British Society of Rehabilitation Medicine
Promoting quality through education and standards

Vocational Rehabilitation: BSRM brief guidance

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FOREWORD

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This brief guidance is very timely because the vocational rehabilitation challenges to health care systems including the NHS, have never been greater. But the risk is that it will only be read by those in training or with a specific interest when in reality the subject and its importance should be part of the training of medical students and all clinicians, whether medical or not.

The guidance is slanted toward the medical clinician as might be expected from the BSRM, but the principles and guidance are part of the universal language of rehabilitation and the need for a multidisciplinary approach and teamwork are appropriately emphasised.

74 years after the formation of the NHS – why is this subject still neglected by a service which still does not provide VR to most of those who need it? The fault lies in the narrow specialisation of modern health care where for example, cardiology does cardiac rehabilitation, respiratory – respiratory rehabilitation, Spinal problems – spinal, upper limb problems – specific rehabilitation , etc, and a patient attending my occupational medicine clinic recently described mentioning a wrist problem to a therapist she was seeing for a neck issue – to be told "I can't deal with that here". Thus the revolving door of often unnecessary referral continues, often with the consequence of job loss.

Our demographics do not help. We have an ageing population and workforce of whom at least 33% have multiple morbidity. While pension age increases the reality is that 50% of the UK workforce fall out of work between 50 and 65 (source ONS 2014).

Policy makers worry about the huge costs of health related benefits and these are increasing, but it can be argued that for a significant number of people work loss can be prevented by low cost VR services.

Adding to this picture is the recent tsunami of long term health problems due to Covid 19 infection, with an additional 1 million people , most of working age , needing multidisciplinary support and VR and at risk of job loss.
Recently the Council for Work and Health wrote to the four CMOs advocating " evidence-based NHS services for people with Long Covid, across the nations of the UK that work with occupational and vocational rehabilitation specialists on return to work."

The CMO response was restricted to a statement that "Developing and delivering effective, research-led support for people with Long COVID is an important part of the recovery from the pandemic "… and that it was funding more research.(6th August 2021)

The challenges facing Vocational Rehabilitation services appear therefore to be very great when even the CMO offices do not understand its effectiveness.

More awareness raising needs to be done. This guidance document is a very useful contribution to this and should be widely distributed.

Professor Ewan B Macdonald

12th August 2021

1. Executive summary and recommendations

1. This document provides brief, practical guidance to support consultants and trainees in Rehabilitation Medicine (RM) and other specialties and disciplines, who offer Vocational Rehabilitation (VR) to adults, and to support consultants in their conversations with service managers and commissioners so that VR services are embedded within health service provision.
2. RM Consultants play a vital role in VR and should be closely involved both at a clinical level and in the delivery development and management of VR services.
3. There is clear consensus on the elements that are critical to the delivery of a successful VR service, and a substantial body of trial-based evidence and other research internationally, and in the NHS, to support both the effectiveness and cost-effectiveness of VR.
4. There are many providers of VR including the Department for Work and Pensions (DWP), voluntary sector, occupational health departments (OH), and private providers including insurers. Individuals also obtain helpful support and advice from unions. The core of the VR intervention is a co-ordinated plan supported by all those working with the employee to optimise their work capability.
5. Since inception the NHS has recognised the critical links between work and health and in 2019 the Academy of Medical Royal Colleges, the Royal College of Nursing, and the Allied Health Professionals Federation published a consensus statement for action on health and work. Despite this document and many others, the NHS does not meet the need for VR.
6. Any individual with physical, cognitive and psychological impairments or health conditions who is experiencing obstacles to accessing, maintaining or returning to employment or other useful occupation may benefit from VR.
7. The RM clinician, with the VR team should work within a biopsychosocial model, aware that psychosocial factors can act as the obstacles to an individual's return to work. The unique contribution of the physician is the understanding of diagnosis and prognosis, and an analysis of how different impairments interact and the treatment of such impairments.
8. In general, service provision can be considered as occurring at one of three levels. Level 1 involves the provision of 'positive' messages about work and signposting to relevant information and sources of help. All clinicians should be able to undertake this work. Level 2 should be within the remit of any rehabilitation service and consists of people with 'straightforward problems' needing tailored information, advice and support to help them return to work, and Level 3 describes specialist VR services for patients with the most complex problems.
9. Ten different elements in a VR intervention can be identified including the initial assessment, information provision, generic work skills, specific work skills, job identification, applying for jobs, liaison with work and other services, return to work, supportive work exit and the final review. Understanding these elements can help provide a service specification and support business case development.
10. All services should capture outcomes but currently there is no national dataset or consensus, so each service will have to decide which measures are most helpful, given the client group and service specification. A sensible data set would include basic demographics, work status, relevant symptom measures, a work instability measure (if available for the client group) and measures of presenteeism, absenteeism and a work-related self-efficacy scale[1].
11. The capabilities and specialist skills for RM physicians are described within the document and map on to the GMC curriculum for specialist training[2]. There are additional capabilities for consultants.

12. People wishing to undertake further training in VR are directed towards Health Education England in 'e-Learning for Health' module 'Health and Work in Undergraduate Medical Education'. This module contains appropriate materials for undergraduates and trainees.

General recommendations

1. In order to practice within Vocational Rehabilitation, RM doctors must operate within the ethical framework outlined in Good Medical Practice[3], and all clinical encounters must be documented accurately. VR doctors need to be aware of the relevant legislation including:
   - Health and Safety Act[4]
   - Mental Capacity Act[5]
   - Equality Act[6]
   - General Data Protection Regulations[7].

   The Health and Safety Act[4] is of particular importance as obligations placed on employee and employer take priority over all other legislation.
2. Specialists must not share clinical information with other professionals particularly employers, colleagues and Jobcentre Plus, without the express consent of the patient. All documents should be shared with the patient prior to sending to a third party unless the patient expressly states that they do not wish to see the document.
3. All doctors should know how to take a full work history.
4. RM physicians working in VR should be aware of local resources and services that support people in the workplace and work collaboratively with them.
5. Local areas should develop their own regional vocational networks and, over time, these networks share more widely, contributing to the development and maintenance of good practice and offering opportunities for training, collaborative research, case presentation/discussion etc.

Initial Assessment

6. Conduct a comprehensive initial assessment. This should include
   - Medical history
   - Work status
   - Employment history
   - Qualifications
   - Other skills
   - Functional assessment (impairments and disabilities including language)
   - Cognitive and behavioural assessment
   - Environmental and social obstacles.
7. Consider whether a third-party report of performance would be helpful, (eg from employer, occupational health or relevant private sector assessment).
8. From the initial assessment, identify whether the individual has the pre-vocational skills in place and if not, agree a programme towards achievement, then review.
9. Ensure the individual is ready to engage with the vocational process, has identified goals and is committed to action.

10. Refer on, where appropriate, for further assessments, (eg specific physical or mental health needs requiring management or advice).
11. Agree with the individual a VR plan.

Information provision

12. Discuss the advantages and disadvantages of informing the employer or colleagues of the disability (disclosure), inform the individual that they do not have to disclose, but disclosure is associated with maintaining employment.
13. Inform the individual of their obligations under the Health & Safety at Work Act[4].
14. Inform the individual that they are protected by the Equality Act[6].
15. Inform the individual about the nature of a reasonable adjustment.
16. Inform the individual, as appropriate, about Access to Work.
17. Refer the individual, as appropriate, to vocational assessment, rehabilitation and support services to give every possible opportunity to remain in work.
18. Inform the individual about appropriate national and local resources.
19. Advise the individual of the need to obtain financial advice about the consequences of changing work patterns.

Generic work behaviours

20. Provide individual or group treatment sessions for identified difficulties that impact on work place behaviours.
21. Support, where appropriate, the individual, to work with their employer to manage job demand.

Specific work skills

22. Conduct a detailed work assessment with the support of relevant colleagues (eg occupational health (OH), occupational therapy (OT), physiotherapy, psychology) the individual and their co-workers and supervisors.
23. Offer graded task practice to address any identified difficulties.
24. Liaise with employer around appropriate work-place adjustments, including the provision of specialist equipment.

Job identification

25. Specialist programmes which support redeployment or identification of potential new jobs should offer:
    - careers guidance and vocational counselling to identify a suitable job
    - links with Jobcentre Plus, or local Employers' Partnership or Employers' Forum
    - 'work tasters' to sample alternative avenues of occupation
    - voluntary work trials
    - permitted work options

- supported work placements.

Such placements need to be well planned and implemented to avoid a negative effect on a person or their relatives. With care they should help to increase confidence in returning to work, help with gaining insight re potential problems (for both patient and employer), allow effective planning to adjust a role or provide appropriate support, plan phased return with supportive review.

Job application skills

26. Specialist VR programmes which support redeployment or identification of potential new jobs should offer job application skills training.

Liaison with other work-services/workplace/place of education

27. Undertake a detailed workplace assessment.
28. When a person is in education or training, contact should be made with the relevant Academic/ Course Tutor and, as appropriate, with the Learning Support Department and/or Personal Tutor, to discuss the identified difficulties and support needs.

Return to work

29. Support individuals with fluctuating conditions (including mental health conditions), to have an agreement with line managers about the actions to be taken in the event of a recurrence.
30. Support individuals to have a return to work (RTW) plan that is graded (phased) in terms of hours, and complexity.

Supportive work exit

31. Support individuals to have planned work exit, addressing financial impact and identifying other meaningful occupation.

Final review

32. Identify if routine reassessment is appropriate.
33. Report outcomes on an annual basis for the service in a service report.

2. Introduction

2.1 Importance of Vocational Rehabilitation (VR)

Access to good work is important. Good work provides structure to the day and companionship. It is associated with improved self-esteem and mental wellbeing, and provides an income.

Every year over 170 million days are lost to sickness absence. The Government's Black Review[8] of the health of the working age population reported the cost to the economy is estimated to be £100bn each year. Research shows that the longer people are off sick, the less likely they are to make a successful return to work. After six months absence from work, there is only a 50 per cent chance of someone making a successful return.

Being able to stay in work or return to work is an essential part of an individual's recovery from a disabling illness. While many patients are able to return to work with little if any need for any assistance, some will need professional help, whether because of ongoing functional changes, workplace concerns, or psychological issues (or a combination of all three factors) and VR is the process which can help them achieve this goal. VR not only supports individuals, but it ensures work-place productivity and is good for the wider society, converting benefits recipients into tax-payers.

Vocational Rehabilitation may be defined as a process which enables persons with physical, cognitive and psychological impairments or health conditions to overcome obstacles to accessing, maintaining or returning to employment or other useful occupation[9].

Alternatively, Vocational Rehabilitation is

"Whatever helps someone with a health problem to stay at, return to and remain in work: it is an idea and an approach as much as an intervention or a service"[10]

In addition, for many people with progressive conditions VR should include, at an appropriate time,

Supporting someone with a health problem to have a good exit from the work place which includes

- understanding the financial implications
- knowing helpful habits and routines and
- having identified meaningful occupation.

2.2 Current context

The BSRM have written four previous documents on VR[9-11-13], Since the last BSRM guidance in 2010 the work environment has changed. This document has been prepared during the Covid-19 pandemic 2020, and this has sharpened focus on rehabilitation services. Following this pandemic many people will experience fatigue, mild cognitive impairment and emotional distress which may impact on their ability to return to work. In addition, the pandemic has altered work practice, and is expected to lead to a global economic decline, with associated job loss. The number of people working in the 'gig' economy has increased. While zero hours contracts offer flexibility, they also contribute to the causes for people needing more than one job, and to more people experiencing precarious employment.

This document provides brief, practical guidance to support consultants and trainees in Rehabilitation Medicine (RM) and other specialties and disciplines, who offer VR to adults. It will support consultants in their conversations with service managers and commissioners to enable VR services to be embedded within health service provision.

3. Background

3.1 What is rehabilitation?

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychological function, participation in society and quality of living[2].

3.2 What is specialist rehabilitation?

Specialist rehabilitation is the total active care of patients with complex disabilities by a multiprofessional team who have undergone recognised specialist training in rehabilitation, led /supported by a consultant trained and accredited in rehabilitation medicine (RM)[2].

3.3 Specialist rehabilitation in Vocational Rehabilitation

In the context of VR the core activities of a Consultant in RM include:

- Diagnosis and medical management of conditions causing complex disability. These include congenital and acquired conditions, single incident and progressive disorders, and also any pre-existing physical, psychological or mental health conditions.
- Anticipation and prevention of physical, psychological and social complications, based on knowledge of a condition's natural history and prognosis.
- Evaluation of potential to gain from rehabilitation and prognosis for recovery.
- Defining VR needs and directing patients to appropriate VR services.
- Coordinating care and collaborating with other colleagues from NHS, social care, DWP, voluntary and insurance sectors.
- Communicating with families to provide information, support them in distress and manage expectations.

RM Consultants therefore play a vital role in VR and should be closely involved both at a clinical level and in the delivery, development and management of VR services. They should be particularly involved with the planning of specialist services for patients with complex needs, but also provide a networking role to support local non-specialist services. They also provide an important resource of advice and training of staff within the VR centres/units with respect to rehabilitation needs and interventions.

4. Vocational Rehabilitation – the evidence

4.1 Programme content

There is clear consensus on the factors that are critical to the delivery of a successful VR service[14].

- Specialist VR services with access to a multidisciplinary team
- Early intervention, open access, responsive and personal services
- Support managing work performance
- Liaison with employers to ensure work-place modifications and redeployment
- Education and support
- Support to re-enter the work place.

4.2 The Cost effectiveness of Vocational Rehabilitation

There is now a substantial body of trial-based evidence and other research internationally, and in the NHS, to support both the effectiveness and cost-effectiveness of VR. The research can be divided into VR for disabilities, long-term sick leave and specific conditions, such as musculoskeletal and mental health conditions.

Disabilities

A cost benefit analysis of the services offered by the Australian Government funded Vocational Rehabilitation provider "Commonwealth Rehabilitation Services (CRS)" for disabilities, illnesses and injuries was undertaken. It showed a total return of $30 for every $1 invested, of which, $16:00 was to the state and $14:00 to the individual[15]. When the Canada Pension Plan Disability (CPPD) Vocational Rehabilitation Program was introduced for disabilities it improved the labour market outcomes for women enough to pass a cost-benefit test of the programme[16].

Long-term sick leave

In Sweden the "Stockholm co-operation Vocational Rehabilitation project" was designed for those on long-term sick leave, but not on a disability pension. It consisted of more frequent, client centred, cross-sector meetings, and demonstrated economic gains of up to €1,278 per person per month[17]. The six year follow up study of this project using sickness absence and social insurance records showed the gains persisted, with an average economic benefit of €36,600 per person over the six years[18]. In the UK, York Hospital NHS Foundation Trust provided early rehabilitation intervention for their staff who were ill and on sick leave. They invested £160,000 and found a 40% reduction in long-term sickness, with cost savings of £1.2 million per year[19].

Specific conditions

Musculoskeletal conditions: Systematic reviews of VR suggest that stakeholder participation and work modification are more effective and cost-effective at getting adults with musculoskeletal conditions back to work than other workplace-linked interventions, including exercise[20]. In Quebec a fully integrated VR disability prevention model for occupational back pain was cost beneficial for the workers' compensation board and reduced the number of days on benefits more than usual care, or partial interventions[21]. In the UK, even a four hour VR intervention costing £135 per person for inflammatory arthritis reduced presenteeism, absenteeism, perceived risk of job loss and improved pain and health status more than written advice alone[22].

At Colchester University Hospital NHS Foundation Trust allowed staff with musculoskeletal disorders early access to rehabilitation and found 53% of staff remained in work and 21% of staff returned to work within eight days. Savings of £586,000 were realised over six months[19]. Extrapolating data beyond standard trial

follow ups for musculoskeletal disorders, it has been demonstrated that VR interventions that only result in a small improvement in return to work remain cost-effective due to the high ongoing sick pay costs associated with being on sick leave. Not only this, but VR interventions have a relatively low cost per Quality Adjusted Life Year compared to other interventions routinely recommended by NICE[23].

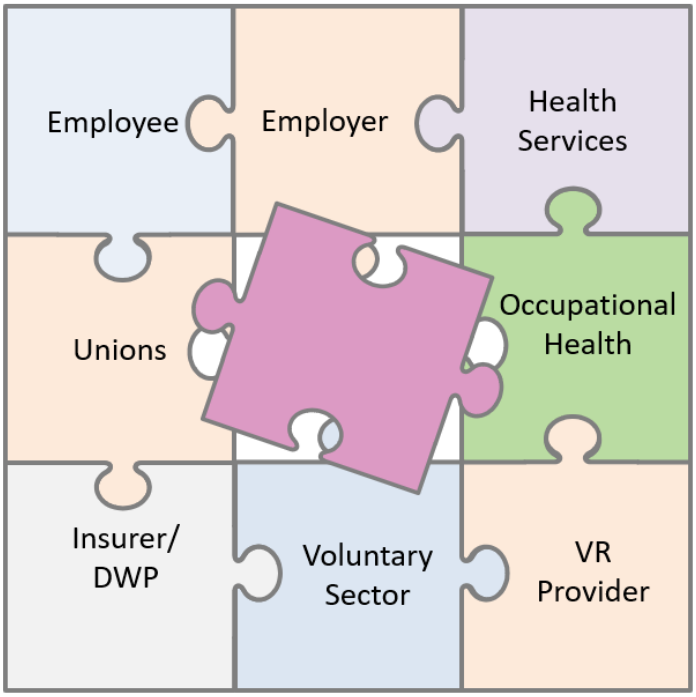
Mental Health conditions: In New York people with Schizophrenia enrolled with VR in the form of the One year Nassau Day Training Program (NDTP), not only achieved cost savings through significantly more months employed for three years after the intervention, but also through significantly fewer admissions for three years after the intervention[24]. The cost effectiveness of VR for Schizophrenia was again demonstrated in Norway in the form of the ten-month Job Management Program (JUMP). In the two years follow up mean mental health costs adjusted for baseline differences were €10,621 lower in the JUMP group than those who received treatment as usual[25]. A systematic review including ten studies on sickness absence in people with mental health conditions showed that VR interventions can be cost effective, particularly when coping skills are taught[26]. The systematic Review authors comment that using Quality Adjusted Life Years and Incremental Cost-effectiveness Ratios as outcomes is not appropriate when trying to measure work productivity and continued employment, sickness absence, return to work and transitions to long-term disability would be more useful outcomes[26].

Evidence for effectiveness of interventions is discussed in Measuring the benefits of VR in Section 6.

5. Vocational Rehabilitation in the UK

Vocational Rehabilitation (VR) is provided in a wide range of settings. Common sources of VR support are the DWP, voluntary sector, occupational health departments, and private providers including insurers. Individuals also obtain helpful support and advice from unions. The VR programme may be led by a VR specialist, but it is essentially a collaborative effort that involves the treating clinician, the individual themselves, their employer and the benefits provider (the DWP or a private insurer, for example). The core of the VR intervention is a co-ordinated plan supported by all those working with the employee to optimise their work capability. Thus, doctors may be approached by other providers of VR for their advice and support. In this situation the doctor has a responsibility to work in the patient's best interests with a team that may be external to the NHS.

Figure 1 – Potential components of Vocational Rehabilitation



Doctors need to be aware of the range of resources available to them in supporting patients in the workplace.

5.1 Resources supporting patients in the workplace

Occupational Health (OH) services aim to both keep employees healthy and safe whilst in work and manage any risks in the workplace that are likely to give rise to work-related ill health. Typically, OH provision is by doctors and nurses, and in some workplaces, physiotherapists. While some practitioners have completed specialist OH physician or nursing training, some advice may be provided by staff with no higher qualification in OH. Consequently, the level of OH and clinical knowledge provided by OH professionals varies between employers.

Provision of OH for working age adults is not a statutory function for the NHS or employers in the UK and consequently is at the discretion of the employer. It is estimated that about half of the UK workforce has OH service coverage, this particularly affects employees in small and medium enterprises (SME). A number of different models of OH provision exist in the UK.

Occupational Health Provision (correct as of December 2020)

NHS based services

Some NHS based occupational health services provide significant services for the commercial sector including service to small and medium sized enterprises.

Healthy Workinng Lives (Scotland)

A Scottish Executive funded project which provides free and confidential advice, training and support for Scottish businesses. Covers all aspects of health, safety and well-being in the workplace.

Commercial Occupational Health (OH) providers

Provide near national coverage of services to a range of industries and businesses. In addition, there has been an increase in the number of smaller independent, privately-owned and operated, OH services.

Fit for Work

Offers free, expert and impartial work-related health advice. Supports GPs, employers and employees to help those who are in work with health conditions or off sick. It is designed to work alongside, not replace, existing OH services and employer sickness absence policies.
https://support.fitforwork.org/app/answers/details/a_id/604/~fit-for-work-advice-line

Department for Work and Pensions (DWP) services

Offered through Jobcentre Plus by Work Coaches who undertake detailed assessments

- Access to work
  – money towards a support worker or for the cost of equipment or travelling to work
- Intensive Personalised Employment Support
  – training and help to get an individual into work
- Specialist Employability Support
  – to help an individual get ready for employment or become self-employed
- Work and Health Programme
  – to help an individual find and keep a job.

Local Authority

Mainly through Adult Social Services Departments – have a number of key functions and commission or provide a range of services which are relevant to the vocational needs of individuals with long-term conditions (LTCs). The range of services will vary but may include:

- Advice and information
- Social work services, often with specialist workers who deal with disabled adults include: those with LTCs, sometimes specialist workers for people with brain injury, and specialist support for people with sensory needs (ie hearing and/or visual impairment)
- Day centre facilities or other resources for occupational, social, cultural and recreational activities outside the home
- Transport concessions, including the 'blue badge' parking scheme.

Trade Unions

Will act as advocates for workers and make workplaces more inclusive for disabled workers. Unions are useful places for advice and support in the workplace, particularly around issues like negotiating reasonable adjustments, and supporting people who report discrimination.

Voluntary sector

Patient-based charities and other voluntary groups providing advice and support, prevocational skills, work training and voluntary placements, eg Disability Rights UK, Leonard Cheshire Foundation etc.

Independent sector

Often funded through insurers. Represents the majority of VR providers. Provided by different types of staff, many of whom have clinical backgrounds.

Occupational benevolent funds

A large number of occupational benevolent funds exist eg military.

5.2 Vocational Rehabilitation in the NHS

Since inception, the NHS has recognised the critical links between work and health[8,20,27-33]. More recently several reports have emphasised this and advocated that addressing work issues is an appropriate part of health care.

In 2019 The Academy of Medical Royal Colleges, the Royal College of Nursing, and the Allied Health Professionals Federation published a consensus statement[34] for action on health and work including a statement for action of particular relevance to VR and Rehabilitation Medicine:

"We will work together, as individual organisations and collaboratively, to enable every healthcare professional to:

- Understand the health benefits of good work, and the long-term effects of avoidable health related worklessness.
- Have the skill to incorporate discussions about working in the context of a health outcome with patients in their care, as appropriate to the health or disability of that individual.
- Feel supported to understand and interact with the wider health and work system, employers, occupational health services and other bodies that have a role in assisting individuals who are not working for health related reasons.
- Recognise their own role to support healthy and safe working environments, looking after their own health and wellbeing and those of their colleagues."

Although these recommendations and requirements are increasingly reflected in education, service provision and service development, the NHS does not yet meet the need for VR eg a survey in 2010 suggested that at best only 10% of the need for VR for people with long term neurological conditions is met[35]. Few commissioned multidisciplinary musculoskeletal services were focused on employment needs or vocational rehabilitation.

5.3 Which patients would benefit from Vocational Rehabilitation?

Any individual with physical, cognitive and psychological impairments or health conditions who is experiencing obstacles to accessing, maintaining or returning to employment or other useful occupation may benefit from VR.

Criteria for the access to VR will vary from service to service and depend on the context within which that service operates. Many services are resource limited, and this prevents them working with the most disabled patients and those who are not yet 'ready for work', however that is defined. Most VR services will work with people who are making key workplace transitions. These include

- Initial employment
- At diagnosis
- Time off with sickness
- Job change which may be due to
    - Job loss
    - manager change
- Progressive difficulties
- Considering retirement

At such points clinicians should be particularly alert to difficulties in the workplace. It can be helpful to ask, 'how is your CVA/arthritis etc affecting you at the moment?' followed by a question asking 'how that plays out in the workplace?'. If patients are asked directly whether they have workplace difficulties, they will often deny it as this can be perceived as a painful assault on identity and a threat.

In many instances the assistance needed is minor and may be limited to assessment, giving advice and setting expectations, and possibly organising relatively simple interventions. A patient with good self

efficacy may simply need a single coaching session to allow them to self manage and negotiate change successfully. This is a VR intervention that should be within the capacity of all clinicians. A significant number of patients will have more complex needs requiring more prolonged input from a multidisciplinary team with expertise, and a smaller group will need more prolonged specialist rehabilitation (in- or out-patient). For the person with a progressive condition, leaving work should be actively managed so they chose to retire at the point at which they are about to lose work capability.

People working in the field of VR recognise that it is not just the diagnosis, prognosis and the physical, sensory and cognitive impairments that create obstacles to successful working, but also how these are affected by personal and environmental factors. Beliefs about work and health, family values and behaviours and work place environment and culture, for example, can all have a significant influence on work success. In musculoskeletal medicine, this has been described using a variety of flags (*see figure 2*).

Yellow, blue and black flags may be regarded as warning signals that psychosocial factors are acting as obstacles to the individual's return to work. These flags can also be used in other areas of VR. Kendall and colleagues have summarized these flags and provide a stepped approach to tackling musculoskeletal problems[36].

Figure 2 – Psycho social flags framework[36]

	**Red flags – medical red flags eg loss of weight, recurrent pneumonia**
	**Orange flags** – psychiatric 'red' flags eg depression
	**Yellow flags** – beliefs, appraisals and judgements
	**Blue flags** – perceptions about the relationship between 'occupation' and health
	**Black flags** – systems or contextual factors eg Equality Act, health care services

While the rehabilitation team, as well as the RM clinician, will be working to a biopsychosocial model, the unique contribution of the physician is the understanding of diagnosis and prognosis, and an analysis of how different impairments interact and the treatment of such impairments.

5.4 Service models for Vocational Rehabilitation

A specialist Vocational Rehabilitation (VR) service for people with long term conditions is characterised by a multi-disciplinary team with expertise in disabling conditions and expertise in VR who through shared education and learning and by working with employees and employers in the work-place can meet the needs of the majority of their patients/clients.

Service models for specialist rehabilitation provision vary according to local policy, geography and existing service provision. For example, in Long-term neurological conditions (LTnC), 142 services providing VR in England were identified. Thirty-three (23%) were dedicated VR services and 108 (76%) offered VR as a component of a generic or neurological rehabilitation service. Most of the services (71.2%) saw fewer than 25 people with long-term neurological conditions each year. Only 13 (9%) of the identified services saw more than 50 people with long-term neurological conditions each year. Almost two thirds of the services (n=85) were well established (had been running for at least 5 years) and only 22 (15.5%) were new or emerging services; set up in the last two years. Only a third (33%) of services reported carrying out routine evaluation or long-term monitoring of vocational outcomes and just over a half (55%) reported using outcome measures. Only a quarter (25%) of services undertook regular audits. Forty-two (29.6%) of the respondents stated that they had never received any training in VR. The situation has changed little since then.

The elements identified as part of the VR process are as shown in figure 5. While there is inevitable overlap, it is rare for any but the highest level providers to offer support with job identification and job seeking. This model has been discussed and validated by the University College London Partners (UCLP) Vocational Rehabilitation Group which has representation from eight different NHS VR services which were established in a range of settings. For a more detailed description of this process see Appendix 1.

https://www.ucl.ac.uk/centre-neurorehabilitation/other-activities

Level Descriptors *see Appendix 1*

Figure 3 – Service level descriptors for VR

https://www.ucl.ac.uk/centre-neurorehabilitation/other-activities

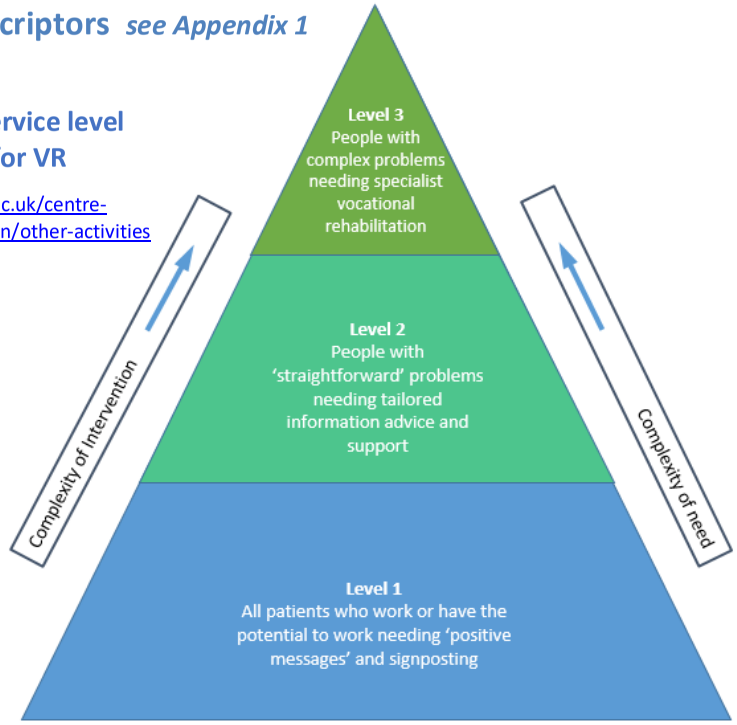
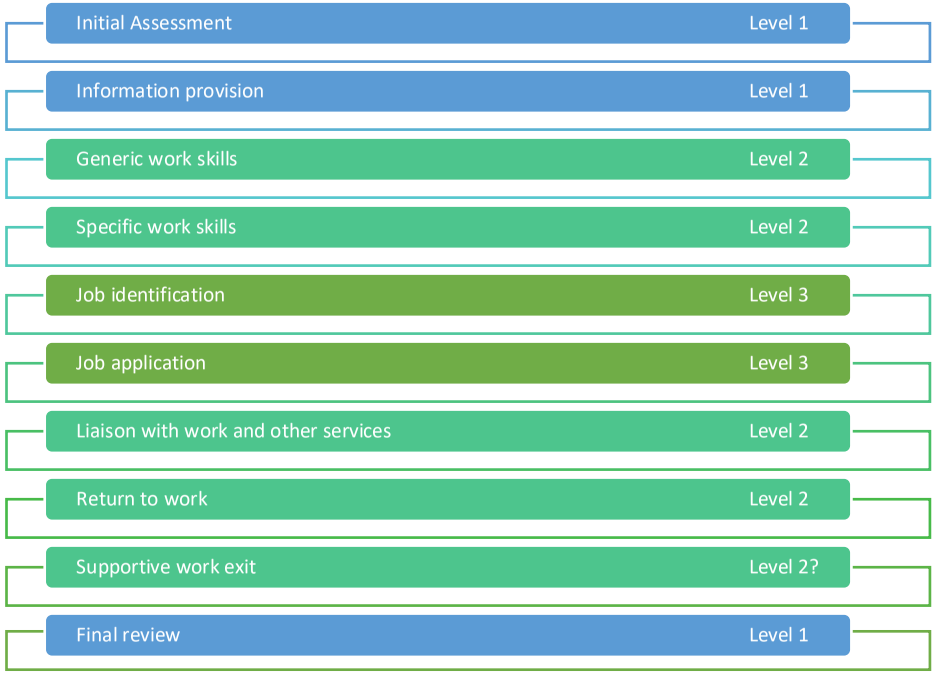


Figure 4 - Potential staffing levels

Figure 5 – The different elements in Vocational Rehabilitation



6. Measuring the benefits of Vocational Rehabilitation

Measuring outcome for VR is challenging. Evaluation can be targeted at the underlying impairments and disabilities including psychiatric symptoms such as anxiety, depression and burn-out; personal factors such as beliefs about pain, or work-place self-efficacy; and perceptions about the work place such as the need for long hours, or supervisor support. For those unemployed at the beginning of the work intervention, change in work status (eg unemployed to employed part-time), is a helpful measure, but for those who are in work measurement is more difficult. A successful intervention may include a patient moving from full time to part time work, or from a higher paid, more demanding work, to lower paid and more flexible work, or even choosing the right time to retire. Work instability scales can be helpful in this situation as they measure the difference between work place demands and person capacity. Different measures of sick leave may also be helpful; such measures can include the frequency of sick leave, the length of absence, the incidence rate for sick leave, the cumulative incidence, and the duration of absence[37]. A patient who has moved from full time to part time work may take less sick leave. Measures can be targeted at the amount of time spent in work, or can examine the financial aspects including income, tax, and benefits. One difficulty with undertaking a cost benefit analysis is that traditional health economic analysis does not look at the use of benefits, and thus the impact can be difficult to demonstrate.

There is no national data set or consensus, and each service will have to decide which measures are most helpful, given the client group and service specification. A sensible data set would include

basic demographics,

- Work status: whether in full- or part-time work; the number of contractual hours they work and the number of actual hours they work
- Relevant symptom measures including fatigue and stress/distress scales.
- A Work Instability Measure if available for the client group[38]
- Patient reported and recorded presenteeism
- Patient reported and recorded absenteeism
- A work related self-efficacy scale.

Commonly used scales include the Work Productivity and Activity Impairment Questionnaire General Health V2.0[39], and the occupational self-efficacy scale.

http://oml.eular.org/sysModules/obxOML/docs/id_98/WPAI-GH_English_US_V2.pdf

Useful papers on this topic are given in Appendix 2.

7. Competencies, specialist skills for Consultants in Rehabilitation Medicine

In order to meet the standards laid out in this document, a pool of appropriately skilled Consultants in Rehabilitation Medicine will be required. The current curriculum for specialist training in Rehabilitation Medicine does not adequately address the specific competencies required for VR. Recommendations for training are detailed in Appendix 3.

Education

The GMC's 'Outcomes for Graduates'[40] describes the principles of holding a fitness for work conversation with patients, including assessing

- social, physical, psychological and biological factors supporting the functional capacity of the patient, and how to make referrals to colleagues and other agencies.
- explain how psychological aspects of behaviour, such as response to error, can influence behaviour in the workplace in a way that can affect health and safety and apply this understanding to their personal behaviours and those of colleagues.

Health Education England in 'e-Learning for Health' have produced a module for medical students 'Health and Work in Undergraduate Medical Education'. This module contains appropriate materials for undergraduates and RM trainees[41].

e-Learning for Health module content in 'Health and Work in Undergraduate Medical Edition'

1. Impact of work and worklessness on health
   - 1.1 Work and health
   - 1.2 Talking about work with patients
2. Enabling patients to stay in and return to work
   - 2.1 The law around work
   - 2.2 Enabling patients to stay in and return to work
   - 2.3 Supporting patients on the benefit of work
   - 2.4 Fitness for work and the Fitnote
   - 2.5 Disability and work
   - 2.6 State benefits for sick and disabled people
   - 2.7 An introduction to Occupational Health Services
   - 2.8 Return to work and stay in work after: surgery, injury and illness
   - 2.9 Recognising illness that may be caused by work
   - 2.10 Living with illness and work
3. Working as an effective team member
   - 3.1 The multidisciplinary team supporting work-related health
   - 3.2 The roles of a work-related team and how they work collaboratively
   - 3.3 Identify impact of physical and mental health on your own productivity
   - 3.4 Recognising and supporting biopsychosocial principles of work-related health amongst colleagues
   - 3.5 Health promotion and prevention of work-related illness
4. Case studies
5. Lecture notes

However, the RM curriculum states that 'All admitting doctors should know how to take a full work history'. For a practical guide on how to bring "work" into any healthcare consultation, please see 'Talking work: A guide for doctors discussing work & work modifications with patients'[42].

Edited extracts (with permission) are included in Appendix 4.

8. Recommendations for Vocational Rehabilitation

8.1 General recommendations

In order to practice within Vocational Rehabilitation, RM doctors must operate within the ethical framework outlined in Good Medical Practice, and all clinical encounters must be documented accurately. VR doctors need to be aware of the relevant legislation including

- Health and Safety Act
- Mental Capacity Act
- Equality Act
- General Data Protection Regulations.

1. The Health and Safety Act is of particular importance as obligations place on employee and employer take priority over all other legislation.
2. Specialists must not share clinical information with other professionals particularly employers, colleagues and Jobcentre Plus without the express consent of the patient. All documents should be shared with the patient prior to sending to a third party unless the patient expressly states that they do not wish to see the document.
3. All doctors should know how to take a full work history and this should be specified within the next edition of Outcomes for graduates.
4. RM physicians working in VR should be aware of local resources and services that support people in the workplace and work collaboratively with them.
5. Local areas should develop their own regional Vocational Networks and, over time, these networks could share more widely, contributing to the development and maintenance of good practice and offering opportunities for training, collaborative research, case presentation/discussion etc.

8.2 Specific recommendations

These recommendations are presented framed around the 10 elements that comprise a comprehensive NHS VR service. The main element is described in the header of each block, with a brief description of the activities and intervention that comprise that element in the first column. The related recommendations are summarised in column 2, and links to further useful advice and resources are in column 3.

INITIAL ASSESSMENT **Has the individual got a job?** **Are they at risk of losing a job?** **Does the individual meet the service specification?** **Are the prevocational skills in place?** **Does the individual want to engage?**		
Intervention	**Recommendations**	**Further advice - links**
Interview and assessment	Conduct a comprehensive initial assessment. This should include: • Medical history • Work status • Employment history • Qualifications • Other skills • Functional assessment (impairments and disabilities including language) • Cognitive and behavioural assessment • Environmental and social obstacles Consider whether a third party report of performance would be helpful. Identify whether the individual has the prevocational skills in place. Ensure the patient is ready to engage with the vocational process, has identified goals and is committed to action. Refer on, where appropriate for further assessment Agree with the individual a VR plan.	Undergoing a disciplinary process at work can have a negative impact on work function, mental health and well-being[43]. Prevocational skills include the ability to maintain a daily routine and access the community. Common referrals include sensory services, mental health services and pain services. A VR plan which may include some or all of the following, information provision developing workplace behaviours, developing specific skills relevant to work.

INFORMATION PROVISION
What does the individual need to know?

Intervention	Recommendations	Further advice - links
• Health and safety • Equality Act (2010) • Reasonable adjustments • Access to work • Disclosure • Local resources • Financial implications • ?Life plan	Discuss the advantages and disadvantages of informing the employer or colleagues of the disability (disclosure), inform the individual that they do not have to disclose, but disclosure is associated with maintaining employment. Inform the individual • of their obligations under the H&S at Work Act • that they are protected by the Equality Act • about the nature of a reasonable adjustment • about Access to Work as appropriate • about appropriate national and local resources. Refer the individual, as appropriate, to vocational assessment, rehabilitation and support services to give every possible opportunity to remain in work. Advise the individual of the need to obtain financial advice about the consequences of changing work patterns.	**Health practitioners** with an identified role in managing work-related difficulties (eg Occupational Therapist) or with expertise related to specific areas of difficulty eg: • Medical consultant (re diagnosis, prognosis, management of seizures, spasticity etc) • Neuropsychologist (re cognitive, behavioural and emotional difficulties) • Nurse Specialist (re continence, self-management of drugs, health education etc) • Occupational Therapist (re motor skills, fatigue, cognitive skills, activity analysis etc) • Physiotherapist (re posture, mobility, balance, etc) • Speech and Language Therapist (re communication and swallowing) **Jobcentre Plus services eg:** • Work Coach • Work Psychologist • Access to Work Support Unit/Adviser **Occupational Health Practitioner** (when involved) **Health and Safety representative** **VR services specialising in supporting people with a LTC** **Related websites and other publications**

		• Disability Discrimination Act (eg Equality and Human Rights Commission) • Employers' Forum on Disability (including booklets on specific conditions) • Health and Safety Executive • Chartered Institute of Personnel and Development **Job Accommodation Network** (including booklets on specific conditions) **Voluntary groups** supporting people with a LTC or with employment issues, some of which have a helpline facility as well as publications. **Locally dependent,** eg • UCL Partners Vocational Rehabilitation Network for London area; The Vocational Rehabilitation Association UK may advise on availability regionally and nationally from the independent sector • National Rehabilitation Centre.
GENERIC WORK BEHAVIOURS (may be individual or group) **What generic behaviours/skills do they need?**		
Intervention	**Recommendations**	**Further advice - links**
• Insight building • Work hardening • Fatigue management • Cognitive strategies • Building coping strategies, (including self efficacy) • Managing relationships	• Provide individual or group treatment sessions for identified difficulties that impact on work place behaviours • Support, where appropriate, the individual, to work with their employer to manage job demand.	See above

• Managing communication • Managing mood/anxiety/depression		
SPECIFIC WORK SKILLS **What does the individual need to do?** **How can they be supported to do it?** **Improvements/Compensations/Modifications of work performance**		
Intervention	**Recommendations**	**Further advice - links**
• Job analysis • Work simulation assessment • Risk assessment • Task practice • Individual project work	• Conduct a detailed work assessment with the support of relevant colleagues (eg OH, OT, physiotherapy, psychology), the individual and their co-workers and supervisors. • Offer graded task practice to address any identified difficulties • Liaise with employer around appropriate work-place adjustments, including the provision of specialist equipment.	See above

JOB IDENTIFICATION What job would meet the individual's needs?		
Intervention	**Recommendations**	**Further advice - links**
• Individual vocational guidance/job matching • Jobcentre Plus • Local volunteer bureaus • Voluntary work trials	Specialist VR programmes which support redeployment or identification of potential new jobs should offer: • careers guidance and vocational counselling to identify a suitable job • links with Jobcentre Plus, or local Employers' Partnership or Employers' Forum • 'work tasters' to sample alternative avenues of occupation • voluntary work trials • permitted work options • supported work placements. • Placements need to be well planned and implemented to avoid a negative effect on a person or their relatives. With care they should help to increase confidence in returning to work, help with gaining insight re potential problems (for both patient and employer), allow effective planning to adjust a role or provide appropriate support, plan phased return with supportive review.	• the requirements of the job match the skills of the person • the needs of the person are communicated clearly to the employer • health and safety training and insurance cover is provided by the employer • there is provision for on-site job coaching, when required • the person is guided and supported in adapting strategies to the workplace • the trial/placement is monitored closely through contact with the person and employer • the trial/placement does not impact negatively on either the person or their relatives.

JOB APPLICATION SKILLS Can they apply for a job effectively?		
Intervention	**Recommendations**	**Further advice - links**
• CV writing • Cold calling • Interview skills • Support with job seeking	• Specialist VR programmes which support redeployment, or • identification of potential new jobs should offer job application skills training.	
LIAISON WITH OTHER WORK SERVICES/WORK PLACE/PLACE OF EDUCATION **What do we need to know from other services?** **What can we teach others?**		
Intervention	**Recommendations**	**Further advice - links**
• Work site visit • Line manager meeting • Co-worker support • OH/Human Resources (HR) • Support with work site coaching	• Undertake a detailed workplace assessment • When a person is in education or training, contact should be made with the relevant Academic/Course Tutor and, as appropriate, with the Learning Support Department and/or Personal Tutor, to discuss the identified difficulties and support needs.	Examples of educational adjustments include: • adjustments to/flexibility in specific assignments/deadlines • adjustments to overall course (eg deferral/repetition of modules etc) • learning support equipment (eg computer, tape recorder etc) • individual learning support (signing, note-taking, reading services etc) • personal assistance • examination support (eg additional time, prompt notes, separate room) • additional general support from personal tutor.
RETURN TO WORK (new or previous job) **What needs to be done to ensure an effective return to work?**		
Intervention	**Recommendations**	**Further advice - links**
• Managing expectations (individuals, families and colleagues)	Support individuals with fluctuating conditions (including mental health conditions), to have an agreement with line managers about the actions to be taken in the event of a recurrence.	Recognise that return to work plans may need to take place over 3 – 6 months.

• Graded return plan • Continued work support • Formal review	Support indivduals to have a return to work plan that is graded (phased) in terms of hours, and complexity.	
SUPPORTIVE WORK EXIT **How can leaving work be managed without regret? How will the individual spend their time afterwards?**		
Intervention	**Recommendations**	**Further advice - links**
Planned retirement/redundancy	Support individuals to have planned work exit, addressing financial impact and identifying other meaningful occupation.	Employer pre-retirement programmes, unions, occupational benevolent organisations courses or mentoring Council for Voluntary Services Citizens Advice.
FINAL REVIEW **What did we do? What changed? What were the outcomes? Did this go as anticipated?**		
Intervention	**Recommendations**	**Further advice - links**
Capture outcomes	Identify if routine reassessment is appropriate Report outcomes on an annual basis for the service in a service report.	Reassessment may be needed in the following circumstances • fluctuation/progression of symptoms • change in job role • change in supervisor, manager or employer • completion of training • career progression, and/or • recognition of need for support.

Appendix 1

Development of Vocational Rehabilitation descriptors

The University College London Partners' (UCLP) Vocational Rehabilitation Network meets monthly and provides a forum for healthcare professionals (HCPs) working in VR to review best practice, discuss guidelines and legislation, review complex cases, and host speakers on current topics of interest.

Core members of the specialist multidisciplinary team includes representatives from the following VR providers

1. National Hospital for Neurology and Neurology Vocational Rehabilitation Service
2. Wolfson Medical Rehabilitation Centre Vocational Rehabilitation Service
3. Royal Free Rehabilitation Centre Community Rehabilitation Team
4. Homerton brain Injury Team
5. Aylesbury 'Working Out' service
6. RNOH SCI Vocational Rehabilitation team
7. Harrow Community Rehabilitation Team

Each of these VR teams had a different model of rehabilitation provisions, ranging from a single committed therapist in a Community Rehabilitation Team (CRT), to a service that, when commissioned, could offer 150 hours of input from a specialist MDT.

Six consecutive meetings were held with at least eight attendees representing the different services, and different disciplines including occupational therapy, psychology, speech & language therapy and doctors. Each service provided a verbal description of their service process with any supporting materials. These descriptions were broken down into discrete elements and entered onto a table, until all VR activities were identified, and a taxonomy agreed to the satisfaction of the participants. Having identified a common taxonomy for the different elements of VR, each service identified the elements that they provided. The services were then divided on this basis into three different levels. Having identified different levels of service provision, a broad service specification was developed

Open debate and discussion was held at each stage until consensus was reached amongst the participants.

A three level model of rehabilitation was agreed. This three tier system is similar to that identified by Eva and colleagues[44] who studied 11 different service offering services to patients with cancer. It also fits with model developed by Playford and colleagues[35] following a national survey of VR which identified specialist VR services, VR services offered as part of specialist neurological rehabilitation and VR offered as part of generic, non specialist rehabilitation.

Appendix 2

Papers on measuring outcomes for VR

Authors (year)	Reference	Type of paper	Health conditions	
Mateen, B. A., Doogan, C., Hayward, K., Hourihan, S., Hurford, J., & Playford, E. D. (2017).	Systematic review of health-related work outcome measures and quality criteria-based evaluations of their psychometric properties. *Archives of physical medicine and rehabilitation*, *98*(3), 534-560.	Systematic review	All	Multiple outcomes
Di Rezze, B., Viveiros, H., Pop, R., & Rampton, G. (2018)	A review of employment outcome measures in vocational research involving adults with neurodevelopmental disabilities. *Journal of Vocational Rehabilitation*, *49*(1), 79-96.	Systematic review	Neurodevelopmental conditions	Multiple outcomes
Elfering, A. (2006).	Work-related outcome assessment instruments. *European Spine Journal*, *15*(1), S32-S43.	Systematic review	Spinal cord disease	Multiple outcomes
Alheresh R, Vaughan M, LaValley MP, Coster W, Keysor JJ.	. Critical Appraisal of the Quality of Literature Evaluating Psychometric Properties of Arthritis Work Outcome Assessments: A Systematic Review. Arthritis Care Res (Hoboken). 2016 Sep;68(9):1354-70. doi: 10.1002/acr.22814. Epub 2016 Jul 27. PMID: 26679938; PMCID: PMC5844471.	Systematic review	Arthritis	Multiple outcomes
Hensing G, Alexanderson K, Allebeck P, Bjurulf P (1998)	How to measure sickness absence? Literature review and suggestion of five basic measures. Scand J Soc Med 26:133–144	Review	All conditions	Sickness absence
Gilworth G, Smyth MG, Smith J, Tennant A. (2016)	The Manual Work Instability Scale: development and validation. Occup Med (Lond). 2016 Jun;66(4):300-4. doi: 10.1093/occmed/kqv217. Epub 2016 Jan 7. PMID: 26747888.	(Psychometrics) Development and evaluation	Manual work	Work Instability
McFadden E, Horton MC, Ford HL, Gilworth G, McFadden M, Tennant A. (2012)	Screening for the risk of job loss in multiple sclerosis (MS): development of an MS- specific Work Instability Scale (MS-WIS). Mult Scler. 2012 Jun;18(6):862-70. doi: 10.1177/1352458511428463. Epub 2011 Oct 31. PMID: 22041093.	(Psychometrics) Development and evaluation	Multiple Sclerosis	Work Instability
Tang K, Beaton DE, Gignac MA, Bombardier C. (2011)	Rasch analysis informed modifications to the Work Instability Scale for Rheumatoid Arthritis for use in work-related upper limb disorders. J Clin Epidemiol. 2011 Nov;64(11):1242-51. doi: 10.1016/j.jclinepi.2011.02.002. Epub 2011 May 6. PMID: 21530170.	(Psychometrics) Development and evaluation	Upper limb disorders	Work Instability

Tang K, Beaton DE, Lacaille D, Gignac MA, Zhang W, Anis AH, Bombardier C; Canadian Arthritis Network Work Productivity Group. (2010)	The Work Instability Scale for Rheumatoid Arthritis (RA-WIS): Does it work in osteoarthritis? Qual Life Res. 2010 Sep;19(7):1057-68. doi: 10.1007/s11136-010-9656-y. Epub 2010 Apr 25. PMID: 20419502.	(Psychometrics) Evaluation	OA	Work Instability
Beaton DE, Tang K, Gignac MA, Lacaille D, Badley EM, Anis AH, Bombardier C. (2010)	Reliability, validity, and responsiveness of five at-work productivity measures in patients with rheumatoid arthritis or osteoarthritis. Arthritis Care Res (Hoboken). 2010 Jan 15;62(1):28-37. doi: 10.1002/acr.20011. PMID: 20191488.	Work Productivity	RA	
Gilworth G, Bhakta B, Eyres S, Carey A, Anne Chamberlain M, Tennant A. (2007)	Keeping nurses working: development and psychometric testing of the Nurse-Work Instability Scale (Nurse-WIS). J Adv Nurs. 2007 Mar;57(5):543-51. doi: 10.1111/j.1365-2648.2006.04142.x. PMID: 17284274.	(Psychometrics) Development and evaluation	Nurses	Work Instability
Gilworth G, Carey A, Eyres S, Sloan J, Rainford B, Bodenham D, Neumann V, Tennant A. (2006)	Screening for job loss: development of a work instability scale for traumatic brain injury. Brain Inj. 2006 Jul;20(8):835-43. doi: 10.1080/02699050600832221. PMID: 17060150.	(Psychometrics) Development and evaluation	Brain Injury	Work Instability
Verstappen SMM, Lacaille D, Boonen A, Escorpizo R, Hofstetter C, Bosworth A, Leong A, Leggett S, Gignac MAM, Wallman JK, Ter Wee MM, Berghea F, Agaliotis M, Tugwell P, Beaton D.(2019)	Considerations for Evaluating and Recommending Worker Productivity Outcome Measures: An Update from the OMERACT Worker Productivity Group. J Rheumatol. 2019 Oct;46(10):1401-1405. doi: 10.3899/jrheum.181201. Epub 2019 Apr 1. PMID: 30936275.	(Psychometrics) Evaluation	Rheumatological disorders	Productivity
Gilworth G, Chamberlain MA, Harvey A, Woodhouse A, Smith J, Smyth MG, Tennant A. (2003)	Development of a work instability scale for rheumatoid arthritis. Arthritis Rheum. 2003 Jun 15;49(3):349-54. doi: 10.1002/art.11114. PMID: 12794790.	(Psychometrics) Development and evaluation	Rheumatoid Arthritis	Work Instability
Reilly, M.C., Zbrozek, A.S. & Dukes, E.M. (1993)	The Validity and Reproducibility of a Work Productivity and Activity Impairment Instrument. *PharmacoEconomics* **4,** 353–365 (1993). https://doi.org/10.2165/00019053-199304050-00006	(Psychometrics) Evaluation	All conditions (disease specific version exist)	Work productivity
Ospina MB, Dennett L, Waye A, Jacobs P, Thompson AH. (2015)	A systematic review of measurement properties of instruments assessing presenteeism. Am J Manag Care. 2015 Feb 1;21(2):e171-85. PMID: 25880491.	Systematic review	All conditions	Presenteeism
Birgit Schyns & Gernot von Collani (2002)	A new occupational self-efficacy scale and its relation to personality constructs and organizational variables, European Journal of Work and Organizational Psychology, 11:2, 219-241, DOI: 10.1080/13594320244000148	(Psychometrics) Development and evaluation	All conditions	Self efficacy

Appendix 3.1

Specialist capabilities in Vocational Rehabilitation for Rehabilitation Medicine trainees Summary of skills and competencies

VR One	**Able to formulate a full Vocational Rehabilitation analysis of any clinical problem preventing work** *In addition to RM One Specialist capability in practice, the RM physician practicing in VR*
Descriptors	Takes a detailed educational and occupational (work, volunteer and leisure) history and is able to identify transferable skills
	Is able to assess readiness for VR, and has an understanding of motivational interviewing and other psychological models and their role in VR
	Can identify patients in whom detailed cognitive screening will be of benefit
	Is able to undertake a functional analysis of work related tasks
	Can assess the working environment, including the environment for people working from home
	Shows familiarity with the 'flag system' to formulate obstacles to working
	Can explain the detailed analysis to the patient in language that is tailored to the patient
	Can explain the concepts used in formulating the VR analysis to others
VR Two	**Able to design a full Vocational Rehabilitation plan for any new patient presenting with difficulty working, with this plan extending beyond the consultants own specific service.** *In addition to RM Two Specialist capability in practice, the RM physician practicing in VR*
Descriptors	Is knowledgeable about the legal frameworks including the Health & Safety at Work Act 1974 and the Equality Act 2010 and can work within the medico-legal framework
	Can identify the information needs for the individual and communicate these considering issues such as reasonable adjustments, disclosure, Jobcentre Plus services, local resources, and financial advice
	Can identify generic work skills needed by the individual such as insight building, work hardening, fatigue management, cognitive strategies, building self efficacy, managing communication and relationships with colleagues, and managing mood disorders
	Can identify specific work skills needed by the individual following job analysis and design/identify appropriate task practice
	Can identify, describe and mitigate risk associated with returning an individual to the work place
	Can identify colleagues and services to support job application and job seeking skills
	Can draw up a return to work plan graded in terms of hours and complexity, with identification of sources of support
	Can support individuals to withdraw from work at the correct time, and identify alternative occupations
	Can provide a clear, reasoned analysis of the vocational plan in letters to other interested parties (with patient consent)

VR Three	**Able to identify and set priorities within the VR plan** *In addition to RM Four Specialist capability in practice, the RM physician practicing in VR*
Descriptors	Can work with individuals to identify vocational goals and actions, recognising that adjustment to limitations can result in the reformulation of goals during the VR process.
	Can identify when urgent action is needed to prevent job loss
	Can identify obstacles to progress in completing the VR plan and discuss these openly with the individual, their colleagues and the rehabilitation team, as needed.
	13. Can identify, articulate and negotiate priorities and a) introduce new goals, previously overlooked and/or b) removes goals that are no longer necessary
VR Four	**Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams** *In addition to RM Seven Specialist capability in practice, the RM physician practicing in VR*
Descriptors	Shows awareness of other relevant and potentially appropriate services including Jobcentre Plus services (eg Access to Work), Unions, Occupational Health, Case Managers, Insurance companies, local authorities and the voluntary sector
	Involves other organisations in the VR plans including, but not exclusively, the individual's work-place through line- managers, HR or OH • suggests their involvement in rehabilitation planning meetings • initiates or undertakes referrals to these agencies
	Engages constructively with the employer and other agencies and services: • attends meetings called by other services about a patient • contributes to, and may lead any meeting whoever organised it • copies letters and other relevant documentation to organisations and services involved with a patient (in compliance with any legislation, usually with the patient's agreement or knowledge)
VR Five	**Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical and legal uncertainties and influences that arise in complex cases** *In addition to RM Eight Specialist capability in practice, the RM physician practicing in VR*
Descriptors	Accepts personal responsibility for resolving complex problems in people with disability which involve the impact of work on health and health on work
	Identifies the many factors that need to be considered in a complex vocational case: • Clinical, relating to the patient • Cultural, relating to the patient, family, workplace and others • Organisational, relating to relationships between different organisations – employers, insurance companies, social services, voluntary services, commissioners etc • Financial including insurance • Legal
	Able to get necessary information on the relevant factors • Inviting people to attend a meeting and/or • Researching and documenting relevant information
	Able to negotiate and mediate between conflicting or competing parties in a meeting and/or individually
	Reaches an agreed decision with a plan, and/or an agreed way forward to achieve an agreed solution later
	Documents the process in sufficient detail for others to understand the facts, influences and reasoning behind the resolution

VR Six	Understanding of how to develop, manage and grow a VR team
Descriptors	Aware of the public health benefits of work including the • benefits of being in good work • effectiveness and cost effectiveness of VR • the health and work policy agenda
	Demonstrates effective clinical leadership • Advocating for the importance of work and VR • Working with colleagues to grow and develop VR services
	Understands in principle the process for developing a business case for VR services
	Aware of the role of and processes for commissioning of services
	Demonstrates capabilities in working with partner organisations outside the NHS and outside Healthcare, such as Jobcentre Plus, the voluntary sector and local authorities
	Recognises the importance of persistence in developing comprehensive rehabilitation services
	Able to identify appropriate measures to demonstrate effectiveness of local VR
	Able to establish a regular audit programme to demonstrate effect of services
	Willing to disseminate audit data, and contribute to research programmes in VR
	Recognises the importance of regular CPD in VR and related subjects.

Appendix 3.2 - Summary of potential assessment tools

Learning Outcomes	cCAT	CBD	DOPS	MCR	Mini-CEX	MSF	PS	QiPAT	TO
Takes a detailed educational and occupational (work and leisure) history and is able to identify transferable skills		X		X	X				
Is able to assess readiness for VR, and has an understanding of motivational interviewing and other psychological models and their role in VR		X		X	X				
Can identify patients in whom detailed cognitive screening will be of benefit		X		X	X				
Is able to undertake a functional analysis of work related tasks		X	X	X	X				
Can assess the working environment, including the environment for people working from home		X		X	X				
Shows familiarity with the 'flag system' to formulate obstacles to working		X		X	X				
Can explain the detailed analysis to the patient in language that is tailored to the patient		X		X	X	X	X		
Can explain the concepts used in formulating the VR analysis to others		X		X	X	X	X		
Is knowledgeable about the legal frameworks including the Health & Safety at Work Act and the Equality Act 2010 and can work within the medico-legal framework	X	X		X	X	X			
Can identify the information needs for the individual and communicate these tailored to individual needs, considering issues such as the Equality Act, reasonable adjustments, disclosure, Jobcentre Plus services, local resources, and financial advice	X	X		X	X	X	X		

Learning Outcomes	cCAT	CBD	DOPS	MCR	Mini-CEX	MSF	PS	QiPAT	TO
Can identify generic work skills needed by the individual such as insight building, work hardening, fatigue management, cognitive strategies, building self efficacy, managing communication and relationships with colleagues, and managing mood disorders		X		X	X	X			
Can identify specific work skills needed by the individual following job analysis and design/identify appropriate task practice		X		X	X	X			
Can identify, describe and mitigate risk associated with returning an individual to the work place	X	X		X	X	X			
Can identify colleagues and services to support job application and job seeking skills		X		X	X	X			
Can draw up a return to work plan graded in terms of hours and complexity, with identification of sources of support	X	X		X	X	X	X		
Can support individual to withdraw from work at the correct time, and identify alternative occupation	X	X		X	X	X	X		
Can provide a clear, reasoned analysis of the vocational plan in letters to other interested parties (with patient consent)		X		X	X	X			
Can work with individual to identify vocational goals and actions, recognising that adjustment to limitations can result in the reformulation of goals during the VR process.	X	X		X	X	X	X		
Can identify when urgent action is needed to prevent job loss		X		X	X	X			
Can identify obstacles to progress in completing the VR plan and discuss these openly with the individual, their colleagues and the rehabilitation team, as needed.	X	X		X	X	X	X		
Can identify, articulate and negotiate priorities and • introduce new goals, previously overlooked and/or • removes goals that are no longer necessary		X		X	X	X	X		

Learning Outcomes	cCAT	CBD	DOPS	MCR	Mini-CEX	MSF	PS	QiPAT	TO
Shows awareness of other relevant and potentially appropriate services including Jobcentre Plus services (eg Access to Work), Unions, Occupational Health, Case Managers, Insurance companies, local authorities and the voluntary sector		X		X	X	X			
Involves other organisations in the VR plans including but not exclusively the individuals work-place through line- managers, HR or OH • suggests their involvement in rehabilitation planning meetings • initiates or undertakes referrals to these agencies	X	X		X	X	X	X		
Engages constructively with the employer and other agencies and services: • attends meetings called by other services about a patient • contributes to, and may lead any meeting whoever organised it • copies letters and other relevant documentation to organisations and services involved with a patient (in compliance with any legislation, usually with the patient's agreement or knowledge)	X	X		X	X	X	X		
Accepts personal responsibility for resolving complex problems in people with disability which involve the impact of work on health and health on work		X		X	X	X			

Learning Outcomes	cCAT	CBD	DOPS	MCR	Mini-CEX	MSF	PS	QiPAT	TO
Identifies the many factors that need to be considered in a complex vocational case: • Clinical, relating to the patient • Cultural, relating to the patient, family, workplace and others • Organisational, relating to relationships between different organisations – employers, insurance companies, social services, voluntary services, commissioners etc • Financial including insurance • Legal	X	X		X	X	X	X		
Able to get necessary information on the relevant factors • Inviting people to attend a meeting and/or • Researching and documenting relevant information	X	X		X	X	X	X		
Able to negotiate and mediate between conflicting or competing parties in a meeting and/or individually	X	X		X	X	X	X		
Reaches an agreed decision with a plan, and/or an agreed way forward to achieve an agreed solution later	X	X		X	X	X	X		
Documents the process in sufficient detail for others to understand the facts, influences and reasoning behind the resolution		X		X	X	X	X		

Learning Outcomes	cCAT	CBD	DOPS	MCR	Mini-CEX	MSF	PS	QiPAT	TO
Aware of the public health benefits of work including the • benefits of being in good work • effectiveness and cost effectiveness of VR • the health and work policy agenda		X		X	X	X			
Demonstrates effective clinical leadership • Advocating for the importance of work and VR • Working with colleagues to grow and develop VR services		X		X		X		X	
Understands in principle the process of developing a business case for VR services		X		X		X		X	
Aware of the roles of, and processes for, commissioning of services		X		X				X	
Demonstrates capabilities in working with partner organisations outside the NHS and outside Healthcare, such as Jobcentre Plus, the voluntary sector and local authorities	X	X		X	X	X			
Recognises the importance of persistence in developing comprehensive rehabilitation services		X	X		X				
Able to identify appropriate measures to demonstrate effectiveness of local VR		X		X				X	
Able to establish regular audit programme to demonstrate effect of services				X				X	
Willing to disseminate audit data, and contribute to research programmes in VR				X				X	X
Recognises the importance of regular CPD in VR and related subjects				X		X		X	X

Appendix 4

Holding a work conversation adapted from Talking work: A guide for doctors discussing work & work modifications with patients[42]

1. Understand your patient's work

As a part of a consultation, work related information is usually obtained. This can include the job title and description of duties of the role.

If this information is available within the patient record, at each clinical consultation, clinicians can ask the patient about their role and whether they are continuing in the same role.

"I see from the records, Mr Smith, you work as a roofer, is that still the case?"

If they continue to work in the same role, this provides the affirmation and the opportunity for the patient to highlight any potential work-related issues which may be contributing to their health. It is important for clinicians to understand these contributory factors to better manage the health condition.

If they have changed roles, it gives the patient an opportunity to highlight the change. In such cases, clinicians can ask about the change and how it has impacted the patient.

"Oh, so now you work as a Site Supervisor. Has that changed your duties considerably?"

The changed role should be updated on the records.

This routine conversation should not be time consuming. It gives the HCPs an understanding of the patient's work role and an opportunity for the patients to highlight any work-related issues which can provide indications for potential impact on health and recovery. This process also ensures that work related conversations become a routine aspect of the clinical consultations with the HCPs.

2. Use realistic positive language when discussing a diagnosis

The words used by HCPs for describing the condition or diagnosis for the patient have a powerful impact on how the condition, its prognosis and impact on their daily life is perceived.

Clinicians/HCPs should avoid using catastrophic and alarming words which may make the patients think that all work-related activities may be harmful and they should not continue to work unless there is evidence that the findings may be the actual cause of patient's presentation. Neutral and supportive words (See Table 1) indicating the appropriate management strategy may be more helpful to allow the patients to continue their daily routine and maintain their functional ability.

Table 1

Neutral description	**"Catastrophic" terms**
Do say	**Do not say**
You may have a degenerative joint disease. Explain natural age-related changes and how staying active or exercising, as appropriate, can help reduce the impact of age-related changes.	You have a crumbling spine Your spinal space is narrowed Your joints are worn

3. Understand the limitations and opportunities to patient's work due to their condition

Having an illness or injury doesn't necessarily mean that the patient would be unable to perform their job or carry on their daily activities. It is important to understand the impact any condition is having on the patient's ability to work. Ask questions such as:

"How is (health condition) affecting you?"

"How does this impact on your work role?"

"Which tasks you think you can manage even with (health condition)?"

"What job tasks are difficult because of this (health condition)?"

"Are there any safety critical aspects which may be affected by (health condition)?"

Working alongside the patient classify their work activities in three categories:

1. Activities/ aspects of the role they consider may aggravate their condition
2. Activities/ aspects of the role they consider can be safely completed
3. Activities/ aspects of the role they are unsure about whether they may be able to complete

This allows the patients to highlight specific areas of concern while also reflecting on other aspects of their work role which they may be able to continue despite the presenting condition and consequent limitations. The focus of conversations should be on ability and what activities they may be able to continue undertaking safely and without detriment to their health.

If there are certain activities which the patient considers that can be safely completed, then within the fit note, consider using 'maybe fit for work' and highlight these activities and encourage the employer to consider a workplace assessment to confirm suitability of the patient to continue working either in the same or modified role subject to the restrictions identified.

4. Consider adjustments that may allow patient to continue working or return to work

Adjustments may include amendments to work arrangements, work premises or job and workload often temporary to facilitate staying at or returning to work, with the aim being to return to usual job. Most of the adjustments can be implemented easily and at little or no additional cost to the employers. Understanding the work role and limitations imposed by the presenting condition are key to identifying appropriate adjustments. Most times the patients may be able to suggest possible adjustments to allow them to continue or return to work themselves, however sometimes they may still be learning to cope with the condition and therefore do not understand what adaptations may be reasonably practicable for their employers to undertake to support them to stay at work.

For more complex adjustments or equipment/ premise modification needs, patient and employers may require specialist occupational health input, or may be able to request a workplace assessment from Access to Work. Some of the aspects for the clinicians/HCPs to consider when discussing adjustments with patients are:

Altered work arrangements
1. Working from home (eg a patient who has suffered a lower limb fracture but is a sedentary office worker may be able to complete their duties while working from home). 2. Moving the patient to a worksite closer to home or on to ground floor or to a quieter space. 3. Reducing or changing work hours (to facilitate graduated return to work, enhance endurance and readjust to workload and routine eg someone who has not worked for several months may struggle to return to full time hours but can gradually build up to it through starting work half days or alternate days for a few weeks, can include starting or finishing earlier or later, but also may be a permanent adjustment). 4. Longer or more frequent breaks 5. Time off to attend medical or rehabilitation appointments (eg physiotherapy or counselling appointments) 6. Flexible working arrangements.

Additional Support Arrangements
1. Provide additional supportive personnel (eg a driver who may have no limitations in driving but is unable to bend and lift may continue to work if additional support may be provided in lifting and loading where necessary). 2. Providing support for travel to and from work (eg if the patient is unable to drive or use public transport), or involve Access to Work where appropriate. 3. Provide a closer parking space. 4. Redeployment to alternative role (either temporary or permanent). 5. Providing additional training, supervision, instructions, mentoring or support. 6. Extra help with managing and negotiating workload. 7. Debriefing sessions after difficult work tasks. 8. Use of mentorship or buddy support systems. 9. Provide regular opportunities to discuss, review and reflect on people's positive achievements – this can help people to build up positive self-esteem and develop skills to better manage their triggers for poor mental health.

Workplace modifications or equipment
1. Moving furniture, widening a doorway or providing a ramp so that a person using a wheelchair or other mobility aid can get around comfortably and safely. 2. Move a person with hearing impairment to area with less background noise. 3. Changing seat to area with natural light for someone with seasonal depression. 4. Provide special equipment (such as an adapted keyboard for someone with arthritis, digital recorder for someone who finds it difficult to take written notes or a large screen for a visually impaired workers), an adapted telephone for someone with a hearing impairment, or other modified equipment for disabled workers (such as longer handles on a machine). 5. Provide BSL interpreters or lip speakers for a person who is deaf or hard of hearing, or screen readers which will read out documents for someone with low vision or learning disability.

These adjustments are provided as a guide to highlight the range of options possible and is not exhaustive. It is anticipated that clinicians/HCPs will utilise this guide to make personalised suggestions within the fit note and then patient and the employer can agree on the recommendations or seek specialist input from an occupational health provider and/or Access to Work.

5 Encourage discussion with line manager

If the patient has some limitations, but may still be able to continue work, ask the patient if they had a discussion with their line manager about the condition and how it is impacting their job tasks. If they do not have a line manager, then consider who could support their return to work. Patients can also consider if their employer has any employee assistance program (EAP) which would assist in their condition.

“Have you discussed this with your line manager?”

“Could you avoid doing these two (limited) tasks and still carry on working?”

“Can you discuss with your line manager if they can make any accommodations to reduce these problems?”

The patient should ask to talk to their manager/employer about the matter. A meeting can provide them with an opportunity to explain the situation more clearly and suggest possible adjustments. It will help the employer understand how best they can support and help the patient. It may also be helpful for the line manager to include other relevant people such as safety reps or HR in these discussions.

In the fit note, a recommendation for a workplace meeting to discuss adjustments and modified duties may be all that is required for the patient to have such discussion with their line manager and agree on a period of graduated return to work. A member of the VR team can attend such a meeting with the manager if all the parties concerned are in agreement and feel it would be helpful.

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