CLINICAL EDUCATION · VOCATIONAL REHABILITATION

From Stroke to Work: *The Journey Back*

An occupational therapy perspective on supporting stroke survivors to return to safe, sustainable, and meaningful work.

Delivered by

Salma Khanam · Founder Step Forward OT

For clinicians working in vocational rehabilitation

> *Returning to work is rarely just about the job. It is about identity, routine, contribution and confidence; the very fabric of recovery.*
>
> Salma Khanam, Occupational Therapist

WEBINAR AT A GLANCE

Session overview

01 Data/ key stats

The scale of stroke in the UK, the impact on work, and why vocational rehabilitation matters.

02 Assessment in vocational rehab

How OTs/ VR practitioners assess functional, cognitive, and psychosocial impact and link this to job demand.

03 Practical strategies

Reasonable adjustments, modifying tasks, environments and expectations to support return to work.

04 When the same role isn't the answer

Honest conversations, managing expectations, supporting clients to identify suitable, meaningful alternative careers/purposeful roles.

05 Working within the system

UK guidelines, legislation, and government bodies that shape clinical reasoning.

Stroke... at a glance.

What causes a stroke

A stroke occurs when the blood supply to a part of the brain is affected.

Damage to the cells in the brain can affect how the body works/ change how you think and feel.

Stroke Association, 2024

Ischaemic stroke

Around 85% of strokes in the UK are ischaemic strokes

Stroke Association, 2024

Haemorrhagic stroke

Around 15% of strokes in the UK are haemorrhagic

Stroke Association, 2024

Transient ischaemic attack (TIA)

Having a TIA is a warning you are at risk of having a stroke.

Stroke Association, 2024

Stroke in the UK

100K+

strokes occur in the UK each year

Roughly one stroke every five minutes.

Stroke Association, 2024

1.4M

stroke survivors live in the UK today

Two thirds leave hospital with a disability.

Stroke Association, 2024

1 in 4

strokes happen to people of working age

Working-age stroke is rising year on year.

Stroke Association, State of the Nation

£26bn

The estimated annual societal cost of stroke in the UK

Includes health, social care, productivity loss.

King's College London, 2020

Stroke is no longer an "older person's" condition. The proportion of stroke survivors who are economically active at the time of their stroke is growing, making vocational rehabilitation a core OT concern.

Stroke and the journey back to work

OF WORKING-AGE STROKE SURVIVORS

Less than

50%

return to paid employment

Many who do return go back to reduced hours, lower-skilled tasks, or leave again within 12 months.

Source: international Journal of Stroke (2023)

Why these numbers matter

65%	of stroke survivors say returning to work is “extremely important” to their recovery and identity.
30%	of returners require workplace adjustments to sustain employment beyond 6 months.
3x	The likelihood of long-term unemployment when no vocational rehab is offered is 3 times higher
<10%	Less than 10% of stroke services in England report dedicated vocational rehabilitation pathways.

Sources: Sentinel Stroke National Audit Programme (SSNAP); Stroke Association, 'A Working Recovery'

MORE THAN A PAYCHECK

Why work matters after stroke

1 Identity & purpose

Work is intertwined with how people see themselves, returning often restores a felt sense of ‘normality’.

2 Routine & structure

A predictable working week supports sleep, mood and rehabilitation engagement.

3 Social connection

Workplace relationships counter the isolation many survivors describe in the months after stroke.

4 Cognitive stimulation

Graded return to work can be one of the most powerful forms of real-world cognitive rehabilitation.

5 Financial stability

Avoiding sudden loss of earnings reduces stress, supports family functioning, and protects mental health.

6 Hope

Working again is often the symbolic milestone that signals ‘recovery is possible’.

The role of professionals in vocational rehabilitation

Why VR therapists/CMs/Coaches lead this work

We are uniquely able to combine knowledge of physical, cognitive and psychosocial recovery with detailed analysis of activity, environment and role. We don’t just treat impairment, we translate it into what a person can do at work.

“The person, the occupation, and the environment — the three lenses we never put down.”

What we provide:

Holistic assessment

Functional, cognitive and psychosocial- mapped against actual job demand

Job analysis

Review job specifications and adapt reasonably in line with their clinical needs

Graded return-to-work plans

Phased hours, adjusted RTW plan, fatigue management

Adjustment advice

check/adjust/adapt/advise with clinical rationale

HR and manager liaison

Translate clinical reasoning into employer-friendly recommendations.

Career re-orientation

Where the original role isn’t sustainable, we support meaningful change.

DSE assessment- adapt works settings

EVIDENCE BASE

UK guidelines/initiatives that shape our practice

RCP

Royal College of Physicians

National Clinical Guideline for Stroke (2023)

Recommends early identification of work goals and access to vocational rehab as part of stroke care.

NICE

Nat. Inst. for Health and Care Excellence

Stroke rehabilitation in adults

Sets expectations for goal-setting, MDT working and meaningful occupation- paid and unpaid.

KCH

Kings College London

Sentinel Stroke National Audit Programme (SSNAP)

SSNAP is not a guideline, but it is the national benchmark for stroke service quality.

NHS

Integrated Stroke Delivery Networks (ISDNs)

The NHS stroke model now focuses heavily on: hyperacute stroke care, integrated stroke pathways, community rehabilitation, and long-term follow-up

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DWP

Mayfield Review (2025)

Keep Britain Working- Final Report

Calls for shared responsibility between employers, employees and the NHS. Backdrop to current vocational rehab policy.

THE THROUGH-LINE

With 2.8M people now economically inactive due to ill-health (Mayfield, 2025), guidance is converging: vocational rehab must be early, individualised, multidisciplinary and continuing.

Supportive UK legislation/schemes

EQUALITY ACT 2010

Stroke is a disability under the Equality Act.

A physical or mental impairment with substantial, long-term effects on day-to-day activities. Employers have a legal duty to make reasonable adjustments — your assessment helps define what those are.

Health & Safety at Work Act 1974

Employer duty to ensure work, including a returner's tasks, is reasonably safe — informs your risk-led recommendations.

Employment Rights Act 1996

Unfair dismissal protections, statutory sick pay, right to request flexible working after 26 weeks.

Access to Work scheme (DWP)

Government-funded grants for equipment, support workers, travel, mental health support and job coaching.

Statutory Sick Pay & Fit Note (DWP)

SSP supports income during absence; the fit note useful when planning a phased return.

Knowing the law lets you advocate clearly - and reassures clients that adjustments are not favours, but legal entitlements.

Government bodies and support services

1 Access to Work

DWP scheme

Practical and financial support for disabled people in work or about to start — equipment, travel, support workers, mental health support.

2 Jobcentre Plus / Work Coaches

DWP

Disability Employment Advisers can support those out of work; a key partner when re-entry is the goal rather than retention.

3 GP

NHS / DWP

The first port of call for many returning workers — issues fit notes, refers into NHS rehab and supports communication with employers.

4 ACAS

Workplace advice service

Free advice for employees and employers on adjustments, return-to-work conversations and dispute resolution.

5 Citizens Advice

National network

Benefits, employment rights, debt and housing support — useful sign-post when financial worry threatens recovery.

6 Stroke Association

Charity sector

Peer support, helpline, return-to-work resources, regional information and co-produced clinical materials.

What we need to understand: Changes post stroke

FUNCTIONAL

Body, movement and daily function

- Hemiparesis or hemiplegia affecting dominant or non-dominant side
- Reduced standing tolerance, balance and fatigue endurance
- Trunk control/seating needs
- Visual changes- hemianopia, neglect, diplopia
- Dysphagia, communication difficulties (aphasia, dysarthria)
- Incontinence, sensory loss, pain
- Change in mobility

COGNITIVE

Thinking, processing and executive skill

- Reduced attention, processing speed and working memory
- Information processing
- Executive functions: Difficulty with planning, problem-solving, organisation
- Reduced insight and self-monitoring
- Word-finding, reading and numeracy difficulties
- Cognitive fatigue: often the hidden barrier to work
- Cog/com challenges

PSYCHOSOCIAL

Mood, identity and relationships

- Post-stroke depression: affects up to 1 in 3 survivors
- Anxiety, emotional lability, loss of confidence
- Identity loss, role change, grief for the ‘former self’
- Relationship and family role shifts
- Financial strain and fear of redundancy
- Emotional dysregulation

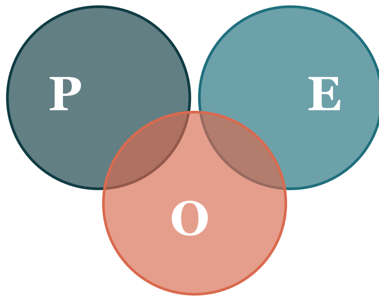
Each domain interacts with the others , fatigue compounds cognitive load, low mood reduces engagement with rehab, and physical limitations can drive psychosocial distress.

PEO model

PEO MODEL

Person · Environment · Occupation

Law et al., 1996



Person
Physical, cognitive, affective, spiritual capacity.

Environment
Physical, social, cultural, institutional context.

Occupation
Tasks, roles and activities the person needs / wants to do.

In vocational rehab

Optimal performance lives in the overlap. When it shrinks, decide whether to upskill the person, modify the environment, or redesign the occupation.

Person: Values/ goal/ outlook/needs

Environment:
- Hybrid working, DSE assessment
- Commute(bus/train/taxi)
- Work routine review

Occupation: JD/Role review/ working hours

Other models: MOHO, KAWA, COPM

Models are scaffolds, not scripts, they slow us down enough to ask the right questions before we reach for assessments and adjustments.

Matching capacity to demand

WHAT WE ASSESS: CURRENT CHALLENGES

Functional

Mobility, dexterity, fatigue endurance, posture, sensation, vision, communication, ADLs.

Cognitive

Attention, memory, executive function, processing speed, insight, social cognition.

Psychosocial

Mood, anxiety, motivation, identity, family role, self-efficacy, coping style.

Contextual

Travel to work, home demands, sleep, finances, caring responsibilities, support network.

WHAT WE ANALYSE - THE JOB'S DEMAND

Physical

Lifting, standing, walking, driving, manual handling, working at height.

Cognitive

Multitasking, decision pace, accuracy, customer-facing demands, novel problem-solving.

Environmental

Noise, lighting, shift patterns, lone working, deadlines, travel between sites.

Social & emotional

Conflict, emotional labour, customer expectations, team relationships, autonomy.

Return to work is feasible when capacity meets demand — the gap between them tells you what to adjust, train, or reroute.

Practical assessments we use in vocational rehab

Type	Domain	Examples	Why it matters
Standardised	Cognitive screen	*OT-MoCA, OCS-Plus, BADS, ACE III*	Identify cognitive risk to job tasks; baseline for monitoring change.
Standardised	Functional capacity	*WORQ, AMPS, FCE*	Quantify performance under work-like demands.
Standardised	Fatigue & mood	*FAS, HADS, Stroke Impact Scale, ESS*	Capture invisible barriers - the leading reason returns fail.
Observational	Job site visit	*On-site or simulated work tasks*	Direct observation of person-task-environment interaction.
Collaborative	Activity analysis	*Task breakdown, role mapping*	Translate clinical findings into job-relevant adjustments.
Collaborative	Goal-setting	*GAS, COPM, work-readiness scaling*	Measure change in what the client values, not just what we measure.

Tool choice should be hypothesis-driven — start from the work questions you need to answer, not the tests you happen to own.

Conversations with HR and line managers

Principles for the conversation

1. **Lead with consent- Always with the client's explicit, recorded permission. They control what is shared.**
2. **Function over diagnosis- Describe what the person can and can't do at work, not the medical detail.**
3. **Frame as collaboration- We're problem-solving together- not delivering a verdict on capacity.**
4. **Be specific & time-bound- Concrete adjustments with review dates**
5. **Educate-Many managers haven't worked with stroke before- fatigue and cognition are unfamiliar terms**
6. **Documentation/email summaries- Reports/Written summaries for HR protect the client and clarify expectations.**

What “reasonable” looks like at work

What counts as ‘reasonable’?

There is no fixed list. Tribunals weigh: how effective the adjustment is, how practical, the financial / disruption cost, and the size and resources of the employer. Most adjustments cost little or nothing.

TIME & PATTERN

- Phased return to hours
- Flexible start / end times
- Built-in rest breaks
- Reduced shift length
- Compressed week / WFH days

TASK & ROLE

- Reduced caseload / volume
- Removal of safety-critical tasks
- Buddy system on complex tasks
- Written rather than verbal handovers
- Temporary redeployment

ENVIRONMENT & TOOLS

- Quiet workspace, screen filters
- Voice-to-text, screen readers
- Adjustable seating / standing desk
- Parking close to entrance
- Access to Work funded equipment

Tip: Always pair an adjustment with a review date. “Try it for 6 weeks, then we’ll meet” removes the fear of permanence and protects the relationship.

Modifying task, environment and expectation

Modify the TASK

What is being done

Grade

Start with sub-tasks; build from familiar to novel.

Sequence

Use written checklists, predictable order, single-task working.

Reduce

Cut volume, cut decision-load, cut multi-tasking.

Substitute

Replace cognitively heavy tasks with strength-based ones during recovery.

Modify the ENVIRONMENT

Where it is being done

Sensory

Quieter desk, lower light, headphones, defined visual layout.

Physical

Seated tasks, accessible bathroom, parking, clear pathways.

Digital

Larger fonts, dictation, calendar reminders, prompts and templates.

Social

Trusted buddy, regular 1:1s, named point of contact.

Modify the EXPECTATION

How performance is judged

Pace

Adjust deadlines; allow longer ramp-up to baseline output.

KPI

can target timeframes be adjusted

Recovery time

Recognise post-effort fatigue, plan recovery, don’t penalise it.

Career timeline

Pause performance review cycles; defer promotion expectations.

Modifications work best as a system — changing only the task while leaving environment and expectations unchanged usually fails.

When the original role isn’t realistic

WARNING SIGNS

Signals that the same role may not be safe or sustainable

Repeated failed phased returns · safety-critical tasks the person can no longer do · unmanaged fatigue across multiple cycles · significant cognitive demands beyond residual capacity · the role itself causing distress or fear

01

Pause and reflect with the client

Loss of an existing role is a grief process. Make space for that before problem-solving alternatives.

02

Map transferable strengths, not just losses

Skills, experience, values, communication style, sector knowledge-catalogue what’s still there.

03

Explore alternative directions together

Redeployment within the employer; sector change; reduced-demand roles; self-employment; volunteering as a stepping stone.

Redirection is not failure — it is one of the most skilled, person-centred decisions OTs in vocational rehab make.

Principles for good vocational rehab

01

Start early

Talk about work in the first weeks, not at discharge. Hope and identity start there.

02

Be person-centred

The client's definition of 'meaningful work' leads. Our job is to help them get there safely.

03

Be realistic and hopeful

Hold both. Don't over-promise; don't pre-emptively close doors.

04

Work systemically

Engage employer, family, GP, MDT - a return-to-work plan rarely succeeds in isolation.

05

Use the law

Equality Act, Access to Work, these are tools, not paperwork.

06

Plan for maintenance, not just return

Most failures happen at 3–6 months. Build in review points and an exit plan.

07

Document clearly

Reports HR can act on- specific, measurable, time-bound.

08

Supervision

Vocational rehab is emotionally demanding. Use supervision; share complex cases with peers.

DISCUSSION · Q&A

Thank you

Questions, reflections, cases to share?

Contact

Salma Khanam, Lead Occupational Therapist

Step Forward OT

salma@stepforwardot.com

Linked In: Salma Khanam

KEY REFERENCES

- Royal College of Physicians (2023). National Clinical Guideline for Stroke for the UK and Ireland.
- NICE (2023). NG236: Stroke rehabilitation in adults.
- Royal College of Occupational Therapists. Getting My Life Back: OT after stroke.
- Stroke Association (2024). State of the Nation: Stroke statistics.
- Mayfield, C. (2025). Keep Britain Working: Final Report. GOV.UK.
- Law et al. (1996). The Person-Environment-Occupation Model.
- Iwama, M. (2006). The Kawa Model: Culturally Relevant Occupational Therapy.
- Equality Act 2010 (UK). Access to Work — GOV.UK.

Resources by slide — slides 1–10

#	Slide	Resources
01	Title — From Stroke to Work	**Stroke Association** *stroke.org.uk* · **RCOT** *rcot.co.uk*
02	Session at a glance	**RCOT — Work and OT** *rcot.co.uk/practice-resources/rcot-public-information/work* · **Different Strokes (working-age)** *differentstrokes.co.uk*
03	Stroke… at a glance	**Stroke Association — What is a stroke** *stroke.org.uk/what-is-stroke* · **Different Strokes (working-age)** *differentstrokes.co.uk*
04	Stroke in the UK — statistics	**Stroke Association — Statistics** *stroke.org.uk/what-is-stroke/stroke-statistics* · **State of the Nation report** *stroke.org.uk/stats-and-facts-about-stroke/state-of-the-nation* · **King's College — Cost of stroke (2020)** *kcl.ac.uk*
05	Impact across three domains	**RCP National Clinical Guideline for Stroke** *strokeguideline.org* · **Stroke Association — Effects of stroke** *stroke.org.uk/effects-of-stroke* · **SSNAP — Sentinel Stroke National Audit** *strokeaudit.org* · **Stroke Association — A Working Recovery** *stroke.org.uk*
06	Stroke and the journey back to work	**International journal of stroke: Effectiveness of early vocational rehabilitation versus usual care to support RETurn to work after stroKE: A pragmatic, parallel-arm multicenter, randomized controlled trial**
07	Why work matters after stroke	**Stroke Association — Returning to work** *stroke.org.uk/life-after-stroke/returning-to-work* · **Mind — Mental health at work** *mind.org.uk/workplace*
08	The OT's role in vocational rehab	**RCOT — Getting My Life Back: OT after stroke** *rcot.co.uk* · **RCOT — Vocational rehabilitation** *rcot.co.uk/practice-resources/rcot-public-information/work*
09	UK guidelines that shape our practice	**RCP National Clinical Guideline for Stroke** *strokeguideline.org* · **NICE NG236 — Stroke rehabilitation** *nice.org.uk/guidance/ng236* · **BSRM — Vocational rehab standards** *bsrm.org.uk* · **Keep Britain Working (Mayfield Review)** *gov.uk/government/publications/keep-britain-working-review-final-report*
10	UK legislation every clinician should reference	**Equality Act 2010** *legislation.gov.uk/ukpga/2010/15* · **Health & Safety at Work Act 1974** *legislation.gov.uk/ukpga/1974/37* · **Employment Rights Act 1996** *legislation.gov.uk/ukpga/1996/18* · **Access to Work** *gov.uk/access-to-work* · **Fit Note guidance** *gov.uk/government/collections/fit-note*

Resources by slide — slides 11–19

Slide	Topic	Resources
11	Government bodies and support services	**Access to Work** *gov.uk/access-to-work* · **Jobcentre Plus** *gov.uk/contact-jobcentre-plus* · **ACAS** *acas.org.uk* · **Citizens Advice** *citizensadvice.org.uk* · **Stroke Association helpline** *stroke.org.uk/finding-support*
12	PEO and KAWA models for formulation	**Law et al. (1996) — PEO Model** *doi.org/10.1177/000841749606300103* · **Iwama (2006) — The Kawa Model** *kawamodel.com* · **RCOT — Theoretical frameworks** *rcot.co.uk*
13	Matching capacity to demand	**RCOT — Vocational rehabilitation** *rcot.co.uk/practice-resources/rcot-public-information/work* · **BSRM — Vocational rehab standards** *bsrm.org.uk*
14	Practical assessments we use	**OCS — Oxford Cognitive Screen** *ocs-test.org* · **COPM — Canadian Occupational Performance Measure** *thecopm.ca* · **WORQ — Work Rehabilitation Questionnaire** *myworq.org* · **Stroke Impact Scale (SIS)** *kumc.edu*
15	Conversations with HR and line managers	**ACAS — Disability at work** *acas.org.uk/disability-discrimination* · **CIPD — Managing health at work** *cipd.org* · **Mindful Employer** *mindfulemployer.dpt.nhs.uk*
16	What ‘reasonable’ looks like at work	**Equality Advisory Service** *equalityadvisoryservice.com* · **ACAS — Reasonable adjustments** *acas.org.uk/reasonable-adjustments* · **Access to Work** *gov.uk/access-to-work*
17	Modifying task, environment and expectation	**RCOT — Activity analysis tools** *rcot.co.uk* · **Stroke Association — Adjusting at work** *stroke.org.uk/life-after-stroke/returning-to-work*
18	When the original role isn’t realistic	**National Careers Service** *nationalcareers.service.gov.uk* · **Working Families** *workingfamilies.org.uk* · **Shaw Trust — Disability employment** *shawtrust.org.uk* · **Remploy** *remploy.co.uk*
19	Principles for good vocational rehab	**RCOT — Professional standards** *rcot.co.uk/practice-resources* · **BSRM — Standards of practice** *bsrm.org.uk*