

A healthy return

Good practice guide to
rehabilitating people at work



IOSH publishes a range of free technical guidance. Our guidance literature is designed to support and inform members and motivate and influence health and safety stakeholders.

A healthy return – good practice guide to rehabilitating people at work

The aim of this guide is to give occupational safety and health practitioners a grounding in rehabilitation, and to provide them with practical support. Others, including managers and human resources personnel, will also find it useful.

The guide contains:

- an overview of rehabilitation
- a 'Work adjustment assessment' to help assess employees with impairments or medical conditions
- case studies that demonstrate rehabilitation in practice
- sources of further information, reading and training.

'A healthy return' is only intended as an introductory text to rehabilitation, with references to further reading and information sources, and not as a definitive guide to the subject.

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PDF versions of this and other guides are available at www.iosh.co.uk/techguide.

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Foreword

Being in work has considerable benefits, not just for individuals but also for their families and for the communities in which they live. We know that being in work is generally good for people's health and wellbeing, and that being out of work leads to poorer health and increases health inequalities. Helping people to remain in or quickly return to work when health conditions arise is therefore important. With changing demographics, it is not just important for individuals, but essential if we are to create a sustainable workforce for the dynamic economy that supports an increasingly ageing population.

Employers can help employees in a number of ways: protect their health and wellbeing and make sure that the huge progress made in reducing work-related illness and injury continues; wherever possible, help them remain in work when health conditions arise by providing support and making reasonable adjustments; help those who have been absent to return to appropriate work that they can perform without risk; and to use the workplace as an opportunity to help improve employees' general health and wellbeing.

This requires a co-ordinated approach, with the focus on producing the best outcome for the individual. Employers, occupational health and other healthcare professionals, trade unions, HR professionals, line managers and occupational safety and health practitioners must all work together, combining their respective skills and experience to create a powerful multidisciplinary team. Within such a team, the occupational safety and health practitioner has the opportunity to use the knowledge and experience they have gained in their traditional role to help make sure that reasonable adjustments are identified which are both appropriate and without risk; to support and ensure the implementation of such adjustments; and to monitor their ongoing impact and effectiveness.

This guide not only helps to identify the opportunities for occupational safety and health practitioners to contribute to the broader health and work agenda, but is also a valuable source of advice and guidance for all those involved in this area. IOSH is to be congratulated on its initiative, which is an excellent example of taking definitive action to bring about change and help make a difference to the lives of working age people.

Dr Bill Gunnyeon CBE
Chief Medical Adviser
Department for Work and Pensions

1 Introduction

“Improving the health of the UK’s workforce will have a critical impact not only on individuals, but on businesses and the UK economy as a whole.... Focusing on specific health issues is obviously important; however, employers should not underestimate the role that better management and engagement of employees can have on the wellbeing – and ultimately productivity – of their workforce.”

Professor Dame Carol Black, UK National Director for Health and Work

Rehabilitation – an outline

Rehabilitation has two main aims:

- to help employees return to work after an illness or disability
- to help employees with chronic health conditions stay in work.

Good rehabilitation practice involves employers, managers, employees and a range of other professionals working together to find solutions to achieving these aims. The methods they use include medical intervention and making changes to the workplace.

Rehabilitation should be part of a wider strategy on employees’ health and wellbeing, whose aims should be to tackle the causes of work-related ill health and injury, get involved before absence occurs, and – through health promotion – encourage employees to take responsibility for their own health.

A recent evidence review¹ found that the best interventions involved employee–employer partnerships and/or consultation. The review highlighted the benefits of addressing factors at both individual and organisational levels, and considering not only employees’ health conditions, but also their attitudes and beliefs. It found that communication and co-operation between employers, employees, occupational health providers and primary care professionals can lead to faster recovery, less recurrence of ill health, and less time off work.

History of vocational rehabilitation

In the UK, there’s been a growing interest in the benefits that

rehabilitation can bring and, in recent years, government and policy-makers have been actively promoting it.

First, the government’s *Revitalising health and safety* strategy, launched in 2000, included national targets for improving health and safety by 2010:

- to reduce the rate of fatal and major injury accidents by 10 per cent
- to reduce cases of work-related ill health by 20 per cent
- to reduce the number of working days lost per worker from work-related injury and ill health by 30 per cent.

The strategy was also included an intention to strengthen retention and rehabilitation services.

Second, one of the core aims of the government’s 10-year strategy (2000–2010) was to help people who are, or have been, ill or injured return to work.

Third, the Department for Work and Pensions (DWP) published a framework for vocational rehabilitation in 2004. This was followed in 2006 by *Health, work and well-being*, a national strategy and ‘charter’ for the health and wellbeing of working age people. In the same year, Professor Dame Carol Black was appointed the first National Director for Work and Health.

Fourth, following a consultation on the welfare reform Green Paper, *A new deal for welfare: empowering people to work*, the government set a long term employment target of 80 per cent of the working age population. The

government aimed for around 2 million more people to join the UK workforce, partly by helping people currently on incapacity benefit to return to work, and encouraging older workers to stay in or return to employment. These aims are supported by the Disability Discrimination Acts 1995 and 2005, and the Employment Equality (Age) Regulations 2006.

Fifth, assessments for the employment and support allowance (which replaced incapacity benefit) aimed to identify what claimants can do and what help they need, rather than just focusing on their incapability for work.

Sixth, the introduction of the Fit Note in April 2010 provided a mechanism for GPs to think about their patient’s ability to work and provide more helpful information to patients to discuss with their employer. The new system creates an opportunity to encourage people back to health through work.

Given these developments, and others on the horizon such as those suggested in Dame Carol Black’s report, *Working for a healthier tomorrow*,² it’s likely that, in the future, more people will be at work with medical conditions and impairments.

Employers and managers will have to do more to manage rehabilitation. And occupational safety and health practitioners will need to support them in this task.

2 Why support rehabilitation?

Work is generally good for people and can help them lead healthier lives, as long as the work is 'good' and they're in safe and supportive workplaces. A 2006 review³ found that:

- there's a strong association between unemployment and poorer health, including mental health, and a large part of this seems to be caused by not being in work
- work can help reverse the adverse health effects of unemployment.

The review also suggested that 'good jobs' may have elements such as employee autonomy/control and job satisfaction.

Unemployed people can lose their skills and confidence. Long periods of inactivity and isolation can have a negative impact on their physical, psychological and social health, as well as their general wellbeing.⁴ It's even been reported that people out of work for more than a year have, on average, eight times more psychological ill health than those in work.⁵

Long term absence isn't just costly for employees – employers and society pay a high price too. In the UK, around 28.5 million working days are lost as a result of work-related illness and injury each year. The Health and Safety Executive (HSE) estimates that this represents an annual loss to UK society of up to £31 billion.

If you're an employer, long term ill health or injury can mean:

- losing the skills of valuable employees
- a reduction in your productivity
- extra expense in the form of finding and hiring replacement or temporary staff, and sick pay.

There can be non-financial costs too. For example, if an employee has a serious accident at work, this can be bad for your brand, reputation and public image. And while your employer's liability insurer may bear some of the cost of compensation claims, over the longer term your premiums could rise if you make frequent claims.

What often goes unrecognised is that an employee's absence can have a negative impact on the day-to-day work of their fellow workers and manager, and this issue has to be dealt with too.

The best and most cost-effective way an employer can support rehabilitation is by setting up a formal occupational health and rehabilitation programme.

A well-managed programme can help to:

- keep employees in work
- reduce employees' short term pain and suffering
- minimise or eliminate long term disabilities
- get employees back to work quickly and safely.

Rehabilitation programmes can more than pay for themselves by significantly reducing compensation claims or even wiping them out entirely because employees either no longer need or want to make them. And even if a claim is made and awarded, providing rehabilitation or offering support generally reduces the costs.

A formal rehabilitation programme can also help employers meet their duties under disability discrimination legislation. For more information on this, see section 11, page 17 and Appendix B, page 23.

The longer an employee is off work, the less likely they are to return. For example, after six months' absence with back pain, there's only a 50 per cent chance of an employee coming back to work.⁶ That's why it's important to begin the process of rehabilitation early, so that employees can:

- return to work in a suitable role
- regain confidence and motivation
- maintain good relationships with their managers and colleagues
- avoid financial hardship, and having to retire from work because of ill health.

It's worth stressing that early return to work is not always the right approach in every case. There are times when rest is the best treatment.

While it's important to minimise the human and financial impact for both the employee and organisation, early return to work should be based on an assessment of the nature and degree of injury in each case. Other issues such as the impact of medication or inability to travel should also be taken into account.

In short, activity in the workplace cannot be compared to activity in general, and early return to work should only be used when it's appropriate for recovery.⁷

How absence should be managed is shown in the diagram in Appendix C, page 24.

Who works in occupational health?

Ergonomists apply human sciences (eg anatomy, physiology and psychology) to the design of objects, systems and the environment for human use. Ergonomic design considers options to make sure that people's capabilities and limitations are taken into account, so that products and environments are comfortable, safe, healthy and efficient for people to use. Ergonomists can help employers design jobs and environments to suit individual workers' needs and help in rehabilitation, eg workstations that allow people to sit rather than stand, or vice versa, depending on their circumstances.

Occupational health advisers are nurses who carry out similar roles to specialist practitioners in occupational health, depending on their qualifications. The term 'adviser' tends to be used by nurses working in occupational health, as they often find the term 'nurse' isn't helpful in a business environment. For more information on occupational health advisers, see section 6 (page 12).

Occupational physicians focus on making sure that workplaces and work practices are safe and not harmful to the health of employees, and that employees are fit for the job they're doing. If there are problems – either with the workplace or with an employee's fitness – the occupational physician's role is to advise on adjustments to the workplace and to give advice and support to the employee. Occupational physicians have an important part to play in getting employees back to work when they're sick or injured. When they assess an employee's fitness for work, they look at their state of health and the conditions in the workplace. They take into account the workforce and the psychological and physical environment, and any impact these may have on the employee's health. Occupational physicians also play a key role in providing impartial, evidence-based advice to organisations – such as insurance and pension companies – about retirement on the grounds of ill health and related matters.*

Occupational safety and health practitioners help employers reduce risks. They aim to promote awareness of health and safety in the workplace and make sure that high standards are achieved and maintained. Their main focus is on preventing work-related accidents and ill health. An increasingly important part of their role is to work closely with other professionals – such as occupational hygienists, occupational health advisers, ergonomists, human resources and training personnel, insurers, lawyers and workers' representatives – to help resolve issues that may be a barrier to rehabilitating employees. There's more on the occupational safety and health practitioner's role in relation to rehabilitation in section 3 (page 06) and throughout this guide.

Occupational therapists work with people to help them overcome the effects of disability caused by physical or psychological illness, ageing or accidents. Occupational therapists often work in hospitals, but some work in businesses, clients' homes, GP practices and other community settings. Others focus solely on helping employees return to work. They assess and treat physical and psychiatric conditions, and when they've completed a course of treatment, they evaluate how effective it has been.

Specialist practitioners in occupational health are qualified nurses trained in occupational health nursing to 'specialist practitioner' level, or who have a specialist community public health nursing qualification, better known as an 'SCPHN'. They often work for large employers or private consultancies. Their work includes assessing work environments for health problems, carrying out risk assessments, providing first aid and medical treatment, and screening potential employees for health problems. They also carry out health surveillance for employees exposed to hazards such as certain chemicals, and maintain employees' health records.

* Adapted from a definition on the Faculty of Occupational Medicine website, www.facocmed.ac.uk.

3 What is the occupational safety and health practitioner's role?

As an occupational safety and health practitioner, one of your main roles is to help prevent employees getting injured or ill because of work, and, if they do, to make sure lessons are learned. Whether an employee's sickness absence is work-related or not, you should also work alongside other colleagues in your organisation to help them return to work as soon as they're able.

If you work in a large organisation, rehabilitation will be dealt with mainly by line managers, supported by occupational health and human resources professionals. If you work in a smaller organisation, your employer may look to you alone to give them advice in this area.

Generally, the decision about whether an employee who's on long term sick leave should return to work is made by the employee and their line manager, and they need sound medical advice so they can decide on what the employee is capable of doing. Here, it's worth noting that to automatically treat someone who has an impairment or medical condition as a health and safety 'issue' or 'problem' could be regarded as discriminatory. You can get useful information on this by visiting www.hse.gov.uk/disability/law.htm.

The main way you can support good rehabilitation practice is by giving advice on risk assessments for employees with medical conditions or impairments. See Appendix E (pages 26–32) on the factors you need to consider when carrying out an employee's 'Work adjustment assessment'.

Another way you can give your support is to challenge attitudes that act as a barrier to rehabilitation. For example, if an employee has a fit note that indicates that adjustments can be made to help them return to work, you can help. You should explain to the manager why health and safety needn't be an obstacle, and work with them to make sure it isn't. In cases such as this, you could advise the manager that an appropriate rehabilitation programme will help the employee return to work safely before they're fully fit.

Similarly, if a manager feels it would be too much trouble to make changes to the workplace which would help an employee to return to work, or an employee is worried about the impact that coming back might have on their health, you need to demonstrate that rehabilitation can benefit both the employer and employee.

The documents listed in the 'References' and 'Further reading' sections (pages 19–20), and in our Occupational Health Toolkit at www.ohtoolkit.co.uk, will help you improve your knowledge of rehabilitation. They will also give you the resources to challenge those who use 'health and safety' and other poor excuses for not considering rehabilitation.

Of course, before you give advice on rehabilitation cases, you should consider whether you're competent to do so. If you think you need training, there are a number of courses you can take. For more information, see 'Training' on page 21.

It's important that you work within the limits of your competence. Where clinical judgments are needed – for example diagnosis or treatment – you should always get advice from a medical expert.

For more information on the occupational safety and health practitioner's role, see the '12-point action plan' in Appendix D (page 25).

Case study 1 – Lower back pain

Scenario

John, a 50-year-old pottery worker, suffered from spells of lower back pain for many years. He eventually went off work while waiting for physiotherapy from the NHS.

Action

- The manager kept in weekly contact and encouraged John to come in for a chat after a few weeks.
- The manager referred John to an occupational health specialist, who suggested the employer should pay for physiotherapy on a private basis to reduce waiting time.
- Once physiotherapy started, John returned to work for four hours a day. Because travelling in the car for a long time and parking were difficult for him, in the first month the employer allowed him to start work after the morning rush hour, leave before the afternoon rush hour, and park in a reserved slot near the work entrance.
- Rather than work on rotating shifts, the employer also let John work days only, and gave him time off for regular appointments with his occupational health nurse and physiotherapist.
- The employer carried out an assessment to look at ways the work could be adapted to John and if there were any health and safety issues.
- As a result of the assessment, instead of John having to carry trays of products on a trolley from a central store to the work area, other employees took turns to bring him his tray.

- Later, the employer introduced a more permanent solution – a scissor platform trolley, which benefited all the pottery workers.
- The employer replaced John's wooden stool with a height-adjustable chair with a back rest.
- In his physiotherapy sessions, John was taught how to improve his posture.
- The occupational health nurse told all employees and managers how to manage back pain.

Comment

This is a good example of early medical intervention, good rehabilitation measures and effective work adaptations. However, the occupational safety and health practitioner should also assess whether other employees:

- are at risk of lower back pain
- should be given adjustable chairs with back rests, and education on good posture.

It's worth pointing out that nothing was done in response to John's earlier bouts of lower back pain. This may have prevented him from being absent in the first place.

Adapted from the EEF guide, *Fit for work*.

4 Good practice in rehabilitation – a summary

- Your organisation should have a clear and up-to-date policy on rehabilitation. This should be part of an overall strategy for managing sickness absence. The policy should clearly define roles, responsibilities and expectations, and be effectively communicated. This will help create a fair and consistent approach, and build trust between employees, managers and the employer.
- Managing day-to-day sickness absence and return to work should be a line manager's responsibility. For complex issues, managers need to draw on advice from human resources, occupational health or health and safety specialists.
- Early intervention is important, particularly in the case of musculoskeletal disorders, stress and mental health, which can become chronic.* Generally, intervention should take place within weeks rather than months.
- Managers should stay in regular contact with employees from the start of their absence. Contact should be weekly. If the illness is prolonged, then less frequent contact may be agreed, but it should be at least once a month.
- Rehabilitation should begin at an appropriate stage. In some cases, such as musculoskeletal disorders, this could be very early. In other cases, say nervous breakdown or where the employee is too ill, early contact should mainly be for welfare purposes – to see how the employee is and whether there's anything the employer can do to help. The decision on when it's appropriate to discuss rehabilitation should be based on the manager's conversations with the employee.
- Rehabilitation should be considered once it's clear that absence could be lengthy, say after the employee has sent in a fit note or has been off work for a month.
- A co-ordinated case management approach is best, beginning with an informal discussion at an early stage – between the manager, employee and human resources specialist – to start looking at rehabilitation options. The manager should assess what the organisation can do to help the employee return to work. The manager should also try to find out if anything is preventing the employee from coming back, as this will help to identify any adjustments that need to be made at work.
- After the initial meeting, the employer may have to arrange for the employee to see an occupational health adviser or occupational safety and health practitioner, or ask the employee's GP or specialist for more information. Here, the employee would need to give the employer their consent. The employer should ask the GP about the employee's ability to do specific work tasks, and their views on the suitability of the rehabilitation measures that have been proposed (see 'Asking an employee's GP or specialist for more information', opposite). The employer needs to ask about what the employee can and can't do and, if appropriate, how long their disability or medical condition might last.
- The employer should assess whether medical intervention, such as physiotherapy or counselling, will speed up the rehabilitation process. For instance, if the employee is on an NHS waiting list for physiotherapy treatment, the employer could arrange for treatment more quickly on a private basis. Here, it's important for the employer to take medical advice so that they can make a decision based on objective evidence. Interventions such as this are likely to be cost-effective for the employer.
- Once the manager has medical advice about what the employee can and can't do, they can plan a programme of rehabilitation.
- The manager may need to make adjustments to the workplace or buy specialist equipment (see 'Examples of reasonable adjustments for an employee', opposite). If these are likely to be expensive, and the employee has a disability, the employer may be able to get funding through Access to Work (see Appendix B, page 23). The manager should also assess how long it will take to make adjustments, as this may delay the rehabilitation process.
- At this stage, the manager will need to start thinking about any health and safety issues, and may need to contact their occupational safety and health practitioner for advice (see section 3, page 06 and Appendix E, pages 26–32).
- The employer and employee should then agree the arrangements for rehabilitation – these should be recorded.
- The employee's progress should be monitored regularly, normally by their line manager. Their manager should keep notes (making sure confidentiality isn't breached) and agree any significant changes to the employee's role with the occupational health adviser or employee's GP or specialist.

* Some employers refer all cases of stress and musculoskeletal disorders to their occupational health adviser on the first day of absence.⁴

Asking an employee's GP or specialist for information

Employers should get their employee's consent if they want further information from their GP or specialist after receiving a fit note. The employer should then ask the GP or specialist for the information in writing. If it's convenient, the employee can hand over a letter from the employer, but usually the employer sends the letter direct to the GP or specialist. The employer should:

- explain that they would like to help the employee get back to work as soon as possible
- summarise the employee's duties, paying attention to things such as job demands, the work environment, working time, travel, and whether the employee is a lone worker
- ask the GP questions about the employee's fitness to do their current job. For instance, they should ask about the possible side effects of medication, the employee's stamina and motivation and, if relevant, whether the employee can lift or move heavy objects. It's important to ask questions about what the employee can do, not just what they can't do

- suggest a range of rehabilitation measures – such as a phased return to work, altering the work or adapting the work environment – to find out if these could help the employee come back to work.

GPs and specialists don't have to give employers information in addition to that on the fit note regarding an employee's fitness for work or rehabilitation. If they don't, the employer may have to make decisions without this information. If they do agree, they may charge a fee. Unless an occupational health adviser makes the request, the report won't necessarily give clinical information about things such as the diagnosis, or the medication the employee is taking.

Adapted from the EEF guide, *Fit for work*.

Examples of reasonable adjustments for an employee

Working arrangements

- Encourage employees to visit the workplace so that they stay in touch
- Offer them a phased return to build up their strength, gradually increasing their hours of work
- Change their working hours so they don't have to travel at busy times, or offer them flexible working to support their work-life balance
- Provide them with help travelling to and from work, or let them park nearer workplace entrances
- Allow them to work from home
- Give them time off work for medical treatment and assessments

Working environment

- Move their workstation so that it's more accessible, or closer to washing and toilet facilities
- Alter the work premises, for example install ramps or improve lighting

Work adjustments

- Give them specialist equipment or modify existing equipment
- Modify their workstation or furniture
- Change or simplify their work pattern, such as no shift or night work
- Give them extra or refresher training
- Modify instruction manuals and standards to suit their abilities
- Modify their work tasks, such as reducing the need for face-to-face meetings or travel if they cause anxiety
- Modify management systems to give them more control
- Reduce their pace of work – give them less difficult targets or deadlines, longer breaks and so on
- Modify procedures for testing and assessing competence or ability to do a job
- Give them a 'companion', mentor or more supervision
- Give some of their tasks to other employees, give them different work, or re-deploy them
- Give them training and information, for example on back care

5 Managing medical information

Confidentiality issues

As outlined earlier, employers must get the informed 'express consent' of an employee if they want medical information about them.⁸ Occupational health professionals, including those employed by an organisation, have a duty of confidentiality and so can't disclose medical information about an employee without their permission.

Occupational health professionals can provide a report on what adjustments to the work they think the employer should introduce. The employee can ask to see the report. It's good practice for the employer to share the report with the employee, even if the employee hasn't asked to see it. You can get more guidance and examples of letters of enquiry from the CIPD's 'Absence management toolkit' and the EEF's 'Managing sickness absence toolkit' (see 'Further reading' on page 20).

Medical records must be stored securely, and should only be seen by medically qualified staff, or those working under confidentiality agreements. Staff who collect and store information must comply with the Data Protection Act.⁹

If the employee doesn't consent to their employer or their occupational health adviser gaining access to their medical information, the employer should explain to the employee that they will have to make decisions without full medical information, which may not be in the employee's best interests. Even if the employee doesn't give their consent, occupational health advisers have a duty of care to tell the employer if there are fitness-for-work issues that could put the health and safety of the employee or others at risk. This can be done without disclosing the medical reason. If there are disagreements between health professionals and others on confidentiality issues, they can get guidance from the Faculty of Occupational Medicine.¹⁰

Fit notes

In the past, medical certificates could give very little information about what was preventing an employee from working. However, the fit note does allow the GP to suggest an adjustment which may help the employee return to work. For example, this might involve working from home, part-time working or flexible hours. After getting consent from the employee, the employer can ask the GP for more information (see page 09, 'Asking an employee's GP or specialist for information').

It's best practice for the employer and employee to stay in touch from the first day of absence – employees can be offended or hurt if the employer doesn't bother to contact them.

Of course, an employee might be reluctant to return to work if their GP says they should be signed off. Here, it may be helpful for the occupational health adviser (or occupational health physician) and GP to discuss the case. When the occupational physician and the GP disagree about an employee's fitness to return, the employer can choose to accept the occupational physician's view,¹¹ or get the opinion of another specialist. Any managerial decisions may ultimately be tested in an employment tribunal.

The employer could also outline what work modifications they can offer if the GP feels the employee isn't fit for their normal job.

Employees can also be signed off for longer than would otherwise be necessary if they're waiting for medical treatment such as physiotherapy. Organisations can cut the length of some absences by organising and paying for early and/or more intensive treatment. This should only be done on the advice of an occupational health adviser, so that interventions are appropriate and employees are treated fairly and equally. There are potential tax implications for businesses that provide private treatment for non-

work-related conditions. To find out more, visit www.hse.gov.uk/pubns/taxrules.pdf.

Many elements of the fit note system are the same as before:

- the GP can still advise the patient that they're not fit for work
- the statement can only be completed by a doctor
- the statement is advice from the GP to the patient that the patient can use as evidence of their fitness for work for sick pay and benefit purposes. The advice on the statement is not binding for employers.

The new system involves several key changes:

- there's a new option – 'may be fit for work taking account of the following advice'
- GPs are no longer asked to issue statements confirming that someone is fit for work
- there's more space for comments on the practical effects of the patient's condition, with tick-boxes to indicate simple adjustments or adaptations that could help their return to work
- telephone consultations are now an acceptable form of assessment
- the maximum validity of a statement is reduced from the first six months of illness to the first three months.

Information on the fit note system has been adapted from the DWP website, www.dwp.gov.uk/healthcare-professional/news/statement-of-fitness-for-work.shtml.

Case study 2 – Badly crushed foot

Scenario

Steve, a 32-year old forklift truck driver, had an accident at work that crushed his foot. Steve had to have his toes amputated. He found it difficult to stand and walk, and suffered from depression.

Action

The employer contacted their insurance company, which had a rehabilitation return-to-work programme led by occupational therapist case managers. The case manager visited Steve to assess his circumstances and then made recommendations on interventions, discussing these with Steve, his GP, other medical specialists, the employer and members of Steve's family.

Steve was referred to the programme 15 months after the accident.

As part of his return-to-work programme, the case manager:

- carried out a workplace assessment
- arranged for Steve to return to work gradually – in a different job but with the same employer
- arranged for private physiotherapy and pain management from a specialist
- organised gym membership and a subscription to a slimmer's class
- arranged for Steve to be assessed by a podiatrist and for an orthopaedic firm to provide special shoes
- had ongoing discussions with Steve's GP.

Steve came back to work 27 months after the accident, initially working four hours a day before returning to full time work.

Comment

While this is a good example of the use of an insurer's rehabilitation service, it's worth noting that Steve wasn't referred until 15 months after the accident. Normally, referral should take place much earlier than this.

Adapted from the DWP publication, *Building capacity for work*.

6 Occupational health advice and rehabilitation support

Managing rehabilitation successfully relies on good occupational health advice. Employers who use occupational health advisers are much more likely to meet their legal obligations under employment and disability discrimination law.

If an employer relies on advice from the employee's GP, they should bear in mind that GPs should only act in what they consider to be the best interests of their patient, and need to be convinced that rehabilitation is appropriate. They have no responsibility to the employer and are under no obligation to give them advice. However, some GPs will respond to requests for help and guidance, particularly if it comes from the employee.

Most GPs don't have occupational health expertise and can't offer the type of advice that occupational health professionals can. For instance, an occupational health specialist can:

- advise on whether return to work is appropriate and what's practicable
- examine the employee, advise on whether rehabilitation is an option and, if so, the adjustments to the workplace that may be needed
- monitor employees on a rehabilitation programme
- give employees advice and recommend specialist advice or treatment
- assess whether it would be useful for the employer to pay for certain treatments
- provide a second opinion on a GP's report, and discuss any differences of opinion they may have
- assess an employee's eligibility for retirement or disability benefits
- support the prevention of work-related illness and injury by advising on a health-related risk assessment, carrying out health surveillance, giving advice at the early stages of an occupational disease, and promoting health.

Legally, if an employer is thinking of dismissing an employee on the grounds of ill health, they must demonstrate that they've taken reasonable steps to discover all the relevant facts. This means getting advice from an occupational health specialist, rather than relying solely on information provided by the employee's GP.

If organisations don't have access to full time occupational health support, other options include:*

Employee's GP or specialist

While they may not have occupational health expertise, they will understand the medical aspects of their patient's condition.

Employment Medical Advisory Service

This service, part of the HSE, offers information on the availability of local occupational health services. You can find your local EMAS office in the phonebook, under 'Health and Safety Executive'.

Insurance companies

Some insurance companies offer rehabilitation support, particularly where absence is work-related or prolonged.

IOSH

IOSH's free Occupational Health Toolkit gives occupational safety and health practitioners a wide range of resources to help tackle key occupational health issues. The site is an occupational health 'hub' for non-medical practitioners, and has lots of tools to help deal with occupational health issues. Currently, it covers MSDs, stress, inhalation hazards and skin disorders. To find out more, visit www.ohtoolkit.co.uk.

NHS Plus

In England, some NHS trusts sell occupational health support services to small businesses. For more information, visit www.nhsplus.nhs.uk. Similar arrangements are available in Wales (www.wales.nhs.uk), Scotland (www.healthinfoplus.co.uk), and Northern Ireland (www.n-i.nhs.uk).

Occupational health service providers

The Commercial Occupational Health Providers Association (COHPA) is a not-for-profit trade association that can help you find a commercial occupational health provider. Find out more at www.cohpa.co.uk.

Rehabilitation or case management specialist companies

Case management is a collaborative process that assesses, plans, implements, co-ordinates, monitors and evaluates the options and services needed to meet an individual's health, care, educational and employment needs. For more information, contact the Case Management Society UK on 0870 850 5821 or visit www.cmsuk.org.

Scottish Centre for Healthy Working Lives

This provides free, confidential advice and information in Scotland on a wide-range of workplace health issues, including health promotion, occupational safety and health, employability and vocational rehabilitation (t +44 (0)800 019 2211), as well as workplace visits. For more information, see www.healthyworkinglives.com.

Workboost Wales

This government-funded service offers confidential, practical and free advice to small businesses and their workers in Wales on workplace health and safety, managing sickness absence and return-to-work issues. Visit www.workboostwales.net or call 0845 609 6006.

* This is not a comprehensive list and inclusion of an organisation does not infer any endorsement by IOSH.

7 Absence due to work-related accidents or ill health

If an employee is absent as a result of a work-related accident or illness, they might be reluctant to agree to rehabilitation. This could be because they're:

- concerned that the source of harm hasn't been removed or aren't confident that what's been done to remove or control it has been successful
- thinking about claiming compensation and feel it may have a negative impact on their claim
- not aware of your organisation's ability and willingness to be sufficiently flexible to meet their needs.

Here, you have a role to play in helping the employee get the confidence to return to work, by making sure that a

proper investigation has been carried out and measures have been put in place to prevent a recurrence. The manager may need to identify, with the employee, any health and safety or refresher training and development the employee might need.

There may also be issues around blame, especially if, for example, the manager had some part to play in an employee's work-related stress. Here, the human resources specialist may have to get involved.

Employers might be concerned that giving help to an employee (such as paying their medical bills) could be seen as an admission of liability. According to the Association of Personal Injury Lawyers' code of

practice on rehabilitation,¹³ solicitors acting for both the claimant and insurer have a duty to consider, as soon as possible, whether rehabilitation will improve an employee's long term wellbeing. Also, the Compensation Act 2006 states that an offer of treatment or other redress doesn't represent an admission of negligence or breach of a statutory duty. Therefore, employers shouldn't hesitate to give employees help to return to work, and may even get assistance from their insurer.

As part of the investigation of the incident or situation that led to an employee's absence, you should assess whether employees carrying out similar work are also at risk, and if things should be done to protect the wider workforce.

Case study 3 – Stress

Scenario

Tara, a 35-year-old clerical worker, felt she couldn't cope with her work, and visited her GP. The GP wrote out a fit note for 'stress', and signed Tara off work for two weeks.

Action

Within the first few days of absence, Tara's manager phoned her, simply to begin dialogue and show concern. The manager dealt with her sensitively, and didn't put any pressure on her by asking when she was returning to work. The manager ended the call by agreeing that they should update each other the following week if Tara hadn't returned to work.

When her manager phoned again, Tara had seen her GP and had received another fit note. At this stage, the manager asked Tara what the GP had advised and if she was waiting for treatment or counselling. Her manager also asked if they could have a chat about her illness, along with the occupational health adviser, human resources manager and someone to act as her companion (a work colleague or union representative). Tara agreed.

As a result of the conversation, it turned out that recent changes to Tara's role had been causing her anxiety, and she felt incapable of doing this aspect of her job. The occupational health adviser and the manager suggested to Tara that, when she felt better, she could return to work on a part-time basis, and that the new duties that were causing her stress would be given to someone else during that period. They also told her that she should be given training to help her carry out her new responsibilities.

Tara was happy with these recommendations. After six weeks, she returned to work on a part-time basis. Once her training was complete and her manager had checked that she felt she could cope with the work, Tara returned to work full time.

Comments

Making early contact with the employee is particularly important in cases of stress, as the risk of long term ill health is high.

Of course, not all cases are as straightforward as this, and there can be complications. For example, if the employee alleges that their manager is the cause of their stress, another manager should make and keep in contact with the employee. They should ask the employee, when they feel well enough, to send in their grievance, or arrange a meeting to start the grievance process.

In cases of severe depression or mental illness, the employee will probably need a course of treatment before the manager can discuss rehabilitation with them. Even so, it's important that the employee doesn't feel forgotten about, so the manager should still keep in touch (where necessary, via a third party such as a relative) to give reassurance and support. For more advice on what to do in such situations, have a look at the 'Line managers' resource' produced by Shift, www.shift.org.uk/employers.

Adapted from the EEF guide, *Fit for work*.

8 Stress and mental health conditions

At any one time, nearly one worker in six in the UK is affected by a clinically diagnosable mental health condition such as depression or anxiety, or problems relating to stress. And it is estimated that mental health problems account for around 40 per cent of sickness absence.¹⁴ Stress is defined on the HSE's work-related stress web pages as 'the adverse reaction people have to excessive pressure or other types of demand placed on them'. Too much or prolonged stress can lead to unhealthy physical, emotional, mental and behavioural symptoms, as well as mental health conditions such as depression or anxiety. Existing mental health conditions can also be made worse by stress.

As far as possible, absence due to stress or mental health conditions should be treated in the same way as other illnesses. When the manager first gets in touch with the employee, they should find out if they want to be contacted by them or other employees. If the employee doesn't want contact, this should be revisited tactfully at a later date. Here, it's important to follow the procedures in your sickness absence or rehabilitation policy.

Most people with mental health problems recover completely and are able to resume work successfully. Clearly, if someone's mental health condition was caused or made worse by work pressures, these need to be tackled.

As part of their treatment, sufferers can learn coping skills. These help them recognise and deal with pressure much better. They learn to tell the warning signs of possible relapses and, when this happens, the manager should discuss and agree adjustments to their work. Employees on medication may experience side effects or it may take time for them to get the right medication and dosage. In both cases, their line manager should monitor them to make sure they can do their job safely.

Before or immediately after the employee returns, they can draw up an 'advance statement' containing instructions on how they would like to be treated and who to contact if they become ill. For more information, visit Shift at www.shift.org.uk/employers/lmr/managingongoing/index.html.

There's a lot of stigma attached to mental health problems and this needs to be managed. Employers should make sure managers are well informed about mental health issues. Many conditions can be treated or controlled, and so shouldn't affect someone's ability to do their job. The employee and manager should agree about what can be communicated to work colleagues and what should remain confidential. Managers shouldn't tolerate gossip or speculation about an employee's mental health condition.

You can get more guidance on tackling work-related stress from the HSE, at www.hse.gov.uk/stress/index.htm.

For more guidance on managing mental health conditions at work, visit www.shift.org.uk. Shift also has a guide for managers on how to provide support to employees with mental health problems, at www.shift.org.uk/work/index.html.

You can get useful guidelines on counselling from the Association for Counselling at Work, www.counsellingatwork.org.uk.

9 Absence due to musculoskeletal disorders

A lot of publicity is given to work-related sickness due to stress. However, HSE statistics¹⁵ show that twice as many cases of work-related sickness absence are caused by musculoskeletal disorders (MSDs). In 2009/10, 572,000 employees who had worked in the previous twelve months reported symptoms of MSDs, of which 43 per cent related to backs and 40 per cent to upper limbs and necks.

A recent report by the Work Foundation¹⁶ shows that:

- most people affected by back pain either remain in work or return to work quickly. Evidence suggests that work can help recovery from MSDs, and that the longer an employee is away from work, the more difficult it is for them to return
- more than half the days lost through back pain are accounted for by sufferers who are absent for over a month
- there are connections between MSDs and stress – stress and anxiety can manifest themselves as MSDs, and depression and anxiety can be common side effects of prolonged MSDs
- the pain caused by MSDs affects employees' performance, including their stamina, concentration, mood, mobility and agility. Also, some medical treatments can have side effects. This needs to be taken into account when carrying out a work adjustment assessment, as it can affect safety, especially with high risk activities such as using heavy machinery or driving.

The Work Foundation also recommends employers should consider:

- early intervention – as the longer employees with an MSD are away from work, the harder it is for them to return
- focusing on capacity rather than incapacity, and using imaginative job design (taking account of good ergonomic practice) to ease the employee back to work
- thinking beyond the physical symptoms – bearing in mind that rehabilitation can aid recovery by helping the employee stay active and avoid isolation.

It's also important that employees with MSDs are given advice and guidance on how to self-manage their condition. Some organisations employ back care advisers, who can offer both employers and employees guidance on preventing and managing MSDs.

10 Maternity leave

It's easy to overlook managing return to work when women come back from maternity leave. After all, maternity leave is common, and most of the time there are no problems. However, a number of issues can affect new mothers, such as:

- a lack of confidence, after a long time away from the workplace
- the need for re-training in skills that will keep them healthy and safe
- an increased risk of stress-related illness, caused by coping with work–life balance, fatigue or anxiety about separation from their new baby
- post-natal depression, which affects about one in 10 women.¹⁷

There may be health and safety issues too – such as if the mother is still breastfeeding and returns to a job that exposes her to hazardous substances. The employer may also have to provide a room where mothers can breastfeed.

Of course, where the mother has suffered a miscarriage or her baby has been stillborn, the employer should show support and sensitivity.

As with other work absences, the manager should keep in touch with an employee who's on maternity leave, as long as the amount and type of contact isn't unreasonable. The employee and her manager should

discuss her plans for returning to work, and the employer should keep her informed of important developments in the workplace. The Work and Families Act 2006 allows women on maternity leave to work for up to 10 days during their maternity leave ('keeping in touch' days). These help reduce the risk of problems when employees return to work.

By law, employers must carry out risk assessments for new and expectant mothers. The assessment should be reviewed with the employee on their return to work. For more information, visit www.hse.gov.uk/mothers.

11 Reconciling health and safety and disability discrimination requirements

Employers have a duty under the Equality Act 2010, which replaced most of the Disability Discrimination Act (DDA). However, the disability equality duty in the DDA continues to apply. An employer has a duty to make 'reasonable adjustments' and to ensure an employee isn't put at a substantial disadvantage by employment arrangements or physical features of the workplace.¹⁸ The employee can play an active role in discussing these arrangements.

Guidance produced by the HSE and the Equality and Human Rights Commission emphasises that:¹⁹

- health and safety law and its implementation is in the interests of all employees, with or without disabilities, and of the employer
- people with disabilities should expect risk management in the workplace that's effective and enabling
- health and safety law and the Disability Discrimination Act, when used appropriately, should work together to increase the employability and retention of people with disabilities
- a positive and sensible approach to risk management can, and should, in most circumstances, encourage the inclusion of people with disabilities in the workplace
- risk assessments shouldn't focus on an individual's disability – they should look at the overall demands of the work and how best to manage the associated risk
- employers should help employees feel safe and supported to disclose and discuss the impact of the work environment on the management of their disability or long term health condition
- employees should work with employers to help them assess and manage risk, and to discuss approaches to making reasonable adjustments.

Health and safety should never be used as an 'excuse' to justify discriminatory treatment. It should be the exception rather than the rule to exclude people with disabilities from particular jobs and tasks. When you're assessing whether an adjustment is reasonable or not, you need to consider:

- how effective will it be?
- will it mean that the employee's disability is slightly less of a disadvantage, or will it significantly reduce the disadvantage?
- is it practicable?
- will it cause a lot of disruption?
- will it help other people in the workplace?
- is the cost prohibitive?

The 'Work adjustment assessment' in Appendix E (see pages 26–32) will help you decide on reasonable adjustments, taking account of potential health and safety risks.

If you give advice on risk assessments for employees with medical conditions or impairments, it's important that you fully understand the national legal requirements for disability discrimination (see Appendix B, page 23 for more information on the Equality Act). Even if the employee doesn't have a disability under the legal definition, reasonable adjustment (as required by UK law) provides a model for good practice in rehabilitation.

It's also useful to appreciate that how you perceive or define the term 'disability' affects your response to someone with a disability. For example, those with a 'medical model' mindset place an emphasis on the illness itself, focusing on a diagnosis and a cure. By contrast, today's employers and policy-makers need to apply the 'social model', looking at what the person can and can't do – the functional consequences – and focusing on using reasonable adjustments to remove or overcome barriers created by society or the working environment.

You can get more information about the social model of disability in Appendix A, page 22.

Case study 4 – Managing MSDs at a major polythene manufacturer

In 1998, a major polythene manufacturer started a rehabilitation initiative to help injured employees return to work. The organisation asked Osteopaths for Industry (OFI) to provide them with a 'musculoskeletal injury management system'. This gave them access to a national network of 3,000 osteopaths, chiropractors and physiotherapists. Each of the organisation's 40 UK sites now has an osteopath within 5 miles, and has an overview of areas where there are high rates of musculoskeletal disorders (MSDs).

The key to the success of the initiative is that OFI treats all injuries within 24 to 48 hours and oversees each case.

An employee who is injured (either at home or work) is initially assessed by a registered physical therapist, who sends a report to the organisation giving details of the injury, the estimated number of treatments needed and whether the employee is fit for normal duties, restricted duties or is unfit.

All employees who take part in the scheme sign an open disclosure form, agreeing that their personal health information can be passed to the organisation.

In 2001, the organisation arranged more than 400 treatment sessions. Each referral had an average of three treatments, and more than 75 per cent of staff treated remained in work while undergoing therapy.

Cost benefit analysis

The organisation carried out a cost analysis of the management system. For every £1 spent on the initiative, it benefited from savings of £12. So, at a cost of £16,000 in 2001, savings for the year were around £192,000.

Health and safety benefits

In 1998, before the organisation used the management system, each case of ill health caused by an MSD resulted in an average of 26 lost working days. In 1999, the first year of working with the system, this figure was down to four. The initiative has been an effective mechanism for raising the profile of health and safety generally, and has contributed to a more positive health and safety culture.

Other benefits to the organisation include:

- most employees who visit a physiotherapist are fit for work
- a substantial reduction in civil compensation claims
- a lower than expected increase in employers' liability insurance premiums
- providing staff with a positive benefit, as the service doesn't discriminate between 'at work' and 'out of work' injuries.

Adapted from

www.hse.gov.uk/sicknessabsence/casestudies/bpi.htm.

References

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- 4 CIPD. *Absence management 4: how do you deal with long-term absence?* www.cipd.co.uk.
- 5 Faculty of Occupational Medicine, Royal College of General Practitioners and Society of Occupational Medicine. *The health and work handbook: patient care and occupational health: a partnership guide for primary care and occupational health teams*. London, 2005: 5. www.facocmed.ac.uk/library/docs/h&w.pdf.
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- 13 Association of Personal Injury Lawyers. *Code of practice on rehabilitation*. Nottingham: APIL, 2003.
- 14 The Sainsbury Centre for Mental Health. *Mental health at work: developing a business case*. London: SCMH, 2007. www.scmh.org.uk/pdfs/mental_health_at_work.pdf.
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- 16 The Work Foundation. *Fit for work? Musculoskeletal disorders and labour market participation*. London: The Work Foundation, 2007. www.theworkfoundation.com/assets/docs/publications/44_fit_for_work_small.pdf.
- 17 The Royal College of Psychiatrists. www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx
- 18 Directgov. www.direct.gov.uk/en/DisabledPeople/Employmentsupport/YourEmploymentRights/DG_4001071.
- 19 HSE. www.hse.gov.uk/disability.

Further reading

You may find the following publications and web links useful.

Chartered Institute of Personnel and Development

Rehabilitation, recovery and retention: maintaining a productive workforce.
www.cipd.co.uk

Department for Communities and Local Government

Fire safety risk assessment – means of escape for disabled people
www.communities.gov.uk/publications/fire/firesafetyassessmentmeans

Department for Work and Pensions

Building capacity for work: a framework for vocational rehabilitation.

Health, work and well-being – caring for our future: a strategy for the health and well-being of working age people.
DWP, Department of Health, HSE.

Disability and the Disability Discrimination Act

www.dwp.gov.uk/employers/dda
www.direct.gov.uk/disability

Disability, health and employment: a short guide for small and medium sized employers.

Disability Rights Commission,
www.equalityhumanrights.com

Top tips for small employers: a guide to employing disabled people. Disability Rights Commission.

www.equalityhumanrights.com/uploaded_files/Employers/top_tips_for_small_employers_emp5.pdf

EEF

Managing sickness absence – A toolkit for changing work culture and improving business performance.

www.eef.org.uk/UK/preview/guidance/allmembers/Managing_Sickness_Absence_-_A_toolkit_for_changing_work_culture_and_improving_business_performance.htm

Fit for work: the complete guide to managing sickness absence and rehabilitation.

www.eef.org.uk/UK/preview/guidance/allmembers/publication30032004.htm

Equality and Human Rights Commission

www.equalityhumanrights.com

European Agency for Safety and Health at Work

Ensuring the health and safety of workers with disabilities. Factsheet 53.
osha.europa.eu/good_practice/priority_groups/disability/links.php

Health and Safety Executive

www.hse.gov.uk/disability
www.hse.gov.uk/stress/index.htm

Managing sickness absence.

www.hse.gov.uk/sicknessabsence

Managing sickness absence and return to work: an employers' and managers' guide. (HSG249).

Managing sickness absence in the public sector. Cabinet Office, DWP, HSE.

On health, safety and productivity

- *Guidelines for boards,*
www.hse.gov.uk/services/pdfs/boardguidelines.pdf
- *Diagnostic tools for handling sickness absence,* www.hse.gov.uk/services/pdfs/diagnostictools.pdf

Ministerial Task Force on Health, Safety and Productivity, Cabinet Office, DWP, HSE.

IOSH

www.ohtoolkit.co.uk

Jobcentre Plus: Access to work

www.jobcentreplus.gov.uk/jcp/employers/advisoryservices/diversity/dev_015798.xml.html

www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4000347

National Institute for Health and Clinical Excellence

Management of long-term sickness and incapacity for work guidance.

SHIFT

Line managers' resource: a practical guide to managing and supporting people with mental health problems in the workplace.

www.shift.org.uk/employers

TUC

www.tuc.org.uk

Workboost Wales

www.workboostwales.org.uk

Other references

Vocational rehabilitation: what works, for whom, and when? Waddell G, Burton A K and Kendall N A S. Norwich: The Stationery Office, 2008.

Work and health. Waddell G and Burton A K. Norwich: The Stationery Office, 2006.

Work matters. College of Occupational Therapists and National Social Inclusion Programme. London, 2007.

www.cot.co.uk

Training

IOSH offers a range of Continuing Professional Development courses, including 'Rehabilitation – the cost benefits of effective sickness absence management', 'Managing musculoskeletal disorders', and 'An introduction to cognitive behavioural therapy'. For a full list of courses and more details, visit www.iosh.co.uk/pdprogramme.

The University of Nottingham offers an MSc course in workplace health that meets the needs of the occupational safety and health practitioner – see www.nottingham.ac.uk/iwho/workplacehealth.

EEF runs sickness absence seminars and courses on 'Long term sickness absence and ill health – when to rehabilitate and/or dismiss?'. For more information, visit www.eef.org.uk.

Appendix A – The social model of disability

Some people make a common mistake when they assess what an employee with a disability or impairment can or can't do – they make assumptions based on that disability or impairment. They see the person with the disability as the problem. This is called the 'medical model of disability'.* Under this model, employees with certain medical conditions, such as epilepsy, would be automatically prevented from carrying out certain work, regardless of the stability of their condition.

The 'social model of disability'[†] considers that it's the barriers created by society or the environment that disable the employee. If the environment is adapted or policies are changed to allow equal access by an employee with an impairment or medical condition, they will not, in effect, be disabled. This model focuses primarily on the barriers to working, rather than assumptions or stereotypes about the individual with an impairment or medical condition.

In the context of the social model, terminology can have the following usage:

- disability: disadvantage experienced by an individual resulting from barriers to independent living, education, employment, attitude and so on
- impairment: long term characteristics of an individual that affect their functioning or appearance
- ill health: short or long term consequences of disease or sickness.

The easiest way to apply the social model of disability is to focus on the needs of the individual. This means asking the employee about what's preventing them from working and what would help them come back. Using the epilepsy example, many people are able to control their condition with medication. Speaking to the employee and, where necessary, getting confirmation from their GP or an occupational health specialist, is the best approach.

There will always be some work that employees with certain impairments and conditions won't be able to do. They will know this. Those who have lived with an impairment for some time will probably be in the best position to give advice on the kinds of adjustments that can be made and the organisations that can advise on specialist equipment. If the impairment is recent, part of the rehabilitation process may be for the employer to help put the employee in touch with organisations that can help them. You can get a list of these organisations on the IOSH Occupational Health Toolkit website, www.ohtoolkit.co.uk. You'll also find some of these organisations listed in the 'Further reading' section (page 20).

It's best to consider health and safety issues as part of the general assessment of the employee's 'work adjustment' needs. It's also important to consider the impact that an employee returning to work can have on their colleagues. If you give some of the employee's tasks to other employees, or medication increases the risk of the employee having an accident, other employees may be put at higher risk.

We've included a tool in this guidance to help assess health and safety and general work adjustment needs (see Appendix E, pages 26–32). In most cases, health and safety shouldn't be a reason why employees can't return to work. If the risk assessment identifies areas of concern that can't be addressed, after having a discussion with the employee, the manager should:

- get an assessment from an appropriate competent person, such as an occupational safety and health practitioner or an occupational health adviser
- decide whether the risk level is acceptable, or whether it's substantial and not reasonably practicable to control, ie most people would consider it prohibitively expensive or difficult, given the circumstances.

If the risks can't be controlled, the manager should consider giving the employee other duties.

Dismissing an employee on health and safety grounds would only be justifiable if it could be shown that all other options had been considered and that it wasn't reasonably practicable for the employer to control the extra risk.

* For more information on the medical and social models of disability, see Rieser R. *The social model of disability, inclusion.uwe.ac.uk/inclusionweek/articles/socmod.htm*.

[†] Barnes C and Mercer G. Disability, work, and welfare: challenging the social exclusion of disabled people. *Work, Employment and Society* 2005; 19 (3): 527–545.

Appendix B – Equality Act 2010

Outline

The Equality Act 2010 applies to all employers and everyone who provides a service to the public, except the Armed Forces. The Act states that it's unlawful for an employer to discriminate against a job applicant or employee who has a disability as defined under the Act. Employers, therefore, have to consider what reasonable adjustments they can make to help the employee work for them.

Under the Equality Act 2010 a person has a disability if:

- they have a physical or mental impairment
- the impairment has a substantial and long term adverse effect on their ability to perform normal day-to-day activities.

For the purposes of the Act, these words have the following meanings:

- 'substantial' means more than minor or trivial
- 'long term' means that the effect of the impairment has lasted or is likely to last for at least 12 months (there are special rules covering recurring or fluctuating conditions)
- 'normal day-to-day activities' include everyday things like eating, washing, walking and going shopping

There are additional provisions relating to people with progressive conditions. People with HIV, cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairments are automatically deemed to be disabled.

Some conditions are specifically excluded from being covered by the disability definition, such as a tendency to set fires or addictions to non-prescribed substances.

Source: www.direct.gov.uk/en/DisabledPeople/RightsAndObligations/DisabilityRights/DG_4001068

Reasonable adjustments

Employers have a duty to make reasonable adjustments for a job applicant or employee with a disability when a policy or practice, or a physical feature of their premises, places that person at a substantial disadvantage.

When deciding on the sort of adjustments that are likely to be reasonable for their company, employers should consider:

- the type of business they run
- the size of the business and annual turnover
- the cost of the adjustment
- the disruption that would be caused while the work is carried out
- how practicable it is to carry out the adjustment
- the potential benefits to employees with disabilities.

Examples of reasonable adjustments include:

- making changes to premises
- altering the employee's working hours
- allowing the employee time off for medical treatment during working hours
- giving the employee extra training
- getting special equipment or modifying existing equipment
- changing instructions or reference manuals
- giving the employee extra supervision and/or support.

Help from Shaw Trust

Shaw Trust is the UK's largest not-for-profit employment organisation, providing training and work opportunities for people who are disadvantaged in the workplace due to disability, ill health or social circumstances. As well as offering advice and support to employees, they help employers hire and rehabilitate people with disabilities, and have a 'Staying in work' service that employers can use to help them manage absence and retain staff. For more information, visit www.shaw-trust.org.uk.

Help from Access to Work

As well as offering practical advice to people with disabilities, employers can get a grant from Access to Work of up to 100 per cent to pay towards any extra employment costs that result from a person's disability.

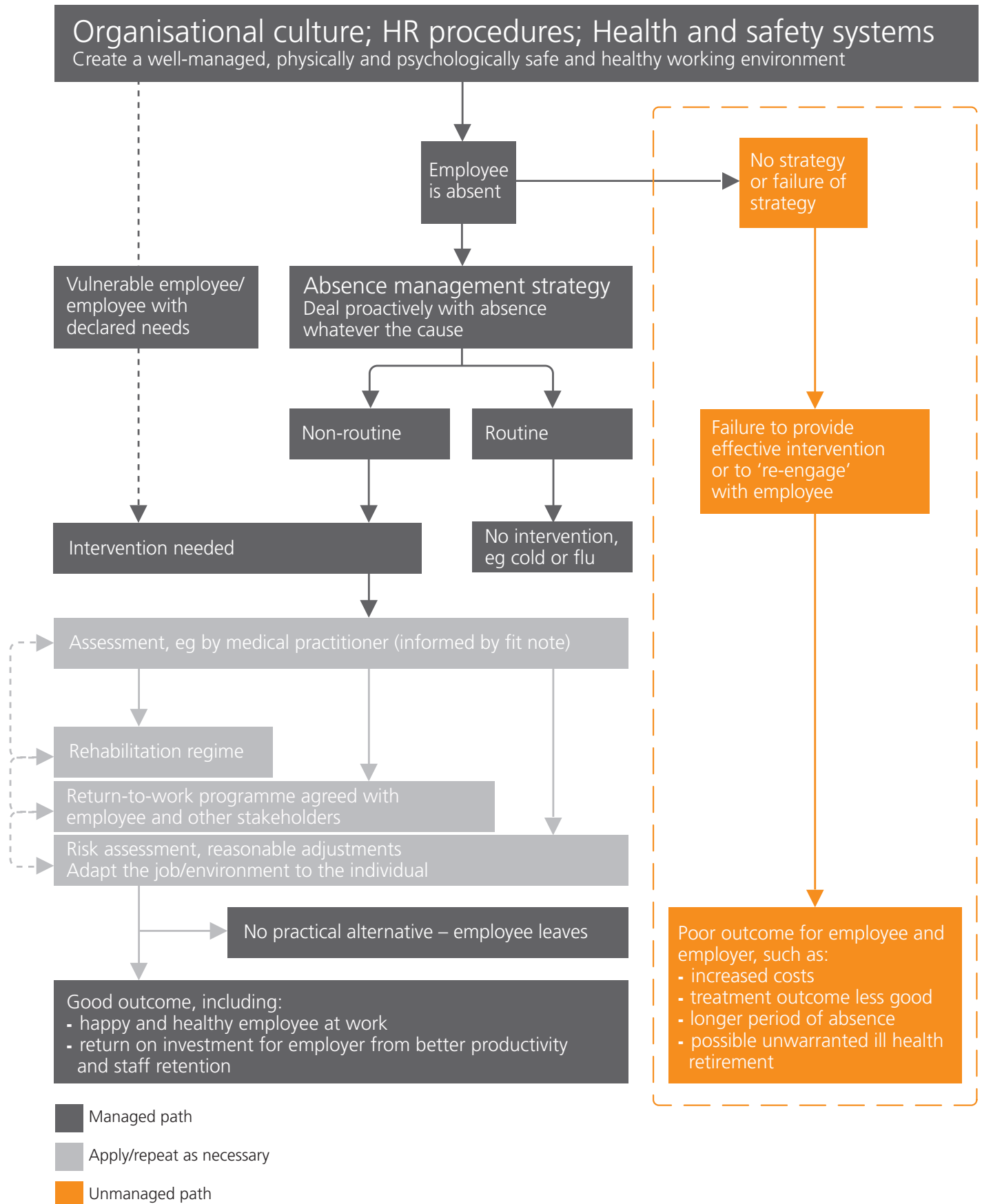
Access to Work can help employers pay for adjustments such as:

- special equipment – to help employees with disabilities function in the workplace
- adapting premises or equipment
- help with the cost of travel to and from work for people who can't use public transport.

For those already in work, the grant is up to 80 per cent of the costs above £300.

For more information, visit www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4000347.

Appendix C – Absence management model



Appendix D – 12-point action plan for occupational safety and health practitioners

- 1 Promote the benefits of work (in a safe and healthy environment) to the wellbeing of employees, including those with common health problems.
- 2 Recommend a rehabilitation policy for your organisation.
- 3 Promote early contact with absent employees and regular case review meetings.
- 4 Put forward a cost-benefit-based argument for buying in good occupational health advice.
- 5 Suggest that employees with musculoskeletal disorders and stress-related conditions are referred early, or help employees to get medical treatment – such as physiotherapy or cognitive behavioural therapy – to aid fast recovery.
- 6 Tackle the myths around rehabilitation – in particular, challenge people who use ‘health and safety’ as an excuse for not considering rehabilitation.
- 7 Give help and support to your managers by helping them carry out risk assessments of employees who come back to work.
- 8 Assess the individual not the illness – don’t make assumptions about an employee’s capabilities based on your perception of their health. In other words, take a holistic view and don’t focus on the medical condition.
- 9 Focus on what the employee can do and how barriers to their return to work can be removed.
- 10 Get help from medical professionals or organisations that specialise in the employee’s disability. They will have a better understanding of their condition and can advise on aids that may support their return to work.
- 11 Assess whether measures put in place to help an employee return to work would also benefit other workers exposed to the same hazards.
- 12 Don’t forget that prevention is best – include rehabilitation as part of a wider strategy on employees’ health and wellbeing. The aims of the strategy should be to tackle the causes of work-related ill health and injury, get involved before absence occurs, and – through health promotion – encourage employees to take responsibility for their own health.

Appendix E – Work adjustment assessment

This section outlines the steps that should be taken to assess the work adjustment needs of an employee with a medical condition or impairment before they've been rehabilitated or given new duties.

Who should carry out the assessment?

The assessor should normally be the employee's line manager, as they have a good understanding of the nature of the work. The employee should be involved in the assessment, as they will know how the condition or impairment might affect their work. By focusing the assessment on the needs of the individual, it's more likely that the employee will support the rehabilitation process. It will also reduce the risk of discrimination.

Specialists such as occupational health or occupational safety and health practitioners should give advice when needed.

Why is an assessment needed?

An assessment is needed because the line manager may have to:

- make changes so that certain aspects of the work are accessible to the employee
- make adjustments to the work or workplace to help the employee work safely and not put others at risk.

The assessment process will help the assessor make an informed decision about what adjustments are needed and whether they would be reasonable. The assessor should back up their decisions with formally documented evidence. This will minimise the risk of not meeting employment, health and safety, age and disability discrimination requirements.

What information will the assessor need?

The employee should discuss their needs and possible access issues, but can withhold confidential information about their condition or impairment. The assessor may need a medical report, preferably from an occupational health adviser who has an understanding of the nature of the employee's work, although there may be enough information in the GP's medical certificate. The report should give recommendations about what the employee can and can't do, if any modifications to the work are needed, and may include suggestions for more help and support. These will form the basis of the assessment. The assessor and the employee have detailed knowledge about the job, and both should have a close look at the nature of the work to decide if any adjustments are needed.

When the assessor carries out the assessment, they will need:

- the job description and/or person specification
- where necessary, a medical report describing any restrictions or adjustments
- a 'Work adjustment assessment form' (see page 29) – for complex work, the assessor may have to divide the work into several manageable chunks
- records of risk assessments that have already been carried out, as well as codes of practice and other safe working procedures relating to the work
- risk assessment forms or checklists for specific areas, such as for manual handling or work with computers
- the assessment guidance at the end of this appendix (see pages 30–32).

Can an assessment be carried out if there is no medical report?

In some cases, the assessment will be straightforward and can be carried out by the manager and employee without a medical report. During the assessment, if the manager or employee becomes concerned about the employee's ability to carry out a task and needs a medical opinion, they should speak to an occupational health adviser or the employee's GP.

Are there any confidentiality issues?

Information about an employee's impairment or medical condition should be kept confidential, unless the employee has consented (with a signature) to the information being passed to others. The manager and employee should agree what can be communicated.

Carrying out the assessment: a step-by-step guide

Using the form on page 29:

- 1 Record the work being assessed and where the employee will be based**
- 2 Record the name of the employee**
- 3 Record the name of the person carrying out the assessment**

4 Record any barriers to working

To identify the potential barriers to working, use the assessment guidance tables (see pages 30–32), the job description and/or person specification, and any information given in the medical report or by the employee.

5 Identify any health and safety concerns

There should already be control measures in place for general risks, so the assessment only needs to focus on extra risks relating to retaining or appointing the employee.

To identify hazards and assess risks, the assessor needs to take account of information in existing risk assessments and health and safety codes of practice, as well as the sources of information listed on pages 19–20.

They should assess the hazards from:

- the work environment
- the use of work equipment
- the use of or exposure to dangerous substances or agents
- the work activity, including interaction with other people
- the employee – if the condition or medication may affect their behaviour
- emergencies – suitability of fire and first aid facilities for the employee.

The assessor must also identify who is at risk. This would normally be the employee only, although some medical conditions and impairments can affect the health and safety of other employees, as well as customers and contractors.

For some activities, such as using computers or manual handling, the assessor may have to use the employer's existing risk assessment format to carry out an individual assessment that takes account of the employee's impairment or condition.

6 Identify the measures needed to improve access and minimise risk

These will normally be actions that the employer and employee can take, without the need for significant extra resources. This may involve, for example:

- adapting the work of the employee or team, so that the employee doesn't need to do certain tasks
- changing the employee's working hours
- adapting the workplace or providing specialist equipment
- providing extra support, such as help with travelling
- revising certain practices, such as emergency procedures.

If the cost of adjustments is likely to be more than £300, the Access to Work scheme (UK only) may be able to help (see Appendix B, page 23).

The assessor must carry out high or medium priority actions before the employee can return to work, unless they can introduce short term measures that reduce health and safety risks to an acceptable level.

7 List any barriers or concerns that haven't been resolved through reasonable adjustments

The assessor should record any concerns they've been unable to resolve. This may be because of a lack of information or expertise, or there may be major cost implications, such as changes to the premises. The assessor needs to decide how much of a priority these issues are in respect of allowing a safe return to work, and then get advice on these areas before they begin step 8. They might have to speak to an occupational health adviser, occupational safety and health practitioner, building surveyor, or someone who can give them more specialist advice on access to work or specialist equipment, such as a disablement resettlement officer or disability employment adviser.

8 Decide whether the work is, or can be made, compatible with the employee's condition or impairment

If the assessor hasn't been able to deal with medium and high priority concerns because reasonable adjustments can't be made, it may not be possible to rehabilitate the employee into their existing job. This could then involve redeploying them temporarily or permanently or, failing that, retiring them on the grounds of ill health or incapability. If the work isn't compatible with the employee's condition or impairment, the assessor should record the reasons.

The assessor should make sure they've explored all possible solutions before making their final decision, and keep a copy of the assessment. If they're proposing a permanent change to an employee's duties, or retirement, the employee should be referred to the employer's occupational health adviser. Such decisions should not be based purely on the GP's assessment.

9 Agree action

If reasonable adjustments can be made, the line manager should agree with the employee what action will be taken, who will take it and when. The line manager should make it clear what must be done before the employee can return to work.

The line manager should agree with the employee what information can be shared with work colleagues. While confidentiality is important, work colleagues can become resentful if they think that an employee on restricted hours or duties is being paid the same as them, unless the reasons are explained. A lack of information can also lead to gossip or conjecture about the employee's condition. This can be a particular problem if the employee has had a mental health condition.

10 Signatures

Once the manager and employee have agreed to the assessment and the action to be taken, both should sign and date it. If they can't agree, they can get advice from a human resources specialist.

Depending on the circumstances, the employee may want to discuss the implications of the assessment with someone else, for example an employee representative, before they sign the assessment.

11 Record the date for the interview

The assessor should agree a suitable date to formally review the assessment, to make sure actions have been taken and are effective. This should be within the first three months of the employee's return to work.

12 Continue to support the employee

The manager should tell the employee how their progress will be monitored. One way of achieving this is for the manager to get a fellow employee to act as a mentor.

Everything should be done to make sure the employee feels welcome when they return to work, and that other employees are treating the employee well.

If the measures put in place don't work, or if the employee's condition changes, the line manager and employee should agree a realistic way forward, for example redeployment.

Work adjustment assessment form

Location and work assessed		
Name of employee		
Name of manager carrying out the assessment		
Potential barriers to working <i>See the guidance tables, as well as the information provided by the occupational health service and employee</i>		
Health and safety concerns <i>Indicate what the risks are and who is at risk – use the guidance tables on the next three pages, as well as the information provided by the occupational health service or employee</i>		
What measures are necessary to help the employee return to work and to minimise risks? <i>List the adjustments that can be put into place to address potential barriers and concerns</i>	Priority <i>High, medium, low</i>	
List any barriers or concerns you've not been able to resolve through reasonable adjustments (seek specialist advice, as required)	Priority <i>High, medium, low</i>	
Taking the above into account, is the work compatible with the employee's condition or impairment?		
<input type="checkbox"/> Yes <input type="checkbox"/> Yes, once agreed action has been taken <input type="checkbox"/> Possibly, but more advice is needed <input type="checkbox"/> No <i>If no, give reasons:</i>		
Agreed action	By who?	By when?
Signatures		
Manager:	Employee:	
Date of assessment	Date of review	

Work adjustment assessment – guidance

Work demands – possible barriers	Examples of work aspects affected	What you can do <i>These are suggestions only – consider the employee, work, equipment and environment</i>
Work that needs good speaking or hearing skills	<ul style="list-style-type: none"> ▪ Work involving a high level of face-to-face or telephone communication with other employees, customers and so on, such as giving presentations, attending meetings, reception work ▪ Work that needs an understanding of complex verbal information ▪ Work in hazardous areas where good communication is essential ▪ Emergency warnings, eg fire alarms 	<ul style="list-style-type: none"> ▪ You may be able to get equipment from Access to Work, specialist organisations or charities ▪ Draw up a personal evacuation plan
Work that needs good writing or reading skills	<ul style="list-style-type: none"> ▪ Reading and understanding complex information ▪ Writing documents ▪ Work that needs an understanding of complex safety instructions 	<ul style="list-style-type: none"> ▪ You may be able to get equipment from Access to Work, specialist organisations or charities ▪ Give the employee information in a form they can easily understand
Work that needs good eyesight	<ul style="list-style-type: none"> ▪ Hazardous environments, such as roads, construction sites, workshops or warehouses ▪ Using equipment where good eyesight is essential, including driving vehicles or operating mobile work platforms ▪ Work where you need to be able to distinguish between colours ▪ Work involving computers or other display equipment 	<ul style="list-style-type: none"> ▪ You may be able to get equipment from Access to Work, specialist organisations or charities ▪ For safety reasons, you may need to give the employee new duties
Environmental factors <ul style="list-style-type: none"> ▪ Design, layout and location of building and work area ▪ Suitability of furnishings 	<ul style="list-style-type: none"> ▪ Workplace layout and access to work areas and facilities ▪ Escape in emergencies ▪ Access to welfare facilities ▪ Work in areas where there is no control on the environment or workplace, eg working outdoors 	<ul style="list-style-type: none"> ▪ If you want to make physical changes to the workplace, get advice from a building surveyor or specialist in access to work ▪ Visit www.communities.gov.uk/publications/fire/firesafetyassessmentmeans for information on evacuation plans for employees ▪ Relocate the employee to a more accessible area ▪ Give some of the employee's tasks to other employees, or get someone to help them with their duties ▪ You may be able to get help with funding from Access to Work
Lone working <ul style="list-style-type: none"> ▪ Consider whether the employee would be at increased risk, eg because they have a significantly greater likelihood of needing emergency medical support or more difficulty telling others that they need help 	<ul style="list-style-type: none"> ▪ Visiting remote sites alone ▪ Working alone in remote parts of premises ▪ Working while suffering from a medical condition that, if uncontrolled, could start suddenly, eg epilepsy 	<ul style="list-style-type: none"> ▪ Give some of the employee's tasks to other employees, or get someone to help them with their duties ▪ Provide an emergency communication aid, eg mobile phone or two-way radio

Work demands – possible barriers	Examples of work aspects affected	What you can do <i>These are suggestions only – consider the employee, work, equipment and environment</i>
Work that needs good stamina, concentration or alertness	<ul style="list-style-type: none"> - Work in hazardous environments - Work where safety skills are critical - Work that needs good perception and understanding of hazards - Driving or operating hazardous equipment - Working at height 	<ul style="list-style-type: none"> - If you have any medical concerns, see 'Medical issues' (page 32, last row) - Give the employee new duties - Give some of the employee's tasks to other employees - Reduce the amount of time the employee spends on hazardous tasks, or increase the number of rest breaks - Make changes to hazardous equipment – you may be able to get help from Access to Work, specialist organisations or charities - You may be able to get funding from Access to Work for taxis or a driver
Work where exposure to hazardous substances or other agents can put the employee at greater risk	<ul style="list-style-type: none"> - Potential exposure to hazardous dusts (eg wood dust), chemicals, biological hazards (particularly respiratory and skin sensitisers), noise, vibration - The employee may have a medical condition that makes them more at risk from sensitising agents. (Labels on some chemical bottles say 'may cause sensitisation'.) - The employee may be unable to use conventional personal protective equipment 	<ul style="list-style-type: none"> - Review your risk assessments for the use of or exposure to hazardous substances and agents - Follow the advice on suppliers' hazard data sheets - Find out if suppliers have alternative types of protective equipment - Reduce the period of exposure - Introduce or increase health surveillance - Give some of the employee's tasks to other employees or, if necessary, give the employee new duties
<ul style="list-style-type: none"> - Physically demanding work - Work that needs dexterity or involves repetitive tasks - Work that needs mobility 	<ul style="list-style-type: none"> - Work involving lifting, bending, static postures or prolonged repetitive movements - Using computers - Work that involves moving to use equipment, facilities or interact with other people 	<ul style="list-style-type: none"> - Review risk assessments for manual handling and computer and other display equipment - Assess the impact of giving the work to other employees - Reduce physical work, provide more rest breaks or work rotation, provide specialist equipment - Go to www.hse.gov.uk/msd for guidance on managing musculoskeletal disorders and www.hse.gov.uk/humanfactors for guidance on managing ergonomic factors - Relocate the employee, adjust the work layout or arrangements, or provide alternative tasks

Work demands – possible barriers	Examples of work aspects affected	What you can do <i>These are suggestions only – consider the employee, work, equipment and environment</i>
Work where the employee has to travel	<ul style="list-style-type: none"> - Visiting other places, buildings or remote sites - Working in the community - Driving, including to and from work 	<ul style="list-style-type: none"> - If the employee can't drive or use public transport, Access to Work may be able to help with transport arrangements - Find out if the employee's medication has any side effects
<p>Psychological hazards</p> <ul style="list-style-type: none"> - Employees who return to work after a stress-related or mental illness often have poor stamina, a reduced ability to concentrate and short term memory problems 	<ul style="list-style-type: none"> - Work in potentially stressful situations, eg child protection, responding to emergencies - Working where the main sources of stress are present – for more information on the sources of stress, see the HSE stress management standards at www.hse.gov.uk/stress/standards/index.htm 	<ul style="list-style-type: none"> - Use the HSE stress management standards as a basis for discussing with the employee the work-related stressors that affect them, and how these could be changed or accommodated - Make sure the employee doesn't return to a heavy workload or lots of unanswered emails - Get someone to help the employee with their duties - If you have any medical concerns, see 'Medical issues' in the row below - Review the procedures for dealing with violence in the workplace, and for supporting those required to work in stressful situations - If the employee has a mental health condition, consider asking them to draw up, with their manager, an 'advance statement' covering symptoms of relapses, who to contact and what support they may need – get advice from Shift at www.shift.org.uk/employers/lmr/managingongoing/index.html
<p>Medical issues</p> <ul style="list-style-type: none"> - The employee may: <ul style="list-style-type: none"> ▫ be taking medication that has side effects ▫ be suffering from a chronic lack of sleep that could cause fatigue ▫ need to be near welfare facilities ▫ need to have hospital or other medical appointments 	<ul style="list-style-type: none"> - Working in environments where it may be difficult to get emergency medical support, eg lone working, remote working, working outdoors, work that involves lots of travel - Working in hazardous environments, or with dangerous work equipment 	<ul style="list-style-type: none"> - Speak to the employee about telling first aiders and work colleagues about their medical condition, and what they can do if the employee has an emergency or relapse - In some cases, the employee may be able to provide contacts for more advice about medical support and training for specific conditions - Provide employee with flexible hours and time off for appointments

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