

Summary

This research sought to establish awareness of, attitudes towards and approaches to vocational rehabilitation (VR) amongst a sample of key stakeholders, including representatives of rehabilitation providers; insurance companies supplying employers' liability, motor, income protection and personal injury/accident insurance; and a cross-section of employers from the very large through to micro employers employing less than 10 employees. We also spoke to academics, some of whom were working in a range of disciplines including pain management, spinal injury/trauma, and representatives of support bodies and associations with an interest in VR.

The sheer diversity of the sample ensured that knowledge of VR and opinions about it varied considerably. Furthermore, it has to be observed that interest and involvement in VR varied across the different segments.

Different stakeholder viewpoints

At base level, **insurers** see VR as a means of potentially reducing the size of settlements by getting claimants back to work. (There might also be some image benefits for insurers to demonstrate corporate social responsibility awareness.) Cases where VR might be appropriate range from major traumatic injuries through to minor soft tissue damage, for example back injuries.

For **independent providers**, VR is their 'bread and butter'. They have an interest in providing a commercially viable service which they can 'sell' to employers, insurers, and solicitors. Providers working within large companies/organisations justify their existence by reducing levels of absence and getting staff back to work sooner using VR processes and interventions.

Employers' interest in VR tends to reflect their size, history, and the degree to which they have a human resources (HR) and/or occupational health (OH) function within their organisation. To a large extent, usage of VR is triggered by a desire, often prompted by the HR department, to reduce levels of staff off work due to sickness or injury. The primary focus is on managing short-term absences where the employee

is off sick for relatively short periods which, cumulatively, mount up over a period. Long-term illness or injury, where the employee is off work for several months, is relatively less frequent and often a secondary issue.

Some employers, especially larger organisations, have fairly generous sickness packages where employees receive full pay for a period of absence due to sickness, followed by a further period of half pay. For such employers, managing absence more effectively can bring immediate cost benefits. For those employers who pay statutory sick pay (SSP) more or less immediately after an employee goes off sick, the cost benefits are not seen as so immediate, especially as many do not recognise the hidden costs of sickness absence such as providing temporary or long-term replacements, overtime paid to other employees to cover the additional workload, and the adverse effect on staff morale.

Especially amongst small, less established employers, the HR function is often rudimentary and attempts to manage sickness absence are fairly basic. Those employees who are seen as genuinely ill or seriously injured are often left alone because of:

- a sense of politeness/reluctance to be seen to be putting pressure on someone who is ill/injured to return to work;
- a lack of awareness that the employer could or should help in this situation – employers tend to assume that the GP is the arbiter and decides when the employee is fit to return to work.

For most smaller employers, VR is an unfamiliar concept. Interestingly, some have, of their own initiative, adopted VR type procedures in order to help employees return to work, such as shorter hours, lighter/different duties. However, they are not aware of and do not appreciate that what they are doing falls within a broader definition of 'vocational rehabilitation'.

Although our sample of **solicitors** was small, indications are that they are broadly supportive of VR and recognise that some form of intervention was in the best interests of the injured party. However, they acknowledge that often by the time they get involved it could be a considerable time post-accident.

Amongst solicitors, there is some awareness that insurers are now offering rehabilitation, although views on how extensively this is happening varied. That having been said, there is some wariness about insurers' motives in offering rehabilitation – it is recognised that it was in the insurer's best interest to secure an early settlement of any claim and to minimise the amount of the settlement.

It should be realised that solicitors are dealing with vulnerable, injured clients and their role and responsibilities in agreeing to or proposing VR is very complex and sensitive. The small number of interviews we conducted have barely scratched the tip of an iceberg in relation to the issues.

Amongst **academics** and **support bodies/associations** there is a general consensus that the main aim of VR is to return those who are ill/injured back to some form of economic activity. Academics tend to adopt a broader perspective and include those who have never been in paid employment as usefully falling within the remit of VR.

Understanding and defining vocational rehabilitation

This research indicates that the term 'vocational rehabilitation' is not very well understood or, indeed, used by many of those more involved in rehabilitation let alone the wider population of employers and, we suspect, the general public. Outside of an 'initiated' minority, who themselves do not always agree on the definition, VR is an uncertain and sometimes unfamiliar term. 'Vocational' has connotations of religion, retraining, a 'vocation' or calling. 'Rehabilitation' is more commonly associated with drink, drugs, crime, and more serious traumatic injuries. This tends to position 'vocational rehabilitation' as less relevant for more ordinary/less acute problems and takes it away from the simpler, more everyday interventions which might include maintaining contact with employees off sick and phased return to work.

There is widespread recognition that the term 'vocational rehabilitation' is not readily understood by most people, and consequently it is adapted to more straightforward terms such as 'getting you back to work'.

Ideas of what VR encompasses vary widely. At its core it is understood to be the process of getting people who have been sick or injured back to work or some meaningful activity. But some take a narrower definition and position VR as distinct from medical rehabilitation or as helping people back into a different job when they are unable to return to their original job. Others take a wider definition and see VR as covering initiatives to do with health and safety at work, prevention of injury or illness in the workplace, counselling and healthcare offered to staff as part of absence management.

What makes for good vocational rehabilitation

Whilst there might be disagreements about what exactly VR comprises and its precise definition, there does seem to be some consistency of opinion about what makes for good VR.

There is general agreement amongst the better informed that VR is a **process** often involving several different initiatives designed to help sick or injured people get back to work. In cases involving more acute illness/injury, VR can involve a whole range of interventions from cognitive behavioural therapy (CBT), provision of special equipment, training, identifying job opportunities, etc. Sometimes, quite simple interventions can have a disproportionate impact, for example, help with filling in job application forms, physiotherapy for back injuries, sorting out childcare arrangements and workplace adjustments.

Key elements of good VR include:

- **early intervention** – it is generally accepted that the longer people stay off work sick or injured the more likely they are to lose contact with the world of work. A non-working self-image and lifestyle can take over, and often this is associated with the onset of mental health and/or financial problems and becoming acclimatised to the benefit system, potentially getting caught in the 'benefit trap'. The sooner people are offered appropriate support and assistance, the greater their chances are of avoiding a downward spiral and of retaining their existing employment or getting into other employment;
- **patient centric** – it is acknowledged that it is crucial that VR interventions are relevant and appropriate for the individual's needs. This implies listening to and observing the person carefully to establish what they really want/need and would like to happen;
- **case management** – especially with cases of more acute injury and illness, the patient is likely to have complex problems and need help on many different fronts, including housing modifications, transport, prosthetics and financial/emotional counselling. Most insurers and providers agree that case managers have a key role in identifying appropriate and effective help, liaising with the various different agencies and facilitating interventions from the relevant parties. Inevitably, there are disagreements about what kind of case management works best, how hands on it should be, whether it should be face-to-face and so on.

In short, more successful VR is likely to be initiated early, involve the patient in developing the solution, and involve a flexible, holistic, case management approach.

Why vocational rehabilitation is not used more

Factors getting in the way of the VR approach being adopted include:

- employers' lack of awareness of the VR option and uncertainty about what they could do to help employees return to work;
- employers' lack of appreciation of the potential business case for VR;
- insurers not managing to identify cases where VR is appropriate and/or an inability to agree/establish liability early on;
- solicitors allegedly resisting the idea of the insurer's representative visiting the claimant to discuss VR;
- clients/claimants refusing to agree to VR for a variety of reasons for example suspicion of the insurer's motives, a reluctance to return to work, and the relative security of the benefit system.

On a more general level, VR is only likely to be used if someone advocates it. Currently, initiation of VR appears largely to be confined to some insurers and more progressive large employers.

Perceived barriers to vocational rehabilitation

Across the stakeholder spectrum, from providers to insurers and even some employers, there is general agreement that the medical profession and the NHS can be a barrier with regard to providing VR to those who are off sick or injured. GPs tend to sign their patients off sick rather too readily; there are also claims of orthopaedic surgeons telling their patients that they are unlikely to return to work. Occupational health practitioners and some providers question the helpfulness of these approaches to the patient, and also the expertise of either GP or orthopaedic surgeon to make value judgements about the patient's condition ***in relation to the workplace***. On a wider level, there is a perceived gap in NHS provision between emergency treatment (which is acknowledged to be excellent) and full restoration. Delays in providing non-urgent treatment also contribute to late VR interventions.

The benefit system provides a secure safety net in Incapacity Benefit (IB) for the long-term sick. It can make return to work seem like a difficult, risky option, especially for those who have disengaged from work, either emotionally or because they have already lost their pre-illness/injury employment. The complexities of the benefit system might also discourage those who have been offered a phased return to work from embarking on such a course.

Amongst many (smaller) employers there is a lack of knowledge about the principles of VR, and a fear of pressurising ill or injured staff back to work with any possible concomitant breach of employment law. Larger employers acknowledge that line managers can be resistant to reaching out to the long-term sick and manage their return to work and that work colleagues can resent the perceived special treatment given to the long-term sick/injured.

Some employers adopt a fairly robust attitude towards sickness in the workplace – an employee is either fit for work and at work, or unfit and off sick. It should also be appreciated that certain workplaces are not suitable for the partially fit, for example building sites, and employers in such industry sectors are reluctant to a risk an early/phased return to work if an employee is less than fully fit to return to work. Likewise, employers may not be able to offer an employee an alternative job/position while they get back to full recovery.

On a macro level, whilst there are many services offering rehabilitation, there is currently no recognised system of accreditation or regulatory body and so the quality of services is uncertain. This leads to some doubt as to whether there are sufficient properly qualified/trained specialist staff with experience in work-related issues. The spread of VR provision is unclear and it may be that services are not consistent and evenly distributed across the country.

The claims culture and the 'no win, no fee' system is seen as encouraging people to make claims and look for a large financial settlement rather than restoration via VR with a reduced settlement. The adversarial system can also get in the way of early intervention. Insurers sometimes claim that solicitors drag their feet when it comes

to accepting the offer of VR; conversely, solicitors (admittedly a small sample) allege that insurers are not always willing to provide early VR.

Finally, it should be realised that claimants themselves can provide another barrier to VR. Some have insufficient motivation to return to work for a variety of psychosocial and circumstantial reasons. Their lack of motivation could be reinforced by their GPs, the security of IB and other circumstantial factors.

1 Introduction

1.1 Background and purpose

The Department for Work and Pensions (DWP) is committed to producing a Framework for Vocational Rehabilitation (FVR) by October 2004 (Ministers have agreed now that the Framework will be published at the end of October). This commitment, outlined in the Department's Review of Employers' Liability Compulsory Insurance¹, represents the Government's commitment to work with stakeholders to transform the use of rehabilitation in the UK.

The Framework will:

- seek to establish a working definition of vocational rehabilitation (VR) and promote the use of a common and accessible language with regard to VR;
- provide a baseline to inform future policy decisions on VR;
- cover all individuals who are ill, injured or have a disability and who need help to access, maintain or return to employment;
- be flexible enough to meet all VR needs, while promoting a consistent approach;
- promote the use of practical interventions.

The resulting Framework may, in turn, lead to the development of policy proposals that will be subject to widespread stakeholder consultation.

The overall purpose of this research was to provide a qualitative exploration amongst a defined list of key stakeholders of current VR approaches, and to elicit information about what seems to work ('best' practice) and what does not work.

¹ Review of Employers' Liability Compulsory Insurance, Second Stage Report, December 2003.

The research would also be used to feed into the development of the Framework in conjunction with the following inputs:

- an extensive review of research into rehabilitation practices to identify common key principles;
- an exploration of current practice to identify those principles which are common to successful approaches;
- a discussion paper to explore key VR related questions with a broad range of stakeholders.

1.2 Research objectives

- To explore, establish and assess stakeholders' understanding of what the term 'vocational rehabilitation' covers and stands for.
- To establish a definition of VR that commands the general support and agreement of stakeholders.
- To obtain stakeholders' vision and objectives for VR in the long-term.
- To identify the various structures and processes involved in the delivery of VR and the roles and responsibilities of the different stakeholders.
- To identify and carry out a comprehensive review of the various VR structures and processes currently being used or provided by stakeholders with a view to establishing:
 - the elements/interventions which are more and less effective;
 - the principles and approaches shared by more and less successful processes.
- To obtain stakeholders' perceptions of the profile of their current VR caseload and to identify the main factors which encourage and limit access to VR.
- To obtain stakeholders' ideas for improving VR processes and, specifically, enhancing their role in the provision and initiation of VR.

1.3 Method and sample

A qualitative approach was adopted involving a series of depth interviews with a defined list of key stakeholders, including employers, insurers, occupational health and safety providers, and vocational and general rehabilitation providers.

The employer sample was divided between large employers with 250 or more employees; small-medium enterprises (SMEs) with 50-250 employees; small employers with 10-49 employees; and micro employers (2-9 employees). Within the sample:

- the person interviewed was the senior manager/director responsible for human resources/managing staff absences from work;
- we sought to get representation of a spread of involvement with VR/rehabilitation within the workplace.

Occupational health and safety providers and rehabilitation providers were drawn from the private and voluntary sector. NHS and public sector providers were excluded from the sample.

In addition, five interviews were conducted with solicitors practising in the field of personal injury claims. This sub-sample was included in the course of the research when it emerged that solicitors were another important stakeholder group.

The final sample structure is shown in Table 1.1.

Table 1.1 Sample structure

	Number of interviews
Large employers	10
Small-medium enterprises	16
Small employers	10
Micro employers	9
Insurers	10
Occupational Health & Safety providers	10
Vocational rehabilitation providers	10
General rehabilitation providers	10
Solicitors	5
Total depth interviews	90

Interviews followed a discussion guide (appended to this report) and were tape-recorded, with permission, for subsequent reference and analysis.

Fieldwork was conducted in England, Scotland and Wales between 12 May and 6 July 2004. A verbal presentation of findings was given to representatives of the Central Office of Information (COI) Communications and DWP on 8 July 2004.

We also conducted two group discussions: one with providers and representatives of support bodies on 14 July and one with academics specialising in VR and societies/associations on 15 July. Both groups were held at COI Communications in London.

2 Main findings

2.1 Background observations on the sample

2.1.1 Employers

The employer sample ranged from very large multinationals with their own Human Resources (HR) and occupational health (OH) departments through to the micro segment where this responsibility is devolved onto the owner/directors.

Awareness and understanding of vocational rehabilitation (VR) or similar initiatives varied enormously. Many larger employers and some small-medium enterprises (SMEs) had instituted some kind of absence management systems to reduce the incidence of time off sick. In some, mainly very large companies, VR in one form or another was already being used as part of this absence management process.

'The team is made up of nurses and different specialities. You've got nurses that do the traditional role of screening, a little bit of treatment, the pre-employment stuff, the ongoing screening, all that sort of thing. They do go out and do more proactive health promotion and training, some presentations to different groups of staff, but they tend to be more health centre based. And then you have a second group that are all registered nurses but have a post registration qualification in occupational health. They do the more proactive occupational health role...they are the ones that get more involved in the management of attendance, that's their bread and butter.'

(Large employer)

In many of these companies, sickness pay packages were pretty generous. Some companies offered six months' full pay then three months' half pay; a minority offered 12 months' full pay. In the circumstances, it was not surprising that they were keen to minimise or, at least, not to encourage employees taking overlong sickness absence. The desire to reduce sickness absence was further reinforced when the difficulty and cost of replacing staff were taken into consideration.

Smaller and micro employers who did not have a formal HR function knew little or nothing about VR and had little experience or understanding of how to manage

long-term sickness absence situations. It was observed that protracted absence from work due to illness was a rare or infrequent occurrence. However, when small or micro employers were confronted by long-term sickness or injury situations it could be a major problem. One person off sick in a small company left a large gap that had to be filled by others, and their absence had a significant knock-on affect for other staff.

Most small and micro employers were inclined to accept a sick note from an employee's GP at face value and wait for the employee to be certified fit to return to work. Their reluctance to contact the employee who is off sick was reinforced by concerns that they might be seen as putting pressure on them and fears that, in a worst case scenario, they might find themselves faced with a claim for unfair/constructive dismissal or be in breach of the Disability Discrimination Act (DDA).

2.1.2 Insurers

It should be noted that the insurers in our sample were, to a greater or lesser extent, advocates of VR, although some were rather more committed to using VR than others.

It was claimed that VR of some kind has been used by insurers in the UK for less than 10 years and ideas about what exactly it was and how it should be done were still in the process of being formed. Some early adopters have developed fairly well established structures and approaches to identifying and handling cases that might involve VR; others were still feeling their way towards developing an approach and procedures that worked effectively. Some insisted that it was preferable to handle cases 'in house' via their own case managers; others had taken the route of using selected independent providers.

Insurers classified cases which might involve VR into three broad categories:

- minor soft tissue cases such as back injuries;
- cases involving catastrophic injuries, for example spinal injuries, loss of limb and acquired brain injury;
- a middle category between these two extremes.

Minor cases were the most common and the easiest to treat via physiotherapy. Catastrophic injuries were likely to be more complicated and difficult to deal with, and involve high value claims.

Across the insurer sample there was fairly widespread agreement that interest in using VR was growing and that it offered an effective and potentially beneficial means of managing some, if not all, cases involving personal injury.

The process of identifying whether VR should be used varied across different insurers. Some claimed that they had decided to offer or consider VR in all cases involving personal injury, even before liability had been established. Others admitted

that their process of deciding whether to offer VR was still fairly subjective and haphazard.

The size of the potential liability and the prospects of the claimant returning to work were likely to weigh heavily on the decision whether or not to go down the VR route. In simple terms, cases involving older, less skilled claimants were seen as less suitable for VR than cases where the claimant was younger/better qualified. The potential financial benefits to the insurance company of getting young, qualified claimants back into work were very significant and made an investment in VR seem more worthwhile.

'Over 50, you tend to think that the prospects of getting somebody back to work, especially if they are in any form of intensive labour areas, are very, very remote ... We would be less inclined to give them VR... a judgement would be made.'

(Insurer)

Some insurers argued that VR was preferable to simple financial settlements because it could be started sooner without liability and could help to restore the person to their former state as far as was possible. Furthermore, it could help to ameliorate and compensate for the adverse affects of injury by providing additional services, improvements to the home, etc.

Some insurers recognised that VR was also good business. In the round, VR was paying for itself in lower levels of financial settlement which reflected greater restoration and reintegration of cases.

2.1.3 Providers

Our sample of providers was divided into occupational health and safety providers, vocational rehabilitation providers and general rehabilitation providers. In practice, it emerged that whilst providers came from different schools and backgrounds, and some specialised in certain areas, all were adopting some variation of the case management approach to provide their clients with the kind of support and assistance that was judged appropriate to their needs.

Some providers were operating as independent entities supplying rehabilitation services to a number of different employers/insurers and solicitors. Others were operating as specialist units which were more or less closely attached to insurers/large employers.

The supposed division between those providing general rehabilitation, vocational rehabilitation and medical rehabilitation/OH was not really marked. Whilst some providers were directly involved with rehabilitation in all shapes and guises, others specialised in particular areas. Specialisations included:

- less serious cases, for example minor motor injuries;
- cases which fell between soft tissue injuries and serious trauma;
- catastrophic injuries;
- ergonomics;
- safety audits and prevention of illness/injury caused by the workplace;
- testing and assessment of injuries;
- occupational health related to sickness/absence from work.

'We first think of it as managing absence. It's getting people back into the workplace. We will get them whatever it takes. We know they've got to get back to work and that's the main thing.'

(Provider)

'I don't think there is a huge difference between vocational rehabilitation and general rehabilitation. Because if you take work as part of your life, rehabilitation is helping you to live your life.'

(Provider)

Independent providers could be commissioned by insurers, employers and, in some instances, solicitors to provide assessments of cases and to recommend appropriate interventions. There were indications that independent providers were recognising that vocational rehabilitation was a growth area and were seeking to position themselves as specialising in this area. Characteristically, independent providers came across as fairly commercially driven operations seeking to attract more customers for their service.

2.1.4 Solicitors

It should be appreciated that we only talked to a small sample of solicitors/lawyers, and indications were that opinions reflected past experience and complexity of cases handled.

In theory, all could see the benefits of VR and most recognised that some form of intervention (e.g. physiotherapy) usually made sense and was in the best interests of the injured party in terms of getting back to where they were before the accident. Acting in the client's interests was not simply seeking to maximise the value of the financial settlement.

Although solicitors recognised the value of early intervention for rehabilitation processes, they acknowledged that often by the time they got involved it could be some time post-accident. (It should be noted that barristers got involved in only a small percentage of more serious personal injury cases. By this stage, it is very late in the process to consider or recommend VR.)

That having been said, there was some wariness about insurers' motives in offering rehabilitation. Solicitors were aware that it was in insurers' best interests to secure an early settlement of any claim and to minimise the cost of the settlement.

'We'll point out that if they do settle they can't go back even if they have chronic symptoms after they've settled it. Whether it's a settlement of £1,500 and you go on to lose £300,000 because you can't work because the injury's so bad, it's too late. So that's something we've got to be wary of. We'll always recommend physio and we'll always recommend they hold off settlement unless they think it's definitely getting better and they're happy to settle. I think most solicitors would be the same, to be honest.'

(Solicitor)

Factors influencing solicitors' propensity to recommend VR or accept an offer of VR included:

- the size and complexity of the claim: if the client had a whiplash injury after a motor accident and there was no dispute on liability then it made sense to accept an offer of physiotherapy. In more serious cases where liability was still in dispute and the client's medical condition/prognosis was more uncertain, then solicitors were likely to be more cautious about accepting an offer of VR from the insurer lest it prejudice their client's interest in subsequent negotiations;
- the adversarial system: an offer of rehabilitation was often an insurer's first move in negotiations to settle a claim, especially in cases where liability was in dispute;
- concerns about the independence of some VR providers: some solicitors claimed they preferred to commission their own assessments of their clients to get a second opinion.

It was claimed that in some instances clients were unwilling to take up the insurer's offer of VR, and the solicitor then had a duty to point out that it might adversely affect the settlement.

Delays in the setting up of VR could occur because:

- it became entangled in the jockeying for position in the early stages of a case;
- the procedures of setting up/agreeing VR took time;
- the solicitor did not feel that VR intervention was appropriate until the claimant's medical state had stabilised.

There was a divergence in views about the degree to which insurers were now advocating or offering VR. One or two solicitors claimed that VR was still only being offered selectively by insurers and many insurers did not offer it at all. On the other hand, it was observed by another solicitor that in the last five years or so, insurers have been more active in suggesting VR.

There were indications that some solicitors felt more at ease with VR if they were in control of commissioning and arranging the VR programme, which could be paid for out of interim settlements from the insurance company.

There were claims that assessments carried out for the insurer of a client's condition/prognosis had been submitted in court as evidence. This had raised some concerns about the independence of the assessment and the motivation of the insurer in having the assessment carried out.

It should be realised that the role and responsibilities solicitors have in agreeing to or proposing VR is very complex and sensitive, especially when it relates to the situation of vulnerable, injured clients. Given the small number of interviews with solicitors, this research has provided only initial insight into the complexities of the role of VR in legal proceedings.

2.2 Trying to define 'vocational rehabilitation'

2.2.1 What is 'vocational rehabilitation'?

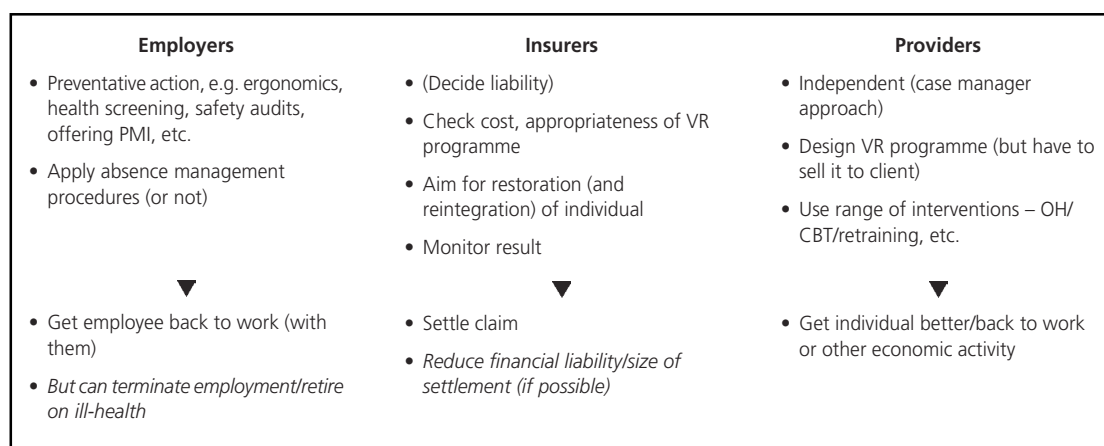
Ideas about what exactly 'vocational rehabilitation' is varied amongst providers, insurers and those employers who have heard of it.

'When I've gone to a meeting and people talk about rehab, we think we know what it means. But of course we all think we are talking about the same thing but it becomes fairly clear that that's not necessarily the case.'

(Insurer)

To some extent, ideas about what VR is reflected in the perspective of the different stakeholders, as Figure 2.1 indicates:

Figure 2.1 Different stakeholders' perspective on vocational rehabilitation



Some took a quite narrow view and saw it as rehabilitation to a new 'vocation' (employment) after sickness or injury. Others took a very broad view and included in VR initiatives in the workplace that were designed to prevent injury or illness as well as initiatives that were designed to manage and reduce absence from work.

'Returning people to work with their old employer, either in their old job or in a modified capacity, I don't see that as VR. I see that as return to work. VR is a very distinct animal that looks at people that can't go back to their original employer and helping them understand what job they can do, how do they access the labour market. Absence management programmes are not VR.'

(Provider)

'We see vocational rehab as not necessarily healthcare, it is an intervention of some description with the focus on returning the individual to the pre-injury work status.'

(Provider)

Some saw VR simply as whatever it took to get people who were injured or sick back into some kind of work or other 'vocationally meaningful' activity. Some included medical restoration in VR whilst others drew a line between medical and true vocational rehabilitation.

'My take on what you are calling VR is simply 'getting somebody back to work'.'

(Insurer)

Whatever the exact definition that people gave to VR, they tended to see it as a process or series of initiatives which sought to move people from being off work through illness or injury back into some kind of employment.

'I think it's easy to get bogged down in semantics. It doesn't matter what you call it. It's the process, isn't it, it's not what it's called. That's why we are starting to use very simplistic phrases, just like 'it's getting you better'.'

(Insurer)

For the purposes of this research we have decided to adopt the broader, more all-encompassing definition of VR, such as *'whatever it takes to get people back into work'* whilst acknowledging that some might have other, narrower and somewhat different definitions.

2.2.2 Responses to alternative definitions of 'vocational rehabilitation'

In order to prompt discussion and help the process of developing an agreed definition of vocational rehabilitation, we assembled a selection of possible definitions. Some came from sources such as DWP and the British Society of Rehabilitation Medicine (BSRM) websites, others were provided by stakeholders or a synthesis of what had been said by various respondents in the early phase of interviewing.

Respondents were shown the definitions below and asked to pick out the one or two that had most resonance with them. We did not adopt a systematic rotation as we felt these should be a stimulus rather than the focus of the interview.

Vocational rehabilitation is a process whereby those disadvantaged by illness or disability can be enabled to access, maintain, or return to employment or other useful occupation.

This definition attracted a fair amount of support from most. Positively, it was fairly succinct and yet quite all-embracing. The reference to 'process' was appropriate without being too specific. 'Access, maintain or return to employment or other useful occupation' was broad ranging and inclusive.

'I tend to like things that are pithy and short. I like this one because it is much wider than the insurance perspective but quite short in the way it is put.'

(Insurer)

'It's quite specific. A lot of people don't know what it [VR] is, but that explains itself quite well.'

(SME)

However, 'disadvantaged by...disability' was rather off-putting and sometimes raised hackles. It was criticised for being too negative in tone.

'That's assuming that if you have a disability you are disadvantaged. I'd resist that, and I think quite a lot of people would too.'

(Provider)

Vocational rehabilitation is a term used by many people to describe an approach whereby those who have a health condition, injury or disability are helped to access, maintain or return to employment.

This attracted some support. It was seen as fairly "worthy", inoffensive and all-inclusive. Positively, the definition covered illness, injury or disability. However, 'term used by many people' suggested some lack of confidence and uncertainty, and some questioned its veracity.

'It's what it's about. We want people to actually return to work, to access and return to employment, to their original employment if possible, but return to employment.'

(Large employer)

Vocational rehabilitation is the process of helping people affected by illness or disability to be employed.

The brevity of this definition was appreciated by some, especially employers, although it was seen as a bit over-simplistic. Others felt that the idea of **return to work** needed to be given more emphasis – ‘to be employed’ was too unspecific. There was also some feeling that a reference to injury was needed.

‘If the last bit was ‘to return to work’ it would be very good. But you read ‘VR is a process of helping people...to be employed’, as if they haven’t been employed before, and that’s where it’s missing the mark, I think.’

(SME)

Vocational rehabilitation is a combination of the active approaches and interventions that are centred on individuals who encounter health related barriers to work, that enables them to fulfil their potential by achieving better work related outcomes.

This was liked by some providers because it conveyed their idea of what VR involved and what it should be. However, it was resisted by most employers and insurers as too long-winded and hard to absorb. It was likely to leave many readers bemused and none the wiser about what VR was. The language also came across as a bit too well-meaning and worthy.

‘I like things that are short and sweet. But the one I’m looking at here I find a little bit wordy.’

(Insurer)

Vocational rehabilitation is a process of interventions whereby people with health problems or disability can build up individual capacity to enable them to be the best they can be.

This definition generally lacked appeal and relevance. It came across as somewhat uncertain as to what VR was, who it was for, and what it could achieve. ‘Best they can be’ came across as a bit weak and unspecific, and some found it a bit patronising. However, there was some support for this definition in Scotland.

Vocational rehabilitation is a carefully managed transitional process that enables those with an illness or disability to find (or return to) a job in a way that saves employers money.

This definition was, in the main, acceptable. However, the explicit reference to saving employers money jarred with most, including employers. Whilst it might be true, there was some feeling that it would not help to gain acceptance for VR in other circles. It also provoked a fair degree of resistance from providers.

'That is interesting. They are simply talking about saving employers money. It's not the one I would wish to see used as a definition of VR.'

(Insurer)

'It's not about saving employers money necessarily, it's about getting value for money.'

(Large employer)

2.2.3 The problem with defining 'vocational rehabilitation'

First of all, the term was new and relatively unfamiliar even to many who were directly involved in rehabilitation situations, such as employers and insurers.

There was some feeling that both the 'vocational' and 'rehabilitation' parts of the name were unhelpful and unfortunate. 'Vocational' has quasi-religious overtones and can suggest 'a calling'. For the less well informed, 'rehabilitation' has associations with criminals, drugs, alcohol, etc. It also implies fairly severe/acute medical or orthopaedic conditions, and does not appear to cover 'minor' injuries, for example soft tissue injuries. Taken together, 'vocational rehabilitation' was often seen by employers as retraining in another vocation rather than help in returning to existing employment.

'What do you mean by 'vocational'? A vocation is religious, it's like a calling, a vocation. I thought we were talking about people being off sick.'

(Large employer)

There were indications that amongst professionals, 'rehabilitation' was widely used as shorthand for VR. 'Rehabilitation for work/employment' was probably a more widely understood concept than 'vocational rehabilitation' and so 'rehabilitation for work' would probably be a more readily understood term. The grander sounding 'vocational rehabilitation' could leave many blinking in confusion.

2.2.4 Towards a definition of 'vocational rehabilitation'

Providers and insurers were aware that there were many different ideas about what 'vocational rehabilitation' is, and little agreement about how exactly it should be defined.

'People call it different things, nobody knows quite what to call it. So at the moment it's called vocational rehabilitation.'

(Provider)

Employers who have addressed the problem of attendance management and time off sick tended to position VR as absence management and either getting an employee back to work or off the payroll. Some also saw it as encompassing preventative actions which could include counselling; a confidential helpline or employee assistance programmes; health screening; access to physiotherapy,

chiropractic. It might also involve private medical insurance and reviewing the ergonomics of the workplace to reduce musculoskeletal complaints and stress.

Health and safety audits were seen as helping to reduce accidents/injuries at work and thus contributed to reducing time off sick. They also helped to limit employers' liability if there were any injuries/accidents at work. This was a hot topic for employers in the context of the claims culture and escalating costs of Employers' Liability insurance.

'We do all the proactive stuff, we have annual health screening, we have an on-site occupational health service at both sites.... There are occupational health trained nurses and physicians, they do pre-employment medicals, surveillance checks, they get involved in risk assessment through work so they look at the actual standard operating procedures and the risk assessments that are attached to them and build in the occupational health element. They also do things like risk assessments from an occupational health point of view. There are a number of things that we do, we provide physiotherapy in Coventry and we have a clinic at this site, we have a chiropractor who comes in once a week with a full day of appointments.... We pay for that and we have a settlement agreement with the Revenue that we pay the tax.'

(Large employer)

Insurers positioned VR as primarily being about getting their client/claimant better and, where relevant, back to work. However, it has to be recognised that insurers also had a direct financial interest in reducing their liability. The sooner and the greater extent to which the client/claimant was restored to (full) functionality, the less the insurer would have to pay out in any settlement.

They saw VR as an appropriate intervention designed to aid restoration and, where appropriate, reintegration of the individual. As such, VR could range from straightforward medical rehabilitation such as physiotherapy, to a multifaceted intervention involving orthotics, counselling, among other things, and inevitably working with employers to help people get back to work.

Some **Providers** tended to adopt a more wide-ranging, broad definition of VR encompassing the physical, social and psychological factors which were preventing the individual's restoration and reintegration. Others classified this approach to getting people back to work as rehabilitation and defined VR as getting people back into a different occupation if they were not able to return to what they were doing before they became sick/injured. In either case, providers saw VR as a holistic process that could embrace everything from sorting out childcare to arranging for a prosthetic limb, and cognitive behavioural therapy.

'You can't treat people by taking an element of it in isolation, hence the advent of bio-psycho-social formulation of problems and of solutions and I think it's quite important that we see work rehabilitation integrated with medical and psychological rehabilitation.'

(Providers/Support Bodies group)

'We can't just look at their injury, like an orthopaedic man will look at the arm or the leg or the back. We have to look at the person in the round. Their support system is vital, it's hugely important on the length of time it takes them to recover and the degree to which they recover.'

(Provider)

Most providers were using VR in a reactive fashion at the behest of insurers (and occasionally solicitors) to deal with specific claims. A minority of those working closely with employers were beginning to extend VR into more proactive areas such as annual medical checks, pre-employment medicals, encouraging employees to self-refer with minor ailments, and developing absence management programmes.

2.3 Perceptions of what vocational rehabilitation might involve

2.3.1 What makes for good vocational rehabilitation

In discussing what makes for good VR, we have drawn together the views of the different sample segments. Some, for instance, employers, may be more active at the early stages of an employee's absence. In contrast, providers may look beyond mere restoration to the (original) workplace. The following section is thus a synthesis of a spectrum of opinion gleaned from across the sample.

In general, a good VR approach involved:

- being proactive;
- early intervention after injury/illness;
- making the patient central to the process;
- undertaking relevant intervention(s);
- not making an (artificial) distinction between medical rehabilitation and vocational rehabilitation;
- adopting a holistic approach to the rehabilitation plan;
- being realistic;
- knowing when to draw the line.

Being proactive involved preventing illness/injury in the workplace by identifying possible trouble spots, changing/adapting the workplace environment to head off injury, strain, etc., and offering or providing access to early treatment, for example physiotherapy or chiropractic treatment **before** the employee goes off sick.

'If you think that the two main reasons that people are off work are stress and musculoskeletal there is a lot more that employers could do to prevent that very early on without allowing somebody to deteriorate into a situation where they have to have any time off work at all.'

(Providers/Support Bodies group)

More enlightened, progressive and pragmatic employers felt that minimising the potential for absence due to sickness/injury amongst the workforce was preferable. There were cost benefits as employees who were not working were non-productive, and it was better for staff morale and reduced possible stress in the workforce who were not off sick because they were not having to cover for absent colleagues. Also, employers felt it was better to prevent a problem occurring rather than allowing it to happen and then having to deal with it.

'There have been occasions where we've had people where the doctor has signed them off sick, we were therefore going to be paying whatever it was sick pay for a period of time, and they've not gone off because we've provided them with intervention.'

(Large employer)

Early intervention after injury/illness consisted of carrying out an assessment as soon as possible of what was needed to get the employee back to work and providing relevant interventions early before the working mindset is replaced by an illness orientated mentality and/or before the employee started to believe they were no longer able to work.

Some providers and occupational health practitioners claimed that assessments should be made as soon as possible, and, ideally, from Day One. (Some references were made to the Australian model as possibly providing an example of good practice.)

Large employers and SMEs were relying on the line managers following triggers set out in their sickness/absence management schedule to contact an employee off work through illness/injury to find out the reasons for the absence and, if appropriate, to refer the case to the HR department. Across this larger employer sample, sickness/absence management procedures varied in their stringency. Length of time off sick before contact from a line manager was initiated could vary from one to ten days.

Some small/micro employers did visit the employee, but most were worried about being seen to be 'bullying' the employee back to work. They thus tended to sit back and keep their fingers crossed and hope for the best.

Part of **making the patient central to the process** involved convincing them that getting back to work sooner was in their own best interests. The VR provider would also need to work with the individual to explore their goals and develop a plan of action and identify what might be the personal and circumstantial barriers to getting back to work and how these might be overcome. It might also involve liaising with

the employer to plan a phased return to work or agree modifications to the workplace to enable an earlier return to work.

Providing **relevant intervention** required accurate identification of what was needed to help the individual get back to work/economic activity, and drawing up a rehabilitation plan taking into account the individual's circumstances and likely functionality. There was a strong sense amongst rehabilitation providers that it was important to focus on the individual's present and potential abilities – what they could do or were likely to be able to do – rather than on what they could no longer do. This would help both in devising a feasible rehabilitation plan and in keeping the employee's mind still focused on work/returning to work.

In some instances, an intervention could be quite basic, such as offering a phased return to work or lighter duties, or making minor modifications to the workplace. Interestingly, there were signs that some small and micro employers had been prepared to do this, especially in the short-term. However, it should be noted that the opportunity to offer alternative types of work was generally more available to larger employers.

There was agreement that good VR involved **not making a distinction between medical rehabilitation (repair) and vocational rehabilitation (restoration/integration)**. There was some feeling that this distinction was arguably artificial. Rather, it was seen as important to recognise that the two processes had a common aim and were complementary. Some providers observed that very often mental health problems developed alongside long-term illness or injury; these had to be addressed before people felt willing or able to return to work.

'I can think of two cases where medical colleagues have referred cases on to me and I've looked at them and thought 'no way is this gentleman going back to work'. My medical colleague actually persuaded the insurance company to pay for alcohol rehabilitation, a huge spend on going to the Priory to dry them out, only to be told by me they weren't going back to work. You've got to take the long view. If someone can't read and write very well...you've got to take these things into account.'

(Provider)

'If you don't treat the medical simultaneously with the vocational, the person's gone off the boil. During the illness part or the injury part their minds aren't on work but you've got to keep them thinking about it, engaged in it and involved in it, so that when they are physically able to pick it up they can.'

(Provider)

It was felt to be important to **adopt a holistic approach to the rehabilitation plan**. This involved not just looking at the individual's presenting symptoms but also taking into account other factors including:

- the individual's personality/goals;
- length of time off sick;
- influence of family/friends;
- what support systems there were/could be;
- other influences (lawyers, doctors, insurer, etc.);
- the individual's functionality;
- their financial situation.

'You have got to get the buy in from the injured person. If they have significant others you want to make sure that they buy in because they can be so destructive to the process. If [the injured person] is quite happy to stay at home and mind the kids they are having no child care costs then they have no incentive to allow them to go back to work. It doesn't matter how good the case manager is or the rehab is, it will be undermined.'

(Provider)

'I had one case where the physio declined to provide treatment because he was so large, so huge. She reckoned it would be counterproductive. So first of all this person had to lose weight. He didn't buy the food, he didn't prepare the food, so it was down to his partner. It wasn't just him, it was both of them that needed to be aware of what was a healthy diet.'

(Provider)

Being realistic involved:

- drawing up a properly costed rehabilitation plan and, insofar as possible, sticking to both the plan and the costing;
- deciding what needed to be done to help the individual get back into work/economic activity, rather than trying to make the individual's world a better place;
- working towards getting the individual a job they can do (not necessarily the job they were in before the illness/injury or into the job of their dreams).

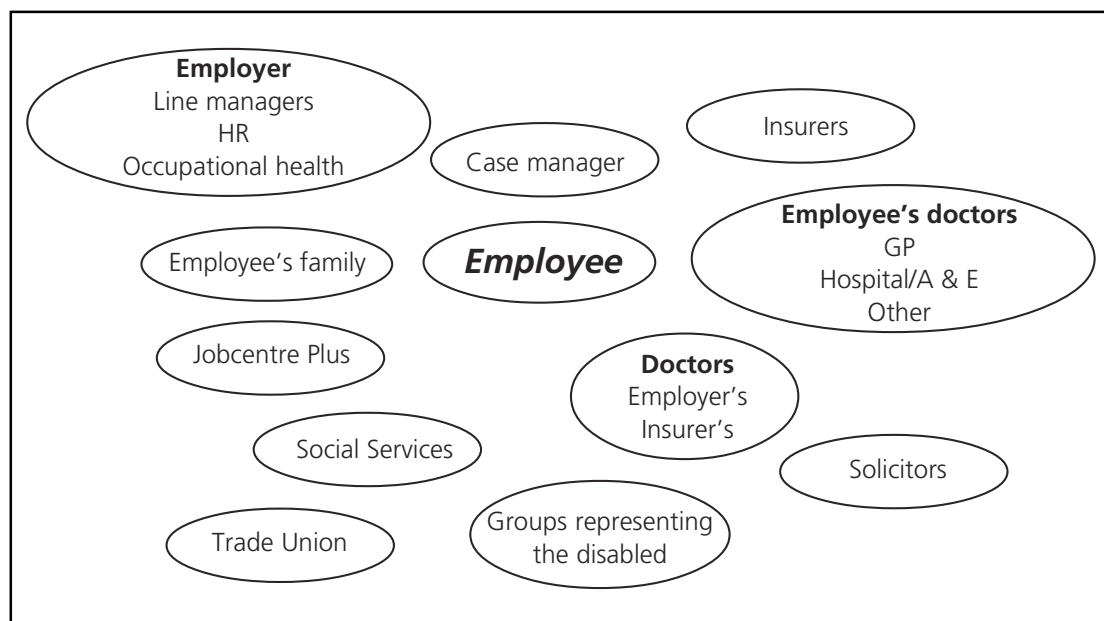
Even allowing for professional differences, some providers and insurers were fairly critical about the rather utopian, 'do-gooder' approach which, they felt, sought to take VR to unrealistic levels, such as looking to purchase a new bungalow rather than modifying the current accommodation.

Finally, VR providers/case managers had to **know when to draw the line**. In some instances it was acknowledged that, however much was done in the way of rehabilitation, the individual was never going to be able to return to any form of employment. In such situations, the case manager needed to recognise that, in the interests of all parties, treatment should be discontinued.

2.3.2 The case manager approach

It was generally agreed that case management lay at the heart of good VR and successful VR provision. The need for case management arose because of the potentially complex situations that could occur when someone was sick or injured long-term. Figure 2.2 seeks to show the key players who might be involved.

Figure 2.2 The key players when someone goes off sick or injured



However, ideas about the full extent of what case management covered varied across different stakeholders. Some insurers hinted that it was essential to keep case management more or less 'in-house'; others delegated the case management role to their selected or preferred providers. Some providers positioned case management as a more hands-on role where the manager had direct contact with the claimant; others felt that it was important for the case manager to facilitate and co-ordinate interventions without getting too personally involved. Sometimes it was claimed that case management for simpler cases could be carried out over the phone – indeed, one provider did all their case management by phone.

Opinions about who was best suited to undertake the case manager role varied. Some claimed that people with a clinical training were well qualified whilst others favoured those with an occupational health background.

There were signs that successful case management required both sensitivity and an ability to identify what the claimant/patient really needed to aid their recovery, and

what was getting in the way of it. It was also thought to be useful for all concerned to have a sense of what was practical and realistic. Whilst case managers saw it as their role to help the claimant recover and get back to work, the more sophisticated and experienced were conscious of the danger of encouraging too great a degree of dependency between case manager and claimant, and unwittingly undercutting the person's ability to do things for and by themselves.

'[A good case manager] is a person who can stay objective without becoming too involved. So many of them I see become part of the family and you can't do that. You are there to facilitate a process, to get that person to be self-managing as fast as possible. There may still be a need for a case manager on an ad hoc basis but they should be in and out as fast as they can.'

(Provider)

Characteristically, the role of the case manager was seen as:

- establishing the current medical condition of the claimant and the prognosis;
- making an assessment of the claimant's domestic circumstances, needs, personality, etc.;
- identifying what needed to be done to help the claimant recover/return to work;
- facilitating appropriate interventions/co-ordinating what needed to be done, for example modifications to home/vehicles, childcare, talking to the employer, and adaptations to the workplace.

'You have to head hunt the right speciality. It's no good having a geriatric physio or someone who specialises in lung function, absolutely useless, if the person has got a musculoskeletal issue, or vice versa. If you've got a respiratory disorder, you don't want someone who specialises in bones and muscles and stuff. So it's not just the discipline, it's the expertise within that discipline.'

(Provider)

2.3.3 Barriers to successful vocational rehabilitation

Barriers to successful VR stemmed from five main sources:

- employers;
- problems related to the supply of VR services;
- the legal/claims process;
- claimants;
- the system.

The above list is not intended to give any priority to any one of the barriers. It should be understood that the relative importance of barriers will vary in different situations and with different stakeholders, depending on the situation of the sick/injured person.

Employers

Employers, especially those without access to OH/HR facilities (mainly smaller employers), were often not well informed about ways of handling long-term sickness or serious injury, and were inclined to accept a GP's prognosis and/or sick note.

Such employers were concerned not to be seen to be harassing their sick employees back to work, and were worried about breaking some aspect of employment law, health and safety regulations, the DDA, etc. Often they were paying Statutory Sick Pay (SSP) fairly soon after the employee went off sick/injured, and, thus, under less financial pressure than if they were having to pay full salaries. Consequently, they were not very motivated to resolve the situation.

'A small business can't afford to pay people when they are off. With overheads and everything else you've got, it's not viable.'

(Micro employer)

'If they had a nervous breakdown and I caught him in the corner sitting down and biting his nails and they were all bleeding, then I suppose that would mean he has something mentally wrong. I would send him home. I'm in business, I wouldn't even try to be a social worker!'

(Micro employer)

Some larger employers identified line managers as a barrier to VR. Some line managers could be reluctant or unwilling or just not very good at reaching out to those off sick, or too busy to get involved with this activity. Sometimes, the line manager was part of the underlying problem – the reason why the employee was off sick. There were also indications that line managers (and work colleagues) could resist phased return to work programmes because it disrupted the routine of the workplace.

There were claims that some large employers were slow to inform OH departments and/or insurers about staff who were off sick with potentially work-related illnesses. This delayed effective intervention.

There were also claims that sometimes, work colleagues or other staff resented the preferential treatment given to the long-term sick returning to work. They saw special consideration being given to the needs of those returning to work as 'rewarding absence' and this sometimes led to complaints about not being given similar facilities/arrangements or treatment.

'We do get the shift managers and people like that saying why do we go through all these lengths. It's the extra responsibility they've got, the extra time they're going to have to put in at the end of the day. It's something else they've got to do and 'it's not fair to be looking after him when there's really good workers who are here 100% of the time and they don't get any fuss but this guy who's been off for whatever is getting loads of fuss'. So trying to explain that to them is a bit difficult.'

(SME)

Company culture could sometimes get in the way of companies adopting VR processes. Some employers were not disposed to get involved with VR initiatives; as far as they were concerned, employees were either fit for work and at work, or not. In other companies, the circumstances of work could operate against VR. For instance, employers argued they could not afford to have semi-fit workers on a building site, and there was little scope for alternative jobs/workplace modifications, etc.

'I am the office. If someone can't work as a chippy on site then he's not working. I can't have him in the office, there's no room!'

(Small employer)

Supply

Views about whether there was sufficient supply of VR practitioners/providers varied. On the one hand, there was a general impression of a mushroom growth of providers with lots of new providers keen to sell their services. On the other hand, there were claims that there was a real shortage of properly qualified/trained staff in OH, physiotherapy, cognitive behavioural therapists with experience of work related issues.

'There's a plethora [of providers] out there. Certainly, six months ago I could have three or four brochures from providers every day, all providing the same kind of services. All professing to do the same thing.'

(Insurer)

'If everybody that was injured got pushed down this rehabilitation route the infrastructure would not support that at the moment.'

(Insurer)

It was also noted that there was no proper directory of suppliers/providers of VR, neither was there a recognised or established accreditation of VR providers. Also, there could be a problem regarding access to, and availability of, specialist practitioners in certain parts of the country, especially more rural, out of the way places; furthermore, there was some concern about whether there were sufficient practitioners with relevant experience, e.g. of traumatic injury, etc.

'We need to define who providers are and get some ground rules about what qualifications they need to have.'

(Provider)

'Case management, to me, requires proper training and proper qualifications. At the moment, technically, I can walk off the street and set myself up as a case manager. I know nothing about it, but I could do that.'

(Insurer)

That said, some providers were working with lawyers and insurers to improve the handling and speedy resolution of claims. Codes of practice and practitioners' guides were also being developed.²

Legal/claims process

Insurers, employers and some providers noted a growing claims culture which encouraged people to make claims in order to get money. There were reports that solicitors (often offering a 'no win no fee' service) were encouraging clients to think in terms of a large financial settlement rather than restoration via VR and a reduced settlement. There were also suggestions that solicitors had sometimes dragged their feet when handling cases and made it more difficult for early intervention to aid claimants' recovery, although solicitors now seemed to be adopting a more positive attitude towards VR.

'If you had asked me about three or four months ago, I'd have said that lawyers get in the way. But I think lawyers nowadays are now beginning to realise that it is in their best interests and the best interests of their clients to grab as much care as quickly as possible.'

(Provider)

The adversarial system of handling insurance claims also got in the way of early intervention and providing assistance to the claimant quickly.

Claimants

This subsection is based on the views of different stakeholders about claimants of personal injury cases or those for whom VR is sought. It should be emphasised that we did not interview any claimants.

It needs to be recognised that some people who are off work through illness or injury do not have or lose the motivation to return to work. For some, the accident or illness provided an opportunity to give up working; for others, the idea of returning to work was too challenging. Sometimes, the injured/ill person's family becomes dependent on them to provide domestic support, e.g. by looking after the children. Lack of

² For instance, the Bodily Injury Case Management Association (BICMA) and the Case Management Society, UK (CMS UK).

motivation to return to work could be reinforced by the security of Incapacity Benefit and other attendant benefits. (The name *Incapacity Benefit* in itself suggests that the recipient has been incapacitated in some way.)

'You will get the labourers that don't want to go back to work, they've been off with a sprained wrist and now it's a permanent disability as far as they're concerned.'

(Provider)

Even those who, in theory, wanted to return to work could be put off if their GP advised a lengthy period of rest.

'One of my employees, a key worker, had an aneurysm just before Christmas a couple of years ago and he was told to do nothing for six months. We were running around like headless chickens, my son was working 24/7 to do his work and meet deadlines. I wanted X to come back even for a couple of hours a week, and he wanted to do a bit but he daren't because the doctors had told him he might have another if he went back to work early.'

(Small employer)

The system

Some providers, employers and insurers identified GPs as one of the barriers to successful VR. GPs were unwittingly exacerbating the problem by repeatedly signing people off sick without seeking to explore the nature of the problem properly. There was some feeling that GPs did not necessarily understand, or appreciate, the correlation between the nature of a patient's job and their actual fitness to work. There were also claims that GPs' willingness to provide Med 3 sick notes encouraged a sickness culture. It was argued that many off work with stress or depression would not be fit for work until they returned to work; indeed, the sick note was making them ill. Furthermore, employers claimed that some GPs were unhelpful, slow to respond to enquiries, and wanted payment before they would provide information about their patients.

'The GP is not understanding of the work sites. He can only treat the ailment, he can't really compare and say this person is fit for work...because he doesn't know what the capacity is or what the job entails.'

(Provider)

'Their [GPs'] attitude is 'I'm providing a service to the individual and if the individual wants to go off sick, then so be it'! Instead of thinking that there is no reason why he shouldn't be at work. And we all know the traditional sick notes ... my favourite one at the moment is something like pendularis. So I rang them up and the doctor said 'well, it's lead swinging'.'

(Large employer)

'If I write a letter to a GP saying can you recommend this person for physiotherapy, can you make a NHS referral, you may not hear from the doctor for two months because they are so busy, they're so fraught. So there is a huge delay.'

(Provider)

Whilst there was general praise for NHS emergency treatment and for centres of excellence (e.g. cardio-rehabilitation and spinal units), it was also acknowledged that the NHS was often very stretched when providing treatment for non-acute cases. It was also widely noted that there was a gap in continuity of care after discharge from hospital. Typically, there were long delays before patients could access additional recuperative treatment such as physiotherapy.

'The ante treatment the NHS gives is great, everybody will tell you that. It's when 'we've plastered your leg, off you go', that's when it begins to fall down.'

(Insurer)

'One of the problems I see is the gap between when somebody has come out of hospital post accident and then we've a long gap and a social worker calls and says 'I'm sorry but our mobility worker won't be available for another three months, can you sit there and hang on a little while'.'

(Provider/Support Bodies group)

The benefit system was another potential barrier to successful take-up of VR. Incapacity Benefit and associated benefits can be seen as providing a secure, safe source of income, especially for those with lower earning potential. Some claimants became acclimatised to the world of benefits and the idea of returning to the world of work, especially to a different employer or different occupation, was quite challenging. The idea of leaving the benefits system for employment could seem like a quite risky option, especially if they were more disabled and if they had been out of work for a long time. There were some indications that the benefit system and its complexities discouraged phased return to work or working part-time. If a sick or injured person worked too many hours they could find their benefits were at risk.

'With the state benefit system, we have had cases where people have not come back to work, particularly when they've been off for a long time and the benefit is a crucial part of their income, because if they do any work the benefit gets cut completely.'

(Large employer)

The tax system with regard to benefits in kind could be another barrier. Although employers were prepared to offer 'perks' such as private medical insurance, physiotherapy, etc., that should contribute towards a reduction in work absence or facilitate an early return to work, their employees could attract a benefits in kind tax liability if they took up these offers. Significantly, some employers were taking it upon themselves to pay their employees' tax liability because they thought that the

benefits of earlier medical treatment outweighed the cost. Employers noted that some employees refused the offer of private medical insurance because they were unwilling to pick up the additional tax burden.

'If you fall down the stairs at work and the employer is negligent and indeed, if the employer is not negligent, the employer has access to our services. If you fall down the stairs at home and the employer wants access to our services it's a potential benefit in kind which has implications for you.'

(Insurer)

Insurance Premium Tax imposed on employers for providing private medical insurance (PMI) was a further cost to employers.

2.3.4 Some pitfalls associated with vocational rehabilitation

Whilst there was general agreement that VR was a good thing, insurers and providers alike recognised that things did not always run smoothly and the provision was not always appropriate. Insurers complained about instances where providers:

- had produced overlong and detailed assessments of cases;
- embarked on VR programmes without properly costing or monitoring the results or benefits of interventions;
- proposed VR programmes with objectives that were unrealistic and unlikely to have a successful outcome.

Providers, on the other hand, were conscious that VR was not a universal panacea, and did not always work well. Sometimes, the injured/sick person was not really interested in or responsive to VR and somewhat inured to being sick/disabled, or there had been a long delay between the original injury/onset of illness and the start of VR. The long-term sick or injured were likely to develop a fatalistic/benefit-centric attitude which made it harder to disentangle their problems and get an upward cycle in operation. In some instances, the VR interventions tried to deal not just with the problems that have occurred since the injury/illness but also problems that preceded the injury/illness and were, arguably, outside the remit of any VR programme. There were also cases where VR had been expected, perhaps unrealistically, to rehabilitate people who, pre-accident or illness, were not capable of working.

'I can think of one case we were sent. The man had such an odd personality before his accident and the chances of anybody getting him back to work were absolutely zero. We were set up, really, not to be able to do anything.'

(Provider)

Providers and insurers questioned the value of training programmes, e.g. IT courses, that did not lead to a tangible end result or benefit for the client in helping them get (back) into the world of work. They also criticised the inappropriate use of short-term residential rehabilitation centres rather than seeking to locate more long-term

support within the community, and case managers falling into the trap of co-dependent relationships with clients, rather than encouraging them to take responsibility for managing their own lives.

2.4 Barriers to the use of vocational rehabilitation

There are indications that VR would not be used unless someone suggested it or requested it. At present, initiators of VR were largely confined to insurance companies (often only in a limited number of cases) and larger, more progressive employers or OH departments.

We suspect that amongst many GPs and most employers, awareness of VR and what it could do remained fairly rudimentary. Likewise, we suspect that awareness and understanding of VR was very limited amongst the general public. (It should be appreciated that the general public is a potential market for VR interventions in that these are the people who might be injured/get ill and their families.)

Whilst providers emphasised that early VR intervention was key to more successful outcomes, there appeared to be a potential gap when people fell ill/were injured and no-one advocated VR.

Whilst some insurers were enthusiastic proponents of VR, others were rather more cautious in their willingness to advocate and/or use VR. This wariness reflected a combination of factors. For instance, the insurer may not know about the claimant and their circumstances (e.g. in third party injury cases), or the likely value of the claim may not justify a perceived substantial VR expenditure (e.g. an older claimant with severe injuries employed in manual work). Also, claims managers were not always best able to identify cases where VR might be suitable or appropriate. Other factors which might impinge on insurers' willingness to suggest VR were cases where the insurer was only partially liable for the accident/injury, and, in a minority of claims, a suspicion of fraud on the part of the claimant.

'Like all insurers, we do have a number of cases where we are sceptical about the honesty of the claimant.'

(Insurer)

Insurers also claimed that some solicitors did not agree to the insurer or their representative visiting the claimant to discuss the idea of VR.

Over and above these considerations, there also seem to be some doubts within the insurance industry about the efficacy and financial benefits of VR. Insurers mentioned the lack of hard data on which to base a judgement.

'A lot of the insurance market still, I think, are not persuaded by rehabilitation. There are 300 companies, people perhaps aren't totally persuaded. No-one has given me hard evidence of where rehabilitation has assisted.'

(Insurer)

There was some anecdotal evidence to suggest that some sick/injured people might refuse to agree to take part in VR because they:

- were suspicious of the insurance company's motives;
- were fearful or reluctant or not interested in returning to work;
- preferred the security of the benefit system or were caught in the benefit trap.

'We do have a number of cases where the claimant is effectively saying 'why should I bother, I'm being paid as much as I was earning by getting Incapacity Benefit'.'

(Insurer)

2.5 The future of vocational rehabilitation?

There was widespread agreement across the sample that VR was a good thing and that it deserved support and encouragement. However, its development would be assisted if its definition and what it encompassed were generally understood and accepted.

Whilst support and usage of the term 'vocational rehabilitation' is by no means universal, and there are variations in what different stakeholders see it as covering, we suspect that by now, it will not really be feasible to change the name. However, consideration might be given to developing a more user-friendly strap line along the lines of 'getting people back to work'.

The credibility and standing of VR and confidence in the process would be enhanced by the introduction of:

- a regulatory body;
- a system of quality control and accreditation;
- recognised training, qualifications and competences for providers and practitioners.

Furthermore, there needs to be more agreement about the principles of best practice and learning from best practice in other countries.

'In the New Zealand system, discharge planning happens almost immediately. They start planning from admission, not at the other end when he is cured or whatever. As soon as you've got some reasonable data – this guy may be another two months before he's going to be fit to start doing something at work – you notify the employer ... As soon as the person is discharged from hospital you get them to go to the work site as soon as they can, or get people to come to him on a regular basis, even if they are only going in for coffee, it keeps that relationship going ... they don't feel like they've lost so much ... We keep them involved in the work cycle as much as we could to keep that opening there and that process going and alive.'

(Provider)

'We shouldn't restrict ourselves to looking at the UK model. There are models out there that need to be examined.'

(Insurer)

Also, more systematic monitoring and long-term research on the outcomes of VR interventions should be carried out to find out more about what worked best, added value, the business case and relative cost benefit.

Consideration should be given to developing a handbook of qualified and accredited providers/practitioners that identifies their expertise and specialisms. The status of occupational health medicine also needs to be enhanced. It needs to be recognised as a specialism in its own right, with its own qualifications and established competencies.

Employers, especially smaller employers, need to be encouraged to take more preventative action designed to reduce absence from work such as employee assistance programmes, health screening, safety audits, etc. They also need to be made more aware of the benefits of early intervention when dealing with absence management. Consideration might be given to developing a helpline service for smaller employers, offering them guidance on how to deal with sickness management situations when they arise.

Insurers could develop packages and policies that encouraged employers to have a more proactive approach to employees when they went off sick. (It has to be acknowledged that some insurers are already doing this, but there are still insurance companies who have yet to be (more) convinced about the benefits of VR.) Insurers could offer to undertake VR regardless of liability, thus enabling them to get rehabilitation started sooner.

Providers need to introduce satisfactory regulation of the industry so that users can have more confidence in what they were buying. They also need to continue spreading the word about the potential benefits of VR to all the key stakeholders.

Government departments and **agencies** need to join together to find ways of overcoming unintended barriers to VR and making access easier. This research has shown that a multi-departmental approach is required.

The NHS needs to look at hospital discharge policy and the ways this linked up with recuperative care and reintegration of the patient. It also needs to look at the way GPs handle patients' sickness absence from work and understand how delays in access to NHS services can impact on employment situations and mental health.

The Inland Revenue needs to examine the extent to which taxation policy might be discouraging employers from providing support services (e.g. PMI, physiotherapy, counselling, etc.) that reduce absence from work. Insurance premium tax on employers who offer PMI is a disincentive; also, if the cost of preventative action is taxed as a benefit in kind then employees might refuse the offer from employers.

'There was one company where they had paid for an employee to get an operation, but the tax man came after them because of benefit in kind. They said they were flabbergasted when it happened because they thought they were really doing the right thing, helping somebody out, it was good for the business as well and they paid the money and they were also hit with a tax bill. And they said there is hardly any incentive for us to be doing it.'

(SME)

The current legal system is not always helpful in furthering the cause of VR. The Department for Constitutional Affairs (DCA) needs to look at ways of dampening the apparent growth of a claims culture. It might consider ways of discouraging/curtailing the activities of 'ambulance chasing' solicitors, e.g. working with the NHS in restricting such firms from putting up posters in A&E departments.

The DCA could also:

- explore the possibilities for developing more consensual approaches to claims resolution that ensure VR can be introduced early on without affecting liability;
- consider setting up a legal framework to take into account the potential pitfalls of VR intervention in terms of possible adverse consequences for the claimant, e.g. if they return to work after VR, settle the claim and then lose their job and cannot find other work;
- develop guidelines as to the evidential status of rehabilitation providers' assessments (should they be 'without prejudice' documents?);
- look at where employment and discrimination law might affect employers' propensity to consider VR, and explore ways of mitigating any negative impact.

The Health and Safety Executive could look at the extent to which employers are aware of, and conform to, the need to provide health and safety warnings in a form and language that employees can understand. (One employer was playing health and safety videos to their employees but the videos were in English and the employees were mainly Portuguese with a limited grasp of English.)

DWP needs to recognise that employers represent the front line against long-term sickness. Most long-term sickness started with a few days off; the longer employees were off work, the greater the chances of them staying off long-term. DWP could look at ways in which it might be able to support and help employers in their attempts to manage absence and reduce the chances of their employees falling into long-term sickness.

There may also be some scope for working with employers to develop back to work packages that do not penalise those who take the 'risk' of coming off benefits and returning to work if it does not work out. Likewise, DWP could consider looking at the name 'Incapacity Benefit' and its appropriateness, both for those who really lack capacity and for those who are classified as such. Consideration could also be given to developing a helpline for the long-term sick/injured which could give them accurate information about the benefits and assistance available to them. Finally, DWP could look at GPs' approach to signing patients off work due to sickness/injury, and how they might be encouraged to modify their thinking.

3 Conclusions and recommendations

3.1 Conclusions

Amongst those aware of VR or similar processes designed to help people return to work, there is a high degree of enthusiasm for, and belief in, these initiatives. This commitment to VR can be observed across our sample which includes providers, insurers and those employers who already understand the process. The groundswell of enthusiasm for VR and faith in its ability to have a genuine impact on getting people back to work after long-term sickness or injury represents a major asset that the Government should seek to support and assist where appropriate.

Assistance could take the form of:

- removing barriers that lie in the way of successful interventions;
- facilitating and fostering structural developments that will help to raise awareness and understanding of VR, and credibility and confidence in the VR process in general, and especially amongst employers and the general public;
- providing constructive support to those who are seeking to reduce the extent and incidence of long-term absence from work.

Short-term sickness absence is the precursor of long-term sickness absence. The more employers do to prevent short-term problems becoming more serious, and to help to address short-term concerns/ailments, the less likely employees are to drift unnecessarily into long-term sickness, lose their jobs, and subsequent benefit dependency.

The findings from this research suggest that time off work with long-term sickness/injury starts in many different ways. Probably the least common type starts with a major accident or injury, more often motor-related, where the injured person may take months to recover from their injuries. More commonly, long-term sickness/absence from work can start with a few days off where the presenting reason, such

as back pain, stress, etc. may, in reality, be masking underlying root problems. As time off work continues, supported by sick notes from GPs, employees can drift into more chronic conditions and potentially long-term incapacity for work.

This research shows that employers have a crucial role to play to alleviate long-term sickness and the drift onto long-term incapacity. If levels of sickness absence are successfully reduced by appropriate interventions then the inflow into incapacity benefits is also likely to fall. The Government, thus, has an interest in working with insurers and employers to support their efforts in encouraging claimants and employees who have been sick or injured to return to economic activity.

3.2 Recommendations

The development of VR would be assisted if an accepted definition and meaning could be agreed and established. It would also help if its name were made more user friendly, although it may be too late to do this.

The credibility and standing of VR would be enhanced by setting up:

- a regulatory body and a system of accreditation and quality control for providers;
- recognised training qualifications and competencies for providers and practitioners.

A handbook of qualified and accredited providers and practitioners should be developed to help those employers, insurers, solicitors and other stakeholders looking for VR interventions to make informed choices. In addition the status of occupational health medicine needs to be enhanced and recognised as a specialism in its own right.

Employers need to be encouraged to take more action to reduce absence from work through for example, employee assistance programmes, health screening, safety audits, and to intervene early to manage sickness absence. A helpline service aimed at smaller employers providing advice on dealing with absence management situations might also be considered, as might development of a toolkit to provide employers with well-defined guidance on how to handle situations involving sickness absence.

Insurers could develop Employers' Liability packages and policies that expect employers to take a more proactive approach to employees when they go off sick, and offer to undertake VR regardless of liability or before the issue of liability is determined.

Providers need to introduce and establish satisfactory regulation and, at the same time, demonstrate and communicate the potential benefits of VR.

Government departments and **agencies** need to join together to reduce potential barriers to VR such as:

- GPs' handling of sickness notes;
- management of patients' expectations while in hospital;
- the gap between NHS emergency care and full restoration/integration;
- tax on PMI provision by employers and benefits in kind for employees.

Consideration might also be given to looking at how:

- VR might be introduced as early as possible into the claims process;
- a more consensual approach to claims management could be developed;
- the benefit system might be discouraging the long-term sick/injured from considering a return to work.

Overall, this research indicates that outside of an enlightened few, awareness of VR and understanding of its benefits is fairly limited. This implies that there is a need for more information and education about VR and how it can help sick or injured people back into some form of economic activity. At a base level, it needs to be more widely understood and appreciated that recovery from sickness/injury is aided by getting back to work sooner rather than later. This suggests an information campaign aimed at the wider general public who are both potential beneficiaries of VR as well as influencers/advisers to those who are off work sick/injured. Education could take the form of seminars for stakeholders including GPs, practice nurses and other primary health care workers, solicitors, barristers and judges, insurers and employers.

