**About the College**

The Royal College of Occupational Therapists (RCOT) is pleased to provide a response to this consultation. RCOT is the professional body for occupational therapists and represents over 32,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health and Care Professions Council (HCPC), and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

Occupational therapy improves health and wellbeing through participation in occupation. The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation can affect physical and psychological health.

**Introduction**

On the 28th of September, RCOT held a Roundtable discussion with our members to discuss how the Department of Work and Pensions (DWP) plans to: work harder for disabled people to provide reasonable adjustments to DWP services; offer better and more tailored employment support to disabled people and rethink future benefit assessments.

The benefits discussed were Employment Support Allowance (ESA), Universal Credit (UC) and Personal Independence Payment (PIP). Occupational therapists are one of the professional groups that can be involved in the functional assessment for PIP, ESA and UC, alongside physiotherapists, nurses and social workers. We are grateful to our members who shared their expertise with us for this submission.

**What more could be done to provide employment support in health settings?**

Firstly, our members acknowledged the incredible strain that the health service has experienced over the past 18 months, with many occupational therapist and others going above and beyond to serve the country at a time of national crisis. The following views are in the context of positive change that could happen in the next 5-10 years in this area, rather than intended as an extra ask on an already stretched system.

Our members felt that NHS staff need to be provided with more training about how to talk to people about their wo aspirations They also need to be allowed to connect to local employment support services to ensure joined up communication between the NHS and other parts of the employment pathway. In essence, more effort is needed across the system to help NHS staff know what help and support is out there already to help people with work and health problems.

In addition, NHS staff need a wider baseline understanding of the DWP’s agenda and the environment in which it operates, need to be able to map out local and national support and be able to confidently navigate this. NHS staff are not always aware of for example, the role of a Job Coach or the support rules that can be used to allow someone on ESA to use permitted earnings.

Other available support that needs greater prominence for health staff is a wider knowledge for example of the Health and Work Programme, the role and purpose of the GP fit note and the AHP Health and Work report, all of which can be used for Statutory Sick Pay.

Our members believe that a greater uptake of the biopsychosocial approach to care in the NHS will help make this change. It will help shift the general focus from just health conversations to those that ask about work and how the illness, injury or disability is making work difficult and what may help resolve this.

NHS staff will need help to make earlier considerations of the psychosocial barriers to employment, rather than leave asking about work till it’s too late and the person may have fallen out of employment. People who are off work sick need to be given support much earlier by the health and care system before they move onto benefits. For example, early toolkits for people who have been off sick for two weeks could be provided to empower individuals with clear advice and signposting to sources of support.

Employment also needs to be embedded as a routine measure across the whole of healthcare. It should be built as standard into data gathering templates, recorded, and reported on. NHS and social care staff would then be routinely prompted to ask about work and focus on employment related outcomes. NHS staff need to be given more confidence to build and develop their scope of practice in this area.

In addition, many secondary care health services do not have employment support included in the commission of their services. This can mean that they are discouraged from offering more support in this area because it is not part of their contracted activity. So, work needs to be commissioned as part of NHS care rather than omitted.

Finally, our members report that the provision of local vocational rehabilitation (VR) is extremely variable and non-existent in some areas. This can mean there are no local specialist services that can support people with work and health problems. In addition, where VR does exist, the threshold for access can be high for example, some VR services will only see people who are in employment rather than unemployed people.

**How could the DWP improve the assessment process to better understand the impact of a disability on a person’s ability to live or work?**

RCOT members felt that those carrying out the assessment process need more training around using a whole person, biopsychosocial approach. This needs to include the obstacles the person is facing to living or working independently; how the environment that the assessment takes place in impacts on the assessment results and how to use a whole system approach to facilitate change and work participation.

Some members commented on the speed of the system also, with people having lengthy, anxiety provoking waits during which one benefit can stop leaving the person in financial peril while waiting for the assessment for the replacement benefit.

Our members also raised the issue that the onus on individuals to collect their own evidence for their benefits assessment can feel like an unfair burden; often the evidence which would have taken a significant degree of time, energy, and effort to provide is overruled. For example, people are asked to provide an evidence statement and then must fill out 50 pages of subsequent questions. More streamlined, shorter information could be provided with just the evidence statement rather than the follow up questions also.

In addition, our members report that for people with long covid for example, the questions do not reflect the levels of fatigue and cognitive problems they are experiencing, and that more sensitive and accurate assessments are required.

For our members who work with people with “high functioning” Autism or Asperger’s Syndrome, the conditions do not seem to be well understood in the assessment process. For example, people will answer questions in very literal ways which minimises the impact of their disability on their ability to live or work. If the right questions are not asked to solicit fuller answers, the assessor may move on and the extent of the person’s disability is missed.

Some of our members expressed shock that despite additional evidence being presented about the degree of impairment due to Autism or Asperger’s, it has been discounted because during the assessment the person “walked in, was dressed and seemed well”. These are examples of reasons given for discounting other evidence supplied by clinicians. and can cause the assessment process to be distrusted.

This discounting of evidence can then amplify NHS staff feeling that they do not have the resources to support PIP claims for example as they take a considerable amount of time to provide back up evidence. Our members have suggested that a simple letter confirming the problems experienced should suffice.

Our members in Community Mental Health Teams (CMHT) feel that that PIP forms have become a whole separate entity within their jobs and feel that they need to ensure that people get the right benefits to help them live and work independently. Many of these people are clinically vulnerable; are not able to express themselves and lack insight into the level and degree of mental health problems experienced. Some do not even believe themselves to be unwell and therefore rely on CMHT staff to provide support for benefits.

Our members are therefore stuck in many instances with the current assessment process with a duty of care to advocate for and support disabled people on one hand and facing the frustration of high evidence requirements that are time consuming and overruled.

Acknowledgment is made that the paper proposes several ideas to resolve some of these problems; the idea of paper-based reviews had support from our members in addition to the idea of DWP home visiting teams.

**In a Job Centre what should be included in a work and health discussion and what skills and experience should the person conducting it have?**

Our members articulated that one of the challenges in this area is that the health and work discussion happens between two individuals (Work Coach and claimant) who often have varied skills and experience of this type of discussion.

Work Coaches have different levels of knowledge and varied ways of working with claimants. Some are fearful of making the wrong suggestion about a health condition or disability and so avoid recommending any work-related activities as it may make a person feel worse. By contrast, some are overconfident and may cause harm to people by making recommendations that exacerbate conditions such as post exertional malaise.

Our members feel that the situation requires healthcare professional input to prevent it being ineffective and harmful. RCOT are aware of various pilots using occupational therapists for example in Job Centres but have not been provided with the results by the DWP, despite requests. Our members also think that Work Coaches need much clearer set standards and set training to ensure consistency and quality.

**Should people be able to spend the PIP mobility benefit money on aids, appliances, and services over and above the current Motability Scheme?**

Our members support the idea of giving people greater freedom of choice about how to spend the mobility money but suggest widening this within a specific framework of how the money can be spent. For example, for people who do not require adapted vehicles, their smaller allowance could be spent on train/ bus services and/or support workers to help them access this public transport.

While supporting this drive for greater personalisation in the benefits system, RCOT also urge some caution around the statutory duties which exist for both health and social care to provide aids, adaptations and services to disabled people. These duties should not be minimised or removed as part of this process; rather the two approaches should work in a coordinated manner together to provide better support, choice and control for disabled people.

**Final general points**

Some of our members also urged caution about the discussion in the paper to consider in the future combining both ESA and PIP assessments. While it is true that the burden placed on people to participate in two separate processes may be reduced by having a combined process, the systems are intended to measure different facets of everyday skills and abilities: PIP is a measure of the impact of a disability on a person’s independent living and mobility skills while ESA considers the impact of illness, injury, or disability on a person’s ability to work. In addition, PIP is not means tested and is paid regardless of income or saving and our members would not like to see this removed by combining benefits. There is also some indication that assessors already cross reference between the WCA and PIP and if this is the case, it should be made explicit to all parties.

Finally, some of our members feel that the voices of disabled people who are trying to navigate the benefits system have not been sufficiently listened to in the creation of the Green paper and urge a greater use of personalised approaches and the creation of systems that can operate in more flexible, person centred ways.

There is a growing critical discourse and dissatisfaction within the profession about the growing health inequalities that disabled people and others face, that the current system appears to be amplifying, and a call for a greater focus on the social determinates of health in all systems.

**Contact**

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