cases are cheaper.

**The drivers for the service are:**

* Helping patients who are off sick or struggling at work to keep their job. Co-production approach
* Very strong links to General Practitioners and Fit Note
* Very strong employer links – daily contact with HR and OH etc.
* Asset based approach from first contact with patient – ‘listen to the patient (employee story’)

**The impact of service development:**

* High patient satisfaction rates and success with mild–moderate cases and chronic health cases.
* High return to work rates and maintenance at work rates
* Prompt prioritisation and assessment (Key Performance Indicators :all patients assessed within two to four days)
* Early signposting and collaboration with General Practitioners, NHS colleagues and third sector and health charities. Employer liaison with consent.

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**Example: Healthy Works**

This is a small private, occupational therapy led company that offers support services around employment to NHS and private companies, particularly early intervention for those with musculoskeletal problems. It is delivered by occupational therapists and includes an Ergonomic Assessment Service and ongoing Display Screen Equipment (DSE) prevention each year, to update and re-educate on posture and office ergonomics. The Ergonomic assessment would include:

* Detailed discussion with the individual regarding treatment/medical input, symptoms including pain levels and difficulties as a result of the condition/treatment. Any other ongoing medical issues.
* Detailed discussion with the individual regarding the work tasks, particularly any medical advice given regarding the performance of tasks in the future, to review this in the light of the tasks needing to be performed.
* Assessment of the tasks that may contribute to/ affect symptoms

Average saving over 1 year

Average cost per client - £ 935.00 versus cost of ill health per year £3800.00

Cost benefit per person over 1 year of: £2865.00

Average saving over 10 years

£252,540.00

*“When standard instructions on workstation ergonomics didn't result in any improvement in back pain, Healthy Works provided expert professional guidance. This was constructive, practical and demonstrated the value of experience in this area” (Antony, 45 years).*

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**Example: Andy the software engineer**

Andy, a 30 year old male working in an office as a Software Engineer for an SME returned to work following a two month absence due to mechanical back pain. His symptoms had not changed, but he was determined to go back to work. He returned on reduced hours, fewer duties and working from home some of the time. He continued to have limited tolerance for sitting. He described how back pain was aggravated by his work duties and was affecting his participation in activities outside of work.

The occupational therapist visited Andy in his workplace. He was interviewed to determine his current independence in his activities of daily living. He then described his typical work duties to identify the equipment used, the postures adopted and the frequency and the duration of the work activities performed. The objective was to identify those factors that risk aggravating his existing pain.

His desk and chair were too low for his needs. His knees rested at a higher level than his hips and he sat at his chair for long periods. This would encourage posterior pelvic tilt and his low back to slump into a rounded posture. Following the evaluation, a report was produced for Andy and his employer. This contained advice to Andy on the work habits he should practise to promote a good posture at work and to minimise fatigue and strain to the affected soft tissues, i.e. taking microbreaks, standing during meetings, organising his work duties to vary his posture, ensuring good midline sitting to avoid maintaining mildly rotated sitting postures. The report also gave advice to his employer on workstation modifications that would encourage good working postures, i.e. a better specification chair, monitor riser, table rising blocks.

Andy was provided with the recommended modifications and reported that he was attentive to using good working habits. He reported that two months after his workplace visit, he no longer suffered back pain and was performing his full duties at work.

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**APPENDIX 3: EXAMPLES OF SUPPORTING PEOPLE ALREADY IN EMPLOYMENT TO PROGRESS**

**Example: Dumfries and Galloway example from Fit for Work Scotland – delivered Scotland wide.**

The service provides advice and assessment services for people who are in work. Employees are eligible for assessment if they have been off work for four weeks, or will be off work for four weeks, and have a reasonable prospect of returning to work.

Once referred, an employee will receive a telephone assessment with a qualified health professional who will identify all the obstacles preventing their return to work. A Return to Work Plan will be produced with recommendations to facilitate a safe and sustained return to work.

Case example: A GP referral was received for an employee who had been off work for over five weeks with a grief reaction relating to the death of a close family member, along with additional stressors relating to home life. Following assessment, the occupational therapist recommended adjustments to her work role including a phased return and a graded return to work tasks. She was signposted to her organisations occupational health service, and her employer was advised to update a previously completed stress risk assessment. The employee was also provided with self-management information relating to her health, and was advised to liaise with her GP regarding a review of her physical health.

Following this a Fit for Work review appointment was offered, and the employee went on to return to her work four weeks from her first contact with the service. During her discharge call from the Fit for Work service she stated that all recommendations within the return to work plan were acted upon, and that advice provided through the service enabled her to return to work quicker than she would have done otherwise. She also reported an improvement in her levels of anxiety and depression.

Case example: A GP referral was received for an employee who had been off work for five months following a diagnosis of heart failure/cardiomyopathy. At assessment she identified she was keen to return to work as soon as possible. Recommendations to facilitate this return to work included a phased return utilising annual leave hours, and consideration of an alternative role during the first four weeks back at work. The employees’ main concern was the stressful calls she had to deal with in a call centre, and so it was recommended that her employer discussed options for allowing a transfer of these calls to another person. It was also recommended to review performance management targets to ensure they were not causing undue stress. Her employer was advised to be flexible to allow attendance at any medical appointments, and the employee was provided with self-help information relating to managing stress and coping with work tasks.

The employee successfully returned to work the following week and on discharge from the Fit for Work service stated all recommendations had been acted on. During closing contact with the case manager, the employee stated ‘thanks for all your time, that’s been absolutely fantastic’.

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**Example: Royal Marsden Hospital, London**

The occupational therapists are cancer specialists who offer vocational support as part of the overall occupational therapy service. A 32-year old woman with newly diagnosed breast cancer referred herself as an outpatient to occupational therapy for the relaxation and fatigue management treatment programme. She felt unable to cope with the sequelae of the diagnosis and treatment and was having difficulties returning to work due to fatigue and anxiety. She received individual sessions in the occupational therapy department to discuss her needs and establish a treatment plan.

Breathing and relaxation techniques were taught, a CD of techniques provided so that patient could continue to practice these at home. Fatigue management principles were discussed, specifically pacing, prioritising, planning, posture and permission. The strategies were devised to suit her individual needs.

The occupational therapy treatment enabled the woman to learn coping strategies so that she could incorporate these into her daily life and return to independence. She was then able to cope with a staged return to work, together with a contract she was able to negotiate with her employer. This was mutually beneficial and successful to both parties. This avoided her needing to be on longer term sick leave and gave her the confidence to live with the diagnosis and treatment, rather than her having the perception that it was dominating her life.

Feedback from the client: “*These occupational therapy techniques gave me the ability and confidence to get back on with life. I am living with cancer rather than dying from it.”*

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**Example: Condition Management Programme (Northern Ireland)**

This innovative service has been delivered across Northern Ireland by occupational therapists for people on sickness related benefits for return to work.

Mr Smith is a 29 year old man who was referred to the Condition Management Programme (CMP) with back pain and depression, by his employment advisor in his local Jobs & Benefit office. Mr Smith worked as a mechanic in a garage but had been struggling to cope with his health condition at work. Mr Smith reported pain and fatigue, with associated low mood and poor confidence as a result.

The occupational therapist provided advice on grading and pacing of daily living activities and pain management techniques. The occupational therapist also provided vocational advice in preparation for return to work by looking at the nature of his duties, tasks, environmental considerations and exploring the adjustments required. Information was given to the employer and co-workers on Mr Smith’s health condition to increase understanding and improve his chances of sustaining work.

Finally Mr Smith attended a seven week group run by the occupational therapist which provided education on various aspects of health and well-being. He commenced phased return to work using the ‘permitted work’ scheme. Within six weeks Mr Smith had gradually increased his hours and resumed full-time employment. Mr Smith reported increased satisfaction with his ability to manage his health condition, and was able to come off benefits and return to work.

*“I feel much better both physically and emotionally. I now understand my health condition, which means I can control it, and not let it hold me back from doing what I enjoy”.*

On a six month follow-up Mr Smith had maintained his healthy lifestyle changes, reduced his pain relief and anti-depressant medication and had sustained in his full time employment. The outcome of attendance at CMP not only demonstrates personal gain for the client but also shows significant financial benefit for wider society.

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**Example: Wellbeing through Work, ABMU Health Board, Wales**

The Wellbeing through Work service is an innovative programme providing short term, early intervention support to help individuals with a risk of developing work limiting health conditions, to remain in employment. A bio-psycho-social self-management approach, underpinned by principles from cognitive behavioural therapy is adopted by the team. It was recognised that the skill mix of the multi-disciplinary team (physiotherapists and occupational therapists) enabled a wide spectrum of interventions to be delivered to support the work based health of the target population.

Referral criteria include being in part time of full time employment and living and/or working within the ABMU Health Board catchment area. One of the design features of the service was to ensure ease of access and people can self-refer on a free-phone number therefore not having to depend on a health professional referral, reducing the burden on primary and secondary care services. The service uses telephone delivery and everybody receives a phone assessment within two days of referral.

The occupational therapy assessment includes gaining information to understand a person’s difficulties in undertaking their work role due to health and social issues and also seeks to understand any cognitive influences upon this, particularly, the development of extreme unhelpful thinking contributing to anxiety and depression. The assessment also includes understanding the strengths of each participant and their support network. Questions around health behaviours elicit information relating to smoking, alcohol intake, and changes in diet, sleep and exercise. After assessment, an occupational therapy action plan is devised in collaboration with the participant which describes the planned interventions. This is designed around the specific needs of the person identified at assessment and may include continued telephone support, face to face sessions or attending the 5 week ‘Managing your Wellbeing Course’ which is an occupational therapy/Cognitive Behavioural therapy based course, promoting self-management of health.

The occupational therapists have all undertaken additional suicide prevention training and have developed the skills to assess suicide intent over the phone. Most of the people for whom information is available were still in work six months after engaging with the service. Here is one of their stories:

*“I first made contact with Wellbeing through Work as I had been struggling with social anxiety for a number of years (I believe, due to a stressful period at work), and it was getting progressively worse. I sent an initial enquiry and I was so relieved to hear that the scheme was aimed at people like me who were working and needed help that wasn’t necessarily available on the NHS. After the telephone assessment I was then given three appointments. During one of these sessions I was asked what situations scared me the most and without hesitation my answer was speaking in front of a room full of people! I am happy to report that in 2014 I made two presentations to 20 people during a seminar for work and then in our rugby presentation night I spoke for around half an hour to 70+ people (and I was told that I did a good job at both events...!)”*

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**APPENDIX 4: EXAMPLES OF EMPLOYMENT SUPPORT TO PEOPLE WITH MENTAL HEALTH PROBLEMS**

**Example: NetWork Service, Renfrewshire**

The NHS NetWork Vocational Rehabilitation Service in Renfrewshire runs with an occupational therapist as team lead and occupational therapy support workers. In the first three years of the service they had 104 job outcomes which equate to a 38% job outcomes from referrals, and there was a 68% reduction in Community Mental Health Team usage following someone gaining work. The vocational rehabilitation service works to support those using both mental health and addiction services.

It offers three main strands of intervention:

* Towards Work: Meaningful Day/Positive Activities: Supporting individuals in their recovery to become involved in community activities, physical activities, green space, creative arts, volunteering and training
* Gain Paid Work: Providing specialist interventions (IPS Individual Placement & Support) to support people into paid employment
* Retain Work: Supporting people to return to work during an episode of mental illness or addiction.

The service won the Renfrewshire HSCP overall Award for Excellence, gained ‘Good Fidelity’ to the prescribed model for the IPS service and has gained national attention and interest for its models and outcomes.

The service has a three year evaluation with support from an external researcher. The indications from the cost benefit analysis, related to people who have gained paid work, have demonstrated that there are financial savings for NHS and DWP services as well as financial gains for people who gain work. Supporting people to gain work and preventing people from falling out of work decreases hospital admissions, reduces demand on mental health services, improves physical health and life choices.

Prior to engagement with NetWork individuals were using an average of 13 mental health appointments per year. Following engagement with NetWork they used an average of five mental health appointments each per year. This represents an average reduction of eight appointments per person per year. Doctor and psychology appointments also reduced during the same period. In the final year of evaluation prior to employment clients had an average of 5.54 appointments per year reducing to 1.94 in the year following employment.

“*What NetWork did for me is they built me back up so that I would take control and apply for my own jobs, going for my own interviews with their support in the background. They basically sat down had a conversation with me and listened to what I wanted to do with my life and said well there’s some options let’s consider them.’*

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**Example:** **Partnership Working to provide an Individualised Placement Support (IPS) employment model. A pilot for Service Users of Birmingham and Solihull Mental Health Foundation Trust**

In September 2016, a 12 month pilot to work in partnership with employment specialists was set up to help Service Users find competitive employment. People with severe mental illnesses are underrepresented in the workforce; with this even lower if also they also have a criminal record. Therefore, in this instance, barriers to participation in valued occupation leads to social exclusion and increased risks of harm to health.

With this is mind two sites were chosen for the pilot. The first was Phoenix Hub and Club house, a rehabilitation day centre. The second was across the Secure Care Service, working with the forensic outreach service as well as Service users approaching their discharge from in patient settings. The model was designed for service users from general adult CMHT services, and there is very limited evidence for its application within inpatient secure care.

The IPS model is that of “place then train”, rather than more traditional models that typically involve partaking in vocational training and sheltered work on a gradual trajectory toward competitive employment. The principles of the model are that the aim is to get people into competitive work, to do so quickly, it is open to all those who wish to work and should try to find jobs consistent with people’s preferences. In addition to this Employment Specialists should work within clinical teams, benefits counselling is included, it provides time unlimited in individualised support for the person and employer, and should develop relationships with employers based upon the person’s work preferences.

A brief survey that was completed in 2015 indicated that the majority of the Service users with Secure Care wanted to achieve employment. As occupational therapists, wanting to support people to achieve what is important to them on their recovery journey, we would want to support these goals.

The model for Secure Services has developed into three distinct phases. The first phase is treatment as usual (Occupational therapists continue to set work related goals with the service user). Within the confines of the building these could include gaining basic skills, skill development groups, accessing internet based training and gaining experience through job roles around the clinic.

Once an approximate discharge date is known and the Service User has expressed an interest in the project then they would move onto phase two. At this stage the service user will meet their employment specialist, complete assessments and draw up a work plan. Some outstanding skill areas may need support at this stage and the role of the assessment is to decide the most suitable partners with who to do that work.

It is envisaged that Service Users will then move promptly onto phase three, securing and maintaining employment. Employment again needs to be appropriate to the amount of responsibility the individual can take on at that time, be that initially voluntary, permitted hours, part time or full time.

In early October 2016 we were fortunate to be able to invite Norman Lamb to visit the project. He was able to meet with Service Users who were starting on their journey with the IPS model and were able to discuss with him their hopes and ambitions for their futures. We invited Norman Lamb back to see the Service users again later in the pilot to see how their employment seeking had progressed.

The next stages of the pilot involve working towards achieving full fidelity with the IPS model, and identifying any potential alterations that may be required for service users from out with the CMHT caseload for whom the model was initially designed. As with all pilots we eagerly await the results. It is hoped that by embedding employment specialists with therapists that this will have a positive impact for our Service Users.

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**Example: Occupational therapy and supported employment**

Individual Placement and Support which can be facilitated and delivered by occupational therapists can offer an effective approach to supporting people with severe mental health problems into competitive employment, and reduce the likelihood of hospital admission. Priest and Bones (2012) in a publication article explore the added value of occupational therapy in supported employment, outlined how occupational therapists have promoted and driven implementation of IPS in secondary mental health services in Sussex. They identify the contribution occupational therapists can make in embedding IPS into clinical teams, supporting the work of employment specialists and championing person-centred practice.

Priest B, Bones K (2012) Occupational therapy and supported employment: is there any added value? Mental Health and Social Inclusion, 16 (4), 194-200.

**Example: Occupational and Environmental Medicine 2013**

A randomised controlled trial has shown that occupational therapy improves long-term depressionrecovery and return-to-work for employees with major depression. This study evaluated whether occupational therapy can improve the treatment of sick employees with major depression.

The occupational therapy focussed on a fast return to work, improving work-related coping and self-efficacy. The primary outcome was work participation while the secondary outcomes were level of depression, at-work functioning and health-related functioning. Intermediate outcomes were work-related coping and self-efficacy.

Those who received occupational therapy (compared to treatment as usual) showed greater improvement in depression symptoms, an increased probability of long-term symptom remission and increased probability of long term return to work in good health. Occupational therapy increased long-term depression recovery and long term return to work in good health with better work and role functioning.

Hees HL, Vries de G, Koeter MW, Schene AH (2013) Adjuvant occupational therapy improves long term depression recovery and return to work in good health in sick listed employees with major depression: results of a randomised controlled trial. Occupational and Environmental Medicine 2013; 70: 252-60.

**Example: Managing mental health (schizophrenia) in the workplace**

An occupational therapy functional capacity assessment was requested by the manager of an international IT business for an employee with schizophrenia. The occupational health department requested an objective occupational therapy assessment of the employee’s capacity to undertake the demands of the role and how to manage his health conditions at work with advice on any reasonable adjustments required to meet the employee’s needs.

The occupational therapist looked at the person’s current duties and tasks to gain an understanding of functional capacity. They were able to meet their job demands but productivity could be enhanced through improved management of some of the symptoms at work. The following advice was given:

* Continue to have an open and practical conversation with colleagues about how the health condition may impact on work and what adjustments/approaches would help
* Organise regular weekly catch up meetings to prioritise the tasks and focus on these so that work is kept up to date
* Utilising in-house support systems so the individual does not feel ‘singled out’
* A workload adjustment was proposed to management
* Advised to trial a later start/finish time for a period of three months
* General principles of reducing environmental distraction such as email traffic should be applied
* Establish a “work buddy or mentor” support
* Identify relevant internal health and wellbeing policies
* Refer to the local NHS occupational therapy mental health team
* Ensure continued attendance at work during heightened symptoms
* Mental health awareness training/education for supervisors/line managers

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**APPENDIX 5: EXAMPLE OF PERSONALISED, TAILORED INDIVIDUAL SUPPORT**

**Example: Macmillan Work Service**

This occupational therapy assessment helped move this case forward allowing Mr Brown to return to work with more confidence after his employer made the relevant adjustments.

Mr Brown a 51 year old man with myeloma referred by his cancer nurse to the work service. He had a stem cell transplant and had been off work six months. He worked in a manual labour role for a local authority and had only limited contact with his human resources and occupational health services. Mr Brown wanted to return to work but his employer considering him “unfit” and was trying to redeploy him.

The occupational therapist met with Mr Brown several times and gained consent to speak with all parties including human resources, occupational health and the union representative to case manage positive discussions. A work needs plan was formulated by the occupational therapist to move the case forward. Positive partnership working with all parties was key!

There was still some doubt on the employers’ part that Mr Brown could still do manual work. The NHS Consultant occupational therapist agreed to do work ability assessment to help with return to work. Mr Brown underwent an occupational therapy work ability assessment which aimed to provide evidence based assessment of his function against his known job demands to reassure everyone involved. The results were shared with the employer and union. The assessment report provided the necessary detail required by the employer and justified the recommendation that he can return to work. Mr Brown felt more confident after the assessment of his ability and agreed to return to work on a phased basis with adjustments. The occupational therapy support offered to everyone was greatly appreciated.

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**APPENDIX 6: EXAMPLES OF SUPPORTING PEOPLE WITH DISABILITIES**

**Example: Employment and Arthritis: Making it Work” program**

Self-management programmes for women with rheumatoid arthritis can lead to improvements in managing work related problems, requesting modifications and productivity at work.

Self-management programmes involving occupational therapists, can reduce the impact of fatigue at work for individuals with inflammatory arthritis. The provision of occupational therapy to assist in ‘keeping people in work’ was the focus of an American study which aimed at preventing work disability and maintaining productivity at work for women with inflammatory arthritis. The 19 women who participated in the self-management programme which received a self-learning manual, group sessions and individual visits with an occupational therapist for an ergonomic assessment. The programme also included a professional assessment by a vocational rehabilitation counsellor.

In relation to their health condition at one year follow up, there were improvements in the experience of fatigue interference at work (Global Fatigue Index) which had been identified as the most important work problem by the study participants. There were also improvements in self-confidence in managing work-related problems including confidence in requesting modifications such as ergonomic changes or organisation of work and increased productivity at work.

Lacaille D, White MA, Rogers PA, Backman CI, Gignac MAM, Esdaile JM (2011) A proof of concept study of the “Employment and Arthritis: Making it Work” program. Arthritis and rheumatism, 59 (11), 1647-1655.

**Example: Cognitive assessments**

An occupational therapy assessment was requested for a person with learning disabilities and changing physical health. The assessment included a functional capacity evaluation and cognitive assessment. Recommendations allowed adjustments and guidance for future work roles.

In this case, the employer wanted to know the physical and cognitive abilities of a longstanding employee who was still working, but was now experiencing physical health issues. As the individual had a learning disability the employer wanted to know what tasks would be suitable for him, as they were considering re-deployment into a less physically demanding role within the organisation. The employee had been working in a warehouse environment for more than 25 years, picking products for orders, and the role resulted in him being on his feet performing manual handling tasks for much of the day.

At the beginning of the assessment the employee explained the details of his current physical health issues, including details of his symptoms including pain and fatigue, along with details of his social situation, how he manages day-to-day personal and domestic tasks and how he felt about the changes that were being proposed to his work role.

Following the discussion, the employee was provided with a variety of physical activities to perform, in order that the occupational therapist could further establish movements and durations of postures which were problematic for him. This included physical postures such as walking, standing, squatting, kneeling, sitting and how he performed manual handling tasks etc. He also undertook other standardised tests with clear set instructions to follow, so the results could be compared to other individuals of a similar age.

Following this, the individual was then tested using various standardised cognitive tests, known as neuropsychological tests, to look at areas such as memory, planning ability to perform activities etc. Again the tests could compare his cognitive abilities to others of the same age. After the assessment the report detailed the results of the assessments and provided the employer and employee with answers to their questions, details of his abilities and guidance for future work role suitability providing reassurance to both the employee and employer.

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<https://www.cot.co.uk/cotss-work/cot-ss-work>

**APPENDIX 7: EXAMPLES OF USING THE AHP ADVISORY FITNESS FOR WORK REPORT**

**Example: HealthWorks, NHS Grampian in Scotland**

HealthWorks is an innovative project that supported 200 allied health professionals (occupational therapists, physiotherapists and podiatrists) to increase their understanding about how to use the AHP Advisory Fitness for Work Report and integrate it into everyday practice. Patients who had Fitness for Work reports completed by AHPs feedback that they fully accepted their work needs addressed in this way and that their employers had found it helpful.

Contact details: Therese Lebedis <therese.lebedis@nhs.net>

**Example: Fit for Work, Scotland**

The Fit for Work Scotland already uses Return to Work Plans by occupational therapists as evidence of sickness absence in same way as GP Fit note which reduces need for GP appointments and cost.

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**Example: Lodge Health, Northern Ireland**

A pilot from this area of the AHP Advisory Fitness for Work Report shows that GPs rated the service highly and wanted a larger service from occupational therapist so all GP practices would have vocational clinics to provide early, pre-crisis intervention. Vocational Support at Lodge Health takes referrals for people with both physical and mental health problems. The referrals are for people in employment but struggling and for those who are unemployed.

The Occupational Therapy process means that each client is offered an initial consultation with the occupational therapist and further appointments as necessary. The AHP Advisory Fitness for Work report is completed and a copy given to both the client and GP and where relevant is shared with employers and work setting visits arranged.

From the GPs’ perspective, they valued the opinion of the occupational therapist about how to maintain a patients work role or seek employment. The GPs also felt communication was improved with having the occupational therapist on site and the GPs’ would have liked to have seen the service extended. The vision is to have vocational clinics in all the local GP practices to provide early intervention and in the long term outreach vocational clinics within the Northern Trust regional area.

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**APPENDIX 8: EXAMPLE OF HELPING PROFESSIONALS RECOGNISE THE VALUE OF EMPLOYMENT**

**Example: Health and Work Champions pilot project**

Public Health England (PHE) and the College of Occupational Therapists (COT) share a common agenda to support people to remain in work following illness, injury or disability. There is a strong evidence base showing that work is generally good for health and well-being. Being unable to work is linked with poorer health and well-being outcomes. Work can be therapeutic and can reverse the adverse health effects of unemployment for healthy people of working age, for many disabled people and for most people with common health problems. Work also increase income, improves social networks and provide a valuable prosocial role that contributes to health and wellbeing.

Both COT and PHE understand that health care professionals are instrumental in giving patients they work with the skills, belief, ability and confidence to make the adaptations needed to remain in or return to work. Together COT and PHE wish to increase the profile of the role health care professionals’ can play in supporting people with illness, injury or disability to remain in or return to employment and to achieve their employment aspirations.

The Health and Work Champions pilot project aims to bring about culture change in the NHS so that work is regarded as a valid and legitimate aspect of good patient care; that it is routinely enquired about in patient consultations as a measure of functional outcome and that brief advice or onward referral is carried out for further employment support as required. The project will use peer to peer teaching to enable the healthcare workforce to understand their role.

In the project 28 occupational therapists have become Health and Work Champions and are delivering a standardised training package to work colleagues in their employing NHS organisation from January 2017 until June 2017. They have been trained by COT and PHE and are being supported throughout the project including refresher and debrief meetings. The training that they are delivering targets doctors, nurses and allied health professionals. The project has advisory support from the Council for Work and Health.

The Health and Work Champions pilot project is being evaluated by a team of academics at Salford University. The evaluation includes pre and post training session questionnaires to gauge change in knowledge, attitude and behaviour in those who have received the training. It will also involve interviews with the Health and Work Champions to discover the impact of acting in this new role. The results of the evaluation are expected in autumn 2017.

It is hoped that if the evaluation of the pilot project shows favourable outcomes that the project could be extended to train additional cohorts of Health and Work champions, to extend it to settings outside of the NHS and could include a larger evaluation to consider the impact on patient return to work and cost savings achieved.

<https://www.cot.co.uk/promote-ot/health-and-work-champions-promoting-health-and-treatment-benefits-employment>

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**APPENDIX 9: EXAMPLES OF OCCUPATIONAL THERAPISTS IN OCCUPATIONAL HEALTH**

**Example: Occupational Health and Wellbeing, Stoney Ridge Hospital, Cottingley**

Occupational Health and Wellbeing Service in an NHS Foundation Trust that delivers services in Mental health, Learning Disabilities, Community Health and Dental. The Trust employs 2,800 staff spread over multiple bases. In 2015 the Trust was identified as one of 12 exemplars in the country by NHS England for the measures it has in place to improve health of staff in the workplace. Occupational Therapists are in the service to prevent absence and help return to work for staff, mainly with mental health conditions. The occupational therapist has made potential saving of £123,816 in 9 months

The occupational therapists are now looking at seasonal variation for stress, anxiety and depression related absences and ‘Hot Spots’ of absences to see if targeted, preventative work is indicated in conjunction with Human Resources input.

*“I told HR that I would not have returned to work by now – if at all – if it had not been for the occupational therapy input.” (*Longstanding staff member 3 months off work with depression)

“*It has been so good to spend time focussing on me, what I need and that I have as much right to have my needs met as anyone else.”* (Longstanding staff member with complex family and work stressors)

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**Example: Occupational Therapy in Occupational Health, Sheffield Teaching Hospital NHS Foundation Trust**

The benefits of providing an occupational therapy service within the Sheffield Occupational Health Service, at Sheffield Teaching Hospital NHS Foundation Trust have been demonstrated. Cost savings to the Trust in terms of reduction in sick leave and improvements in numbers working independently or with support. The trust has seen a two thirds reduction in numbers of staff on sick leave.

Occupational therapy Interventions include:

* Initial assessment (impact of health condition on physical ability, function, psychological health and occupation)
* Worksite assessment
* Job analysis
* Functional Assessment (ability to carry out the functional tasks identified from the worksite visit and job analysis)
* Work rehabilitation (to improve ability to manage requirements of the role)
* Education and advice on work ability and managing health in the work place.
* Equipment and adaptation advice
* Redeployment advice

Case study example of Occupational Therapy impact:

A 54 year old woman was referred for an occupational therapy assessment by the Occupational Health Service. She worked as a catering assistant in the hospital catering production unit. At the time of referral she had been redeployed into an administrative role for three months within the unit as she was unable to manage the physical requirements of her role due to chondromalacia patellae of her right knee, which had been causing her difficulties mobilising. Mrs Jones had only ever worked in catering and had been unable to secure a permanent administrative role in the Trust and therefore was facing the prospect of leaving the Trust on grounds of ill health.

An Occupational Therapy worksite visit was carried out with Mrs Jones and the unit manager. Discussion and observation of the role requirements were completed and the Occupational Therapist observed that no adjustments had been put into place for Mrs Jones prior to her redeployment. The occupational therapist then carried out a functional assessment in the Therapy Department, choosing assessments of the relevant tasks required for Mrs Jones to work as a catering assistant.

Based on the results of the assessments and the occupational therapists’ clinical judgement, recommendations were made on adaptations to the catering assistant role and a suitable phased return after the necessary risk assessments were carried out. Following the occupational therapy advice, Mrs Jones was able to return to work on a gradual phased return.

The occupational therapist carried out a follow up assessment three months post return to work. Significant improvements in function were observed and both manager and Mrs Jones reported she was now managing her full role and hours working in her original catering assistant role. This intervention was carried out with three assessment sessions and advice via telephone and occupational therapy reports.

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**Example: Occupational Health Service, Castleford & Normanton District Hospital, South West Yorkshire Partnership NHS Foundation Trust**

The service is offered to a staff group predominantly from two large NHS Foundation Trusts; alongside service level agreements with other health and social care organisations equating to 9000 staff. Clinic appointments are offered alongside telephone assessment, work assessments, and home assessment by an occupational therapist.

Interventions include:

* Occupation-focused assessments for job retention and return to work
* Occupational therapist primarily assesses general functioning, workability, and fitness to return to and maintain work from a specialist perspective
* Also focus on medium-longer term input in relation to remaining well at work i.e. through work/life balance interventions and condition management goals
* Home environment assessments are carried out if necessary, however, most are completed in occupational health clinic and in the work environment
* Managers, HR and other relevant parties are included where required and agreed with the staff member to support positive communication.

The service has decreased long term sickness absence by 25% and this saves a total of £85,241.52 in one year. For Job retention there has been an overall cost saving for the Trust of £182,529.

*“The Occupational therapy role has enabled staff to return to work in timescale agreed; essential in ‘bridging the gap’ for staff returning to work”* (Manager)

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**APPENDIX 10: ADDITIONAL INFORMATION FROM CHAIR OF COT SPECIALIST SECTION WORK ABOUT OVERALL APPROACH TO CLOSING THE DISABILITY EMPLOYMENT GAP AND ROLE OF OCCUPATIONAL HEALTH**

**Overall approach to closing the disability employment gap**

It is the view of the College of Occupational Therapists Specialist Section –Work that Health Work and Disability in its widest sense needs a multidisciplinary approach and one that recognises we are facing shared challenges in the workplace.

* Solutions cannot be devised in professional silos, and we recognise that one professional’s solution is potentially an increased demand on another professional group. COT Specialist Section –Work is endeavouring to develop a shared response through the dialogue generated from the Green Paper and welcomes this opportunity to contribute
* This response primarily outlines responses to the questions posed in the Green Paper and also provides some evidence of occupational therapists contribution to the challenges which demand speedy solutions. Many solutions will require cultural change, new ways of working and a shift in traditional power relationships.
* All this is taking place on top of the emerging H&SC Partnerships which represent the single biggest reform to the way health and social care is delivered since the creation of the NHS, revising how care services are jointly delivered by partnerships.
* This response has the underpinning assumptions that the world of work is changing, that keeping people in the work is right thing to do and that the current status quo is not sustainable.
* However, it is worth noting some of the comments from recent research on health and disability and what this means in practice for disabled people in work struggling and off work trying to return (See Closing Disability Gaps at Work by Ralph Fevre et al 2016).
* If this research and the real experiences of disabled people are not carefully considered and changes implemented including the very real matter of equality proofing and more robust rights to redress using the Equality Act, it could cost money rather than save money. This and other research highlights that without careful consideration proposals that emanate from the Green paper need to go beyond piecemeal supplementation that seek to solve the problem, improve the quality of care and the journey and finally avoid fragmented care.

Furthermore large-scale redesign of service is hard and requires commitment from both national policy-makers and local leaders.

Thus we need to:

* Be realistic about the time and capacity needed to support change. Are funded pilots evidenced based and thoroughly devoid of planned disparity and ‘black box’ commissioning?
* Truly develop a receptive culture for change which includes adequately resourced workforce development and a culture that supports experimentation and change with the best available evidence
* Support transformation with a strong communications and change management strategy which includes dedicated senior leadership and front-line staff with protected time to support workforce development and planning
* Build roles on a detailed understanding of the work, staff skills and user needs
* Invest in the teams, not just the roles - the quality of teamwork is directly and positively related to the quality of user care, staff wellbeing and innovation in health care
* Ensure robust triage mechanisms - it is vital to ensure that patients are correctly triaged so that the correct professional sees an individual that is appropriate for their skills and that there is clinical supervision
* Develop and invest in a training capability
* Build sustainability for new and extended roles
* Evaluate change – frequently ‘evidence’ is anecdotal in nature, lacking objective measurements and is not peer reviewed
* Adopt a systematic approach to development and change

**Making occupational health part of the solution**

Whether occupational health provision is private or public the use of OH requires employers to be willing to do five things:

1. To identify workers who have a disability
2. To understand the disadvantage that the disabled worker faces in relation to identified aspects of their job because of their disability
3. To adjust the provisions, criterion and practices inherent in their workplace that create the disadvantage for the worker with the disability
4. To build a constructive dialogue with the employee which allows for a revisiting of agreed adjustments, the need for which can vary and change with developing and or fluctuating conditions
5. To communicate to employees their willingness to support them when they disclose a disability and to use occupational health to arrive at best decision making

Occupational health as the standard health intervention in the work place is capable of playing a fundamental part in determining the issue of disability; identifying for employers those employees to whom the employer’s duty to make reasonable adjustments applies, with meaningful recommendations for reasonable adjustments to aid the employer’s compliance with the Equality Act.

The impact of an employee’s disability on work, even if reflected in short term absences or poor performance rather than absence, will only addressed by standardised interventions of occupational health which recognises individual health and work needs.

In the light of what we know about the growing scale of disability issues within the working age population, it is no longer safe to assume that the conventional management of sickness absence, capability and performance is the answer alone. The opportunity to proactively and positively manage disability may be lost by such an approach. There is a need within these processes to identify at an early stage those who have a disability, and then to apply a different approach which should address the issue of in work support including adjustments, in the short, medium and long term with a process of inbuilt review, to pre-empt, prevent and adapt to changing needs, sustaining performance and retention of employment.

The House of Lords report highlighted the need for employers to be assisted in understanding and fulfilling their duty to make reasonable adjustments ([http://webarchive.nationalarchives.gov.uk/20160105 concepts-and-questions/index.html](http://webarchive.nationalarchives.gov.uk/20160105%20concepts-and-questions/index.html)) Occupational health, could be important agents of change in this process. This role is entirely compatible with the guidance provided to Occupational Health. An exemplary model of how occupational health can assist in this role and work alongside an employer to meet their obligations under the Act and achieve job retention is to be found within Steelite UK (Creating longer, more fulfilling working lives: employer practice in five European countries CIPD Policy Report May 2016 at pp96-100)

It can be appreciated therefore in the future development of occupational health services and provision that the sensitivity and skills of occupational health professionals will most often have the potential to uncover those with a disability in the workplace, and to raise awareness of the concomitant duty on the employer to make reasonable adjustments, particularly in relation to ‘hidden disabilities’, who face particular difficulties.

However, there are a number of problems with this process at present described as follows:

1. Where occupational health provision can be of variable quality and not necessarily skilled in disability assessment. Occupational health also does not necessarily see its role to define disability for an employee or employer. Further it is often authorised contractually to address only the questions asked of it.
2. Largely absented from the workplace, it relies on referrals from management and human resources, and can be viewed by some as “policing workforce sickness to ensure that people return to work as quickly as possible, or are helped to leave if return is seen to be unduly delayed”.
3. Remoteness and decreased accessibility of occupational health to employees appears to discourage self-disclosure and self-referral. Disclosure of health conditions by employees is a significant issue, particularly for those with underlying or hidden disabilities and mental health conditions. Further employees will often be unaware that their condition amounts to a disability or will not self- define as disabled even if aware of the concepts within the Equality Act.
4. The service provided is increasingly telephonic; usually time limited and algorithmic. The reporting mechanism is to human resource departments, and or line managers. Access to occupational health, and the quality of that access, is often controlled against a backdrop of cost restraints. Identification of those with disabilities may also be affected by line manager’s rationing of access to services, with line managers with no medical qualifications becoming ‘key ‘interlocutors’ on matters of disability and the interpretation of reasonable adjustment. The employee may feel alienated from and indeed suspicious of the process and practices described.
5. What has been described is neither the wish nor aspiration of many within occupational health. There are many examples of best practice amongst human resource practitioners and occupational health professionals, notably those accredited by the Chartered Institute of Personnel Directors, the Faculty of Occupational Health Medicine and the Society of Occupational Medicine.
6. In our view however, a referral to occupational health or a failure to refer will often be an opportunity missed in terms of the potential for disability management. It is an opportunity to deconstruct the real issues for the employee and employer in relation to the employee’s disability as it impacts on work, and identify effective solutions for those either struggling at work or absent. By way of example we now examine a body of evidence relating to the treatment of those with cancer which illustrates well the challenge that exists for those protected by the Act in enforcing their right to reasonable adjustments at work.

Making Occupational Health part of the solution:

It is our experience that occupational health has a tendency to provide excessively cautious advice on disability status and the need for or specification of adjustments. Generic (and sometimes anodyne) information is too often passed back to employers, leaving employers with the job of working out what might or might not be possible to return the employee to, or retain them in work.

Those advising on either side need to be alert to the inadequacies of poor quality assessments and recommendations, the wide and varied solutions that are available to minimise disadvantage, through physical adaptations and aids, but most often, subtle and varied adjustments that can be made to any number of policies, practices and procedures in a workplace to address disadvantage.

Overall, in our view, the absence of commonly agreed protocols on disability (or the failure to live up to them), are unhelpful. Those who are best placed at present to identify disability must as a profession, despite their agency to the employer understand the criticality of their role. We would go further and state that it should, if it does not already arguably exist, be a professional duty to identify whether an employee is likely to be protected by Act, and to raise the attendant issue of reasonable adjustments, where this is appropriate.

Best practice for employers would be to consider anyone with a long term health condition as someone for whom the issue of adjustments should be considered, with debates about status and reasonableness brought in only as a last resort. However, such an approach while perhaps prudent for an employer relies on an informed and risk assessed understanding of the Act and their duties and/or good will from employers, as well as employees having access to occupational health, and feeling confident that they can disclose health conditions. This is not the reality for many employees, a matter that has been picked up by the HLSC. More is needed if we are to bridge the gap and retain those with a disability in employment, through compliance with the Act.

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**APPENDIX 11: ADDITIONAL INFORMATION FROM THE EDINBURGH COMMUNITY OCCUPATIONAL THERAPY NEURO–REHABILITATION TEAM**

**Feedback from Community Occupational Therapy Neuro-rehabilitation team,**

**Edinburgh.**

Overall there appears to be an emphasis on MSK and mental health conditions and health problems. It is appreciated that this makes up a significant population but it does not identify the needs of those diagnosed with neurological conditions: those that are progressive (e.g. multiple sclerosis) or those that have potential recovery (e.g. stroke). Our experience relates to the needs of this population as they return to work, or look to obtain work having been unemployed.

It is essential that those who work in Job Centres are aware of the “hidden” impairments that relate to neurological conditions: mainly language, cognitive or visual impairments. Having awareness that these impairments may be present and where to signpost people to for support to progress their journey into work may be helpful. We have invited our local job centre to join us for “Stroke Awareness” training and to signpost people for an occupational therapy assessment to identify what support in relation to visual/cognitive/speech impairment support would help when they enter a workplace, have an interview or complete application forms. This pathway requires development and could involve third sector e.g. Stroke Association if specialist occupational therapy assessment is not required.

It would appear that school leavers with a neurological disability are often transitioned into further education, but we are aware of a gap in support services to support individuals directly into the job market or apprenticeships, directly from school. This can lead to a long-term unemployment picture for those that do not want to go into further education, and a more pro-active and preventative approach, starting in schools may help.

In order to retain work and develop careers in the workplace, we have started a peer support group: “Back to Work after Stroke”: a peer support group consisting of stroke survivors. They share lived experiences and offer peer support. Having an awareness of where to get expert help if needed is also important. Our Work and Training Support Worker attends this group.

Having a “buddy” or mentor in the workplace has worked well if an employer can provide this. Our own Work & Training Advisor follows people’s progression through a phased return and this enables any issues to be resolved in a timely way. He can also increase awareness of an individual’s neurological impairment, but also highlight their abilities, since he works within a Team of occupational therapists and has access to occupational therapy assessments. Having this information available in more workplaces may assist with successful returns.

In relation to 1) work related and 2) benefit assessments: we recognise that a sharing of these two types of assessment results may be beneficial to an individual if it prevents repetition for that individual. For example if an occupational therapist has completed a detailed functional capacity assessment for return to work, this may prevent attending another assessment for PIP or ESA. We have recently been involved in sharing information with DWP (with client consent) and this has been to the advantage of individuals due their occupational therapists having supported them through a lengthy rehabilitation programme and understanding what their abilities are. However, this is ultimately the individual’s decision to share this information and there will be times when more personalised assessments are required by different agencies.

Often when a failed return to work happens, it is due to the employers lack of understanding of a health condition, what an individual’s abilities are, or indeed the lack of understanding of reasonable adjustments needed. Providing better awareness of conditions for employers is key to this change. The Stroke Association recognise this and have leaflets for employers. More awareness/ training for employers is recommended and the Third sector appear to be keen to provide this. Promoting this by social media may be an affordable way forward? Also highlighting the “Disability Confident” symbol to encourage more employers to participate may help.

The AHP Advisory Fitness for Work Report has been welcomed by our service. It is helpful and if we complete additional assessments/ have other evidence, then we append to the Fit Note. On the whole it is helpful to individuals, GP’s & employers. Most acknowledge that a GP short consultation cannot provide the detailed assessment and evidence that e.g. an occupational therapist can provide while supporting someone through a neuro-rehabilitative programme, which optimises people’s level of function. When a copy has been shared, with consent, with a GP most are grateful for this supporting evidence.

We are confident that occupational therapists provide a key part in assessing and providing appropriate interventions for an effective return to work. Our neuro-rehabilitation service provides specialist assessments, work hardening, graded programmes as someone progresses through a rehabilitative programme. In particular an occupational therapist will always assess cognitive and visual function in detail within a neuro-programme. Employers appear particularly interested in cognitive abilities to ensure safe productivity in the workplace.

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**APPENDIX 12: ADDITIONAL INFORMATION FROM THE WELSH MENTAL HEALTH OCCUPATIONAL THERAPY NETWORK**

**The Welsh Mental Health Occupational Therapy Network wish to submit our comments with a particular emphasis upon mental health:**

***Chapter 1: Tackling a significant inequality***

Individualised Placement and Support approach is currently being developed within Wales. At this stage, bids to support people aged 14-25 in mental health services in work, education and training have been supported and recruitment is imminent. Expansion is planned to embed the approach across services for adults with mental health problems across all ages.

Evidence is well documented by the Centre for Mental Health – IPS has been delivered in the UK for some time and offers in work support for individuals and back to work support and job matching. In this area we are hoping to work closely with current employment support providers and DWP to provide a more joined up service for any individuals with mental health problems wishing to start, return or stay at work.

There are projects that provide employment support via peer networking.

There are projects that are provided in partnership with Local authorities and third sector, and strengthening of links with the DWP.

The Fit for Work initiative provides back to work support, however there is little provision for those already in work or who have returned to work, which the evidence indicates is a priority area for input.

There are clear commissioning guidelines for developing IPS services which could be utilised for any new service being proposed. Centre for Mental Health has published a number of information leaflets on line including one on commissioning.

***Chapter 2: Supporting People into Work***

Building Work Coach capability

The approach needs to be individualised and tailored to the persons’ capabilities, and readiness to engage in work. There needs to be greater links between employees in job centres with staff working within mental health services and other employment support agencies. Work coaches need to know employers that have met the criteria of Disability Confident Employers, and those that have committed to the Time to Change Wales pledge. These employers will be more sensitive to the support needs of people with a range of health problems. Occupational therapists have the skills to match the person to the job, taking into account their skills, support needs, and personal preferences. They can also identify supports required in order to achieve sustainable outcomes.

Work coaches require a good knowledge of employment support services, specialist mental provision within the locality that may be called upon to support individuals and provide a person specific tailored plan, and give the necessary direct input. For example, an occupational therapist can assess through activity analysis, a full skills assessment, ergonomic assessment in the workplace, environmental adaptations to include seating, accessibility, and the social environment within the workplace.

Supporting people into work

Key areas that are evidence based are around the work place culture and environment as much as the individual. In addition:

* Flexibility in the workplace re patterns of work, hours, duties and adapting roles
* Healthy working environment that focuses on improved health and wellbeing for all, challenging work practices such as long hours cultures, lack of breaks, job insecurity.
* Employers that promote openness and transparency around health issues in a supportive environment
* Actively addressing stigma through legislation, campaigns such as ‘Time to Change Wales’
* Employers investing so that awareness of signs of ill health are identified and addressed within a values framework- such as measures of staff wellbeing that include satisfaction, performance, sickness levels etc.
* Individualised Placement and Support, (IPS) Wellbeing Through Work Models, Condition management Programmes are all key example supported by evidence internationally and within Wales. There needs to be a co-ordinated approach to join agencies and ensure that people access the right service at the right time. Within Mental Health services there needs to be greater priority given to employment as an essential and intrinsic part of recovery principles.
* The barriers to offering internship include the inflexibility of the benefits system to accommodate changing and fluctuating needs and presentation of health symptoms; stigma remains a barrier as attitudes in practice have not shifted, and complex organisational systems are difficult to navigate.

Improving access to employment support

There needs to be a defined and streamlined pathway between health and employment support providers. Targeted support is essential that bring together the individual, mental health services and employment services. Health and employment support agencies need to be better coordinated to ensure that the individual gets the right support at the right time.

The benefits system needs to be more flexible for individuals to try work experience without risk of financial disadvantage. Fear of financial loss and hardship is a major barrier and the associated stress a contributor to longer term health problems and dependency on services. Connecting with occupational therapists in mental health services can help people through analysing and overcoming challenges to getting into work, as well as navigating local support outside of mainstream services

Support should be provided by multi stakeholders including potential employers – there is a need to reduce stigma and discrimination within the workforce and teach employers mental health awareness so that they can start to support individuals as soon as they notice there might be a problem. Occupational Therapists are able to undertake activity analysis and can help individuals to get back into routines in preparation for work. Their role involves building good networks within communities, thus increasing support networks available to individuals – this in time reduces the demand on public services and allows individuals to take control over their own lives.

The voluntary sector can provide training courses and offer placements for individuals to experience working – this might be the first time that they have actually carried out any work so any opportunities for a positive experience is important. The development of social enterprise can offer opportunities for individuals to earn a competitive wage in a work environment that is supportive to their needs.

Social media can be a great way to engage with people – the use of apps is now taking off – offering 1:1 sessions that are not punitive in any way can also help individuals to engage. We need to understand the causes for non-engagement and address them appropriately. It is really important to be sensitive to the needs of individuals who have not worked for some time.

***Chapter 4: Supporting Employers to recruit with confidence and create healthy workplaces***

Embedding good practices and supportive cultures

Organisations often have low expectations about the capacity of people with a range of disabilities to sustain work, and work to a high standard. There is often a focus on what people can’t do, rather than what they can. Also a focus on the disruption and cost associated with adaptations to the work environment- both physical and work based practices, not associated with the confidence of return in terms of long term productivity in a climate of high unemployment and short term contracts.

Employers that have signed up to initiatives such as Disability Confident employer and Time to Change Wales, should demonstrate measurable outcomes that are declared publicly. Large organisations, such a health trusts should lead on this by example.

Employers need to know where to get support, including that which complies with the Equalities legislation, accessible work environments, mental health support and wellbeing services. A one stop shop would streamline this- providing information and access to support.

Funding to charities that is targeted at work based interventions and support for people with long term conditions e.g. schizophrenia, MS.

Public campaigns should highlight good practice but should also show case positive outcomes where disabled people have been employed to reduce discrimination and change attitudes.

Different approaches are required for different sized organisations, e.g. hairdressers would have different support available to a large employer, e.g. access to occupational health services. For Voluntary Organisations that actively employ disabled people funding incentives should support their longer term sustainability. Smaller employers should be able to access financial support to upgrade premises, provide additional support at key times etc.

Published outcomes for organisations that employ disabled people need to be publicised.

Moving into work: style of selection needs to be more creative and flexible than the traditional interview. The concept of working interviews is sound. Systems for recruitment, including on line need to be simple and accessible.

Staying in Work: we support the core components to support health and well being in the workplace. Cultural and organisational barriers need to be understood and overcome where these clearly impact on health, e.g.- correct workstations, breaks, taking up wellbeing initiatives, having the infrastructure to support good health, rather than dealing with sickness and poor health. Positive incentives for maintaining good health.

SSP to be reformed to encourage a phased return to work- AHP Advisory Fitness for Work Report to be utilised to guide this process and ensure successful return to work duties.

***Chapter 5: Supporting employment through health and high quality care for all***

The health care profession needs to conduct the assessment with the person, and collaborate with the employer and Job centre plus.

In a target driven NHS immediate presenting health needs are prioritised. A shift in the skill mix towards staff groups that are not focussed on medical presentations but on enabling the person to manage and live their lives is required, e.g. occupational therapists have the skill set, framing knowledge base and focus on occupational function and benefits of return to work are central to this.

We consider occupational therapists are best placed, in preference to doctors. A Fit note not a Sick note gives a different emphasis. Occupational therapists focus on strengths and overcoming barriers. They utilise specific occupational assessments and problem solving techniques to identify and overcome potential challenges. Timing of early intervention can inspire and maintain hope despite a disease/diagnosis, and shift the expectation from can’t do to can do.

A Fit Note that defines a plan for return to work or maintenance, including phasing of hours, duties, adjustments to working patterns or adaptations. The format needs to be easy to follow by employers and work coaches, and indicate other support that is required and available, e.g. access to work. The Fit Note needs to be adapted to capture the above information, and take a higher profile. A review process needs to be built in for people with progressive conditions and those with fluctuating presentations. For people with mental health conditions this may include relapse indicators and support mechanisms.

Mental Health and MSK

There needs to be provision to access at primary care level. This should include access to occupational therapists to provide early assessment, prevent job loss, promote retention, and early re-establishment of work habit and routines. The occupational therapist can provide the links with employment services and employers.

Information needs to take a multi-media approach, eg online, apps, public health leaflets, surgeries, pharmacies, dental surgeries, waiting areas in surgeries, clinics, mainstream public routes. Single points of access to services can help in signposting and directing to appropriate support.

Transforming the landscape

There needs to be a combination of strategies to ensure accessibility. Empowerment of people to initiate self-referral is crucial, and should not be restricted by eligibility criteria that exclude those identifying that they need the service.

Creating the right Environment

We need a process for mapping out existing services and networks, reducing duplication, utilise existing networks where they are effective, sharing of buildings, staff and estate. Joint training, co-location, partnership arrangements, competency frameworks will support. Occupational therapists are often the conduit to coordinated access to services.

Training in the importance of employment focussed screening questions at initial contact with a service is required. Correlation between ‘the job question’ and positive employment outcomes needs to be established to reflect known and established evidence. Success stories should be publicised and celebrated routinely.

Indicators need to include:

* Compliance with the ‘job question’
* Improvement measured of wellbeing and health, e.g. work based healthy initiatives and incentives
* Measures of people retained or returned to work, training or education
* Indicators of confidence in managing health conditions
* Access to occupational health

Evidence can be brought together – showcase good practice with real life success stories delivered by people that have benefited, raise the level of expectation, engage employers, decision makers with people with disabilities

The value of work needs to be explicit in terms of personal values to the person, organisations, and financial savings. E.g. the evidence is that employment of someone with severe and enduring mental health reduces relapse (hence fewer admissions), improved social engagement and social support hence less requirement for services and active economic contribution to society.

***Chapter 6: Building a movement for change: taking action together***

There is a lack of long term sustainable support- short term funding of projects a problem and affects confidence. Also the inflexibility of benefits restricts exploration of job opportunities for fear of financial hardship. A lack of expectation and confidence is reflected in attitudes by health and social care staff and service innovation frequently fail to prioritise work, as this is not seen as a ‘core business’ against immediate health indicators. We believe services need greater integration and transition needs to be supported through funding and resources. The whole culture in primary and secondary care needs to be more focussed on work, wellness and managing the impact of conditions in relation to employment.

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