

Inside issue number 1

- * The VAT debate.
- * University courses.
- * Rehab Conference 12th February 2008, One Great George Street, London.
- * Is Rehabilitation in good health?
- * Job Retention and Mental Health 20th March 2008, ORT House Conference Centre.
- * Links with absence management.
- * Rehab First Forum 14th May 2008, Victoria Plaza, London.
- * Employers with heads in the sand.
- * Association for Counselling at Work.
- * Time to talk with OH?
- * Vocational Rehabilitation Toolkit.
- * Employment Advisers in GP surgeries.
- * A place for Social Enterprise?
- * Work, Disability and Rehabilitation - Making the best job of it.
- * Web links.

Quarterly news views and comment from inside and outside the Vocational Rehabilitation Association

VocRe Forum Quarterly News Views and Comment from the VRA

A view from the chair



Dear Colleague

Welcome to the first issue of VocRe Forum, the successor to ReHab NetWork. I stated in the October Newsbrief that the magazine will be available not only to VRA members but to stakeholders and potential stakeholders across the VR and employment sectors both in the UK and ultimately abroad. However following a re think, we have decided that the magazine should and will primarily remain exclusive to members, but we will be sending out copies to key stakeholders, (as a one off), to encourage them to join the VRA and participate and contribute towards our activities.

The VRA NewsBrief will continue to be produced when appropriate to provide member only updates and newsflashes.

Our aims for the VocRe Forum are for it to be published quarterly, have a mixed format; be distributed by e-mail with a copy held on the website and a reference library developed over time; have wide appeal and be circulated to all paid up members; contain topics reflecting the sector and not just the VRA; provide links into the existing web forums.

None of this would however be possible without the generous investment of both time and resources by Mark Howard, Director of Health and Protection Solutions, and on behalf of the VRA 's Board of Trustees I wish to express my deep appreciation. Mark will edit the VocRe Forum but we will be looking to you to contribute your views no matter how controversial on topical issues affecting the sector, and of course your response to the views expressed by guest contributors as well as fellow members.

To kick off, I note that the DWP is carrying out a consultation aimed at helping more disabled

people into work by improving the specialist employment support available to people with disabilities was launched in early December by Anne McGuire, Minister for Disabled People.

The consultation period is due to finish on 11th March 2008. The VRA Trustees will be responding collectively to this consultation and if you do not wish to submit an individual response you are welcome to submit your views for inclusion in the VRA's response.

I also noted for those of you who missed it that Jenni Bacon had written a helpful note which my colleague Andrew Frank has kindly passed on, informing us that "the DWP has published its report "Ready for work - full employment in our generation", setting out the Government's approach to the next phase of welfare reform designed to create a society in which as many people as possible can share in the rewards of work.

There are references throughout to the links between work and health but I thought you might be particularly interested in Chapter 4; "Sustainable employment for disabled people and people with health conditions". (See *the weblinks on the last page*). Chapter 4 starts on page 61 and you might wish to look specifically at pages 67 and 68 headed "Changing the culture - helping people to remain in work".

Finally, the VRA's next AGM is scheduled for Thursday June 26th, venue to be agreed. So please ensure you note your diaries. It will be the first to be held under the VRA's status as a Registered Charity and Company Limited by Guarantee. We will be calling for nominations for Directorships for the 'new' company' and details of how to submit expressions of interest will be forwarded to all members by John Willis, our Company Secretary, shortly. .

Thank you for your continuing support

Association for Counselling at Work launches free resource for employers

The Association for Counselling at Work (ACW) is the home for counsellors in workplace settings and the forum for all professionals with an interest in counselling, employee support and psychological health at work.

ACW promotes professional counselling and the development of employee support in the workplace. As a specialist division of the British Association for Counselling and Psychotherapy (BACP), ACW promotes best practice and provides a forum and mutual support network for individuals and organisations working in this area.

"Many of the sickness absence surveys are now suggesting that work-related stress and mental health are the leading cause of long term lost working days, as well as a major source of invalidity claims at work. There is mounting evidence that counselling at work can provide the social support that many need when they are not coping with the excessive pressures. We hope that these guidelines will make a difference and help 'the many' who suffer silently."

(Professor Cary Cooper, CBE, Professor of Organisational Psychology and Health at Lancaster University and President of BACP).

According to World Health Organisation estimates, at least three employees in ten suffer from mental health problems – ranging from short-term depression to more chronic conditions. The leading employers quoted above have long known that providing staff with access to counselling services is part of the answer. But did you know that workplace counselling is not only effective it is cost effective? These guidelines feature detailed case studies proving that counselling provision can save money for business.

The guidelines are being supported by The Health and Safety Executive (HSE), The British Occupational Health Research Foundation (BOHRF), The Commercial Occupational Health Providers Association (COHPA) and the Employee Assistance Professionals Association (EAPA).

(See web links on the last page of the newsletter to access a copy of the guidelines)

Vocational Rehabilitation and the VAT gap

One would have thought that the news brought about by an HM Revenue and Customs move, earlier in 2007, confirming that rehabilitation services should not incur VAT would be good news indeed.....alas this is not so for such services as psychological support and non-clinical vocational rehabilitation.

This position does not present a clear market position for rehabilitation service pricing and for the cost benefit conscious market in which vocational rehabilitation service providers work in the extra 17.5% does make a difference.

The ruling is apparently based upon the premise that the purpose of rehabilitation providers is to improve the physical and psychological health of the individual.....so why do psychological and non-clinical vocational rehabilitation services still incur VAT?

The problem is due to a mix European tax legislation and the fact that psychologists and non-clinical vocational rehabilitation specialists are not registered as health professionals.

Having said this, there are instances where services provided by non-registered health professionals can be exempt. Such cases have to be overseen by a registered health professional, must provide for the medical needs of a client and be delivered in a hospital or similar institution.....perhaps still not sufficient?

With the current focus on providing return to work programmes based on a predominantly non-medical biopsychosocial model we really should be pushing for VAT parity for all service providers involved in a client's rehabilitation.

[Have your say on this issue.....](#)

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VRA Corporate Members



Vocational Rehabilitation Toolkit

The COTTS work committee have recognized the need to draw together information and resources about vocational rehabilitation provision in the UK.

An updated document has been produced, aimed at benefiting all practitioners,

whether working in the NHS, public, private or volunteer services.

COT have recently recognized the work the committee has carried out and have agreed to publish it for the benefit of all BAOT members.



How can cost effective service provision be best effected? Provocative thought from the editor

We have seen a significant growth in the “rehabilitation industry” over the last ten years but where has this taken us?

It is quite clear that in most cases there is a continually running central theme, that of work and the focus of returning injured people back to work.....cost effectively.

It seems that there is a growing school of thought that believes that cost effective service provision can only be driven through “sizeable” businesses.

Perhaps insufficient thought has been given to the type of business model that works for optimal benefit of all parties involved.

Is there is a more cost effective delivery model waiting in the wings?

One that provides 'comfort' for all parties and does not compromise performance, client outcomes and delivery cost.

The model might be a social enterprise. Such a social enterprise would be defined by its nature; social aims and outcomes with the explicit focus on returning people to work.

To some this may be a very “lefty” opinion.....tell me what you think



[Have your say.....](#)

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Rehabilitation Conference 2008

The conference was presented by Claims Management magazine and looked at the current and future shape of rehabilitation in personal injury and clinical negligence claims.

The conference promised to increase understanding of, and engagement in, the rehabilitation

industry by insurers, solicitors and claims managers.

The keynote address; "Getting better outcomes by positioning employers as service users" was given by Susan Scott-Parker OBE - Employers' Forum on Disability.

A full report on this conference will be included in the next issue of VocRe Forum.



Job Retention and Health

20th March 2008, ORT House Conference Centre, London NW1.

This conference will look at the recent initiatives to provide effective job retention. In particular it will look at the recent findings of the Richmond Fellowship Management pilot programme around the country. This has established ten job retention services around the country.

Key themes - The conference will give attendees a wide view of the work being done in the sector. Commissioners and practitioners will be able to develop ideas about how to set up new services and improve existing services.



PAVILION

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Rehabilitation First Forum

14th May Victoria Park Plaza, London.

With a new code of practice and a firmer focus on standards and accreditation, the rehabilitation movement continues to gather pace. As the market evolves so has the Post's rehabilitation event.

Through a combination of keynote sessions, extended interactive

workshops and an exhibition showcasing the latest innovations in the rehabilitation market place, this new forum will offer something for everyone, from insurers to providers to solicitors, whether you are relatively new to rehab or an experienced player in the sector.

For further details contact:
Amy.Hawes@incisivemedia.com





MSc/PgDip/PgCert Vocational Rehabilitation

This part-time course is suitable for people working in rehabilitation, human resources, employment and disability services.

It focuses on vocational rehabilitation for people employed in agencies and services who help individuals, including those with disabilities, to gain or retain employment.

You examine the current political and sociological context of employment for people with disabilities and the barriers they face. You also develop practical skills and interventions to improve your current practice.

Core and optional modules allow you to develop a programme of study to meet your personal and professional needs.

You can take any module individually for continuing professional development. Alternatively, you can work towards a named award by taking the appropriate number of credits on a specified route. This may be a postgraduate certificate, a postgraduate diploma or a masters degree.



A postgraduate qualification and professional development in Workplace Health

This programme is an innovative development in education and training for those who wish to increase their knowledge and skills in the management of contemporary issues in workplace health. It was developed in consultation with over 30 leading national experts in workplace health and almost 1,700 members of the Institution of Occupational Safety and Health to pinpoint emerging priorities in workplace health and to identify practitioner education and training needs. A Programme Advisory Board is consulted regularly to inform curriculum development, ensuring that the programme remains cutting-edge and continues to meet practitioner needs. The course is provided by the Institute of Work, Health and Organisations, a World Health Organisation Collaborating Centre for Occupational Health and internationally renowned centre of excellence in research and postgraduate education. Professor Amanda Griffiths is Director of Studies.

BSc (Honours) Vocational Rehabilitation

On this course, you learn how to

- deal positively with people with disabilities and identify their potential for work
- analyse job requirements
- assess a person's capacity to fulfil a job
- identify and solve complex problems that limit employment choices
- promote health in the workplace



University of Brighton

Case Management for Health and Employment MA (PGCert PGDip)

The course is specifically designed to meet the needs of working professionals in case management and will enable them to achieve a nationally accredited postgraduate qualification. It will broaden participants understanding of the case management sector and develop advanced skills in the professional practice of both vocational and medical case management.



Getting Better? Extracts from a recent article, written by Joy Reymond-Head of Rehabilitation Services at Unum, in the Post Magazine 1st September 2007

The rehabilitation process has been hampered by a distinct lack of co-ordination. The many different areas of rehabilitation provision need to work together if there is to be a thriving and large-scale rehabilitation market that provides a reliable and high-quality service. We are all hopeful that the UK Rehabilitation Council will provide the focus required.

Most of the associations currently devoted to developing rehabilitation are small; the relationships between them cordial but uncoordinated; focusing on differentiation rather than integration.

Many different disciplines embrace various aspects of rehabilitation, but there is no 'centre' no 'core discipline' to which the branches of rehabilitation can attach themselves.

Rehabilitation is an unregulated activity, except insofar as it is covered within the activities of another regulated profession. There are no constraints on practitioners in using the term rehabilitation in their job title. Likewise, the use of the term in a practitioner's job title does not provide any guide as to what skills the practitioner possesses. So how does any purchaser understand what they are buying?

On the positive side there are now many encouraging signs, amongst them:

- * Government acknowledgment of the importance of rehabilitation.
- * The Civil Justice Commission raising concerns over 'rehabilitation farmers'.

The Department of Work and Pensions' (DWP) key issue is whether rehabilita-

tion can provide the solution to the problem of the appalling number of people who have fallen, and continue to do so, out of work never to return.

Lord Mackenzie launched the new vocational rehabilitation task force; supported by the CBI, Association of British Insurers and the TUC last summer. The aims of the task group are to identify what services are currently available, why businesses do not provide more support and what needs to be done to increase understanding and ensure wider provision of support services.

Lord Mackenzie stated".....Very few employers offer occupational health or vocational rehabilitation. This task force will identify why this is the case, what barriers are preventing wider provision and what needs to be done to change this.

"Employers must recognize that rehabilitation is not purely medical but also a management activity and they must do more to help their employees return to work."

For some years the rehabilitation community has accepted the need for a lead body to co-ordinate activity and provide a voice for medical and vocational rehabilitation in the UK but there has been no impetus to make it happen.

Nearly 40 leading rehabilitation specialists met to examine and ultimately endorse a proposal to create the UK Rehabilitation Council.

A shadow rehabilitation council has been struck to do the groundwork to enable the full Council to be established.

This is a grand venture for the shadow rehabilitation council. It deserves both Government and private sector support, and is seeking funding from the Government .

Aims

The councils priorities are to look at the most urgent needs:

- * Enforceable standards for rehabilitation practitioners.
- * Accreditation.
- * Recommendations for further training.
- * Advice to Universities and other teaching bodies.
- * Recommendations and endorsement of best practice.

- * One-stop shop for any person or organization requiring information about rehabilitation.
- * Active engagement with stakeholders, especially Government ministers, departments and agencies, to ensure joint working and sharing agendas and priorities.
- * Information exchange.
- * Increased understanding of the benefits of rehabilitation in the country at large.

[Have your say.....](#)

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Managing absence and attendance

The most effective measures to tackle short term absence include return-to-work interviews, trigger mechanisms, disciplinary measures and training line managers. For longer term absence the most effective approaches are providing an occupational health service and rehabilitation programmes.

The Government has launched a range of initiatives to reduce the numbers of people on incapacity benefit and promote the health benefits of being in employment. These include the Welfare Reform Act 2007; Pathways to Work; Health Work and Well-being and the appointment of a new national director of health and work.

In line with changes in the UK economy and the shift towards services industries and away from manufacturing, the prevalence of mental ill-health and musculoskeletal injuries has increased.

Employers implementing absence management initiatives are putting increasing emphasis on demonstrating a return on investment. Recent evidence in general shows that rehabilitation programmes and occupational health service provision are the most effective measures for reducing long term absence. Vocational rehabilitation tools involving functional assessment and case management to return individuals to work and preventative measures based on the bio-psycho-social model are also being used.

Employers heads in the sand?



One in four employees experience stress, anxiety, depression and other forms of mental ill-health in any given year (Office for National Statistics). Yet research shows senior executives are largely unaware of this and so are unable to manage it effectively.

Nearly three-quarters of 550 British businesses surveyed by mental health charity Shaw Trust estimated that 5% of employees or less suffered from a mental health problem at any one point in their working life, while almost half suggested that none of their employees would.

Time to talk with OH?

Article first appeared in Occupational Health magazine.

Radical and innovative ideas were put forward recently including a national health at work service and a Royal College of Occupational Health at a meeting of OH nurses and others involved in workplace health.

The ideas were discussed at a meeting to look at how a national occupational health strategy might be developed. Dame Carol Black believes that OH does not have the importance or value needed to keep people in work and healthy and enable them to get back to work very quickly.

In November last year a 'stakeholder' meeting met to look at five key issues:

- * Health protection
- * Access to OH and standards across the UK
- * Return to work programmes
- * Supporting networks in the wider NHS
- * Health promotion

It is also understood that ideas have been put forward for the setting up of a new National Health at Work Service.

Other innovative ideas include:

- * A Royal College of Workplace Health
- * A 'health passport' for everyone of working age

Government trebling the number of employment advisers in GP surgeries

Opportunities to work with GPs?

The government has announced that it is launching an £8m pilot advice and support service for smaller businesses as part of a new approach to help people with stress and other mental health conditions.

It is trying to more closely align employment and healthcare services; trebling the number of employment advisers in GP surgeries and changing the process for issuing medical certificates to reflect the emphasis on "capacity" rather than "incapacity".

Work, disability and rehabilitation: Making the best job of it

M Anne Chamberlain OBE, BSc, MBBS, FRCP, FRCP&CH,
Emeritus Professor of Rehabilitation Medicine, University of Leeds
Article first published in "Clinical Medicine Vol7 No6 Dec 2007"

ABSTRACT – The relationship between a person's health and their work was recognised as central to the good practice of medicine by Charles Turner Thackrah (1795–1833) in his seminal work, *The effects of arts, trades and professions on health and longevity* (1823).

The connection is largely forgotten in current clinical practice; the UK has a high level of dependence on benefits mainly in those with non-severe disabilities. Recognition of the value of preventing this by access to early, usually multidisciplinary, rehabilitation and prevocational rehabilitation via a general practitioner and in hospital practice is needed as a priority. This requires that all NHS staff adopt a biopsychosocial approach to illness and are taught about the workplace needs of patients and the value of early rehabilitation. Communications within the NHS and with other agencies have to be improved by the development of better pathways with dedicated staff time for this activity. The creation of the Director of Health and Work position and the refocusing of occupational medicine present an unrivalled opportunity to improve our practice.

KEY WORDS: biopsychosocial model, disability, occupational medicine, vocational rehabilitation, Worklessness.

Rarely can one individual achieve major significant change. Charles Turner Thackrah, however, was such a person. With a handful of others, he founded one of the first provincial medical schools, located in Leeds, in 1831. He was a superb teacher, a clear-headed researcher, a founder member of the local theosophical society, and he laid the

foundations of occupational medicine in the UK. His knowledge of his patients in their (often terrible) workplaces surpasses ours today.¹ It is this recognition of the patient as a worker which needs to return to the centre of our practice and strategy in the modern NHS. Its marginalisation has brought profound problems and Theodore Roosevelt's 1903 Labour Day address statement still remains true, 'Far and away the best prize that life offers is the chance to work hard at work worth doing'. Social changes were as great in Thackrah's time as today, with the dislocation of rural workers into urban areas and no legislation to tame the capitalism which was seen as the duty of mill owners. One in eight of the population was a pauper; poverty, disability and worklessness were closely intertwined. Up to the first world war, although enfranchisement was advancing for selected parts of the population, the worker had few rights.

Lessons from the world wars—A million and a half British servicemen were wounded in the first world war. Robert Jones, an orthopaedic surgeon, was charged with responding to this by the provision of essentially orthopaedic rehabilitation facilities. The Ministry of Pensions established government instructional factories to retrain the large number of disabled ex-servicemen. Osler stated, 'There is no question of greater national importance than how to make these men again effective citizens, capable of earning their own living'.

These training centres persisted for many years, became skill centres and have now disappeared. This 'war socialism' was quickly lost in the succeeding boom and slump. Simultaneously, rehabilitation also disappeared. The Fracture Committee of the British Medical Association in 1935 and an interdepartmental

committee of the Ministry of Health and the Home Office in 1939 both noted the loss of intensive rehabilitation and the subsequent loss of ability to get people back to work speedily. Their effect was limited, and in 1940 when the second world war had been raging for a year no rehabilitation was available in the UK. The government, however, ordered a rapid response. By the end of 1943, rehabilitation was made available to service patients and was firmly established to all by 1945. Rehabilitation was then defined as, 'The restoration of a sick or injured person to his previous state of health and physical efficiency'. It was further stated that:

To achieve this as rapidly and completely as possible necessitates consideration not only of the patient's specific disability but also of his general condition. It involves a continuous restorative process beginning early, at the moment when the patient is fit to take an active interest in his progress, continuing through the ambulant stage and ending with a course of strengthening and hardening to the requirements of his original or new occupation.²

Rehabilitation could certainly deliver, and the successful UK response and victory in the second world war is acknowledged as greatly dependent on it. The early services rehabilitation units, such as Headley Court, Surrey, were dynamic places. Patients participated in graded classes lasting five to six hours each day. Ninety-five per cent of servicemen were rehabilitated back to work, even if not to their previous role. Service rehabilitation continues to this day with similar regimes and similar success. Unsurprisingly the cost of it was questioned by those holding the budget in the 1970s as two fighter pilots per annum had to return to their jobs to justify the costs.³ It did much more than that.

Transfer of services to the NHS

After 1945, those who ran rehabilitation services in the armed forces transferred their skills to the new NHS. Thus Frank Cooksey established domestic rehabilitation at King's College Hospital, and Phillip Nichols started a completely new venture at Mary Marlborough Lodge, Oxford, where he gave some control for the first time ever to those with the most severe disability who previously often lived out their lives in institutions and were certainly not seen in public.

Rehabilitation services became available across the UK. The programmes were intense and those participating came to realise within a few weeks that their activity levels were higher, they could return to work, and would again earn a wage. There were at least 25 such rehabilitation centres, rarely adjacent to teaching hospitals. Only one, Garston Manor, Watford, had an industrial rehabilitation centre sited alongside it as Piercy had recommended in 1956. This experiment was successful: it allowed graduated entry into the industrial environment or, where this had been too early, allowed the person to receive the required medical or therapy input. The experiment was never repeated.

William Beveridge (British economist and social reformer) recognised the value of rehabilitation. When the NHS was founded only 5% of the population was over retirement age and the institution was geared to the return of the worker to work. Rehabilitation was intrinsic to the new service. Many reports (of Tomlinson, Piercy, Tunbridge, Mair) said the same, that rehabilitation and its philosophy have to be incorporated into clinical practice and into undergraduate teaching, being based on a sound and funded academic base. These reports have been almost entirely ignored.

Modern rehabilitation practice

Rehabilitation contributes much to modern medical practice and there is a substantial evidence base for its effectiveness.(4) It has the capacity to considerably improve the independence, quality of life and participation of those who are newly disabled. Diminution of dependency and costs are often achieved following just a few weeks of intensive inpatient rehabilitation. For example, the time taken to rehabilitate a 37-year-old man following a stroke was only seven weeks in the Leeds neurological rehabilitation unit, the potential weekly bill for care at home being reduced from £1,232 to £168.(5) The total cost of his rehabilitation would have been recouped by the system (albeit mainly a different part of the system) in 12 weeks (R Baden, personal communication, 2006).

In progressive disability or chronic disease, progression of disability can be slowed by rehabilitation.(6) Now most people with multiple sclerosis (MS), even those with severe MS, live in their own homes. They receive packages of care and can benefit from intermittent rehabilitation to preserve essential abilities such as transferring.(7) In the 1960s they remained until death in long stay geriatric wards.

The technology of rehabilitation has improved greatly. Assistive technology (eg functional electrical stimulation communication systems) has much to offer, being increasingly combined with orthotic or prosthetic prescriptions. Walking training equipment allows an increasing percentage of body weight to be put through the legs and may allow earlier return to a normal walking pattern.

Intensity of therapy, however, remains low in the UK, less than that available in the second world war and for two decades after it less than in many rehabilitation services in other parts of western Europe. The link between intensity of therapy and outcome of rehabilitation, including length of stay has been known for a consider-

able time.(8) Yet the value of delivering more than two to three hours per day is rarely understood by commissioners.

For best practice it is agreed that medical rehabilitation should not be a bolt-on service after medical and surgical interventions and vocational rehabilitation (VR) should also be integral to NHS practice.

Vocational rehabilitation is defined as, 'A process whereby those disadvantaged by illness or disability can be enabled to access, maintain or return to employment or other useful occupation'. The process has several components including assessment, a variety of interventions at the level of the person and disability, work modification, work hardening, return to work strategies, and amelioration of difficulties in the journey to work and the work environment. It has been shown to be cost effective (two to five times but some say to a much higher level). In a recent study of people with MS attending a neurological rehabilitation outpatient department the average cost of VR was £900 (D Playford, personal communication). One outpatient studied moved from a salary of £50,000 to £100,000 in a matter of weeks.

Severely disabled persons can also be trained and helped to return to work. Tyrerman records that 28% of those who have sustained severe traumatic brain injury and received VR returned to paid occupation.(9) The saving to the public and personal purses is substantial. Yet in the NHS, rehabilitation, whether medical or vocational, seems to be increasingly marginalised in hospital. As trusts struggle with large debts such medium-term planning is abandoned.

It has been argued that VR should take place in the community yet many primary care trusts are also in financial difficulty and established domiciliary therapy rarely addresses vocational needs. Some politicians seem to

view the provision of rehabilitation after injury as a non-core NHS activity believing (although many are uninsured) that it will be provided by insurance companies. The connection with the cost of not working is not made. Many with non-traumatic conditions such as stroke have unnecessarily low rates of return to work and poor access to vocational services.

Worklessness and health

Worklessness has profound health implications.¹⁰ In young men out of work for more than six months the risk of suicide is 40-times that of their contemporaries and the risk of ill health exceeds that from smoking 10 packets a day. In the EU, 42.2% of disabled people are employed compared with 64.5% of nondisabled persons. In the UK the numbers on incapacity benefit (IB) reached 2.7 million in 2002, yet 3 million people with disability are working. Perhaps those not working have extremely severe disability?¹⁰ The reality is otherwise. The main diagnoses of those on IB are mental illness (but not severe psychotic illness, rather, depression and anxiety) in 42% and musculoskeletal problems in 21%. Only 10% have complex neurological impairments (and there are many reports of effective VR even here).

Factors contributing to worklessness in disease and disability

Many medical factors can have a bearing on employment.^(11,12)

The nature of the condition is important, especially when chronic, fluctuant or progressive. In, for example, inflammatory arthritis, morning stiffness may require that the person rises at 5 am for work at 9 am. The employer needs to understand the worker's condition but often does not.⁽¹³⁾

Non-medical factors may relate to the person's attributes such as their level of education and skills or to external factors such as the general

level of employment in the region, geography and beliefs general to society. A particularly powerful set of beliefs commonly encountered include: those who are disabled should not work; those who are ill should not work; and the person not at work because of illness (or surgery) should not return to work until 100% cured.

The NHS may be part of the problem

Disability organisations have found the NHS unhelpful in terms of retention of, or return to, work.⁽¹³⁾ Access, both physical and to services, was poor, attitudes were seen as unhelpful, and staff were seen as ignorant of the workplace with a lack of urgency and inflexibility. The processes of referral, appointment, investigations and therapy were so slow that jobs were lost. Job retention, however, is extremely important. There is only a six-month window of opportunity between not attending work due to illness and progressing to being permanently in receipt of IB. It is essential that all health workers appreciate this tight time frame for addressing their patients' needs.

Major problems of communication exist between individuals in different parts of the NHS. They also exist between the NHS and other agencies. O'Connor *et al* found no contact between the local job centre seeing their patients with complex MS and clinicians yet disability employment advisors do not have the medical knowledge to deal effectively alone with the impact of specific cognitive deficits, fatigue and visual disturbances on work.⁽¹⁴⁾

The rehabilitation centres of the 1970s have largely disappeared with a consequent loss of expertise to the NHS and to its teaching of staff. Occupational medicine is now rarely taught at undergraduate level and students know little of their patients' workplaces.

The World Health Organization model of disease and disability is rarely applied in hospital practice. The student usually learns that pathology results in disease, with signs and symptoms. Yet the International Classification of Functioning, Disability and Health define the consequences more comprehensively in terms of impairment, loss of function and loss of roles (participation). The related biopsychosocial model is rarely used. The consequences are visible throughout the NHS with a lack of engagement with the person as a worker. This has to change, not least because it badly serves NHS staff themselves rarely giving them good return to work programmes with consequent high costs for sickness and early retirement costs.(15) Some idea of how we might change can be derived from the recent practice and policies of the Department of Work and Pensions (DWP).

The DWP has been extremely active over the past five years in removing many disincentives to returning to work after being on benefits and, has produced a strategy for progress which is reducing the numbers going onto IB (which few previously left, except by death or retirement, if they received this for more than a year). The Pathways to Work scheme is producing good results. It includes health programmes focused on return to work and, increasingly, on job retention.(16) In contrast, the NHS has made few responses. It is beginning to recognise the problem at the most senior level of the Department of Health stating that, 'Trends of long-term capacity associated with common health problems represent a massive failure of health care. There is clearly a need for a fundamental re-think'.(17) If we accept that there is a problem for the NHS to address, then there are things that might be done which mirror the identified problems. Solutions might include:

- * The recognition that rehabilitation and early VR are part of funded health service practice both in hospital and the community

would facilitate job retention and early return to work.(18) For those with complex new disabilities 'ambulant rehabilitation' must be available early at sufficient intensity to get the patient back to work.

- * Poor processes and fragmented pathways have to be guarded against; communication has to be improved within the health service. All specialties and general practice need defined paths of interaction with occupational health physicians, rehabilitation physicians and therapists. Job plans should reflect this. Certification of a patient as sick presents an important opportunity for rapid rehabilitation to prevent job loss.
- * Rehabilitation services must be capable of delivering care in a timely, accessible and suitably intense manner. Their financial value to the state, not just to the health service, has to be acknowledged.
- * All staff in the NHS should have knowledge of the workplace and be aware of their patients' work. Teaching of rehabilitation and occupational medicine will need to play a greater part in the training of all medical undergraduates, other disciplines and at post-graduate level for general practitioners. Enhanced training in the health issues of their clients is needed for disability assessment advisors. It is essential that interchange of information about a patient with a complex chronic disease or disability occurs between them and the treating health professional. We have to be prepared to teach those in the DWP and possibly in the workplace.
- * Medical thinking needs to embrace the biopsychosocial model much more: all areas of medicine should use this approach.

Concluding remarks

A sense of urgency is essential; an opportunity exists. Occupational medicine recognises that there is a shift in the focus of its activities:

The move away from the control of serious specific diseases in well-defined dangerous trades to the management of non-life threatening conditions that occur widely, and which may also have causes outside work, has led to a progressive shift in emphasis during the twentieth century.(19)

Thackrah was the founder of occupational medicine and of a great medical school. His enormous abilities in teaching and research, his clear thinking and his perception of his patients as workers should inspire us to repair the fragmentation of this great service.

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- * The potential for growth is huge, particularly through integrated services with such as services as:
 - Occupational Health
 - Absence Management
 - Trauma and Incident management
- * Cost benefits have been identified and in most instances closely guarded; does this help?
- * Providers are being asked to deliver competitive advantage and to become more innovative.
- * The VRA and CMSUK have to work together.

Have your say.....

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Web links

Tim Dawson article - Ready for Work: Full employment in our generation:

www.dwp.gov.uk/welfarereform/readyforwork

Association for Counselling at Work: Guidelines for Counselling in the workplace:

Guidelines for counselling in the workplace (3 MB)

www.counsellingatwork.org.uk/acw_guidelines_web.pdf

The Sainsbury Centre for Mental Health Policy 8; Mental Health at Work: Developing the Business Case:

www.scmh.org.uk/80256FBD004F6342/vWeb/pcKHAL79TMF9

What Works at Work? - Review of evidence assessing the effectiveness of workplace interventions to prevent and manage common health problems:

www.employment-studies.co.uk/pdflibrary/whwe1107.pdf

The Work Foundation (supported by Abbott) Fit for Work? - Musculoskeletal Disorders and Labour Market Participation

www.theworkfoundation.com/Assets/PDFs/fit_for_work_small.pdf

Sheffield Hallam University:

http://prospectus.shu.ac.uk/op_UGlookup1.cfm?id_num=529&status=TN

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<http://courses.brighton.ac.uk/course.php?cnum=644>

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The VRA have published and are continuing to develop National Standards of Practice for professionals working in the fields of disability management and vocational rehabilitation.

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