

Training and Development for Advanced Practitioner Health Professionals in Occupational Health and Wellbeing

Report prepared for:



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Summary

Occupational Health (OH) is the specialism in healthcare which provides services to reduce sick absence and promote health and well-being in the working age population.

In 2009/10, 28.5 million days were lost overall (1.2 days per worker), 23.4 million due to work-related ill health and 5.1 million due to workplace injury (HSE 2011) at a cost to employers of about £17bn in 2009 alone (CBI/Pfizer 2010).. Musculoskeletal disorders and stress were the most commonly reported illness types.

International reports on return to work initiatives indicate that the UK is lagging behind both European neighbours and globally in addressing OH. Only 1 in 7 workers in the UK benefit from comprehensive occupational health support. Reforms in Australia Canada and parts of the USA have mandated the task of assisting return to work utilising the Allied Health Professions and have demonstrated significant impact on long-term disability cases.

It is now widely recognised that 'good' work is good for you and that working should be considered within rehabilitation programmes wherever possible.

This paper discusses how occupational services are more effective when using a multi-professional approach. It explains the value of healthcare professionals in OH in addressing absenteeism and presenteeism and improving individual's attitude to working whilst recovering from an episode of ill-health. It explains the value of the Council for Work and Health's support for the development of an educational programme which will provide:

- Access to education in work, health and wellbeing for multi-professional engagement.
- Recognised qualifications in work, health and wellbeing with joint options available for GPs, nurses, AHPs, psychologists and ergonomists.
- Individual tailored professional training modules to run alongside generic modules, meeting unique professional needs.

Advanced Practitioner Health Professionals in Occupational Health and Wellbeing work both as teams and autonomously and can demonstrate considerable cost savings.

For example:

- A trust saved £170,000 for the cost of £21,000 in physiotherapy services.
- A person with mental health problems was supported back to work by Occupational therapists saving nearly £20,000 in benefits.
- A Foundation Trust cut its long term sickness rates by more than 40% through early intervention with physiotherapy and psychotherapy.
- In Wales in 2009, a psychology service improved the Work and Social Adjustment Scale from 16.1% at assessment to 56.9% after counselling across its client base.
- In the NHS alone, £555 million can be saved in sick absence in 3 years by improving the health and well-being of the workforce.

- The pilot of the Allied Health Professional (AHP) Assessment of Fitness for Work is indicating a successful innovation in returning people to sustainable work, relieving GPs of a task which can be completed by alternative and cheaper workforce.

These improvements in service delivery are evidence based, but still dependent on commissioners of occupational health and wellbeing services having the confidence to commission competent multi-disciplinary teams to provide a range of services, from fast track access to therapies for common health conditions, to a multidisciplinary case managed service for those with complex conditions. Commissioning is dependent on knowledge of the value of purchasing a multiprofessional service and the confidence that the workforce can deliver and therefore through:

- Awareness of the success these changes have had at international and local level.
- Understanding of the cost value in:
 - Not wasting GPs time in non-medical interventions;
 - Offering cost effective options for employers to support an employee in work;
 - Retaining people in work and off state benefits;
- Nationally consistent post registration training for AHPs, psychologists and ergonomists. There are examples of good programmes and practice, which can be developed into a coordinated and joined up approach.
- Standard levels of training required to achieve HPC or similar registration
- A national lead for AHP, psychologist and ergonomist training in the field of work, health and wellbeing.
- Nationally recognised standards of competences for AHPs and psychologists in this field by which to set expectations of commissioner, employer, or practitioner.

This paper highlights the pace of change in practice and education in healthcare. The Higher Education Institutes (HEIs) are developing an awareness of OH within the undergraduate curriculum, but often the specialist in occupational health has reached the status through their personal endeavour to understand the needs of the specialism and carve out their career. The opportunity to develop sustainable and replicable training through a development of a framework of specialist competences will help meet Dame Carol Black's call for action (2008) and Steve Boorman's vision (2009) in helping people to remain in or successfully return to work.

This paper recommends:

- A set of core competencies for those working in the work, health and wellbeing.
- A consistent and nationally recognised education programme [or identification that current programmes meet requirements] to develop practitioners to meet those competencies.
- A defined career pathway for those entering the speciality.
- A way of recognising professionals who meet the competencies, by the three bodies of the HPC, the Faculty of Medicine (FOM) and the Nursing and Midwifery Council (NMC)

The support of this project will lead the way to more occupational health practitioners, skilled in effectively keeping people in work, which will have a positive impact on national and local

productivity and lessen incapacity benefit payments in addition to improving individuals' health and well-being.

2. Introduction

This paper has been written for the Council for Work and Health as an adjunct to the paper presented in June 2010 titled '*Training and qualifications for occupational health nurses*' (Harriss, A. 2010), which described the training needs of nurses working in this speciality,

The purpose of the paper is to:

- Inform the Council for Work and Health of the involvement of the Allied Health Professionals (AHPs), psychologists and ergonomists in improving the health and wellbeing of the working age population generally.
- Provide examples of the specialist-occupational work undertaken by AHPs, psychologists and ergonomists and demonstrating the benefits.
- Describe the current position regarding post registration training in work, health and wellbeing for the AHPs, psychologists and ergonomists.
- Seek the support of the Council members for a proposal to provide a robust educational framework for AHPs, psychologists and ergonomists working in work, health and wellbeing.
- Develop a link with Nurse and Doctor educational programmes to improve multidisciplinary working.
- Propose a way of recognising AHP's, psychologists and ergonomists who have meet defined competencies in health work and wellbeing and can provide specialist return to work services.

This paper is a collaborative piece of work produced by the professional bodies of The College of Occupational Therapists, The Chartered Society of Physiotherapy, The British Psychological Society, The Ergonomics Society and individual members of their occupational health specialist sections.

Terminology

The term occupational health (OH) is used in this paper to encompass the wide range of health protection and fit for work services provided by the participating AHPs, psychologists and ergonomists and includes: work, health and wellbeing programmes, occupational and vocational rehabilitation, ergonomics, return to work, and communication with the workplace.

The term biopsychosocial is used as an umbrella term to describe the whole person approach to self-management and wellbeing that practitioners adopt in addressing the role of work and the stresses that work may place on the individual.

A full glossary is located at the end of the paper.

3. The size of the UK ill-health problem

In 2009/10, 28.5 million days were lost overall (1.2 days per worker), 23.4 million due to work-related ill health and 5.1 million due to workplace injury (HSE 2011) at a cost to employers of about £17bn in 2009 (CBI/Pfizer 2010).

Musculoskeletal disorders and stress were the most commonly reported illness types.

4. The health professionals and their role in work health and wellbeing

Allied Health Professionals (AHPs) are a group of healthcare professionals allied to medicine. Of the group, the Chartered Society of Physiotherapy and the College of Occupational Therapy reported they had members who worked in occupational health. This group represents (30,127) occupational therapists (OTs) and (50,000) physiotherapists, of which we estimate that at least 2,500 physiotherapists and 500 OT's provide OH services. The British Psychological Society have 15,244 practitioner psychologists, most of whom engage in OH, while The IEHF currently has around 1500 members. The parent bodies and representative practitioners have been involved in writing this paper.

What are AHPs?

AHPs are defined by the Department of Health (DH) as 'a diverse group of highly skilled and statutory-registered practitioners who, following specific and scientific training, deliver high quality care to patients across a wide range of care pathways and in a variety of settings. They perform functions of assessment, diagnosis, emergency care, treatment and discharge throughout the care pathway.

All AHPs have four common attributes:

1. *they are, in the main, first-contact practitioners;*
2. *they perform essential diagnostic and therapeutic roles;*
3. *they work across a wide range of locations and sectors within acute, primary and community care;*
4. *they deliver high quality care to patients across a wide range of care pathways and in a variety of settings from primary prevention through to specialist disease management and rehabilitation.'* (DH 2009)

Physiotherapists and Occupational Therapists frequently support and enable people to recover from poor/suboptimal functioning (whether through organisational design and management or through illness) and manage their disability or health condition, and to live independent lives.

Physiotherapists use their distinctive blend of knowledge, understanding and skills to help restore movement and function when someone is affected by injury, illness or disability. Physiotherapists deliver services to individuals, groups and organisations related to an individuals' employment or particular work activity. They are involved in the rehabilitation of employees with a wide range of conditions, with a view to restoring a person's fitness and capability to meet the demands of their job.

Occupational therapists are experts in occupation and have the unique knowledge and skills needed to help people maintain employment, to provide vocational rehabilitation and to achieve good physical and psychological health and wellbeing.

What are Psychologists?

Professional psychologists apply scientific methods to understanding human behaviour by observing, measuring, testing and statistically analysing the results to show that what they find is reliable evidence and not just down to chance. The scientific knowledge gained by this research is then used by practising psychologists (those dealing with clients and other professionals) in almost every setting.

Psychology is the scientific study of human mind and behaviour: how we think, how we act, how we react and interact, both individually and as groups, and the thoughts and feelings behind such behaviours. Psychology contributes to our understanding of many of the problems faced by the modern world as they are rooted in human behaviour, so

psychological knowledge can help us to find solutions. There is increasing recognition that mental health and well-being has an impact on physical health, and that psychological insights can help us in our personal and professional relationships and activities.

What are Ergonomists?

Ergonomists deal with the interaction of technological and work situations with the human being to ensure that the work situation should not compromise human capabilities and limitations. Ergonomists work to prevent adaptations leading to unacceptable physical or mental stress through balance of the two main technical areas: Work physiology (addressing the energy requirements of the body) and Environmental physiology (analysing and addressing the physical working conditions - thermal, noise and vibration, and lighting).

Ergonomics is the application of scientific information concerning humans to the design of objects, systems and environment for human use. Utilising skills in anthropometrics - the science of using data on dimensions of the human body in various working postures, and biomechanics - the operation of the muscles and limbs, ensures that working postures are beneficial, and that excessive forces are avoided.

All members of the AHPs and the three groups of psychologists are regulated by the HPC, and the ergonomists register with the The Ergonomics Society.

The HPC which was set up to maintain a register and protect the public.

The HPC:

- maintains and publishes a public register of properly qualified members of the professions;
- approves and upholds high standards of education and training, and continuing good practice;
- investigates complaints and takes appropriate action;
- works in partnership with the public, and a range of other groups including professional bodies;
- promotes awareness and understanding of the aims of the Council. (HPC 2009)

Ergonomists register with the Ergonomics Society, where they are accredited through assessment of knowledge, professionalism and experience and work to the Ergonomics Society's code of professional conduct.

These practitioners work in a wide range of settings including the workplace, Job Centre Plus and condition management, health care sector, education, social care, and private practice. These practitioners are encouraged by their professional bodies to include 'work' as an outcome measure in their assessment and treatment of the working age wellbeing of the working age population and to facilitate return to work. This includes fast-track treatment (e.g. psychological services such as counselling and cognitive behavioural therapy (CBT) and physiotherapy), preventative services (e.g. workplace ergonomics) and management services (e.g. workplace modification and occupational and vocational rehabilitation). Practitioners are also involved in public health programmes to improve health and wellbeing of the working age population by facilitating health behaviour change through provision of physical and mental health programmes. These programmes promote and offer support in increased activity, weight management, stress management and resilience training. Occupational psychologists are also involved with the health working population (e.g. job design, workplace bullying and coaching).

4. The International Perspective

Surveys indicate that UK is lagging behind both European neighbours and globally in addressing OH. For instance a TUC study (2002) found that only 13% to 23% of workplaces had access to rehabilitation, as a specific aspect of Occupational Health support. Similarly, the HSE commissioned survey of Occupational Health mirrors these findings (HSE 2002) with only 1 in 7 workers in the UK having the benefit of comprehensive occupational health support. Reform in the early 1990s in Australia resulted in legislation being passed that mandated the task of assisting return to work, to an assigned specially trained rehabilitation co-ordinators/case manager, drawn heavily from the AHP professions. Similar reform has occurred in Canada and specific parts of the USA. These reforms have demonstrated significant impact, with New Zealand for example, halving the total number of long-term disability cases within 5 years of reform.

These overseas examples suggest that there is significant scope for improvement in the UK in the provision and hence impact of occupational health. This low starting baseline is partly to do with the UK culture of healthcare professionals, and those in employment (both employee and employer). Most people are still signed off work by GPs and referred to a waiting list for treatment rather than fast-tracked to the appropriate professional before sign-off. The UK worker works longer hours and enjoys their work less than any other nationality in the developed world (Shapiro, 2010).

Another factor is the increasing number of unemployed people in the UK since the recession started. This has an obvious impact on the number of people claiming benefits and utilising the services of, amongst others, occupational psychologists in Job Centre Plus. High quality organisations should provide appropriate outplacement support for those they make redundant, but that often assumes that there is a company left behind to manage and administrate such support. If the entire company has closed quickly this can be difficult to achieve.

5. The specialist work undertaken by AHPs, psychologists and ergonomists in occupational health and the benefits.

It is now widely recognised that ‘good’ work is good for you and that working should be considered within rehabilitation programmes wherever possible.

The Black Report (2008) has charged the health professions with a drive to return people to work, citing research evidence that work is good for the individual, is advantageous to the country’s productivity and a relief to the overburdened benefits system.

The Boorman Report (2009) has calculated that a reduction in sickness absence in the NHS staff could realise a £555 million saving in three years. Dr Boorman believes that if we can demonstrate sickness absence improvement in the NHS then his vision will spread out across the breadth of industry. In keeping with the Boorman recommendations, there are a number of work-based mental health initiatives that have been developed to ensure exemplary employment practice in terms of mental wellbeing, such as “Leading by Example” and the “Mindful Employer” programme.

Kendall, Burton, Main, and Watson (2009) recommend a stepped approach to tackling musculoskeletal disorders once a person is off work. The first step – within the first 2 weeks is to provide support and encouragement to the employee to return to work. This is the role of all primary care practitioners whether working within occupational health or the workplace or without. This needs to be included in the pre-registration curriculum for all occupational therapists and physiotherapists to ensure it is embedded into practice.



From: Kendall, N. A. S., Burton, A. K., Main, C. J., & Watson, P. J. (2009).

Level 2 and above require specialist practitioners who understand biopsychosocial issues and physical/ psychological work demands so that they can provide appropriate advice to the employer about accommodations. The level of skill of the practitioner steps up with the level of support required with those managing long term absence requiring a high level of skill to manage the employee and to mediate workplace negotiations regarding return to work. There is a rapid growth in services for work rehabilitation for those with common mental health problems in business and industry and a similar pathway is perceived to be required.

In July 2009, NHS Chief Executive, David Nicholson CBE, and Karen Middleton, Department of Health Chief Health Professions Officer emphasised the high importance of AHPs in rehabilitation and re-ablement of individuals (Chief Health Professions Office Conference 2009).

'Early access to occupational health services, is seen as key to returning individuals to work at the earliest and most appropriate point' Karen Charman, head of Employment services, NHS employers HSJ conference *Tackling staff sickness and absenteeism* 21/09/10.

The change in the Welfare to Work Act (2010) has broadened the role of AHPs, psychologists and ergonomists to allow them to contribute to the assessment process in addition to medical practitioners. The new Work Programme will support people back into work, with a longer time frame in which medics and AHPs, psychologists and ergonomists can provide the rehabilitation support.

As people who have long-term and fluctuating conditions will be encouraged to engage with work through not losing their benefits entirely as they return to work, there will be a greater need for AHPs, psychologists and ergonomists to be educated about occupational health issues to provide the practical advice as well as therapeutic interventions. Dr Nerys Williams, (HSJ conference *Tackling staff sickness and absenteeism* 21/09/10.) deputy director of occupational health from the Department of Work and Pensions, highlighted the implications of the aging population and future high rates of people living and working with chronic diseases. She discussed the need for health professionals to be increasingly concerned with 'work focused' healthcare, to ensure people with long-term health conditions stay in employment.

Many large organisations have already invested and achieved significant benefits in staff health and wellbeing. This has been through the provision of multidisciplinary occupational health services and staff benefits (e.g. gym membership and flexible working). Many of these companies have published results demonstrating increased productivity and reduced sickness absence as a result of these initiatives. Some examples are given below.

Occupational Health Physiotherapy

A report by PricewaterhouseCoopers (2008) found consistent evidence that health and wellbeing initiatives by 55 UK employers ranging in size from 70 to 100,000+ employees had reduced absence rates and improved productivity. In one instance, an organisation introducing a Call Centre experienced a return of £34 for every £1 they invested in terms of reduced absence rates and improved staff retention by providing in house and discounted physiotherapy for their staff.

FirstScotRail offer physiotherapy, at work massage, chiropody and ergonomic improvements. 40% of cases referred to physiotherapy returned to work after an average of five sessions. Sickness absence decreased from 6.2% to 4.2%, saving around £3million per year (Employers Forum on Age, www.efa.org.uk/pages/how-firstscotrail-improved-the-health-wellbeing-of-its-workforce).

Anglian Water: through the use of physiotherapy based services, Anglian Water has reduced direct absence costs by £289,000 with a return on investment of £3 for every £1 spent. In addition, claims for back pain reduced by 50% and ill health retirement by 90% (Hunter et al 2006).

York Hospitals NHS Foundation Trust cut its long term sickness rates by more than 40% through early intervention with physiotherapy and psychotherapy. The number of staff off work for more than four weeks dropped from 99 to 57 and the number of staff off sick for more than three months dropped from 52 to 28. The Trust's return on investment was 2:1 (Dean 2009).

Physiotherapy and Occupational Therapy

The Royal Mail's occupational support and therapy programme, including physiotherapy, has had substantial financial benefits, with the programme providing a return of approximately £5 for every £1 invested. Absence was cut by 25% over three years and 3,600 employees, absent through illness or injury, were brought back into work. Before the programme, the estimated cost to the Royal Mail of absence and restricted duties in the study group was £1,384,501. Since the programme, this has fallen to £127,738. On the premise that absence and restricted duties would have continued at similar rates without the rehabilitation programme, the saving is in excess of £1m a year (HSE 2009).

Occupational Therapy

Within Hammersmith and Fulham, the primary and secondary care mental health vocational services have been set up to allow for rapid access to appropriate levels of vocational support in line with the needs of the individual. The vocational service employs a team of occupational therapists (known as clinical vocational specialists), who work exclusively around removing clinical barriers to seeking or retaining work.

The Individual Placement and Support Model is used extensively in mental health as the gold standard, and described by the Sainsbury Centre as 'by far the most effective way of helping people with severe and enduring mental health problems into mainstream employment' (Community Care 2009). The model demonstrates a holistic approach and its results show participants 'twice as likely to gain employment, hold jobs for longer, and enjoy higher salaries than participants in more traditional methods of vocational rehabilitation'. It is now being piloted with other client groups, spreading the specific knowledge base and skills across mental and physical services to develop a biopsychosocial framework, in line with a more holistic view of vocational support.

Psychology

The use of a Systemic Clinical Psychological approach to the implementation of the HSE Management Standards Approach (2005) to tackling work-related causes of stress has been effectively employed in a large hospital in South Wales. This approach resulted in a sustained reduction in the sickness absence of front line clinical staff and significantly increased staff engagement in organisational health review processes to identify and manage sources of work-related mental ill-health. This work won the Health and Safety Executive Award for Best Management Practice in Tackling Workplace Stress, in the National Healthcare People Management Excellence Awards, (2010) Elsewhere similar approaches have demonstrated a reduction in reported bullying and staff turnover rates (Jennings 2008).

The Cardiff and Vale University Health Board Employee Wellbeing Counselling Service, a Psychologically led, fast access, self referral service, has consistently demonstrated the functioning in end of year clinical outcome audits dating back to 2004. For example, in the 2009/2010 results, staff absence from work fell by 6.9% in pre and post counselling comparisons, while the average rate of normal functioning, as measured by the Work and Social Adjustment Scale rose from 16.1% at assessment to 56.9% after counselling.

Case management using AHPs and psychologists

OHSxtra Pilot for NHS Fife and NHS Lanarkshire. This pilot used a case management model for employees who were either absent from work due to a health problem, or at work but having some difficulty doing their job due to a health problem. The case manager could refer to physiotherapy, occupational therapy, CBT and counselling. The pilot reduced the number of employees absence and duration of absence. For every £1 spent the savings was £1.69 in direct costs only (Hanson 2007).

Currently small and medium enterprises (SMEs) businesses are less likely to have the resources to invest in such staff support and require access to similar external services in order to provide equity in service provision for their staff. This is privately purchased or provided through health insurance or via the NHS. The health for work advice line is available to these employers. They can explain their problem to an Occupational Health Advisor who will formulate a clear plan of action detailing how to best address the issues the employer is facing and provide information on support networks available to the business.

To support this there needs to be fast track access (through self referral) to physiotherapy and psychological services. These schemes are becoming available through the NHS. Research has shown that people who self-refer to physiotherapy take fewer days off work (on average 4 versus 7) and are 50% less likely to be off work for more than one month when compared with people referred via the more conventional route.

AHPs, psychologists and ergonomists cross the boundary between health and industry, taking an individual through the activities of their work to develop the strength and stamina necessary to carry out their job. Returning to work is now recognised as an outcome to measure the success of AHP, psychology and ergonomists treatment. The cost benefits to their organization, the saved sickness benefits and the well-being of the individual are a calculation of the value of treatment.

Fit notes

The new **Statement of Fitness for Work** - 'Fit Notes' - were introduced in April 2010 and replaced Med 3 and Med 5 medical statements (DWP 2010a). The statement is designed to promote short-term modification to work to encourage individuals to continue working safely through their recovery and consider work as part of rehabilitation. AHPs providing return to work rehabilitation services are well placed to give recommendations on work capability to employers. An AHP Fit Note is under development to support return to work and the Statement in claiming Incapacity Benefit.

6. The current position regarding training of AHPs, psychologists and ergonomists in work, health and wellbeing

AHPs and psychologists graduate as educated and skilled practitioners who are expected to develop and hone their general skills in the initial period of autonomous practice, maintaining and updating their continuing professional development (CPD). The HPC approves AHP and psychology pre-registration education programmes. It sets an expectation that all AHPs and psychologists will be able to provide a CPD portfolio demonstrating comprehensive professional development over the previous two years at any time in their professional career. Amongst AHPs, psychologists and ergonomists the culture of CPD, particularly to support specialisation and development into a range of occupational roles, as well as to ensure individuals remain up-to-date with developments in practice, is well-established.

Pre-registration programmes

Current pre-registration curricula for Physiotherapy, Occupational Therapy and Psychology does not specify coverage of occupational health, although the philosophy of the biopsychosocial model is encompassed in the teaching. The paper's working party has identified the importance of professional bodies seeking to strengthen students' development of knowledge and skills relating to occupational health and support that, on registration, AHPs, psychologists and ergonomists understand the importance of work to health and health to work and use returning to work or to a meaningful occupation as a goal and an outcome measure for interventions.

Post-registration programmes

AHPs, psychologists and ergonomists providing health work and wellbeing services undertake post registration education programmes to develop specialist skills for example in ergonomics, vocational rehabilitation and occupational health and safety. The psychology domains of occupational, clinical and health require a masters or a doctorate before registration with the HPC can be sought. For Occupational Psychologists further study is undertaken on a voluntary and ad hoc basis within specific areas of interest (e.g. counselling or coaching, stress management, equality and diversity issues such as bullying).

The Association of Chartered Physiotherapists in Occupational Health and Ergonomics (ACPOHE) is developing self regulated competency standards for physiotherapists working in occupational health and wellbeing and has a series of 8 short courses designed to assist practitioners achieve the competency standards.

There are a number of MSc programmes in occupational health, ergonomics, vocational rehabilitation that provide relevant training to Physiotherapists, Occupational Therapists and Nurses. The curricula for these programmes are not regulated by the professional bodies nor the HPC, although professional bodies do assert their expectations of Master's degrees in broader terms, as well as offering forms of recognition for programmes that are presented against their quality assurance and enhancement processes.

In 2009, Kirk describes the change in occupational health from the 'factory nurse' model of care to the modern approach of case management and rehabilitation. Harriss (2010) reports that this has resulted in inadequate provision of education for nurses in the development of competence in occupational health and describes the evolving specialism.

Today's occupational health practitioner must be able to take a biopsychosocial approach. Whilst keeping on board the employee, employer and GP, they must be able to:

- de-medicalise the employee's role where self-management is the ultimate goal;
- have a strong public health and prevention vision;
- understand fit for work issues and evaluations;

- have a firm knowledge of current manual handling, ergonomics and hazardous substance legal frameworks;
- demonstrate outcomes in both health and financial data.

This is in addition to competence in their traditional role and therefore requires specific, recognised education and practical provision.

There is a requirement today of a double flow through occupational health, providing a multi-professional approach for those with complex presentations, whilst allowing a fast-track component to run alongside, where common health conditions can be dealt with efficiently with lesser impact on work. For example, the 60% - 70% of conditions which involve musculo-skeletal and mental health conditions would be best suited to rapid access and return to work strategies, rather than joining the same pathway as more complex conditions.

In the guidance *Implementing a scheme for Allied Health Professionals with Special Interests* (DH 2003) training requirements are passed over in favour of identifying competence through 'a balanced assessment of the AHP's professional competence ... both formal qualifications and experience.' Whilst this upholds the individual AHP's responsibility to work within their scope of practice and to undertake CPD to support their field of work, it does not help commissioners nor providers to understand the baseline of competence and expertise against which to assign roles in OH.

Recent enquiries to higher education institutions (HEIs) on the incorporation of OH modules into educational programmes for AHPs suggested that coverage of occupational health is not prioritised in pre registration programmes that are already under pressure regarding content.

There are some models of good practice that can inform education design and delivery. For example, 'preceptorship' is an NHS development which has spread from nursing out to encompass AHPs and offers post-registration work experience to embed the skills learned (DH 2010).

For example, in physiotherapy, this has been introduced at NHS Lothian, with a specialist work rehabilitation rotation. Senior rotational physiotherapists work in the staff physiotherapy service acquiring skills in occupational health and wellbeing. The programme is supported by training and mentorship by a Clinical Specialist Physiotherapist in occupational health.

7. Summary of the current situation

The AHPs working in OH - namely physiotherapists and occupational therapists - and psychologists, have an essential role to play in the provision of health and wellbeing services and share common educational needs with nurses and doctors.

Commissioners of occupational health and wellbeing services need to be supported and empowered to commission competent multi-disciplinary teams to provide a range of services from fast track access to therapies for common health conditions to a multidisciplinary case manager service for those with complex conditions.

There is

- A lack of consistent post registration education for AHPs and psychologists. While there are examples of good programmes and practice, there is a lack of a coordinated and joint approach.
- No identified national lead for AHP and psychologist training in the field of work, health and wellbeing.

- No agreed standards of competences for AHP's and psychologists in this field by which to set expectations of commissioner, employer or practitioner.

8. What is needed?

We believe there should be, at a minimum, collaboration between the professional associations representing the different AHPs and psychologists working in work, health and wellbeing. The development of this paper was an initial step in this target. Together they could define:

- A set of core competencies for those working in the work, health and wellbeing specialism.
- A consistent and nationally recognised education programme [or identification that current programmes meet requirements] to develop practitioners to meet the competencies.
- A defined career pathway for those entering the speciality; possibly leading to a way of recognising professionals who meet the competencies, that is approved by the 3 bodies of HPC, FOM & NMC.

Collaboration/consultation also with the Faculty of Medicine (FOM) and Nursing and Midwifery Council (NMC) would be desirable as there may be considerable overlap between the competencies and training required.

We would like the Council for Work and Health to support the development of educational programme which will provide:

- Access to education in work, health and wellbeing for multi-professional engagement.
- Recognised qualifications in work, health and wellbeing with joint options available for GPs, nurses, AHPs and psychologists.
- Individual tailored professional training modules to run alongside generic modules, meeting unique professional needs.

The Council's support of collaborative work across the professional bodies to work together on such an initiative will help facilitate a culture shift in the approach to OH and wellbeing in the UK.

Our vision

Our vision is for the development of a structured and progressive educational programme that meets defined competencies and provides a defined career pathway.

To support the development of Advanced Practitioners we would like to develop a multi-professional post registration programme for AHPs and psychologists working in the field of occupational health and wellbeing. This would provide the underpinning knowledge (to be supported by clinical practice) to manage safe and sustainable return to work for complex cases. We use the term complex meaning those with psychosocial obstacles to return to work rather than complex medical conditions. The programme should facilitate deeper level critical thinking in line with the requirements of advanced practice, as well as supporting ongoing contributions to the evidence base for occupational practice.

For physiotherapists and occupational therapists, we see a flexible modular M level programme allowing practitioners to select the modules most relevant to the work they do. We envisage that the modules would build to form an M level certificate/diploma/ MSC covering the following areas;

- H&S and UK legislative framework.
- Perspectives on work (e.g. global, political, economic, technological, social, cultural).

- Ergonomics – physical psychological and organisational.
- Medical ethics.
- Epidemiology.
- Employment law.
- Vocational rehabilitation.
- Functional task analysis and measurement.
- Communication skills.
- The user's (stakeholder's) perspective on work (e.g. culturally competent/relevant, personal responsibility, the recovery model, condition management).

The situation with regards to psychologists will require further exploration. There is clearly a significant discrepancy between the training required for HPC registration between the 3 professions represented in the working party and the post registration training needs.

Short term

- Agreement of competencies for AHPs and psychologists recognised as required to work within OH; the core competencies will be aligned to those of doctors and nurses working in OH.
- Post-registration educational programmes designed to provide the framework to meet the competencies.
- A method of confirming an individual's achievement of the identified competencies, either through learning or portfolio of knowledge and experience.
- A recognised post-registration award to identify core curriculum OH competencies across the professions.

Mid-term

- UK-wide provision of recognised P/G courses at progressive levels of skill by HEIs for nurses, AHPs and psychologists in OH.
- Increasing incorporation of public health / work-related modules into nursing and AHP U/G programmes.
- Use of awards in OH employment criteria.

Long term

- OH awards recognised as essential criteria for working in OH.
- Health, work and wellbeing embedded in pre registration programmes.

9. What if we don't improve the competence of practitioners to support the Government's drive to keep people in work?

Failure to act to improve the competencies of AHPs and psychologists in the UK governments' return to work agendas has significant social and financial implications;

- The Department of Work and Pensions reported an increase of 115 thousand working age benefit claimants to 5.9 million in the year to February 2010. Of these people, 2.61 million claim employment and support allowance (ESA) and incapacity benefits (DWP 2010b).
- Bevan et al (2009) highlights the problem in re-engaging with work once on the benefits system.

These reports all demonstrate the ongoing risk in not providing a skilled workforce to support people to remain in work whilst recovering from illness or injury.

The current cost of sick absence; key annual figures 2009/10:

- **1.3 million** people who worked during the last year were suffering from an illness (long standing as well as new cases) they believed was caused or made worse by their current or past work. **550,000** of these were new cases.
- **28.5 million** days were lost overall (1.2 days per worker), **23.4 million** due to work-related ill health and **5.1 million** due to workplace injury. (<http://www.hse.gov.uk/statistics/>)
- This cost employers about **£17bn** in 2009 alone (CBI/Pfizer 2010).

It is estimated that the annual costs of sickness absence and worklessness associated with working age ill-health are over £100 billion. In the context of both an ageing and growing population, this will increase with more long term illness at work and more workers with caring responsibilities. Increasing dependence on the work force will require healthier workers and early intervention will be crucial. Evidence shows that long periods away from work can be detrimental to an individual's health. (Black 2008 quoted in: 2020health project brief: Valuing Work as a public health outcome: 2010).

Often AHP and psychologist work has been seen as secondary to mainstream medical interventions, as outcomes and investigations use death as the leading outcome influencing investment. The current government is looking to reduce NHS costs and AHP and psychology posts will be scrutinised in view of value for money.

Occupational health and wellbeing is an area where AHPs and psychologists can use hard facts to demonstrate their value. Provision of training to provide effective AHP and psychologist services can increase the productivity within industry and reduce incapacity claims through encouraging people to use work as part of their rehabilitation through:

- delivering cost-effective services;
- helping prevent people becoming unwell and needing sick leave;
- getting people back to work on full normal duties;
- facilitating a managed return to work if alternative or modified duties are required.

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Summary of current post registration opportunities for AHP's and psychologists in work, health and wellbeing

Psychologists;

Occupational Psychologists:

MSc level basic qualification (knowledge dimension) covering 8 areas

A typical qualification process for occupational psychologists is BSc/BA psychology (recognised by BPS)

⇒ MSc occupational psychology (recognised by BPS)

⇒ 2 years supervised practice completing the Qualification in Occupational Psychology (owned by the BPS) completion of which grants Chartered status.

At this point the person can register to use the legally protected title of occupational psychologist with the HPC. The person has 'registered' on the qualification before that, but in a legal sense registration only occurs with the HPC.

The BPS is the professional body and the HPC is the regulatory body

The MSC course has 2 dimensions

1. The Knowledge Dimension which is divided into eight areas, which must all be covered by accredited programmes. The topics may be grouped in different combinations from those listed below, and education providers are free to map topics in any academically coherent combination.

KD.1 Human-machine interaction.

KD.2 Design of environments and work: Health and Safety.

KD.3 Personnel selection and assessment.

KD.4 Performance appraisal and career development.

KD.5 Counselling and personal development.

KD.6 Training.

KD.7 Employee relations and motivation.

KD.8 Organisational development and change

2. the research dimension

Clinical Psychologists

A typical qualification process for Clinical Psychologists is

- BSc / BA (Hons) Psychology (accredited by the BPS)
- At least 2 years work experience as an Assistant Psychologist or equivalent
- Doctorate in Clinical Psychology (Clin.Psy.D) (accredited by the BPS)

As with Occupational Psychology, following qualification the person can register with the HPC to use the legally protected title of Clinical Psychologist. Again, while the BPS is the professional body, the profession of Clinical Psychology is now regulated by the HPC.

Organisational Health Psychology is a relatively new and emerging specialty within Clinical Psychology. While part of its focus is the promotion of employee mental health wellbeing on an individual basis, via evidenced based employee assistance / treatment programmes and psychological education, it is also concerned at an organisational / corporate and strategic level to identify, address and prevent sources of stress and mental distress at source. It is usually positioned independently from Occupational Health Services but works collaboratively with all key stakeholders including Occupational Health, Human Resources, Health and Safety, Organisational Development and Training, Senior Management and Staff Representatives etc.

While there are no specific, accredited, post-graduate training courses for Clinical

Psychologists working in Occupational or Organisational Health, some practitioners in this field have gone on to gain further experience and qualifications in Systemic Psychotherapy (accredited to Masters level by the Association of Family Therapy).

Physiotherapists

Physiotherapists qualify either through a BSc(Hons) programme or through a pre-registration MSc/postgraduate diploma programme (completed after gaining a first degree in a cognate area).

Programmes are approved both by the HPC (a condition of their being run) and by the CSP, and include elements that underpin and support physiotherapists' post-registration development and specialisation in occupational health. Some HEIs provide Master's programmes in ergonomics, public health and associated subjects that physiotherapists access as part of their CPD.

The Association of Chartered Physiotherapists working in Occupational Health and Ergonomics (ACPOHE) deliver 8 post-registration courses that support physiotherapists working in occupational health. One of the courses has achieved CSP endorsement and ACPOHE is in discussion with the Glasgow Caledonian University to deliver accredited courses, leading to a national award.

Occupational therapists

Registration is initially via a BSc in Occupational Therapy or, if an alternative first degree has already been obtained, then an MSc or Post Graduate Diploma in Occupational Therapy. Both these qualifications will include elements of Public Health and Occupational Health in the curriculum.

Post registration, an OT is able to specialize in many different fields and most training opportunities will be on the job or through the College of Occupational Therapists.

An OT may choose to do further postgraduate study; most commonly (modules of) a Masters in Advanced Practice, which may or may not have an Occupational Health/Public Health element to it. This will depend on the research interest and professional practice of the OT concerned.

Many HEIs will accept OTs on multi-disciplinary courses that are for AHPs e.g. MSc in CBT, MA in Social Work, MSc in Mental Health, etc.

There are currently no accredited, stand-alone Masters level or equivalent, training courses for OTs working in Occupational Health.

Acknowledgements

This paper has been written for the Council for Work and Health to highlight the role and value of skilled advanced practitioners in occupational health (OH) and the current challenge in acquiring those skills and the knowledge which sets occupational health practitioners apart.

The paper has been written as an adjunct to the paper presented the Council in June 2010 titled '*Training and qualifications for occupational health nurses*' (Harriss, A. 2010), a valuable document which describes the training needs of nurses working in this speciality.

Research highlights the value of the multi-professional approach to occupational health and the various skilled streams of intervention required to support an individual to remain in or return to work (Waddell et al 2004). There is a need for employers, human resource officers and commissioners of both health services and education to recognise the complexity and the fine relationship between mental and physical health, social status and social influence on an individual, all of which need addressing for that individual to sustain a successful role in the workplace.

Although it began as an Allied Health Profession's report, this paper has grown considerably in representation as additional professions engaged in occupational health have requested to contribute to a common voice. The healthcare professionals working in OH include ergonomists, occupational therapists, physiotherapists and psychologists. They each have an essential role to play in the provision of health and wellbeing services in the UK.

This paper is a collaborative piece of work produced by the professional bodies and specialist practitioners of The College of Occupational Therapists, The Chartered Society of Physiotherapy, The British Psychological Society, The Ergonomics Society.

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