Mapping Vocational Rehabilitation Services for people with Long term neurological conditions:

Summary report

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March 2011

Disclaimer:
The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

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ACKNOWLEDGEMENTS

We are grateful to all the people who took considerable time and care answering the questionnaire. We are aware how time consuming this was and hope they find the report both interesting and helpful.

We should like to thank the 5 Centres: Working Out Programme, Community Head Injury Service, Aylesbury; Vocational Rehabilitation Service, Disability Options & Community Stroke Team, Tower Hamlets; Neuro-Rehabilitation Unit, The Walton Centre, Liverpool; Midlands Centre for Spinal Injuries, Robert Jones Agnes Hunt Orthopaedic Hospital, Oswestry; and West Sussex Community Neuro-Rehabilitation Team who participated in the detailed case studies. Their skill and dedication emerged clearly during the interview process. Their insights were invaluable, we hope we have reproduced them accurately.

Finally, we should like to thank the expert panel. Everyone contributed actively to the success of the expert panel. They generously gave us the benefit of their experience and knowledge. The debates were always lively and added enormously to our interpretation of the data.
Chapter 1 BACKGROUND

LONG TERM NEUROLOGICAL CONDITIONS

‘Long-term neurological conditions’ resulting from disease of, injury or damage to the body’s nervous system affect some 10 million people in the UK. Approximately 350,000 need help with daily living as a result (Department of Health, 2005). They are the third most common reason for seeing a general practitioner and account for some 20% of acute hospital admissions.

Long-term neurological conditions (LTNC) can be broadly categorised into a) sudden onset conditions, for example: acquired brain injury or spinal cord injury, sometimes followed by a partial recovery; b) intermittent and unpredictable conditions, for example: epilepsy, or early multiple sclerosis, where relapses and remissions lead to marked variation in the care needed; c) progressive conditions, for example: motor neurone disease, Parkinson’s disease or later stages of multiple sclerosis, where progressive deterioration in neurological function leads to increasing dependence on help and care from others; and d) stable neurological conditions, but with changing needs due to development or ageing, for example: post-polio syndrome or cerebral palsy in adulthood (Department of Health, 2005). Even within these four disease trajectories, the needs of a client can change over time as their condition deteriorates or fluctuates.

Long-term neurological conditions affect people in different ways and often result in impairments that can affect a person’s ability to carry out specific activities, which in turn may limit their ability to perform optimally in a job or work role. These impairments include i) physical or motor impairments such as paralysis, muscle weakness, incontinence; ii) sensory impairments such as visual or hearing loss, pain and altered sensation; iii) cognitive/behavioural problems such as poor memory, attentional difficulties, confusion, dis-inhibition and a lack of insight; iv) communication problems such as difficulty speaking or using language to communicate and in fully understanding what is being said; and v) psychosocial and emotional effects such as personality changes and low mood, anxiety and depression (Department of Health, 2005).

Some effects, such as impairments in fine motor skills, cognitive functioning, organisational abilities and fatigue may limit a person’s capacity to work in the competitive job market (Department of Health, 2005) and yet may be so subtle that they are ‘invisible’ to others (Japp, 2005). These present particular problems, since not only are they frequently missed by health services during a hospital stay but also by service providers and employers who without knowledge about the way a long term neurological condition can affect an individual, may assume the person does not have a disability and may result in unrealistic expectations about performance in a specific task (Japp, 2005).

But it is not these direct effects of the condition that determine the need for help or support in returning to or remaining in work but rather the interplay between these and other contextual factors, both personal and environmental. Personal factors, such as a person’s beliefs and attitudes about work, their confidence and expectations; and environmental factors, such as the physical work environment, the nature of the job; and the beliefs and attitudes of line managers, employers or other family members may be more important determinants of whether the person with a long term neurological conditions can or will work. Hence, it is these factors that services intending to help or support people with a long term neurological conditions to find, return to, remain in or relinquish work must also address.
The NSF for Long term conditions (Department of Health, 2005) was developed to address long-standing inequities in health and social care provision for people with neurological conditions. The 11 quality requirements set out a clear vision to improve the quality, consistency and responsiveness of services providing treatment, care and support to ensure people with long term neurological conditions can live as independently as possible.

Quality Requirement 6 is concerned with vocational rehabilitation. It states that people with long term neurological conditions should ‘have access to appropriate vocational assessment, rehabilitation and ongoing support to enable them to find, regain or remain in work and access other occupational and educational opportunities’. Although vocational rehabilitation is defined as ‘whatever helps someone with a health problem to stay at, return to and remain in work’ (Waddell et al., 2008), QR6 identifies the need for five types of support, i.e. support to a) enter training or work opportunities, b) remain in or return to an existing job, c) identify and prepare for alternative work options, d) plan withdrawal from work at an appropriate time, conserving pension and other rights; and/or e) access alternative occupational and educational opportunities. These services are supported by a growing evidence base to suggest that work is extremely important to people with long term neurological conditions and can improve quality of life (Phillips et al, 2010) and help maintain independence (O’Grady et al, 1995).

Generalist versus Specialist Services

NHS services have been conceptualised as either general or specialist. The National Service Framework for long term conditions (DH, 2005) describes general rehabilitation services as ‘local community rehabilitation providers, working closely with appropriate professionals to provide, among other things:

a. a basic vocational assessment with the aim of helping people to develop work-related skills;

b. informed guidance about available options, including advice on welfare rights and benefit entitlements;

c. practical support to manage problems in the workplace;

d. liaison and advice to employers to adjust work duties, patterns or environments as appropriate;

Specialist vocational rehabilitation services are seen as working alongside and in partnership with local rehabilitation services.

One of the major barriers to successful work outcomes for people with long term neurological conditions in the UK is the lack of specialist vocational rehabilitation. In a mapping survey of vocational rehabilitation for people with acquired brain injuries (ABI) involving 240 British Society of Rehabilitation Medicine members in the UK, only 8/97 (8%) rehabilitation services for people with ABI provided specialist vocational rehabilitation (62% addressed vocational issues), six of these were in the NHS and two with private agencies (Momentum, [formerly Rehab UK]). This is believed to be less than 10% of the estimated service requirement (Deshpande and Turner- Stokes, 2004). For people with other long term neurological conditions, the extent to which services exist to meet vocational needs remains unclear.

In acute onset conditions like stroke or TBI, most rehabilitation occurs in the acute and post acute phases (Department of Health, 2002; Gladman et al, 2007) and is hospital or outpatient based. Community teams exist, but they mainly offer short term interventions focussed on regaining independence in daily living skills in the home and its immediate vicinity (Walker et al, 1999; Walker et al, 2000; Powell et al, 2002) with little scope for long term follow up. Referral criteria are often defined by the need for help from more than one health discipline. Many of these services are not designed with
returning people to work in mind. By six months post onset of stroke or TBI, most rehabilitation will have ended (Gladman et al, 2007; Stroke Association, 2006; Lock et al, 2005).

**The Importance of Work**

There is growing evidence delineating the health benefits and importance of work. Work contributes to identity and purpose (Dyck, 1995), confers status and financial benefits (Catanzaro & Weinert, 1992) and helps define a person in society (Holmes, 2007). It contributes to well-being (Department of Health, 2008) and can improve health and quality of life (Aaronson, 1997; Waddell & Burton, 2006). Work also provides structure and social networking opportunities, which for people with mobility problems, or for whom the ability to socialise or participate in leisure activities may be compromised by lack of confidence, cognitive impairments or fatigue, may be central to social inclusion (Abbot et al, 2009).

Worklessness is known to have a detrimental effect upon health (Waddell and Aylwood, 2005). It has been associated with loss of physical and mental fitness, obesity (Viner and Cole, 2005; Morris, 2007), low mood (Waddell and Burton, 2006) and to pose a health risk greater than heart disease (Waddell and Aylwood, 2005) and is associated with an increased risk of death particularly from suicide in unemployed young men (Bartley et al, 2005).

**Government Policy**

Shifts have occurred in work policy over the years, and also the role of vocational rehabilitation for people with disability. In the 60s and 70s the roles of the NHS and DWP were integrated through the placement of disablement resettlement officers in NHS institutions. In practice this appeared to work well, but through lack of robust evidence was lost in subsequent NHS reconfigurations and a shift of rehabilitation services to secondary care settings and along with it the mechanisms (of co-location) for ensuring work is a health outcome.

In recent years, a number of policy directives have driven a change in thinking about the relationship between work and health. Lord Darzi (2007) recognised the need for health services that enable people to remain healthy, support people to stay healthy at work and help those who are struggling with ill health to get back to appropriate work faster. In ‘Working for a Healthier Tomorrow’, Dame Black (2008) sought to establish a new vision for health and work in Britain. At the centre of this report were three principal objectives: prevention of illness and promotion of health and well-being; early intervention for those who develop a health condition; and an improvement in the health of those out of work, so that everyone with the potential to work has the support they need to do so. Importantly this report tackled the assumption that illness is incompatible with being in work, and also made the point that work is a health outcome “Early intervention for those who develop a health condition should be provided by healthcare professionals who increasingly see retention in or return to work as a key outcome in the treatment and care of working age people” (Black 2008).

Multiple factors underlie this change, including the need to:

- remain globally competitive and meet productivity demands by increasing employment (by redressing rising unemployment, sickness absence and inequality in the jobs market faced by disabled people),
- tackle the major public health challenges of an ageing population (including an ageing workforce and a rising number of people claiming ill health retirement)
- address worrying health trends such as the increase in mental health problems, alcoholism, obesity and diabetes, and
- curtail the rising number of people claiming inactive health benefits,
These reports illustrate a shift in thinking behind the relationship between work and health – a shift towards the notion that work is ‘good for you’ and intrinsically linked to well being.

In Health, Work and Well-being (HM Government, 2005); Improving Life Chances for Disabled People, (PMSU, 2005); Building Capacity for Work: A UK Framework for Vocational Rehabilitation (2004); and the Green Paper: ‘A New Deal for Welfare: Empowering People to Work’ (2006), plans were outlined for ensuring disabled people were given full opportunities and choices to improve their quality of life, including being able to work. In response to this, a number of initiatives were established by the Department for Work and Pensions (DWP), which were intended to support disabled people coming off benefits and back into work. These included Pathways to Work (which offers people making new claims for benefits the opportunity to receive payment whilst seeking further employment) and the Condition Management Programme (CMP) (for those moving onto longer term benefits). Although Pathways was shown to impact positively on employment in pilot areas (DWP, 2006a) neither it nor the CMP, are thought to meet the needs of people complex physical and cognitive disabilities such as those with long term neurological conditions (Frank and Thurgood, 2006; Radford and Walker, 2008; Ford et al, 2008).

Pathways was targeted at people with conditions such as mental illness, musculoskeletal conditions and heart disease rather than the needs of people with complex neurological conditions. It has been described as a ‘top down’ approach, where the benefits system interacts with employment agencies (Frank and Sawney, 2003). Services are short term, measured on throughput (rather than longer term follow up) and are often delivered by people with little training in the impact of impairments associated with long term neurological conditions. To be effective for people with complex long term neurological conditions, they need to be accompanied by ‘bottom up’ NHS resources, delivered by people with an in-depth understanding of the conditions and associated effects.

A number of supporting policy and clinical directives (National Stroke Strategy, 2007; National Clinical Guidelines for Stroke, 2008; NICE Multiple Sclerosis Guidelines, 2004; Aragorn and Kings, 2010; Department of Health, 2005; RCP/BSRM, 2004; BSRM 2010) have called for clinical services, which support people with long term neurological conditions to remain economically active. Many of these have acknowledged the need for health based services that address the unmet vocational needs of people with long term neurological conditions, and call for cross partnership working between health, social care, the DWP and other agencies in the third and independent sector to bridge service gaps and ensure that people with long term neurological conditions can access services when they need them (British Society of Rehabilitation Medicine, 2010).

Since the Coalition Government came into office in May 2010, the emphasis on Public Health and Wellbeing has been strengthened by proposals to reform and streamline the existing welfare system (Universal Credit: welfare that works, 2010) and DWP services operated under the JobCentre plus umbrella (such as Pathways to work and the Condition Management Programme), which currently support people coming off benefits back into paid employment. A new ‘leaner, fairer’ amalgamated system involving benefit and work programme reforms is proposed, supported by the notion that ‘work always pays’.

A new ‘Universal Credit’ system, underpinned by a practice of “conditionality”, will be backed by tougher sanctions to push people who have the capacity to work but are financially disincentivised by the existing benefits system, to ‘do as much work as is reasonable for them’.

The existing DWP welfare to work scheme will be replaced by a single ‘Work programme’ with support individually tailored to the needs of disabled people. It is intended that the Work Programme will address the needs of those who have been out of work for some time, those currently on Employment Support Allowance (formerly incapacity benefit) and long term recipients of incapacity benefit. The Government is also keen to enhance the role of the Third Sector,
including new social enterprises, in delivering these services and in incentivising them to keep people in work and support all customer groups.

People with complex disabilities will be supported by a Work Choice programme, intended to assist those facing the biggest barriers into work, by providing more intensive support to help people find and remain in work. This programme is intended to be more flexible and less prescriptive than previous programmes and will include help with applying for jobs, close liaison and support for employers and brokerage between employers and patients and support in the workplace. However, there remains concern that individuals with long term neurological conditions who have hidden disabilities such as cognitive impairments will need additional support from health care professionals who are trained in the recognition of such disabilities and have skills in designing interventions to ameliorate their impact.

The role of GP commissioning will be critical to the development and maintenance of vocational rehabilitation services. Consortia will be responsible for commissioning healthcare services across a range of clinical or service areas, including community health services, rehabilitation services and wheelchair services. Consortia may agree to commission some health improvement services jointly with local authorities and have an obligation to co-operate with local authorities and participate in their Health & Wellbeing Boards. They have the power to arrange for provision of services that aim to secure improvements in health including the power to enter into partnership arrangements (e.g. pooled budgets, lead commissioning) with local authorities, and make grants to voluntary organisations which provide or arrange for the provision of similar services to those in respect of which the consortia have functions. These responsibilities and powers could be used to develop work support and vocational rehabilitation services in partnership with other providers.

**Employment and Long Term Neurological Conditions**

People with long term neurological conditions who do not access work, who fail to return to work after injury or onset or who are encouraged to relinquish work prematurely may be financially disadvantaged, more prone to bankruptcy (Relyea-Chew et al. 2009), have poorer quality of life (Andelic et al. 2009; van Velzen et al. 2009) and adverse health outcomes such as anxiety and depression (Franulic et al. 2004; Simpson et al. 2007; Ponsford et al. 2008, Phillips et al., 2010). These consequences result in increased consumption of health resources including GP services and consultant contacts (Phillips et al., 2010). Despite protection from discrimination by the Equality Act Act 2010 (http://www.legislation.gov.uk/ukpga/2010/15/contents accessed September 2011), they are also less likely to be gainfully employed and more likely to be in poorly paid jobs, disadvantaged in promotion and to take early retirement than their peers (BSRM, 2010).

**British Society of Rehabilitation Medicine Recommendations for Best Practice**

New and existing guidelines (Tyerman and Meehan, 2004; British Society of Rehabilitation Medicine, 2010) indicating how vocational rehabilitation services should be organised and delivered for people with long term neurological conditions recommend: early intervention with information and support to prevent breakdown of relations with existing employers; rapid response to problems as they arise; open access to allow people (particularly those with progressive or intermittent conditions) to re-access services when required; and that services be sufficiently individualised to meet people’s differing and changing needs.

These guidelines (Tyerman & Meehan, 2004; British Society of Rehabilitation Medicine, 2010) demonstrate a growing consensus and evidence base about the benefits of vocational rehabilitation services. However, there is increasing
Concern they are in-accessible for people with long term neurological conditions, many of whom fall into 'hard to reach' groups, and it remains unclear to what extent existing services fit with these recommendations or meet the differing needs of people with long term neurological conditions.

Currently there is no existing directory of vocational rehabilitation service provision for people with long term neurological conditions in England. Pickard et al. (2004) mapped the rehabilitation resources for head injury in the eastern region of England but did not specifically record vocational rehabilitation services. Gladman et al. (2007) have mapped specialist rehabilitation for neurological conditions but this did not include all regions in England, nor did their research relate specifically to the provision of vocational rehabilitation services.

Equity

In its Spending Review (2010) The Coalition Government made a firm commitment to equality for disabled people, indicating that the proposed welfare forms are designed to support disabled people into work while providing unconditional support to disabled people who have the highest support needs.

Equity of access to services was also highlighted in the Darzi report (Darzi, 2007) the NHS Improvement Plan (DH, 2004) and Our Health, Our Care, Our Say (DH, 2006) and was one of the problems the NSF for long term neurological conditions was developed to address. Certain groups of people with long term neurological conditions may have difficulty accessing vocational rehabilitation services because of attitudinal barriers, social and cultural factors, limited resources and service availability or because of their impairments. Others may struggle because of conflict about commissioning pathways (many health care commissioners believe that vocational rehabilitation is not a health intervention) or because services are unable to respond to their changing needs over time. There is a need to understand the barriers to vocational rehabilitation service delivery in the English NHS and the potential for existing providers of vocational rehabilitation services to adapt to the needs of people with long term neurological conditions across the four disease trajectories. The extent to which existing services meet the needs of people from black and minority ethnic groups or those from areas of economic deprivation is also unclear.

In order that vocational rehabilitation services can be developed appropriately we need to know what vocational rehabilitation services exist for people with long term neurological conditions, what proportion of eligible patients access vocational rehabilitation services, and the characteristics of general and specialist services and how these meet the needs of patients with different disease trajectories. In addition, we need to know the characteristics and practices of successful services so that these can be reproduced in other settings for the benefit of patients.

Aims

The aims of this study were to

- describe currently available specialist vocational rehabilitation services for people with long term neurological conditions in England;
- provide guidance to commissioners and providers about the barriers and facilitators to establishing successful vocational rehabilitation services and structures, processes employed by such services with exemplars of good practice; and
- support partnership development.
Chapter 2 METHODOLOGY

PHASE 1: ESTABLISHMENT OF AN EXPERT PANEL

An panel comprising 20 health/vocational rehabilitation ‘experts’, including professionals selected on the basis of their expertise and reputation in the field of vocational rehabilitation and service user representatives, was set up to ensure the research was meaningful and relevant to all stakeholders. Professionals were selected from a range of professions, types of service provider (DWP, NHS, Independent and third sector), expertise in different neurological conditions and geographical location. Service user representatives consisted of people who had experience of the impact of a long term neurological condition (with each of the four trajectories being represented) and the issues surrounding work.

Three meetings with the expert panel were held each year. Formal consensus development techniques (Murphy, et al., 1998), ensuring a wide range of knowledge and experience was brought to the group, were used throughout the research. In the first year the panel was asked to;

a) agree descriptors for different types of vocational rehabilitation service and interventions to inform the development of the questionnaire.

b) create a working definition of specialist vocational rehabilitation services for people with long term neurological conditions for the purposes of mapping.

c) define minimum entry criteria for participation of services in the mapping exercise and

d) ensure organisations that have memberships of professionals interested in vocational rehabilitation were listed and prioritised for the mapping exercise

In the second year of the project, the expert panel was asked to;

e) Inform development of a sampling frame for selecting services for the case studies and agree selection of case study sites

The panel was asked to agree criteria for the selection of services to be included in the case studies and to assist in and ratify the selection process. Many of the criteria were predetermined in the proposal in an effort to ensure the research addressed issues of equity identified in the NSF. The agreed criteria are listed in on page 22 in table 4.1

Between the second and third meetings, the panel were asked for their help in developing and validating a tool, known as a Context, Mechanisms, Outcomes (CMO) configuration, which formed the basis of the interview schedule and analytic framework for the case study phase of the project. Time was spent at the third meeting discussing the group’s responses, finalising and validating the CMO and agreeing the criteria for the selection of case study sites.

f) agree criteria for exemplars of good practice

g) agree dissemination of outputs including development of an online community and directory of services

The Expert panel were asked to consider the dissemination of outputs. One of these was a forum for knowledge sharing around vocational rehabilitation for health care professionals. Two approaches were suggested. One was the dissemination of the work to the participants and a conference is planned for next year for this purpose. The second was the development of a webbased network. This has been supported by NHS Networks and is currently being developed http://www.networks.nhs.uk/nhs-networks/vocational-rehabilitation. The Panel felt that there was a need for a website
to be developed where a) a map of all services identified (with a clickable links to service details b) an audit tool for service providers, c) a guide for commissioners, d) the final report, and e) links to existing guidelines and other sources of information and support including that from the statutory (DWP, Health), independent and third sector DWP could be hosted. A second website suggested was a directory of mapped services available to service providers and service users. After discussion this will be hosted by NHS Choices.

In addition to panel meetings, the expert panel were consulted several times by email and invited to;

i) comment on revisions of the service provider questionnaire.

ii) Suggest literature to inform development of the CMO

iii) complete a questionnaire to validate the CMO

h) **Comment on research findings**

In the final expert panel meeting, a presentation of the service mapping findings and preliminary findings from the case study investigation was made to the group and provisional conclusions discussed at length. Comments have been used to inform the discussion in this report. Suggestions for further work were raised.

**PHASE 2: DEVELOPMENT OF A VOCATIONAL REHABILITATION SERVICE PROVIDER QUESTIONNAIRE**

With the help of the expert panel and using the ‘gold standard’ recommendations for best practice for vocational assessment and rehabilitation for people with long term neurological conditions (BSRM, 2010), we developed a 44-item, 29-page questionnaire in 10 sections and two parts (A and B) to identify and map vocational rehabilitation services and explore current practice.

- In part A, questions explored: funding sources; referral numbers and waiting times; BME groups served; time established; whether vocational rehabilitation needs were identified and referred-on or interventions provided; cross partnership working; training; professions and people involved in provision; client groups and disease trajectories served; timing of support; the nature of the intervention delivered; audit and evaluation; and factors influencing service development. Both general and specialist vocational rehabilitation services for people with long term neurological conditions completed this section.

- In part B, questions explored in more depth: the components of the specialist vocational rehabilitation assessment and intervention; relationships with other agencies; and the people involved in service delivery. Only service providers identifying themselves as providing a **specialist** vocational rehabilitation service, in accordance with our working definition (detailed below), were asked to complete Part B.

"A specialist vocational rehabilitation service for people with long term neurological conditions is characterised by

1. a **multi-disciplinary team** with
2. **expertise in Long term neurological conditions** and
3. **expertise in Vocational Rehabilitation** who through
4. **shared education and learning** and by
5. working with employees and employers in the work-place
6. can meet the needs of the majority of their patients/clients."
Questions were developed to measure fit with the recommendations for best practice for vocational assessment and rehabilitation for people with long term neurological conditions (BSRM, 2010), and the extent of implementation of QR6 of the NSF for long term conditions (Department of Health, 2005). Questions were also designed to probe: the differences between general and specialist vocational rehabilitation services and the extent to which services met the needs of people from BME groups. Most of the questions were closed or semi-closed questions. However, additional questions probing perceptions about resources for, enablers of and/or barriers to future service development relied on a free text response. Details of any other known vocational rehabilitation services for long term neurological conditions were also requested.

The questionnaire (see Appendix A) was designed as a self-administered postal questionnaire using Dillman’s ‘Tailored Design Method’ (Dillman, 2000). Steps were taken to try to ensure maximum response with minimum response error, including clearly worded questions, a clear description of purpose and importance and clear instructions, emphasising the potential outputs in the form of a directory of vocational rehabilitation services for long term neurological conditions in which their service could be included. To reduce perceived costs to respondents, the questionnaire was kept as concise as possible.

**MAPPING SURVEY OF VOCATIONAL REHABILITATION SERVICES FOR PEOPLE WITH LONG TERM NEUROLOGICAL CONDITIONS**

Following the piloting phase, questionnaires were sent in three tranches to professional networks and organisations felt by the Expert Panel most likely to be involved in health based vocational rehabilitation service delivery (in priority order). The self-administered postal questionnaire survey was conducted in three tranches as follows and demonstrated in figure 3.1 page 17.

**Tranche 1:** College of Occupational Therapists Specialist Section Work (COTSSWork), College of Occupational Therapists Specialist Section Neurological Practice (COTSSNP), British Society for Rehabilitation Medicine (BSRM) and services cited in the Vocational Rehabilitation after Acute Brain Injury Guidelines (Tyerman & Meehan, 2004).

**Tranche 2:** Work Psychologists at JobCentre Plus (WPs at JCP), Association of Physiotherapists in Occupational Health and Ergonomics (ACPOHE)*, British Association of Spinal Cord Injury Surgeons (BASCIS)** and College of Occupational Therapists Specialist section of Independent Practitioners (COTSSIP)

**Tranche 3:** Vocational Rehabilitation Association (VRA)

**QUESTIONNAIRE SURVEY DATA ANALYSIS**

Data from the questionnaires was entered in to an excel spreadsheet and descriptive analysis was undertaken to identify patterns in service delivery, features of services and types of interventions offered to different clients/disease trajectory

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*There were no responses to our email address to ACPOHE members so no further mention of ACPOHE is made

**On examination of the BASCIS membership, it was discovered that all members were also members of the BSRM so a decision was made not to approach them for a second time.”

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groups. Data analysis was prioritised by tranche to ensure that each group was completed before mailshotting the next groups’ questionnaires.

**Phase 3 – Qualitative Study - Developing Explanatory Evidence of the Impact of Vocational Rehabilitation (VR) Services.**

Vocational rehabilitation services are complex systems with interconnected, interdependent components including people, rules, processes, social & financial capital, and structures, which vary across the UK. It is important to acknowledge the existence of this complex context in order to gain an in-depth and realistic understanding of effective implementation of vocational rehabilitation services.

Complex interventions, according to Pawson et al. (2004) and Sridharan et al. (2006), are comprised of theories, involve the actions of people, consist of a chain of steps or processes that interact and are rarely linear, are embedded in social systems, are prone to modification and exist in open systems that change through learning.

As a philosophy of science, critical realism is situated between the extremes of positivism and relativism (Pawson & Tilley 1997; Delanty 1997), and involves identifying underlying causal mechanisms and how they work under what conditions (Pawson & Tilley 1997; Pawson 2002; McEvoy & Richards 2003). Because causal mechanisms always occur in a particular social context, there is a need to understand the complex relationship between these mechanisms and the effect that context has on their effectiveness. Pawson and Tilley (1997) within their approach to realistic evaluation sum this up as: outcome (the regularity of vocational rehabilitation impacts) = mechanism (the reactions to vocational rehabilitation programmes which lead to patterns of behaviour) + context (the social and organisational conditions which enable vocational rehabilitation mechanisms to operate). The analytical work of realistic evaluation focuses on the development and refinement of theoretical explanations that link context, mechanism and outcome, informed by stakeholder perspectives, empirical data and theory.

A case study approach was used which is methodologically complementary to realistic evaluation, which advocates the use of multiple methods for the collection of descriptive & explanatory data, and focuses on the importance of context (Yin, 2003). In order to assist in explanation building and transferability of findings, multiple cases have been included. The timeframe allowed for five vocational rehabilitation services (cases) to be included, comprising differing types of vocational rehabilitation services (general & specialist), and stage of implementation (established & developing).

**Selection of the Case Study Sites**

With advice from the Expert Panel and survey data, five sites identified from the survey were selected to ensure representation of the following criteria across cases (see figure 3.1, page 17).

**Methods of Data Collection:**

Within each vocational rehabilitation service, semi-structured interviews with purposively selected service providers, including multi-disciplinary team members & service managers were conducted. The roles of each person interviewed are listed below:

**Aylesbury**

- Service lead
The interview schedule was underpinned by an initial programme theory which provided a potential explanation of how vocational rehabilitation services work, identifying key components and influences. The programme theory was developed through analysis of (draft) best practice recommendations (BSRM, 2010), and in consultation with the expert panel. Recommendations were summarized into key themes within each of three domains: contextual influences, vocational rehabilitation components and impacts. Realistic evaluation focuses on the evaluation of mechanisms, rather than service interventions per se. However we decided to focus on vocational rehabilitation components in the early stages of the case study research for two reasons: interventions made more ‘clinical sense’ to the expert panel than the more purist definition of mechanisms, and we postulated that some mechanisms may be ‘hidden’ within vocational rehabilitation services. We anticipated that the exploration of vocational rehabilitation components within cases would provide better opportunities to identify mechanisms ‘in situ’ in addition to those that were suggested by the programme theory.

The programme theory was then plotted diagrammatically for consideration by the expert panel. A consultation workshop was held on 09/12/09 when the programme theory was presented and discussed by panel members. A questionnaire was then distributed to expert panel members to confirm the integrity of the programme theory, or to identify any missing elements. This exercise confirmed the relevance of all aspects of the programme theory. Some debate ensued about whether ‘providing assistance with travel to work’ was a legitimate component of vocational rehabilitation, but this was retained with the consensus of the expert panel. The final version of the programme theory was then transformed into interview questions which were designed to probe how it resonated with local services (the cases), and to gain views about how the programme theory worked, for whom, and in what circumstances.

Interviews were conducted by one member of the research team (BJ) audio-recorded, fully transcribed and managed in MaxQDA©. Documentation describing the vocational rehabilitation service and the service context(s), together with routinely collected data (i.e. audit, performance, financial) were also collected to help contextualise findings.

DATA ANALYSIS:
The process of data analysis was as follows:

1. Transcripts were read multiple times by the interviewer (BJ) to gain a comprehensive overview of the issues raised by interview participants. Field notes and documents were used to clarify issues that were unclear.

2. Codes were then applied to ‘meaning units’ within each transcript. A meaning unit was defined as a section of transcript within which one issue was developed by a participant. Whilst most codes were derived from the programme theory, additional codes were used for data that were felt to be relevant to the objectives of the case study.

3. Tabulated summaries of codes were constructed for each transcript using the three major domains of the programme theory outlined earlier (contextual influences, vocational rehabilitation components and impacts).

4. Meetings were held with the project team to review the coding frame, and to discuss emerging explanations across cases. These explanations were couched in ‘realist’ language, focusing on what appeared to be working, and in what circumstances. Reflecting the principles of realistic evaluation, attention was paid to the proximity of vocational rehabilitation components and contextual influences.

5. Paying particular attention to contextual influences, these explanations were subsequently synthesized with questionnaire data on barriers and enablers to vocational rehabilitation service development, and are described within this Report (Chapter 4).

Chapter 3 MAPPING STUDY - RESULTS

QUESTIONNAIRE RESPONSE

In total 142 services providing vocational rehabilitation for long term neurological conditions were identified. Responses to the questionnaires were obtained as demonstrated in figure 3.1
FIGURE 3.1 CONSORT DIAGRAM OF SELF-ADMINISTERED QUESTIONNAIRE SURVEY MAPPING VOCATIONAL REHABILITATION SERVICES IN ENGLAND FOR PEOPLE WITH LONG-TERM NEUROLOGICAL CONDITIONS
DEVELOPMENT OF TYPOLOGY AND MODEL OF VOCATIONAL REHABILITATION SERVICES FOR PEOPLE WITH LONG TERM NEUROLOGICAL CONDITIONS

In total, 142 services providing vocational rehabilitation for long term neurological conditions were identified. Thirty-three (23%) were dedicated vocational rehabilitation services and 108 (76%) offered vocational rehabilitation as a component of a generic or neurological rehabilitation service.

LEVELS OF SERVICE

In total, we identified 6 levels of service which are demonstrated in figure Y. At the lower end (bottom left pale blue circle) basic components of vocational rehabilitation were being delivered by generic rehabilitation services (n= 24) where vocational rehabilitation provision included identifying vocational needs and sign-posting to other services and/or providing limited vocational interventions.

At the top end of the continuum (top right dark blue circle) VR-specific services (n=25), typically characterized by multi-disciplinary teams, with quarterly staff training assessed vocational needs, provided vocational education, vocational interventions, work site liaison, vocational re-assessment and assisted with job seeking in addition to job retention.

However, the majority of services (n=84) lie somewhere in the middle of the specialism/skill base continuum and are delivered as a vocational rehabilitation component of a neuro-rehabilitation service and intervene during hospital stay and/or following hospital discharge.

The range of vocational rehabilitation provision within this category is very varied, involving anything from vocational assessment and signposting to other services for vocational interventions to the provision of all vocational interventions including work site liaison and re-assessment.

As 60% of the services identified fell into this category, we attempted to identify levels of vocational rehabilitation within these services. Four sub-categories were identified: levels A, B, C & D (see Figure 3-5)

‘Level D’ services (n=8) provide vocational assessment, vocational education and refer on to other agencies for vocational interventions

‘Level C’ services (n=17) do as level D but in addition, consist of a multi-disciplinary team and provide limited vocational interventions.

‘Level B’ services ( n=32) do as for C and D but also provide staff training at least annually and deliver most vocational interventions, including work-site liaison.

‘Level A’ services (n=27) build on Level B, providing quarterly staff training in addition to the interventions provided by Level B services and offer vocational re-assessment and assistance with job seeking (in addition to job retention).
Within each level, some services were condition specific and others dealt with people from across all disease trajectories. In level D, four were condition-specific and four services dealt with several long term neurological conditions. In Level C, nine were condition-specific and eight dealt with all long term neurological conditions. At Level B, the split was 50:50 and at Level A, sixteen were condition-specific and eleven worked across the four disease trajectories. Of the 25 vocational rehabilitation specific services, thirteen were pan disability services, that also saw people with long term neurological conditions, six were neurology specific and six were condition specific services.

**NUMBERS SEEN**

Most of the services (71.2%) saw fewer than 25 people with long-term neurological conditions each year. Only 13 (9%) of the identified services saw more than 50 people with long-term neurological conditions each year (Table 3-1 in Appendix 2). Almost two thirds of the services (n=85) were well established (had been running for at least 5 years) and only 22 (15.5%) were new or emerging services; set up in the last 2 years.

**WAITING TIME**

The average waiting time for clients to access vocational rehabilitation services varied. Forty-three percent of the services identified saw people within one month of referral (10% within one week), 22% between 1 and 2 months, 19% between 2 and 4 months and 7% (10 services) stated that the waiting time for clients to access their services was in excess of 4 months.

**TRAJECTORY SEEN**
Most of the services (97.2%) saw people with sudden onset neurological conditions, such as stroke or TBI. However, between 50 and 60% of the services identified addressed the needs of people from across the other neurological disease trajectories. One third of the services identified (n=45) were pan disability services, rather than specific to people with neurological conditions and 40% were condition-specific (See Table 3-2 in Appendix 2).

**INTERVENTION TIMING**

Only one fifth of services (n=30) saw people at the time of diagnosis. Seventy percent identified people during a hospital stay or follow up appointment but most (83%) services intervened at the point when problems were identified.

**PROGRAMME CONTENT**

The majority of services provided support to people planning to return to an existing job or to those who need help finding alternative employment because they are unable to return to an existing job (94% and 92% respectively). Although fewer services saw young adults in the transition between school and education, we were encouraged to identify 82 services meeting this need and 85 services that helped people looking to change their job or progress in their career. Fewer services (n=58) addressed the needs of people considering retirement (Table 3-3 in Appendix 2).

Most of the services identified indicated that they were working in a way that was consistent with the BSRM recommendations for best practice (2010) i.e., their service included features considered important to achieving meaningful vocational outcomes for service recipients. These included identifying vocational needs; referring to and accepting referrals from other agencies and liaising with them; planning and providing vocational interventions; providing vocational education; helping people find and remain in work; liaison with the workplace; long-term follow up and monitoring of progress; providing vocational re-assessment; recording outcomes; and auditing and service evaluation. However, while most of the services indicated that they liaised with other agencies, only 64 services (45%) worked with other agencies in a defined pathway and while the majority of services (96%) provided vocational assessment, fewer (80%) said they provided vocational interventions. Less frequently available were vocational education, follow-up support and vocational re-assessment (Table 3-4 in Appendix 2).

**AUDIT AND TEACHING**

Only a third (33%) of services reported carrying out routine evaluation or long-term monitoring of vocational outcomes and just over a half (55%) reported using outcome measures. Only a quarter (25%) of services undertook regular audits.

Forty-two (29.6%) of the respondents stated that they had never received any training in vocational rehabilitation (Table 3-5 in Appendix 2).

**PROFESSIONALS INVOLVED IN DELIVERING VR**

A wide range of professionals from diverse backgrounds are involved in vocational rehabilitation service delivery. Occupational therapists (present in 77% of services) and psychologists (clinical psychologists, neuropsychologists and work psychologists present in 26%, 35% and 10% of services respectively) were the main providers of vocational rehabilitation within health based services offering some form of VR. Other providers were core members of the rehabilitation teams including Physiotherapists (present in 54% of services), SALTs (in 46% of services) rehabilitation assistants (in 46% of services) and social workers (in 17% of services). Thirty nine percent of services had medical input from either rehabilitation physicians, physicians,
neurologists or occupational health physicians. Thirty eight percent of services had input from an employment advisor, job coach, job broker or careers advisor, and 8% involved a placement officer. Case managers were involved in 13% of services.

**QUESTIONNAIRE PART B — TOWARDS GREATER DEFINITION OF VOCATIONAL REHABILITATION SERVICES**

In part B of the survey, services that identified themselves as fitting our working definition of a specialist service, responded to more detailed questions about vocational assessment, relationships with other agencies and vocational interventions. 70 services completed Part B.

Most of the services offered all aspects of vocational assessment, except medical examinations (only 39%), ergonomic assessment (53%) and looking at work place policies (51%) and all vocational interventions. The main shortfalls were in carrying out residential placement assessments (only 16%). Support with job seeking and re-assessment were the least often provided.

Nearly all of these services liaised with, referred onto and accepted referrals from other agencies but this was done on an ad hoc basis rather than as part of a mutually defined pathway.

The main limitations of these self identified specialist services, was that few offered support with job progression (57%) or job training (54%) and few arranged temporary work placements (57%). Similarly, few offered training in computer, clerical or other transferable skills (36%) or counselling (30%). However, some of these limitations are likely to relate to the nature of the service users. For example residential placement assessments are more likely to carried out for people with spinal cord injury or cerebral palsy and given that not all of these services provide for these groups, these components may be unnecessary.
Chapter 4  BARRIERS AND ENABLERS TO DEVELOPMENT OF VOCATIONAL REHABILITATION SERVICES

AIM
The aim of this chapter is to identify perceptions about barriers to, & enablers of the development of comprehensive vocational rehabilitation services. It draws on two sources of evidence generated from the study:

- survey respondents’ views about barriers to and enablers of the development of vocational rehabilitation services, and
- case study participants’ views about contextual influences on the impacts of vocational rehabilitation services.

SURVEY FINDINGS
Within Section 7 of the questionnaire (see Appendix 1), service providers were asked to answer questions relating to the current and future development of the vocational rehabilitation element of their service, focusing on initial development of the service; barriers to the future development; ambitions for further development; and perceived gaps in services. These survey questions were developed using structures suggested by the modernisation agency\textsuperscript{12} modified following discussion with the expert panel to reflect the development of the contextual aspects of the realistic evaluation framework. The questionnaires demanded yes/no answers but plenty of space was left for free text.

CASE STUDIES
The case study component explored the views of service providers about contextual influences on the impacts of vocational rehabilitation, which were postulated to span from micro (e.g. service user characteristics) to macro (e.g. societal attitudes to disability) levels. With the expert panel’s help, 5 case study sites were identified and agreed that fulfilled a range of contextual criteria that might impact on service delivery and outcomes.

Table 4.1 To show the purposive sampling approach

<table>
<thead>
<tr>
<th>Criteria/Centre</th>
<th>‘Working out’ Aylesbury</th>
<th>Vocational rehabilitation service</th>
<th>Disability Options Team Tower Hamlets</th>
<th>The Walton Centre Liverpool</th>
<th>Oswestry Spinal Injury Centre</th>
<th>West Sussex Community Neuro rehabilitation team</th>
</tr>
</thead>
<tbody>
<tr>
<td>New/emerging</td>
<td>X</td>
<td>X</td>
<td>K</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Well established</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Substantial BME population</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Condition-specific</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Several disease trajectories
Component of general rehabilitation service
Vocational rehabilitation specific service
Area of high unemployment/deprivation
Area of low unemployment/deprivation
Urban location
Rural location
Fit guidelines well
Job seeking in addition to job retention
Cross-partnership working
Young adults entering work

*The stroke element of this service is well-established whilst it is currently widening it’s referral criteria to include all long term neurological conditions

PROGRAMME THEORY

A coding frame was developed from the theoretical work undertaken by the expert panel which was then applied to data from each case. Synthesis across cases was completed thematically, and theoretical propositions of what worked, for whom and in what contexts were constructed.

<table>
<thead>
<tr>
<th>Contextual factors</th>
<th>Programme components</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service user characteristics</td>
<td>Timely and long-term support</td>
<td>• Job retention</td>
</tr>
<tr>
<td>• Cognitive capacity</td>
<td>• Early and rapid intervention</td>
<td>• Return to work after single or multiple episodes of extended sick leave</td>
</tr>
<tr>
<td>• Functional capacity</td>
<td>• Responsiveness to service user needs during the course of their condition</td>
<td></td>
</tr>
<tr>
<td>• Educational background</td>
<td>• Vocational assessment (global appraisal of an individual’s work/training programme, general functional capabilities and social / behavioural characteristics)</td>
<td></td>
</tr>
<tr>
<td>• Social behaviours / family circumstances</td>
<td>• Employment assessment (assisting individuals to make an informed choice about an appropriate and specific job / training)</td>
<td></td>
</tr>
<tr>
<td>• Attitudes &amp; values</td>
<td>• Providing tailored interventions</td>
<td>• Withdrawal from work on health grounds</td>
</tr>
<tr>
<td>• Work history</td>
<td>• Facilitating single or multiple work adjustments</td>
<td>• Entry to alternative occupation</td>
</tr>
<tr>
<td>Employer characteristics</td>
<td>• Provision of explicit verbal and written advice</td>
<td>• Transition from education to employment</td>
</tr>
<tr>
<td>• Responsiveness to the Disability Discrimination Act and willingness to implement vocational rehabilitation recommendations</td>
<td>• Worksite meetings</td>
<td></td>
</tr>
<tr>
<td>Service characteristics</td>
<td>• Availability of appropriate staff education and training</td>
<td>• Provision of specialist</td>
</tr>
<tr>
<td>• Condition specificity of vocational rehabilitation service</td>
<td>• Availability of resources, including staffing</td>
<td></td>
</tr>
<tr>
<td>Locality characteristics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Connectedness of services at a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SYNTHESIS

The two sources of data have been synthesized around a peer-reviewed framework that consolidates theories and models of implementation (Damschroder *et al.*, 2009). Implementation focuses on the theory and science of closing the gap between knowledge (usually in the form of evidence or policy) and everyday service delivery, and includes initiatives such as evidence-based practice, research utilization and knowledge transfer.

Implementation theory emphasizes the importance of the organisational context within which staff operate, in shaping implementation within health services (e.g. Greenhalgh *et al.*, 2004). There is a recognition of the “dynamic interplay between individuals and the organizations in which they work, and how that interplay influences individual and organisational behaviour change” (Damschroder *et al.*, 2009, p5) which is neglected in theories of individual behaviour change. Whilst there are a number of conceptual and theoretical frameworks which have been developed the Consolidated Framework for Implementation Research (CFIR) has attempted to consolidate these (Damschroder *et al.*, 2009), identifying the following domains:

- **Intervention characteristics**, including core elements, and peripheral elements which are adapted to ensure ‘fit’ within a particular organizational setting
- **Inner context**, such as the structural characteristics, networks and communications, culture and climate
- **Outer context**, or the economic, political and cultural contexts within which an organization sits
- the **Individuals** involved with implementation (in this case, the vocational rehabilitation staff), and
- the **Implementation Process**, or the process through which vocational rehabilitation services are instigated and sustained.

The CFIR is a pragmatic attempt to address the complexity of implementation by unifying constructs from the literature, and its use may reduce the danger of ignoring relevant issues by reliance on any one theoretical position.

VOCATIONAL REHABILITATION CHARACTERISTICS

This domain considers those aspects of vocational rehabilitation interventions themselves which may inhibit, or enhance, the development of services.
**CORE COMPONENTS**

*Two core approaches to vocational rehabilitation* which, although described interchangeably by case study participants, could be differentiated by their focus, as follows:

- **Job Retention** – where interventions were planned to return the service user to their employer in the same, modified or new job role, and

- **Return to work** – where support to engage or re-engage with the job market was provided, and may include a change from any previous occupation that the service user was engaged in.

Central to all services was *action planning around goals* as the primary tool for the development and delivery of vocational rehabilitation interventions. Goals are regularly reviewed (to a maximum of three monthly) with the service user, and appear to be the primary tool for program development, maintenance, multidisciplinary working and relationship building with the service user (and employer). Action planning is usually formalised in a written document with copies provided to the service user. Action planning may, depending on service user wishes, include *service users’ family and carers* to implement and support professional interventions. Where provided, this support is considered extremely important for the success of interventions which often occur in the home.

**Practical Tips**

- Model local Job Retention and Return to Work pathways
- Clarify opportunities and capacities for family and carer engagement in vocational rehabilitation
- Systematic approach to assessment, goal setting, and intervention planning

**JOB RETENTION**

There was a *lack of clarity as to what constitutes vocational and employment assessment*, and all services appear to undertake a comprehensive “initial assessment” of service users’ pre injury status and their current circumstances. This initial assessment is *variable in whether it addresses issues relating to work* in any depth. If the focus is job retention, then occupational therapists become involved and this seems to begin the process of return to work activities such as contacting employers and clarifying pre injury work tasks. If it is assessed that job retention is a possibility, a functional/ task based analysis provides the base for rehab activities aimed at building the skills needed for return to the same job. If the focus is return to work, the initial assessment is a precursor to further in-depth rehabilitation assessment with work as a focus. This may include extensive neuropsychological assessment and have multi disciplinary input to determine the most appropriate vocational rehabilitation interventions for service users.

For some services, job retention appears to be an *additional role which relies on the interest and skills of individual occupational therapists*, and stems from professional ‘ownership’ of occupation. There was *little consistency in specialist education and training*, with descriptions of significant practical learning curves for occupational therapists in both neurological and vocational rehabilitation services. In this way, occupational therapists considered vocational rehabilitation interventions in job retention as an extension of their existing skills, and a response to service user need. Involvement in legal or benefit issues relating to compensation or the Disability Discrimination Act were areas in which they expressed a lack of knowledge and skill. There was *debate about these areas being outside their clinical remit*, and some service users were signposted to services such as the citizen’s advice bureau or other legal sites for further advice or advocacy on these matters. The internet ([www.direct.gov.uk](http://www.direct.gov.uk)) was quoted several times as resource of “just in time” information. *Lack of time and resources* coupled with a *large geographical service area* also affected the capacity of non specific vocational rehabilitation providers to engage in complex job retention cases.
In non-specialist vocational rehabilitation services, occupational therapists gave examples of job retention interventions which indicated that they are providing sophisticated interventions in complex situations. These included liaison with employers, leading worksite meetings, managing worksite adaptations in conjunction with Access to Work, creatively designing and seeking out specialist equipment and aids, and assisting with travel to work interventions. Their examples indicate confidence in their dealings with employers and awareness of the issues from both employer and service user perspectives, although primarily they would see their role as being in support of the service user.

For specialist vocational rehabilitation providers, job retention interventions appeared to be integral rather than additional. For example one service described a pattern of neurological rehabilitation interventions specifically designed to address service users’ needs for a return to their pre injury employment. Having clarified a service user’s previous employment situation through liaison with employers and occupational health contacts, assessed work tasks and completed a detailed task analysis, neurological rehabilitation interventions were then customised around the overarching aim of restoration of employment skills. Influences on the success of this approach included differing perceptions of readiness for return to work amongst General Practitioners, employers and occupational health providers, and access to multidisciplinary teams which offer staff and resources particularly psychological services, to support vocational interventions.

Job retention appears to be addressed (with client consent and as a goal in the action planning process) by occupational therapy functional assessment undertaken at the worksite. The process that was reported to work best was the Occupational Therapist making an early contact with the employer, meeting with the employer in the workplace, and completing a task analysis for the service user. From this task analysis, discussions with employers about job demands and available clinical information are synthesised into an individual vocational rehabilitation intervention programme. Individual action plans need to focus on rebuilding the specific skills the person needs to perform their job: if rehabilitation interventions are not focussed on work tasks, then the job retention process may be extended. From this first meeting with employers, ongoing liaison with them by the occupational therapist regarding the readiness of the service user to return to their previous job is required. The occupational therapist will also negotiate with occupational health services and primary care (e.g. General Practitioners) about the readiness of the service user to return to their previous employment. Having ease of access to other professional disciplines (psychology/neuropsychology in particular for people with cognitive difficulties, speech therapy for stroke) enables these other disciplines to also be taken to worksite meetings to address employer concerns and to assist in the development of appropriate rehabilitation interventions for service users.

Whilst a range of job retention interventions are utilised, it was evident that maximising the ‘real-world’ application of interventions (e.g. reading in a noisy environment) was important, often demonstrating a high degree of creativity from vocational rehabilitation staff. Other, organisational approaches to providing real-world opportunities for service users for job retention activities included work preparation programs developed with, or drawing on the resources of other organisations. However other ‘organisational’ strategies such as purpose-built environments to enable work task simulation were highlighted as an area of need by several services.

### Practical Tips

- Clarify local expectations of clinical staff with regard to vocational rehabilitation
- Ensure access to high quality vocational rehabilitation education and training
- Develop service level agreements for specialist assessment when required
- Establish early contact with the employer
- Maintain a ‘real-world’ focus on work
RETURN TO WORK

Any transition of service users from medically based rehabilitation services to a disability employment service requires bridging support to ensure that the functional (and particularly hidden cognitive) limitations of service users’ conditions are fully understood. Providing this bridging support between employment and vocational rehabilitation for service users was variously addressed by services, ranging from a complete service with an employment placement specialist based in house, to signposting to other employment / disability services. In-house return to work services are multi-faceted, and include canvassing for employers, arranging placements for service users, and the completion of detailed vocational / employment assessments including writing CVs and interview skills. Staff require considerable tenacity and skills in networking with employers, establishing networks with employment placement advisors in other services to extend the range of employer contacts, and developing understanding of the labour market. Whilst these activities enhance individuals’ credibility, they highlight the fragility of these services if they leave or services are re-designed.

Within this approach, specialist vocational rehabilitation interventions included intensive initial assessment, group programs for work preparation and employment support, and the integration of therapeutic interventions from neurological rehabilitation services such as information groups on cognition and memory. Examples of co-location with neurological rehabilitation highlighted the importance of a “whole system approach” to service planning, led by the Vocational rehabilitation service, drawing in (and developing) capacity to support work placements and other return to work components. One vocational rehabilitation Return to Work service employed an employment placement consultant who had a significant role in sourcing work placements and employment for service users as well as negotiating benefit and other financial issues for them. Whole systems working in this case was characterised by the development of local networks (both formal and virtual) for both employers and employment service providers, and training Job Centre and other staff.

Other approaches included a “partnership model” with a Disability Employment Service to manage its return to work services. Here, occupational therapy staff from the vocational rehabilitation service worked in a Disability Employment Service several times a week, delivering interventions (e.g. brain training) in a work oriented rather than health care environment. These complement therapeutic interventions such as speech therapy and psychological interventions which were managed by the vocational rehabilitation service in parallel to the search for employment. In this case, the disability employment service is the primary provider of all employment related training, work placement activities (supported by worksite assessment if required by the vocational rehabilitation service), voluntary activities and employment skills development such as CV writing and interview skills practice. However these services were closely connected to the vocational rehabilitation service enabling ongoing rehabilitation, liaison and joint working between service users, the vocational rehabilitation service, and the Disability Employment Service.

A “mixed partnership” approach to the delivery of return to work interventions included one service that linked its service users to a patient advocacy organisation via a one-on-one work clinic conducted fortnightly at the service. This representative was employed to conduct vocational assessments, provide a counselling service, source contacts information and resources for service users. Through the advocacy organisation, voluntary work placements were set up, and contacts and leads for potential employment opportunities provided. As funding for the post was provided by the advocacy organisation, this arrangement was exclusive for people with a particular long term condition. Service users with other conditions who are seeking to return to work are signposted to general services in their locality such as Job Centre Plus and Access to Work should they require transport to work or workplace adjustments. Other vocational rehabilitation services adopt a less integrated approach to the organisation and delivery of return to work services, and focus on “signposting” to local disability support services.
When people are not returning to their previous job (because the job is no longer suitable or no longer available), vocational rehabilitation task is more complex. Not only does a new job need to be found which meets the interests and skills of the service user, but there is a process of them accepting the need for change, developing the skills for a new job as well as mastering the skills of seeking employment (developing a CV, targeting appropriate positions, writing applications and being interviewed for jobs), and negotiating their disability status in the job market with potential employers.

**Practical Tips**
- Develop partnership working with Return to Work service partners
- Develop entrepreneurship in creating useful links with local employers
- Integrate employment skills into other neurological rehabilitation services
- Support clients in regaining/developing skills for seeking and securing new employment

**SERVICE USER PERSPECTIVES**

The *tailoring of vocational rehabilitation plans* to service user needs was supported by the goal setting process and there appeared to be a prevailing view amongst service providers that as long as the goal setting and individual focus of programs is present, then goals including vocational goals can be met. The relationship between service users and vocational rehabilitation providers appears to be a supportive, problem-solving one. The health condition of the service user appeared to be an explanatory factor in vocational rehabilitation only to the extent that it tailored the nature of both rehabilitation and vocational interventions. Whilst each individual circumstance was approached as a unique case, the *familiarity of vocational rehabilitation staff with the types of difficulties a particular client group may present* informed the development of individual action plans.

Whilst significant functional limitations may be present, vocational and alternative occupational options will be explored and supported as long as this what *the service user wants and has the motivation* to pursue. The role of work in the life of the service user pre injury or illness appears to influence their motivation to return to employment. If a service user had limited employment history prior, they were considered unlikely to want to pursue employment post injury. Families were also seen to have a role in influencing motivation either by encouraging their family member to have a rest from work, or encouraging them to return to work enabling some sense of “normality” to return. Service users who may already be disadvantaged in the labour market due to limited language skills or limited transferrable skills (or both) are further disadvantaged by functional or cognitive restrictions.

Service users who appeared most at *risk of not accessing vocational rehabilitation* were those with mild to moderate traumatic brain injury who were discharged early from accident and emergency services, bypassing early referral pathways through inpatient hospital or community rehabilitation services. Primary care services do not appear to consistently adopt a referral role for this group: one vocational rehabilitation service indicated the main referral route was employment services often after a history of failing to maintain employment. It is this group which were also cited as being most at risk of having hidden cognitive difficulties which affected their capacity to retain or maintain employment post injury. Due to their relative invisibility, problems with cognition also appear to require significant explanation to non-clinical services, and bespoke interventions to address their specificity. For these reasons, successful vocational interventions for service users facing these problems can be **resource intensive**, and require **responsiveness over time**.

Return to work services required staff (employment placement officers) or in services available to them (partnerships or local connections with disability service providers) that specialised in **developing relationships with employers** which may enable service users to undertake “work tasters” or work placements to test their
abilities, and access further training and job seeking support. If these opportunities are used, these need to be closely monitored and supported by the rehabilitation service provider who can use them to further define an appropriate job for the service user. For some clients, work placements were an important means of facilitating the growth of confidence and skills over time, particularly where there were opportunities to address psychological barriers to return to work, assess general employment issues and provide opportunities for clients to develop a more informed view of the world of work. Where work placements required clients to access other services and people as part of placement activities, placement success appears to be mediated by clients’ cognitive factors (e.g. initiation) where there is limited capacity to follow-up opportunities associated with that placement. In these cases, clients’ willingness to disclose relevant information of their long term neurological conditions and/or needs, and the mediation activities of placement advisors between client and employer, appears to be a key factor in determining placement success.

Practical Tips
- Tailor vocational rehabilitations realistically to individual service user contexts
- Explore case-finding strategies for vulnerable groups, or those who may ‘fall through the net’
- Build capacity for work placements to help service users develop an informed view about work

Evidence Base
The evidence base was highlighted in a number of ways in this study, principally making reference to national guidance such as NICE Guidelines for MS; NSF for Long Term Conditions; College of Occupational Therapy policy document "Work Matters"; BSRM guidance on Vocational Rehabilitation for Acquired Brain Injury; and specific scientific papers (e.g. Lock et al., 2005; and O’Brien, 2007). A comparison with other countries ‘Knowledge that return to work post spinal cord injury is lower in England than other countries.’

Practical Tips
- Ensure local access to evidence-based resources for vocational rehabilitation

Inner Context
This domain refers to the barriers and enablers that operate through the structural and other characteristics of the settings in which vocational rehabilitation services are implemented and operate.

Service Infrastructure
The success of Job Retention interventions was linked to early and rapid intervention. This was enabled by close relationships between the health-based service staff and the vocational rehabilitation service staff that were developed through co-location. In this context, service user referral pathways were easier to develop, allowing early intervention with the service user whilst they were recovering from their illness or injury and concerned about employment issues. Where neurological and vocational rehabilitation services were co-located, clear sign-posting of vocational rehabilitation mitigated against the clinical hegemony of functional restoration.

However a number of centres (n=45) within the survey reported a lack of a rehabilitation service infrastructure locally to support vocational rehabilitation. This may reflect lack of services or lack of a local strategy. In addition to ‘clinical infrastructure’, vocational rehabilitation services can often be prone to fragmentation across the numerous service partners: JobcentrePlus, health services, social services, the voluntary sector as well as work related occupational health services. Partnership working was seen as essential to successful vocational rehabilitation. A number of critical partnerships were identified in the case
study data. Firstly, the need for JobcentrePlus and Health funded services to work effectively together, and
secondly, for better liaison within different sectors of the health services, and finally links with employers.

The need for clear pathways and links with JobcentrePlus and its services was seen as a clear development
need. There was apparent paradox with some case study respondents being critical of the services offered by
JobcentrePlus in supporting people with long term neurological conditions who are seen as having complex
health needs. More specifically JobcentrePlus was seen to focus on people who are unemployed and on
benefits, but not have the resources to support people with progressive conditions or complex cognitive
disorders. However, from the case study sites it is clear that 'joined up’ services with shared pathways
are the most effective in supporting people with long term neurological conditions to return to work whether in
retaining previous employment or obtaining a new post. This view was strongly endorsed by the professionals
on the expert panel, although individual service users on the expert panel reported unsatisfactory experiences
with Jobcentreplus, reflecting the views expressed by some services in the questionnaire. While some services
had developed effective and clear pathways this was most successful in areas where services were truly
multidisciplinary. Characteristics of these teams included regular meetings, shared education, co-location, and
perceived expertise.

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<tr>
<td>• Develop shared pathways across Vocational Rehabilitation service partners</td>
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<tr>
<td>• Ensure that relevant knowledge and skills related to long term neurological conditions are evident in these pathways</td>
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**LINKS WITH EMPLOYERS**

Job Retention interventions were thought to be successful due to the presence of occupational therapists
within the worksite and their ability to reassure employers. Success was also aided by positive employer
attitudes: employers appeared to be particularly supportive of job retention if their relationship with the
service user was positive prior to their development of a health condition. The ability to provide ongoing
support to people who have retained their jobs appears to be critical to them sustaining employment, or
negotiating alternative employment, including promotion, with the same employer. Ongoing support built
certainty for employers and service users, including a point of contact, a means to address any subtle
difficulties that were not apparent on immediate return to work (particularly for people with impaired
cognitive function), and any ongoing issues of adjustment once service users were back in the workplace.
However a primary concern was often the cost of reasonable adjustments which, in most circumstances, could
be partially addressed by Access to Work.

Where new employers were accessed for work placements, tasters or jobs, they were described as having
attitudes sympathetic to disability employment, and had the time and resources to support the introduction of
a person with a disability into work. Often however the support for disability employment may have resided
with one manager, and when that manager left, new management may not always have been so supportive.
Vocational rehabilitation providers cited a change of manager as a period when the service users may
experience difficulties in the workplace. Essentially employers also had to have the insurance coverage
necessary to enable them to take a person on voluntary or on placement and the ongoing support of an
employment advisor.

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<tr>
<td>• Develop a service strategy that promotes engagement with employers</td>
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<td>• Develop resources for employers that provide information on support available, and practical guides for supporting people living with long term neurological conditions in the workplace</td>
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FUNDING AND COMPETING PRIORITIES
The commonest barrier to the future development of vocational rehabilitation that was reported in both the survey and case studies was limited funding. Most of the vocational rehabilitation identified in this study was delivered by Community Rehabilitation Teams. Such teams have a wide range of responsibilities, of which maintaining safety in a vulnerable population, and treating people with severe disability (for example, those who have difficulty transferring) take priority over those with vocational rehabilitation who may have invisible disability, and often appear to function well in a less demanding domestic environment.

Practical Tips
- Use business planning frameworks to identify the costs and benefits for local commissioners in investing in Vocational Rehabilitation
- Explore opportunities for pooled funding across service partners to deliver comprehensive vocational rehabilitation service models

OUTER CONTEXT
This domain refers to the economic, political and social factors that influence vocational rehabilitation services.

POLITICAL RESPONSIBILITY
Survey respondents reported that some health PCT commissioners were reluctant to fund vocational rehabilitation services as they saw this more properly as the domain of the Department for Work and Pensions, despite QR6 of the NSF for long term neurological conditions and other recommendations about the importance of work in NICE guidelines. However, it was felt that vocational rehabilitation is properly the domain of health services for the following reasons

- People with long term conditions present to health services
- Specialist skills in terms of symptom management (fatigue, spasticity, cognitive difficulties) are provided by health care professionals. Individuals with acquired brain injury are particularly vulnerable to prolonged unemployment if their cognitive difficulties, particularly frontal executive functioning, are not recognized.
- Acutely unwell patients need support to engage with employers.
- Vocational rehabilitation is simply one aspect of rehabilitation which aims to support participation in societal roles. This has a bearing on perceived outcomes. Many vocational rehabilitation interventions may aim to improve behaviours, skills, and participation in structured activity. These may not always result in a return to work but are successful rehabilitation interventions improving participation, well-being and quality of life. Such outcomes are inherent in the aims of the NSF for long term neurological conditions and the stroke strategy.

This issue is likely to exacerbate local uncertainties about funding which risk the sustainability of those vocational rehabilitation services already embedded within local and regional networks of health services, partner organizations and employers.

VOCATIONAL REHABILITATION STAFF
This domain refers to the barriers and enablers that operate through the staff engaged in delivering Vocational Rehabilitation Services.

**Human Resources**

Staff bases were reported to be poor not only in terms of **numbers** but also in terms of **skill mix** with many teams wanting greater access to psychology services, benefits and legal advice and expertise in the job market.

**Staff Turnover**

Where referral pathways for job retention needed to be established with services external to the vocational rehabilitation service, problems with **staff turnover** in those external services impacted on the referral process. Where this was the case, time resources were consumed in creating and sustaining relationships across services. In localities where formal referral pathways were lacking, there was a potential array of services that may also see job retention as their remit, impacting negatively on timely referral to specialist services, potentially making the task of returning them to their previous employment more complex.

**Education and Training**

As highlighted earlier, **few staff received regular education and training** in vocational rehabilitation and 30% of services had received no training in this area. Areas highlighted as important for training included increasing knowledge and skills in vocational rehabilitation through greater opportunities for training. There was support for a nationally recognized vocational rehabilitation syllabus and competences. Therapists expressed considerable uncertainties about the legal implications of working within a client’s workplace. Anxiety also existed about the legal responsibilities about advice given around the Equality Act 2010 and reasonable accommodations, with concerns that inaccurate advice could result in litigation. There was also fear about perceived risk for clients, that poor advice might result in worse outcomes.

**Practical Tips**

- Develop of integrated workforce and organisational development plans for vocational rehabilitation
- Use national competency, knowledge and skills frameworks as the basis for the development of education and training opportunities

**Instigating and Sustaining Vocational Rehabilitation Services**

This domain refers to the barriers and enablers identified in the processes and strategies used to implement and sustain vocational rehabilitation services over time.

**Entrepreneurship**

There were many examples of pockets of vocational rehabilitation excellence led by ‘**trailblazers**’, usually a single clinician (occupational therapist, physician or psychologist). However, concerns were expressed over sustainability, even in settings where the services were well-established and seen as expert. Where services were led by a single enthusiast it was clear that that service was vulnerable to that individual leaving. Little succession planning at an organisational level was evident, and we assume that this reflects the low priority given to this work in many settings. This was perhaps best expressed by the following survey comment ‘Commitment of staff team to keep programme going - against the odds - programme under threat in 2000 due to funding difficulties - winning the NHS Nye Bevan Modernisation Award for South East region safeguarded service in short-term’. Being "evaluated example of good practice" for QR6 on NSF-long term neurological conditions also provided some ongoing protection in the face of funding shortfalls. Other comments suggested that for many practitioners practicing rehabilitation meant delivering a vocational rehabilitation service. To not deliver vocational rehabilitation was to deny a key aspect of the rehabilitation;
that is, that rehabilitation aims to increase participation in life roles, and to deny part of the skill base that has been developed by many occupational therapists, psychologists and physicians.

**Practical Tips**
- Use benchmarking or leadership development to share good practice, and increase capacity in embedding vocational rehabilitation services

**SUMMARY**

Together, the survey and case study components of this study identified a range of barriers to, and drivers for the development of vocational rehabilitation services. These operate from a service user level, influencing whether individual plans achieve meaningful impacts, to a macro, policy level, where uncertainties about funding and lead responsibility for commissioning services risk losing the service expertise that has, for the most part, evolved through service delivery. The following figures provide an indication of the relative strengths of barriers and drivers, as perceived by service providers across England.
Drivers to service development

- Vision: 100
- Evidence base: 74
- Strategic decision: 58
- New resources: 45
- External demands: 44
- Support for Innovation: 29
- Competition from: 11
- Other: 30


**Chapter 5 DISCUSSION**

**KEY FINDINGS**

The findings from this mapping study suggest that vocational rehabilitation services fail to meet the needs of people who have difficulty working due to neurological disability. Services are scanty and see only small numbers of patients. Over 10 million people live with a neurological condition, of whom a million are disabled. 10% of those receiving incapacity benefit have neurological disability (Black 2008). Many people needing access to vocational rehabilitation services will not identify themselves as disabled having hidden disabilities such as mild cognitive impairment or low mood. We identified 142 services, the majority of which treated less than 10 patients per year. Assuming (generously) that on average each service treated 20 patients per year we see that these services treated only 2,840, that is less than 3 in a thousand of those with identified disability and less than 3 in 10,000 of all those with neurological disorders. Similarly an earlier survey identified 250 specialist neurological rehabilitation services, suggesting less than half of neurological rehabilitation services view vocational rehabilitation as intrinsic to their service.

Teams offering vocational rehabilitation feel themselves to be under-resourced in terms of staff numbers, expertise and access to a range of disciplines. This is compounded by inadequate levels of education and training in this field for health care professionals. A further problem is that there is no clear guidance on how data should be collected in this complex field and hence reduced ability to identify the benefit(s) of an intervention designed to keep someone in, or help them return to, work. These problems, combined with a lack of clarity about commissioning responsibilities, and a changing context of health and social care services suggests such services are fragile.

In contrast the case studies and the mapping suggest that there is a clear consensus about the nature of vocational rehabilitation, and that this coincides with the perspectives in the National Service Framework for long term neurological conditions and the BSRM guidance on vocational rehabilitation for long term neurological conditions. When vocational rehabilitation is offered it is offered to a high standard, by therapists who are both skilled and creative in their approach. Certain key mechanisms emerged for the successful implementation of vocational rehabilitation. These included the advantages of health services that were co-located with employment services, and associated with that the need for co-ordination of services. This type of cross boundary working was highlighted in the BSRM in both 2000 and 2003. (BSRM 2000, BSRM 2003). Services which had established these links delivered the largest range of services and were seen as successful.

The importance of multiagency multidisciplinary teams in supporting work retention needs to be clearly recognised. A core team at a minimum should consist of occupational therapy and psychology with access to JobcentrePlus. The majority of work psychologists based in JobcentrePlus did not respond to our survey which demonstrates the extent of the separation between DWP and NHS. Where services were not co-located, enormous energy was spent developing personal links which were vulnerable to staff turnover. Some 10 years after the BSRM report on vocational rehabilitation for acute brain injury the recommendation about cross boundaries working has not been implemented.

The need for job retention interventions to be tailored to the individual’s work demands and activity limitations was seen as critical, and in the case of job seeking interventions, the need to focus on both work and employment skills and the benefits of accessing work placements were also seen as important.
INTERPRETATION

LIMITATIONS

As there is no existing directory of services, we were unable to determine to what extent we had successfully identified and mapped vocational rehabilitation services for people with LTNC. Neither were we able to determine how comprehensive our response rate was, as our strategy involved approaching member organisations and networks, which held no records of their members’ work roles, therefore of those initially approached only a proportion would have been expected to respond. Moreover, not all service providers belong to formal network or special interest groups. Many of these groups require health care professionals to become individual members and this may be cost prohibitive. Alternatively providers of pan disability or generic rehabilitation services, who do not specialise in VR or align their interests with any one condition or group of conditions may be less likely to be members of one of the networks we used to reach providers in this survey. It is therefore possible that VR rehabilitation of some sort is provided by pan disability services in areas, particularly in rural areas where there are fewer condition specific or specialist rehabilitation services for people with LTNC (Gladman et al., 2007).

It is also possible that some services may have opted out of identifying themselves as a provider of VR, particularly where this was not an agreed part of the service.

In turn, we do not know whether the ‘gaps’ on the map are true gaps or whether services exist in those areas that have either not been reached by our mailing strategy or chose not to take part in the study. We attempted to address this issue in the 3rd tranche of the survey, by asking all VRA members to respond to the email invitation, even if only to indicate that they did not provide VR for people with LTNC or that they provided VR for people with LTNC but did not wish to take part. However, the response to this was so poor that we were unable to cross-check our records.

However, it is believed that this map of services provides a realistic ‘snapshot’ of current service provision and that even if more services were identified, the overall ‘picture’ of the locations of services, types of services, the nature of provision by service type or disease trajectory and the clients whose needs are addressed would not change markedly.

Other limitations include information specific to individual conditions. We sought responses according to disease trajectory, which may have obscured important information about inequity and unmet need for specific neurological conditions, particularly services for people with conditions already considered hard to reach and that are already thought to be under-represented and poorly provided for.

We also have little information from the postal survey about how services were commissioned and managed when delivered as part of a wider rehabilitation service.

Although the questionnaire was developed in full collaboration with the expert panel there were some design limitations which may have affected the response rate. These included the combination of open-ended and closed questions, some with unordered and some with ordered categories requiring respondents to switch between different question structures increasing cognitive effort (Dillman, 2000) and possibly leading to decreased motivation to complete and/or data error.

Social desirability may have also resulted in respondents making their service appear more comprehensive than it is in reality (Dillman, 2000, Jones & Rattray, 2010).
Although these limitations are acknowledged the effect they may have had on the response rate or response error is unclear.

RELATED RESEARCH

These findings from our study are supported by other studies from the NSF for long term neurological conditions Policy Research Programme. In the study led by Professor Ray Fitzpatrick examining the experiences of people with long term neurological conditions, the vast majority of the participants who had progressive neurological conditions (multiple sclerosis, Parkinson’s disease and motor neurone disease) had not been in paid work in the last three years. Of the remainder, whilst the majority did not feel the need of support in relation to employment, between 19% and 27% cited different forms of support they would have wanted but did not receive.

The study of Community interdisciplinary neurological rehabilitation teams demonstrated people with long term conditions accessed community interdisciplinary neurological rehabilitation teams to maintain physical functioning and psychosocial well-being. This concept of maintaining function is particularly critical to people with progressive conditions who should be able to access these services despite appearing to be ‘high-functioning’. There is a perception that community rehabilitation teams are for people with significant disability but for people with long term neurological conditions struggling in the workplace their disability may be invisible. As in our study this study concluded that specialist expertise in long term neurological conditions, or a particular neurological condition, was common to those services valued most by people with long term neurological conditions, and that voluntary sector organisations, particularly those with a focus on specific neurological conditions, were central to the delivery of care.

The study of Transition to Adulthood for Young Men with Duchenne Muscular Dystrophy by David Abbott & Professor John Carpenter observed that two thirds of parents had insufficient information about options for what their son did next in his life. At the time of the interviews, about a third of the young men had been at home during the day and not doing any kind of education, training, or work for between a few months and seven years. Half the young men interviewed were, or had been, in a mainstream school. Most families were unclear about the process of formal transition planning. Almost all saw college as the next step, although there was often not very much choice of college because of access problems; some were directed towards residential college. Only one person had had a paid job. Those who had tried to find jobs faced insurmountable difficulties related to employers’ attitudes, access problems, and a lack of specialist and useful advice. Vocational rehabilitation services which supported people as defined in the National Service Framework Quality Requirement 6 would ensure interventions for people who need it.

With regard to young adults with congenital disorders undergoing transition there is a real concern that with connexions and the career service being axed in response to the need for budget cuts there will be no advocate for these individuals.

POLICY DRIVERS

In undertaking this research we subscribe to the UN Convention on the Rights of Persons with Disabilities: the right of disabled people to: ‘work on an equal basis with others in a labour market and work environment that is open, inclusive and accessible’.

We agree with Liz Sayce (HMSO 2011) that ‘Employment matters. Work is positive for health, for income, for social status and for relationships. Employment is a core plank of independent living and for many people work is a key part of their identity ’ and acknowledge that supporting people with disabilities to enter, remain and
progress within the workforce is important to Department of Work and Pensions, Department of Health, The Treasury and to patients

We are strongly supportive of the view expressed in the Black report (2008) that an integrated approach to working-age health should be underpinned by the inclusion of occupational health and vocational rehabilitation within mainstream healthcare; clear professional leadership; clear standards of practice and formal accreditation for all providers; a revitalised workforce; a sound academic base; systematic gathering and analysis of data; and a universal awareness and understanding of the latest evidence and most effective interventions.

We agree with government policy that people should be able to define their own needs and take control of the services they receive. We note that the cross-sector concordat, ‘Putting People First: A shared vision and commitment to the transformation of adult social care’, established a framework between central government, local government and other partners in December 2007 which led to the introduction of personal care budgets. We support the extension of this concept to personal health care budgets and the ‘Right to Control’ initiative which includes Access to Work and Work Choice as qualifying services.

We note the excellent strides made in the delivery of stroke services which are now commissioned to a quality standard developed by NICE. We recognize the need for services to develop locally in response to local need and resources but feel that strategic leadership is critical as vocational rehabilitation crosses boundaries demanding input from both the NHS and JobCentre plus.

CONCLUSIONS

1. Vocational rehabilitation services do not meet the needs of people with long term neurological conditions. Particular concern exists around the needs of young adults as they enter the work place, few services worked with school leavers.

2. Vocational rehabilitation teams are under-resourced in terms of staff numbers, range of disciplines, and expertise

3. There is no consensus on how outcome data should be collected and it is not collected routinely.

4. There is consensus about the nature of vocational rehabilitation, which is summarized in the National Service Framework for long term neurological conditions and the BSRM guidance on vocational rehabilitation for long term neurological conditions.

5. Key mechanisms for the successful implementation of vocational rehabilitation included the presence of multiagency multidisciplinary teams and the co-location of health services with employment services

RECOMMENDATIONS

A PERSON CENTRED SERVICE
1. Money should follow the individual so they can receive vocational rehabilitation/job support interventions from where they choose, be it NHS, Jobcentre Plus, independent or voluntary sector.

2. Individual budgets should be made available to patients as part of personalized health budgets or similar mechanisms to enable them to purchase vocational rehabilitation and job support.

3. The specific needs of people with deteriorating conditions to receive support in order to maintain their work needs to be recognized within service structures, as well as those looking to retain jobs after illness, and those seeking new work need to be recognized.

TRAINING

1. Nationally agreed competences should be developed for different aspects of vocational rehabilitation. These could be based on the competences developed by the Vocational Rehabilitation Association which will be published in 2012, or those being developed by the Council for Work and Health and developed further by Skills for Health, and accredited by the Sector Skills Council.

2. Nationally recognised multiagency, multidisciplinary training in vocational rehabilitation should be made available for health professionals. Such courses could be hosted by deaneries or other appropriate hosts.

3. Funding should be made available for the development of short, skills-based courses to which both work and health care professionals could attend.

CAPACITY DEVELOPMENT

1. Vocational Rehabilitation should be embedded in all rehabilitation services, especially neurological rehabilitation services. A lead for Vocational Rehabilitation should be designated for each service. Each member of the neurological rehabilitation team should have time for Vocational Rehabilitation embedded in their job plan.

2. Vocational Rehabilitation champions should be appointed for each health sector. Vocational Rehabilitation champions should have time for Vocational Rehabilitation embedded in their job plan.

3. We are supportive of the UKRC and BSRM call for a national rehabilitation strategy, which should incorporate vocational rehabilitation. We note the Rehabilitation Strategy for Scotland has a model for vocational rehabilitation that outlines the support structures that should be available to individuals in workplaces to promote health and well-being at work and identifies a rapid access referral process through which individuals should be able to secure support and specialist advice from a dedicated vocational rehabilitation team consisting of a range of professionals.

JOINED UP WORKING

1. At a national level, there should be strategic and policy leadership to ensure closer working between JobcentrePlus and NHS services.

2. At a local level, vocational rehabilitation champions should be appointed from both the health sector and JobCentre Plus to ensure partnership work. Whole systems working may be characterised by the development of local networks (both formal and virtual) for both employers and employment service providers, and training Job Centre and other staff.
3. DEAs and other JobcentrePlus employees should be able to make referrals directly to NHS vocational rehabilitation services.

4. Pilot studies should be established to evaluate different methods of working between JobCentre Plus and Health Care Professionals. An example would be more placements of DEAs in hospitals and primary care. In the past, Disablement Resettlement Officers were often based in rehabilitation services and were felt to be extremely successful in ensuring work return.

EVALUATING PROCESS AND OUTCOME

1. Standardised methods of recording vocational rehabilitation interventions should be identified. Examples of such an approach include the ICF Core set for Vocational Rehabilitation.

2. Standardised approaches to recording outcome should be established and recorded.

3. Work status for people with long term conditions should be considered as an outcome for the Quality Outcomes Framework