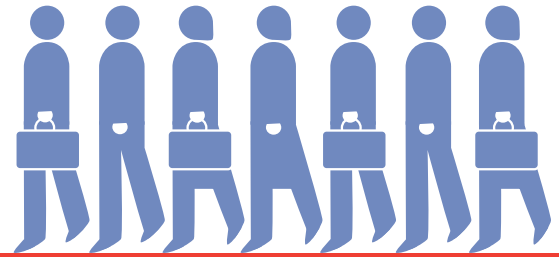


The Health and Work Handbook



Patient care and occupational
health: a partnership guide for primary
care and occupational health teams



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Foreword

Work is important for people. The best way to achieve economic independence, prosperity and personal fulfilment, it also helps reduce health and social inequalities. Due to changing demographics, having more people in work is also increasingly important for communities and our economy. The health and wellbeing of people of working age is therefore of fundamental importance to our future.

Every week around 1 million people report sick. 3000 of those will remain off at 6 months and 2,400 will not work again in the next 5 years. After 2 years on Incapacity Benefit an individual is more likely to retire or die than return to work. Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury is essential if we are to reduce absence and prevent people becoming dependent upon benefit. The workplace also provides an environment where people can be provided with the support and encouragement to take responsibility for improving their own health. Success will depend on all those who in any way contribute to the health and wellbeing of working age people working together.

Primary care teams and occupational health professionals have a central role to play in this. Patients view their GP as their first point of contact when health problems arise and trust their advice and guidance. They are well placed to offer simple fitness for work advice to their patients and to provide the focused support necessary to assist their recovery and retention in work. Occupational health professionals can provide more specialist advice and support in developing return to work programmes, which will ensure not only that those individuals can return to work, but that such return can be sustained. It is clear that close working and effective communication between both groups is essential if we are to ensure the best outcome for patients, their families, their employers and our society.

The Health and Work Handbook will help to focus both primary care teams and occupational health professionals on the role they can play and the major contribution they can make to helping keep people in work, with all the advantages that brings. For the benefit of all those in work or seeking to return to work, I hope you will read it carefully.

Dr Bill Gunnyeon
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Section 1 Introduction

This is a handbook for primary care and occupational health teams who care for and advise patients of working age.

Why is the relationship between health and work so important in patient care? For the general practitioner (GP) and primary care team, the key questions are:

- is your patient's job making them ill?
and
- is your patient's health status adversely affecting their capacity or fitness for work?

In tackling these questions in relation to the care of a patient, primary care and occupational health teams need to bear in mind several important points:

- Injury, illness and disability do not necessarily equal inability to work (although the patient may have a different view)
- Long term sickness absence can lead to job loss, long term dependency on state benefits, poor self esteem and loss of personal confidence
- 'Worklessness' (being unemployed or economically inactive and in receipt of working age benefits) causes poor health and health inequality, and this effect is still seen after adjustment for social class, poverty, age and pre-existing morbidity. The age-standardised rate for the long-term unemployed who rate their health as 'not good' is three times the rate for those in higher managerial and professional occupations. People who have never worked have the highest rate of chronic health problems, six times higher than the rate for those in higher managerial and professional occupations¹
- People who are out of work experience poorer mental health than those in employment. They make increased use of GP and hospital services and use more prescribed medication
- Anxiety and depression are two to three times more common amongst unemployed people². It has been reported that, if unemployment lasts longer than 1 year, they experience 8 times the levels of psychological ill-health of those in work
- Being out of work can lead to increased smoking³, consumption of alcohol⁴, use of illicit drugs and risk taking sexual behaviour⁵
- At both individual and population levels, worklessness leads to increased mortality rates

- Only 21% of people with mental health disability are in employment compared to 50% of people with disabilities generally, and 75% of the working age population⁶
- Many of the 400,000 people on Incapacity Benefit want to work, and could do so if they had support⁷
- The negative effects of unemployment are reversible on re-entry to work

The primary care team has a vital role in reducing absence and unemployment related to health issues:

- Where health problems may be affecting fitness for work, what the GP and the community team say to the patient is vitally important. Positive messages about the right work being an enhancer of health can be conveyed to patients
- The GP can direct the patient towards sources of help and advice to help them return to work
- Where work might be affecting health, the primary care team can spot work-related ill-health early enough to intervene and prevent irreversible problems arising
- Contact and communication between primary care and occupational health teams can reduce the risk of ill-health leading to long-term absence and unemployment

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Section 2

Roles, responsibilities and ethics

1. Roles

- Professional roles differ between primary care and occupational health practice. In patient care, the role of the doctor and nurse includes diagnosis and treatment, and may require giving impartial opinions. GPs, community nurses and other primary care professionals are usually acting in a therapeutic role, while occupational health professionals are more frequently required to give an impartial opinion to third parties (e.g. employers)
- While primary care teams have a responsibility for comprehensive and continuing care, occupational health teams are mainly responsible for advising employees and employers on fitness for work and on the potential for work to cause illness
- Primary care teams take the needs of family and the local community into account, while occupational health teams consider the health and safety of the workforce and members of the public, and the needs of the employer
- Both primary care and occupational health teams promote good health and aim to prevent disease. Developing opportunities to work together helps to ensure patient well-being. In recognizing that a return to work improves health outcomes in the long-term, primary care teams have an important role in encouraging patients to remain at work, or return to employment (see Section 5)
- Primary care and occupational health teams have access to different resources, all of which are important components of care. Primary care teams can access local health and social services while occupational health teams have access to employers' resources, including: managers with responsibility for health and safety, human resource and training departments and (sometimes) welfare officers or employee assistance programmes
- Occupational health teams should refer employees to their GP for confirmation of diagnosis (if this is not clear), or where treatment for health problems is appropriate. Similarly, where possible, GPs and practice nurses should refer employees with suspected work-related conditions to an occupational health professional
- Occupational health teams advise employees and employers on:
 - the results of risk assessments of workplace exposures that might cause health problems, and measures to control workplace health risks

- the impact of the working environment and workplace hazards on the employee's health
 - the results of health surveillance for work-related illness in terms of necessary restrictions or adjustments to work
 - the impact of the employee's health on their ability to work, the date of a likely return to work, measures to help rehabilitation to work or redeployment, and any permanent or temporary adjustments to their job in relation to the Disability Discrimination Act 1995
 - statutory requirements such as reporting specified work-related conditions under the Reporting of Injuries and Dangerous Occurrence Regulations 1995 (RIDDOR)
- GPs and occupational physicians have roles in providing access to benefits for those who cannot undertake work for the foreseeable future. GPs issue sick notes (see Section 4), and primary care and occupational health teams can advise employees to seek other benefits (e.g. Disability Living Allowance, Industrial Injuries Benefits).
 - GPs may be asked to provide information on health conditions and prognosis for interpretation to occupational physicians or independent assessors with regard to an employee's eligibility for ill-health retirement benefits. In this role, occupational physicians do not act on behalf of the employee, but for the pension fund / trustees.

Frequently asked questions

My patient may have a work-related illness. His current job may make this condition worse. I am aware that there is an occupational health department in the patient's company. What should I do?

Contacting the occupational health department, with your patient's consent, facilitates confirmation of the diagnosis, but more importantly, will initiate an investigation into whether your patient's job is potentially harmful to his or her health. Adequate controls may already be in place to reduce the risks to health to low levels. However, it may be that additional measures can be put in place to reduce risk still further. Health surveillance (screening other workers for signs and symptoms of ill-health) may be started by the occupational health department to monitor your patient's condition, and to look for other similar cases.

In June 2005, the University of Manchester launched an occupational health surveillance scheme entitled THOR-GP (The Health and Occupation Reporting network - General Practice), funded by the Health & Safety Executive. This project collects limited data from GPs on the incidence of occupational disease or work related ill-health in their patients. The scheme is open to reporting from GPs who have at least a Diploma in Occupational

Medicine. If you are interested in becoming a reporter of occupational disease in your practice, further information is available at:

www.coeh.man.ac.uk/thor/thorgp/

2. Responsibilities

- As well as having varying and complementary roles, primary care and occupational health teams have specific professional responsibilities, usually related to their 'duty of care'. A doctor or nurse has a legal obligation not to harm a patient physically or psychologically through carelessness
- A doctor or nurse giving an impartial opinion is under a duty to do so competently. This will require:
 - obtaining all relevant information (such as GP or specialist reports)
 - taking into account the views of all relevant parties
 - ensuring the opinion is honest, objective, equitable, accurate and supportable
- Doctors have a duty to act in the best interests of patients/employees, mindful of their responsibilities to all parties: individuals, other workers, society, and the requirements of the law
- Occupational health professionals often act in difficult circumstances where there are conflicts between an employer and employee. It is essential that their opinions are impartial and fair, and are seen to be so. Primary care teams are less likely to be involved in these areas, but must also be aware of the need to be impartial, and not to express opinions that are not objective

3. Confidentiality

- Primary care and occupational health teams are bound by a duty to respect the confidentiality of patient/employee information. Both are required to comply with the requirements of the General Medical Council, the Nursing and Midwifery Council and other professional bodies. Additionally, there is a duty to respect patients' human rights. Occupational health services treat individual occupational health records in the same way as personal medical records held by GPs. Employees' rights of access to health information are detailed in the Data Protection Act (1998) and its associated Code (Part 4: Information about Workers' Health). The Freedom of Information Act 2000 may affect what health care associated information is available in the public domain from hospitals and other public bodies, but will not affect patient confidentiality

- When occupational health professionals give advice to an employer they will not normally refer to clinical details. An occupational health practitioner may state that an employee is fit, unfit or that restrictions are required, but the employer does not need to know the clinical details behind that advice, except with the written consent of the individual, if it is considered essential in the particular situation
- Exceptionally, where it is in the public and/or workforce interest, and the individual refuses unreasonably to consent, disclosure without consent can be made. If this ever happens, the doctor or nurse will have to be prepared to justify the breach of confidentiality to their professional body and also in Court. This applies to both primary care and occupational health teams
- Health surveillance may be a problematic area for occupational health services, as this is carried out because there is a residual risk that exposures to chemical, physical or biological hazards at work may cause ill-health. Such surveillance may be a statutory requirement. Prior to surveillance there must be an agreement between the employer and employees, with a clear understanding of the purpose, context, and information to be provided, and the possible outcomes. Employees are usually required to attend for surveillance as long as they remain in a particular job. If they refuse to attend or to allow the results on their fitness for work to be given to the employer, they may no longer be allowed to undertake their role. This may be necessary so that the employer can meet their duty of care
- A doctor carrying out a pre-employment medical assessment does **not** owe a specific duty of care to the patient / potential employee. However, in practice there is a professional duty to the applicant to provide a competent assessment of fitness for the relevant role, consistent with the requirements of disability discrimination legislation and good employment practice
- If a GP is approached directly by an employer for an opinion on the fitness of one of his/her patients to take up a particular job, the advice should follow the format used by occupational health departments: fit, unfit, or fit with restrictions or adjustments. Details of diagnoses or medication are usually not relevant or appropriate when supplied to non-medical personnel, and the patient must give consent for the report to be supplied
- However, if a GP is approached by an occupational health service for a report, they can assume that details sent in the report will remain confidential, as would be the case when supplying medical details to

any colleague in primary or secondary care

- The same requirements apply to information required for purposes of assessing ill-health retirement. It is not unusual for pension fund trustees to request diagnoses, treatment and prognosis in order to assess eligibility for an early ill-health retirement. Such information can only be released with informed consent

Frequently asked questions

My patient, Mr Pete Jones, has a condition that seriously compromises his ability to drive all types of vehicle. I have advised him to stop driving a car, but I am aware that he drives a forklift truck (FLT) at work. The company's occupational health department has written to me for a report on Mr Jones's fitness to drive an FLT. My patient does not want me to reveal his condition, as he might lose his job. What should I say in my report?

Both you and the occupational physician have a duty to protect the health & safety of the patient, other workers and members of the public. If the occupational health department is aware of the problem, they may be able to arrange for Mr Jones to have temporary restrictions or redeployment to another role. The medical information you give to the occupational health department remains confidential, but both your own and the occupational physician's opinions need to be impartial. You should both try to influence Mr Jones to accept that revealing the problems is in his best (health & safety) interests. Information given to the occupational health department must be accurate and, if it is incomplete (at the request of the patient), then it must be made clear in your report that information is being withheld.

4. Purpose of a consultation

- The purpose of a consultation with a GP or primary care nurse is usually well understood by both parties. It is likely to have been initiated by the patient, and be related directly to his/her health needs. This is not necessarily the case in an occupational health consultation. Occupational health teams need to ensure that the employee is clear about the purpose of the occupational health consultation, and GPs may wonder about the content of an occupational health consultation:
 - Is it related to health surveillance (looking for health problems)?
 - Is it at the request of management?
 - Is it at the request of the employee himself/herself?
- These scenarios have slightly differing ethical implications. Where an employer has referred someone to the occupational health team, the employer should normally have discussed the purpose of the referral

with the employee. The occupational physician or nurse will conduct the consultation accordingly. For example:

At the start of the consultation:

- A personal introduction and explanation of who the occupational physician / nurse represents
- A brief account of the difference between occupational health and primary care roles
- A check to see if the employee understands why he/she is being seen by the occupational health service
- A confirmation of purpose – to give advice to the employee and employer on fitness to work, including any restrictions and/or adjustments to work
- A confirmation of the confidential nature of the consultation and records

At the end of the consultation:

- A confirmation of opinion on fitness to work
- An opportunity for the employee to agree or dissent from opinion – if not resolved, then the employee's views to be stated in report
- A request for consent from the employee for the occupational health department to send a report, and if not given by the employee, an explanation of possible consequences
- An explanation of what will happen next

This format is standard in occupational health practice, and ensures that the employee is absolutely clear about the purpose, impartiality and confidentiality of the occupational health professional's role.

Consequently, it is strongly recommended that doctors avoid acting as both GP and occupational physician to an individual, as the potential for blurring of roles and confusion is too great.

Frequently asked questions

An employee consults his company's occupational health department and admits that he has a problem with drug misuse. He is responsible for supervising the control of a chemical process that, if incorrectly controlled, could lead to release of toxic substances into the workplace and environment. He does not want his problem revealed to the employer or to his GP.

The occupational health department's primary responsibility is to advise the employee on dealing with his drug problem, and identify the most appropriate avenues for help and support. Part of this will be to make every reasonable (and continuing) effort to persuade the individual that their GP should be informed and involved in their care. With consent, the occupational health department could contact other agencies, e.g. drug

abuse support groups, to provide treatment. Because of the overriding duty of care to the workforce and public, the occupational health department will also need to advise management on restrictions to the employee's duties during the period of treatment (without revealing the diagnosis). The employee will be encouraged to seek support from managers, if an appropriate company policy is in place. A period of monitoring (which may include random drug testing - if there is an occupational health policy in place for this) will probably be undertaken.

Further reading

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Section 3 Communication

1. Between primary care teams and occupational health professionals:

- Good communication is crucial to the partnership between primary care and occupational health. Without it, there is the potential for inefficiency and misunderstanding
- All communication needs to respect confidentiality and consent (see below)
- Sharing information and opinions contributes to a fair and objective assessment of an individual's fitness for work

Occupational health best practice includes:

- Informing the primary care team of work-related facts that may have a bearing on the health of their patients
- Explaining the reasons for requesting reports from primary care, and specifying the information required from the GP
- Providing a full explanation to patients of the reasons for communicating with their GP, and obtaining written and informed consent. Patients should be offered a copy of the occupational health professional's letter, should understand how any information from their GP will be used, and with whom it may be shared

Primary care best practice includes:

- Considering the implications for the patient's job of any diagnosis or treatment plan
- Finding out from the patient if their employer has an occupational health service with whom you can communicate, as occupational health professionals are keen to be involved in patient management sooner rather than later, in order to help with rehabilitation
- Giving clear information and accurate diagnoses on medical certificates whenever possible
- When asked to provide a report, GPs should act as quickly as possible, as delay can be detrimental to their patients' livelihoods. Good practice is to return reports within 15 working days unless the patient asks to see the report before it is sent (see below)

2. Between GPs or primary care teams, occupational health professionals and other specialists:

- Other medical specialists play an important role in advising on prognosis or technical issues related to illness or disease that might affect fitness for work (e.g. recovery periods after surgery or after

myocardial infarction, frequency of epileptic fits affecting ability to do certain jobs, severity of skin disease or asthma). The primary care or occupational health team may therefore want to seek specific advice related to continuing physical or psychological impairment from a specialist looking after a patient

- Specialists can give guidance on medication that might be more suitable for working patients e.g. non-sedating drugs for depression, and treatments might be adjusted to suit working hours (e.g. dialysis)

3. Confidentiality and consent

- Both primary care and occupational health teams have a general duty of confidentiality to the patient
- General practice clinical notes form a lifetime health record, which is transferred between practices if the patient moves. Occupational health records are held securely by the occupational health department and are not accessible to others beyond the occupational health service
- Transfer of information between primary care and occupational health departments, other than in exceptional circumstances, requires the written consent of the patient, according to the provisions of the Access to Medical Reports Act 1988. Under this Act, the patient has 3 options:
 1. They can refuse to give consent
 2. They can give consent and request to see the report before it is sent to the occupational health department
 3. They can give consent and decline to see the report before it is sent
- If the patient disagrees with the factual content of the report, he/she can ask the GP to alter it. If the GP refuses to change the report, the patient can add comments or withdraw permission for it to be issued. The onus is on the patient to contact the GP to view the report. If no contact is made within 21 days of the report being written, the GP should send the report to the occupational health department; delaying the report further does not help the patient
- In all such areas, both primary care and occupational health teams must bear in mind that 'informed' consent means that the patient understands what information is being released, to whom, the purposes for which it will be used and the possible consequences of that use

Case studies

1. A health care worker came to the occupational health department at the suggestion of her GP and her manager, both of whom felt that workplace factors might be relevant to the way she was feeling. She had felt below par for some weeks, was worried about patients after finishing work and could not relax at home. Her GP was aware of domestic tensions and stress but wondered if there were problems at work. Her manager felt that usually excellent performance was below standard. A period of assessment and observation including (with management agreement) a trial of work in a less demanding area with additional support, allowed a diagnosis of clinical depression to emerge. With the patient's consent, the occupational health team and the GP were able to share their understanding of the issues. Appropriate treatment by the primary care team, and the occupational health team's recommendations for a supervised gradual return to work programme, resulted in full recovery. Workplace confidence has been restored, a career retained and vulnerability recognised allowing the identification of potential preventative strategies to minimise the risk of recurrence.

2. A secretary came to see her occupational health team when chemotherapy and radiotherapy were planned as part of the treatment for cancer. The occupational health assessment was that she would probably need time off work during treatment, but that once treatment was complete, her capacity to do her job would not be impaired. The recommendation of temporary changes and their likely duration allowed line managers to make suitable arrangements to cover absences. Encouraging her to remain at work where possible was therapeutic and helped to 'normalise' her life. These views were conveyed to both her GP and her treating consultant, who were able to tell the occupational health team the technical details of treatment and the likely outcomes. Liaison between primary care and occupational health continued throughout her treatment, helping and encouraging her to work.

Frequently asked questions

Can GPs refuse to provide a report for an occupational health department?

There is no legal requirement for GPs to provide reports. However this would not be good practice as a patient might be disadvantaged if the occupational physician does not have all the necessary information to make a decision regarding fitness for work

Can a GP charge a fee for a report?

Providing reports for occupational physicians is not part of a GP's general medical service under the Primary Care Trust contract. A GP may decide to charge an appropriate fee. The BMA provides a list of suggested fees but is not allowed by law to recommend fees. The fee should depend on the

complexity and length of the report and whether it is simply a statement of fact or whether an opinion is requested.

Does a GP have to give an opinion on fitness to work if requested by an occupational health department?

There is no obligation on the GP to give a 'fitness for work' opinion to an occupational health department. In fact, occupational health professionals do not usually ask for the GP's opinion on the employee's fitness for work, as they realise that the GP may not have all the relevant information about the workplace. The GP's only responsibility in this area is to give an opinion in relation to medical certification (see Section 4).

What does a GP do if a patient refuses to allow the GP to disclose medical details that the GP thinks are relevant to the case?

The GMC makes it clear that the GP has a duty to provide relevant information. If consent is not given by the patient, the GP should word the report in a way to make this clear; e.g. this report is based on only part of the GP record. Where the GP believes that withholding information would lead to a serious risk to the public or others, they may choose to disclose the information, having warned the patient that they were going to do so.

Will the information in the GP report be kept confidential or will it be passed on to the company's human resources department?

No information can be disclosed by the occupational health department to third parties (managers or work colleagues) without the patient's permission. Where specific clinical information is disclosed, it will be done in the interests of the patient. For example, a shift worker with Type 1 diabetes mellitus gave permission for his diagnosis to be disclosed to the HR department. They were able to alter his shifts to accommodate meals at regular times and insulin injections. Other 'reasonable adjustments' under the provisions of the Disability Discrimination Act (1995) can only be made where the employer is aware that they may be necessary. Limited clinical details may therefore help the employer understand the situation and their legal obligations.

Section 4

Fitness for work

Medical certification

- For absences of less than 7 days a GP is not normally required to provide certification under their terms of service. For absence lasting for more than 7 days patients may require advice on fitness for work, which their GP is obliged to record on an official statement such as a form Med 3 or Med 5. This advice relates to the patient's usual occupation, and the purpose of a medical certificate is laid down in the NHS regulations: "to support a claim to prove inability to work or incapacity for self support for the purposes of an award by the Secretary of State"
- The form must be filled in with an accurate diagnosis, wherever possible. If the GP believes this would be harmful to the patient then they may complete the Med 3 with a less precise diagnosis and then complete a Med 6 form, which is sent to the local Jobcentre Plus office for the attention of a Department for Work and Pensions (DWP) medical officer
- Specific advice on fitness for work and medical certification can be found in document IB204 'A Guide for Registered Medical Practitioners', available on the DWP website: www.dwp.gov.uk
- GPs sometimes feel under some pressure to provide sickness certification for patients in circumstances where they are unsure if this is appropriate. GPs feel uncomfortable when they perceive a tension between their role as patient advocate and gatekeeper to financial benefits
- Evidence shows that prolonged sickness absence has substantial risks to an individual's health and job security. Fewer than 50% of individuals who have been absent from work for more than six months will ever return to work. It is therefore important that primary health care teams are able to emphasize the risks of prolonged sickness absence and the positive health advantages of work, e.g. in the recovery from depressive illness or musculoskeletal problems such as low back pain
- Patients need not be fully fit to return to work. It is possible to recommend a rehabilitation program into the work place either in a letter to the employer or within the "Remarks" box on a Med 3 certificate. Rehabilitation programmes may last up to three months and short-term adjustments might include decreased hours or altered duties. Permanent job adjustments may also be required to help a disabled individual to remain at work (Disability Discrimination Act 1995), and occupational health professionals can advise employers,

employees and primary care teams. Further help and support can also be sought via the Disability Employment Advisor (DEA) at the local Jobcentre Plus office. GPs can refer directly to the DEA using the “Remarks” section on the Med 3. State support for those seeking and able to work includes grants for equipment, transport and communication aids under the Access to Work scheme, training and skill enhancement and work trials

Dismissal on grounds of medical incapacity to work

- It is important that patients and their GPs are aware that an employee can be dismissed on grounds of medical incapacity to work while still being certificated as unfit for work
- A GP or occupational physician may be approached by an employer to give an opinion on whether an employee is likely to return to work within a given period of time. It is most helpful if the doctor gives an opinion with time periods specified. For example, an opinion that an employee is unlikely to be fit to return to work within six or twelve months is more helpful than a statement that it may be ‘some time’ before the employee is fit. The employer may dismiss the employee on grounds of medical incapacity if they have not returned to work within a ‘reasonable’ length of time. If the legality of the dismissal is contested, an Employment Tribunal will consider whether or not the dismissal is fair
- Primary care and occupational health teams should not advise the patient (or management) on whether dismissal is fair or appropriate. That is a legal question, best left to management, the employee, and his or her legal or trades union advisers

Ill-health retirement

- An employee may subscribe to an occupational or private pension scheme. When an employee is permanently unfit to work either the employer or employee may apply to the pension fund to have their pension rights enhanced on the grounds that they are unable to work because of ill-health. This may include drawing their pension early and/or having added years paid into their contributions fund
- The pension fund will have criteria by which their trustees judge whether or not an employee should receive these benefits. The decision will be made after receiving medical advice from a doctor who will have considered all the relevant evidence. The criteria for ill-health retirement often state that the employee must be unlikely to

return to their usual job before retirement age because of a well defined medical condition. Some schemes say, too, that the employee must also be permanently incapable of returning to 'comparable' work. The trustees will consider whether all treatment options have been exhausted and whether reasonable adjustments to the duties have been considered to keep the individual in employment. It is therefore possible that an employee may be dismissed on grounds of medical incapacity and yet not fulfil the requirements for ill-health retirement and pensions benefits

Disciplinary proceedings and management investigations

- Occupational health and primary care teams may become involved in cases in which the employer is in dispute with the employee, and a disciplinary process is pending. This may result in dismissal of the employee, or a formal warning
- In these circumstances the doctor or nurse is sometimes asked to give an opinion as to whether the employee is fit to attend an investigation or disciplinary hearing. The employee may be suffering from stress-related or depressive symptoms and may have requested sick certification. In these circumstances it is likely that the effects of an unresolved dispute on the employee's mental health may be greater if the proceedings are postponed. An employee may be unfit for work but fit to engage with the management process. The doctor or nurse will have to assess whether attendance is likely to cause serious deterioration in the employee's mental or physical health, for example if there is a significant risk of suicide
- Management investigations or disciplinary meetings do not have to be held in the workplace; they could be held away from work, at a 'neutral' location such as a hotel. This may be a helpful suggestion if the employee is anxious about going back into the workplace at this stage

The following questions may be used to determine fitness to attend a disciplinary meeting, or engage with the management process leading to such a meeting:

- Does the employee have the ability to understand the allegations made against them?
- Does the employee have the ability to distinguish right from wrong?
- Is the employee able to instruct a friend or representative to represent their interests?
- Does the employee have the ability to understand and follow the

proceedings, if necessary with extra time and a written explanation?

Compensation and the benefits system

- Advice on the benefits available to patients who are disabled as a result of injuries or diseases arising from work, or who suffer from a prescribed disease - Industrial Injuries Disablement Benefits - can be found on the Department for Work and Pensions website (www.dwp.gov.uk). Occupational health departments and GPs should advise patients to consult Jobcentre Plus or social security offices
- Compensation for work-related ill-health or injury may also be sought through the Courts. GPs and occupational physicians may need to provide factual reports

Frequently asked questions

Is it true that occupational health practitioners are going to take on the sickness certification role from GPs?

No, this would not work in practice. The new GP contract announced pilots looking at alternatives to GP sickness certification notes, including occupational health nurses and physicians issuing fitness for work advice. Even if these demonstrate that such alternatives can be effective, access to occupational health professionals is limited and could only be part of any future solution.

Can an employer ignore a sick note?

There is not a simple answer to this. A doctor's statement is strong evidence of incapacity unless there is evidence to the contrary. The employer may wish to take further advice from an occupational physician, particularly in cases of long-term absence, but should follow Inland Revenue advice in relation to Statutory Sick Pay (www.inlandrevenue.gov.uk/helpsheets/e14-suppl.pdf). If there is a difference of opinion between a GP and occupational physician regarding fitness for work, it should be resolved by communication. If not, the employer can make decisions about the individual's continued employment (in their 'usual' job, or any other) based on what it considers to be the most appropriate evidence. It is likely that this will be the occupational physician's view, because of their expertise and knowledge of the workplace, but any managerial decision may ultimately be tested in an Employment Tribunal.

Section 5

Rehabilitation and adjustments to work

Rehabilitation

- Rehabilitation for work has been defined by the British Society of Rehabilitation Medicine (BSRM) as a process by which those disadvantaged by illness or disability can be enabled to access, maintain or return to employment, or other useful occupation. This is currently seen as an issue of great importance by a wide range of stakeholders
- Those with an interest in rehabilitation include individual workers and their families, healthcare workers, employee representatives, employers, insurers and government. Failure or lack of rehabilitation can lead to long-term sickness absence and dependence on state benefits such as Incapacity Benefit. For the individual and their family there may be deterioration in general health and position in society; for UK business, sickness absence is associated with direct costs of around £11-12 billion per year and multiples of this in indirect costs; and for society, 2.7 million people in receipt of Incapacity Benefit at an annual cost of £13 billion is a real problem
- Musculoskeletal, mental health and cardio-respiratory problems are the most common reasons for absence from work and for receipt of Incapacity Benefit. The traditional biomedical model of illness is not adequate to explain the level of symptoms described and the clinical findings. The biopsychosocial model of disease looks at the different influences that shape how an individual experiences symptoms, and attempts to explain behaviour in response to illness and disease

Practical example 1 – back pain

Miss Patel, a staff nurse at the local DGH, has had two weeks off work with low back pain. Her GP had seen her initially, excluded serious underlying pathology, and advised her positively about remaining active and early return to work. She feels much better, although still suffering some pain, and would like to go back to work. The GP signs her back to work.

Unhelpful practice:

Twenty four hours later Miss Patel returns to the GP, as her manager has said that he is not happy with her returning to duty until she is fully fit and has asked her to see her GP for a further certificate.

Best practice:

Miss Patel sees her occupational health department before she returns to work, and the department liaises with her line managers to ensure that her return is phased and that her role is adapted as necessary to enable her return to work.

Back pain is very common (with a life-time prevalence of 60–80%), and a lot of people experiencing back pain can continue activity with slight modifications until it settles. Others perceive that activity will cause pain (and therefore ‘harm’) and so are inclined to avoid activity. This may be compounded by a tendency to attribute the problem to work, and therefore avoid work, awaiting a complete recovery. There is little difference in pathology between those who stay in work and those who do not – the differences are mainly psychosocial. Both the Royal College of General Practitioners¹ and the Faculty of Occupational Medicine² have produced back pain guidelines that are evidence-based and stress that early intervention and return to work improves speed of recovery and outcomes.

Practical example 1 – ischaemic heart disease

Four weeks ago Mr Joe Robinson had an uncomplicated myocardial infarction at the age of 44, with no obvious prior risk factors. Mr Robinson is taking a cocktail of drugs, and his angiogram and stress test have been satisfactory. He is to attend a coronary rehabilitation program.

Unhelpful practice

Mr Robinson visits his GP, who issues a sick note for 8 weeks and warns him that he should anticipate being off work for 3 to 6 months in total.

Best practice

His manager contacts him to ask how he is doing, and suggests the involvement of the occupational health department. The occupational health nurse liaises with the coronary rehabilitation nurse, and both agree that under the right circumstances he could return to his office-based job within the next four weeks. A phased return to work, and reduced duties, are negotiated with his manager.

How can an occupational health department in the workplace help?

The role of OH in a case such as this is:

- to assess the functional capabilities of the individual against the requirements of the job
- to advise what duties the individual would be able to cope with, in order for the manager to be able to consider restricted duties
- to devise a structured rehabilitation program, which may include:
 - phased return to work (gradually increasing hours over, say, 2 to 4 weeks)
 - gradual re-introduction of more manual aspects of the job
 - temporary change of shift pattern
 - additional support from work colleagues

Additionally, it may be that physiotherapy or psychological therapy is available through work, or that employers may be prepared to fund specialist investigations or treatment privately.

There are potential problems for patients receiving benefits or employers' sick pay and returning to work on a phased or reduced-hours basis. Employers deal with these situations in a number of different ways – sometimes paying full pay during the resettlement period, sometimes expecting the employee to use paid holiday to cover the reduced hours and sometimes offering reduced pay. Occupational health departments and GPs can help to explain to employers the importance of not creating financial disincentives to resettlement.

Disability Discrimination Act 1995

Under the Disability Discrimination Act (1995), employers have a legal duty not to discriminate against disabled people in employment terms because of their disability. A disabled person is someone who has a physical or mental condition which has a significant effect on their ability to carry out everyday activities and which is long-term (i.e. likely to last twelve months or more). There is a duty to make reasonable adjustments to accommodate the effects of the disability, either to physically amend the workplace, or more likely to adjust working arrangements as in a rehabilitation program. Additional support for this can be accessed by the individual by involvement of Disability Services through Jobcentre Plus, including availability of funding through the Access to Work scheme.

Permitted Work

For those patients not in employment, it is recognised that the opportunity to do some work can help to improve their condition and hopefully lead eventually to a return to regular employment. A person can do certain Permitted Work (formerly called Therapeutic Work), and still receive Incapacity Benefit. Advice and approval can be obtained from Jobcentre Plus advisers. Permitted work includes: paid work (currently not exceeding £67.50 per week) which is part of a treatment programme done under medical supervision while the claimant is an in-patient or regularly attending as an out-patient of a hospital or similar institution; or work supervised by a person employed by a public or local authority or voluntary organisation providing work for persons who have disabilities. It is also possible for people on Incapacity Benefit to do unpaid voluntary work or to work as a local authority councillor.

Changes in disease pattern

When the Clinical Standards Advisory Group (CSAG) wrote its Back Pain Report ³, Incapacity Benefit for back pain was on an exponential rise.

Recent figures show a reversal in trends for back pain, and an increase in benefits for mental health problems⁴. This suggests that education alters medical behaviour in relation to certification, but tends to suggest that those who might previously have been off work with back pain might now be off with mental health problems. This highlights the need for co-operation between primary care and occupational health professionals in supporting patients with significant time off work with health problems.

References

1. *Clinical Guidelines for the Management of Acute Low Back Pain*, RCGP, 1996, and Review, 1998
2. *Occupational health guidelines for the management of low back pain at work - principal recommendations*. Carter JT, Birrell LN (Editors) Faculty of Occupational Medicine. London, 2000
3. Clinical Standards Advisory Group. *The epidemiology and cost of back pain*. London: TSO 1994
4. Waddell G, Aylward M, Sawney P. *Back pain, incapacity for work and social security benefits: an international literature review and analysis*. The Royal Society of Medicine Press, 2002

Section 6

Sources of support and advice

Local

- Your local NHS occupational health department may be able to assist with specific enquiries. Most departments are not able to accept NHS referrals from GPs, but consultant occupational physicians will always be willing to talk about interesting or difficult occupational health issues, and give general advice to GPs. They may be part of the NHS Plus network of NHS-based occupational health departments that provide services to small and medium-sized enterprises and other employers. For further details, see: www.nhsplus.nhs.uk
- There are many occupational health service providers in the UK, including national organisations and smaller consultancies, offering occupational health advice to employers on an item-of-service basis or a service level agreement. Further details can be obtained from the Commercial Occupational Health Providers Association: www.cohpa.co.uk
- Medical and nursing staff of the Employment Medical Advisory Service - based in local Health and Safety Executive offices - are trained in occupational health and will provide general advice to GPs, or can direct you to other local resources. For further details, see: www.hse.gov.uk
- There may be an Occupational Health Project in your local area, delivering occupational health advice in the primary care setting. Check the TUC's WorkSMART website for further information: www.worksmart.org.uk/health

National

- Department for Work and Pensions: the DWP Corporate Medical Group website has a wealth of information on medical certification of sickness, benefits and employment and health. There are educational resources, including free DVD / videos, desk aids and a CPD section. www.dwp.gov.uk/medical
- Driver and Vehicle Licensing Agency: for advice on fitness to drive ("At a glance"). www.dvla.gov.uk
- Health & Safety Executive: the HSE's website has guidance on a wide range of occupational health and safety issues, including musculoskeletal problems, stress and managing sickness absence. You can order publications and free leaflets aimed at employers and employees. www.hse.gov.uk

Books

- Useful books for the primary care team include:
 - *Practical Occupational Health* 2nd Ed. Agius & Seaton, OUP, Oxford, 2004 ISBN 0-34075-947-X
 - *Fitness for work - the medical aspects*. 3rd Ed. Cox, Edwards & Palmer. OUP, Oxford, 2000. ISBN 0-19263-043-1 (see also Section 7 – Educational Activity)

Training in occupational medicine

- Information on careers and training in occupational medicine can be obtained from:

The Faculty of Occupational Medicine
www.facocmed.ac.uk

The Society of Occupational Medicine
www.som.org.uk

Section 7

Educational activity

- All those involved in delivering patient care in general medical practice and other primary care settings should be competent in those aspects of an individual patient's care that relate to their work, in line with their role and responsibilities. Likewise occupational physicians should maintain competent clinical skills and have a working knowledge of current guidelines for the management of common chronic diseases. Appropriate learning opportunities should be readily accessible to all those working in primary care and in the occupational health sector

Best practice

For GPs to be aware of:

- The scope of the role, duty of care and responsibilities of the occupational health physician and nurse
- The need to record the patient's job and health issues related to work in the clinical notes
- The importance of communication: with patients about health related to work, between staff involved in providing care, confidentiality and consent, reports
- The need to consider fitness for work and medical certification
- The potential for adjustments and rehabilitation, permitted work, the Disability Discrimination Act and available benefits
- Sources of support and advice for doctors and patients

For occupational physicians to be aware of:

- The scope of the role, duty of care and responsibilities of the GP, primary care nurses and allied health professionals, non-clinical staff and community pharmacists
- The value of communication: with patients about health related to work, between staff involved with providing care, confidentiality and consent, reports
- Fitness for work issues, including: medical certification, ill-health retirement, disciplinary proceedings, dismissal
- Adjustments and rehabilitation: chronic disease management, permitted work, the Disability Discrimination Act and available benefits
- Sources of support and advice for the occupational health team and patient. Learning opportunities should be available locally via Primary Care Trusts' educational provision and national bodies (e.g. Faculty of Occupational Medicine, Society of Occupational Medicine, Royal College of General Practitioners), by face-to-face and distance learning formats

- All those with a role and responsibility for providing patient care in the

primary care setting and the occupational health staff interacting with them, should include learning activities in their annual personal development plan (PDP), through a prioritisation process that considers health related aspects of their patients' work, including chronic disease management. This PDP should be reviewed annually by an appraiser who is aware of the importance of occupational health aspects of the appraisee's work and expects to see evidence of learning applied in practice

- Evidence of appropriate prioritisation of occupational health in a PDP^{1,2} might be via:
 - A significant event audit or adverse event (e.g. patient losing their job because of potentially avoidable reason, lack of adjustment of workplace, lack of self-management or medical care of chronic disease)
 - Audit of case notes (e.g. extent of recording of occupational health status in patients' notes)
 - Self-reflection by a primary care team member who realises a learning need after informal conversation about occupational health of patient, or after reading a relevant article etc.
 - Completing a learning needs questionnaire

Case study

Vision Logistics Ltd is a large national company that has a number of distribution centres around the UK, handling goods for a number of Internet companies. They have recently won a new contract and to service it have opened a new distribution centre in a retail park situated on the outskirts of a large town with high unemployment. The citizens of the town who have been unemployed for a number of years have welcomed the new jobs. Many have no previous experience of this type of work and are generally unfit after years of unemployment. The distribution centre works 24 hours a day, operating 3 shifts. All are busy and although there is machinery for heavy lifting many jobs have to be done manually.

Six months after opening, the human resources manager and the company's occupational physician meet to review sickness absence. They have noticed that at any one time 10% of the workforce has been signed off with musculoskeletal problems such as sore backs and arm strains. They decide to hold a significant event analysis (SEA) meeting and invite representatives of the workers, safety reps and the safety officer. They undertake the standard stages of a significant event analysis²:

- Considering the nature of the event

- Gathering information about the event and circumstances creating it (extent of pre employment medical assessment, manual handling training, use of lifting equipment, shift patterns, risk assessments)
- Discussing findings at the team meeting and making an action plan to improve practice so that the likelihood of the event recurring is minimised

Most of the workers are registered with a local general practice. After the SEA meeting, the occupational physician arranged to attend the practice during a protected learning session to share the outcomes with the practice. The GPs and the occupational physician agreed how they might work together in the future. The occupational physician also gave the GPs an update in occupational medicine that they were able to add to their PDPs.

Frequently asked questions

Where do I get more information about incorporating occupational health issues and learning in my PDP?

See reference 1 or encourage your Primary Care Trust to organise local protected learning time event for whole primary care workforce.

What higher educational training in occupational medicine is available for GPs?

The Faculty of Occupational Medicine has a diploma that is suitable for GPs who have part-time occupational health jobs. The Faculty can provide a list of approved training courses.

Where might an occupational physician find up to date information on chronic disease management?

The “blue book” about the new GP contract has a summary of the evidence-based medicine, on which the 10 disease areas of the new GP contract, are based. A number of useful websites on disease management are available, containing on-line learning modules.

General websites for CPD include

www.sign.ac.uk/

www.prodigy.nhs.uk

www.gpnotebook.co.uk

Websites with free on line learning include

www.coeh.man.ac.uk

www.doctors.net.uk

www.onmedica.net

www.dwp.gov.uk/medical

References

1. Chambers R, Moore S, Parker G, Slovak A. *Occupational health matters in general practice*. Radcliffe Medical Press, Oxford, 2000.
2. Wakley G, Chambers R. *Continuing professional development: making it happen*. Radcliffe Medical Press, Oxford, 2000.