



13 July 2001 12.15 to 2.00pm, Health and Safety Laboratory

Job retention and rehabilitation is a topic of interest, which is relevant to employers and employees. At this meeting we aim to discuss recent developments in this area, in addition to the role that rehabilitation plays in the return to work process.

Current developments in job retention and rehabilitation

Dr Jim Ford, Medical Director, Job Retention Initiative, Department for Education and Employment.

The role of rehabilitation in the return to work process

Ms Sarah Woodbridge, Senior Occupational Therapist/Ergonomist, Derbyshire Royal Infirmary.

To book a place please either return the slip below or contact Jo Elms on 0114 289 2679 or email at healthyworkmatters@hsl.gov.uk

**A light buffet will be provided.
Please park in the pay and display directly outside the building.**

Name:

Company:

Address:

Tel:

Fax:

email:

and send to: **Jo Elms
Health and Safety Laboratory
Broad Lane
Sheffield S3 7HQ**

If there are any occupational health topics that you would like the newsletter to cover please include in the space below.

1 _____

2 _____

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the newsletter of the Sheffield Health Development Group

Job retention and rehabilitation pilots

"It's Occupational Health, Jim, but not as we know it"

Bidding for the Ideas phase of the Job Retention and Rehabilitation Pilots closed on 30th March. A number of occupational health providers are expected to emerge as partners or lead bidders in the possible areas of the generic pilot, as defined by the populations of the Health Authority/Boards of Leicestershire, Sheffield, Birmingham, Lechyd Morgannwg, Greater Glasgow, Wiltshire, West Kent, East Kent, Tees, Newcastle and North Tyne. A separate mental health specific pilot will operate in North Cheshire, South Cheshire and Wirral. The pilots are about testing healthcare and workplace interventions at six weeks of certification to keep disabled people in work, and obtaining data on the cost-effectiveness of health and employment strategies to inform any longer term decisions about investment in job retention services. These approaches will be tested by random allocation individually and together, and against a control group, to produce robust data; this evaluation will be complemented by more traditional methods running in parallel. The mental health pilot will cover the full spectrum of mental health, and because of smaller numbers, only the combined intervention strategy will be used. Informed consent is an important feature of the JRRPs, so that those allocated to the control group

will understand that they still have access to the full range of services under NHS, and be covered by the DDA.

The first stage of the procurement process sought innovative ideas and evidence of collaborative working. The second, feasibility stage will be under contract to DfEE, and will be followed by a third stage of implementation planning leading to live service delivery in 2002. £12M has been set aside for the two pilots, plus the over-arching evaluation, which is expected to take up a significant part of this - perhaps up to 25%; however this work is innovative and bids are expected to reflect its' true cost. The JRRPs offer an opportunity for organisations to work in partnerships crossing the traditional boundaries of health and employment, participating in and influencing leading edge national policy; they also offer employers and healthcare professionals the chance to obtain additional resources for their patients and employees. JRRPs create a further opportunity for occupational professionals to demonstrate their clinical leadership in combating ill-health related incapacity, whether due to the effects of work on health or vice versa. Health related unemployment, must rank as one of the most serious of occupational diseases. As causing social exclusion and possibly leading to poverty.

Further details can be found at: www.dfee.gov.uk/nddp, or by contacting:

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Network meeting - Job retention and rehabilitation

Editorial

Welcome to the fourth issue of Healthy Work Matters. In this issue we take a look at Job Retention and Rehabilitation, which will be the focus of the network meeting 13 July 2001. Additionally we also have information regarding ergonomics in the workplace.

Full details of the next network meeting can be found on the back page.

I would like to encourage you to send in your thoughts, comments and views on the Newsletter and any occupational health issues you would like us to cover. Additionally if you have any questions or answers regarding occupational health issues please take advantage of our new letters section. Finally, don't forget to visit our Website, which is full of useful information, and back issues of the newsletter.

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Letters Section

Call for rehabilitation services for small enterprises

Rehabilitation for work

Rehabilitation for work has been practiced in many organisations under a multitude of titles, "Phased return to work" and "Managed rehabilitative care" being two of the more popular. No matter what the title such programmes are about helping people to get back to work in the most supportive way possible. They are also about managing out obstructive systems and acknowledging that most employees want to work, and will work, if we make it possible. Most importantly, they are about ways of achieving a permanent return to work.

Employees who have been ill for a lengthy period need to regain fitness of a suitable standard before returning to work. General Practitioners are dependant on the information they have about a job in making their decisions about when someone is fit to return to work. Employers frequently find the "Fit to return to light work" doctor's note hard to cope with. They don't have any light work, or if they have it's already taken up with others who are on "light work" If the G.P. is told there's no light work the alternative is probably a longer period of sickness absence or a return to work that will lead to further periods of more frequent ill health and potentially even longer absence.

When people are away from work for more than three to four weeks there is the potential for them to become 'de-socialised'. They lose contact with what's happening in the workplace, changes may have happened, not only in the way work is done, but also in fellow workers lives, fitting back in can be difficult. For those away for longer periods rebuilding social networks can be even more difficult.

Acknowledging these challenges is the first step in achieving "rehabilitation for work" programmes that have permanence, that demonstrate your support of the workforce, that retain the skilled worker in your employment, that meet the requirements of related legislation and, that avoid the costs associated with recruitment and training of replacement employees.

Other than those employees absent following surgery the majority of long term absences are associated with muscular or bone injury, such as back or knee damage, and mental ill health including stress and depression. There is no value in bringing employees back to work early if to do so has the potential to either exacerbate their ill health, or to create another challenge to their health or safety. Rehabilitation for work is about examining those challenges and designing an individual programme for any employee who needs help in overcoming obstacles to such a return.

Interventions such as early supportive contact with the sick employee help to build a framework for rehabilitation. Contact with the GP to let him/her know what the job entails and what adaptations you could make to accommodate an early return may be of value. Consider a "phased return", where the employee comes back on a gradually increasing basis, jointly managed by you and the GP or caseworker dealing with the employee. This may mean finding ways of funding the return but in some cases the DSS will help support the initial stages of such a programme. Often employees on this type of programme achieve a full return to full working capacity far sooner than those waiting for full fitness before returning to work.

There are very few cases where such a programme is longer than three to four weeks. Where it may be longer it would be of value to consider temporary part time or job share arrangements. Help with adaptations and equipment for those few employees with more permanent disabling health challenges is available through the DfEE Employment Services.

Building a regular review into the management of these cases is essential to unblock those few light work opportunities you may have. A properly managed rehabilitation for work programme will help you to retain a healthy, productive workforce. Help in instituting such programmes is available from many sources. Initial guidance is available from Jean Raper, Lecturer in Occupational Health, University of Sheffield,

I have worked as a personnel adviser in both public and private sector organisations. These organisations reflect significant contrasts in terms of size, culture and the way in which

rehabilitation issues are managed.

When employees who work in large organisations fall ill or incur injury, they generally experience the benefits of support from experienced occupational health and personnel resources.

Job retention support from the Employment Service

Through its national network of Jobcentres, the Employment Service provides employment and job retention support to disabled people requiring additional advice and information to overcome employment barriers. In the 1999-2001 year, around 97,000 disabled people were placed into work through the Employment Service and nearly 5,000 people were helped to retain their jobs through specialist Employment Service support.

This specialist support is provided by and through Disability Employment Advisers (DEAs) who work as part of a local Disability Service Team, in conjunction with

Occupational Psychologists and other specialist advisers expert in ergonomic assessment. Most DEAs are based in and can be contacted through local Jobcentres.

Some employers may not recognise that the costs of adjustment in money and time can be less than those of recruiting a new employee. DEAs thus work together with employers and disabled employees to identify appropriate job retention solutions. These might include an in-depth employment assessment, referral to period of Work Preparation, advice on adjustments to work patterns or job content, or possibly provision of practical support in

the workplace through the Access to Work programme. If a disabled employee wants to consider alternative employment, job seeking advice and support can also be provided.

Comprehensive information on services for jobseekers and employers is available on the Employment Service website: www.employmentservice.gov.uk. Specific Disability Service information can be accessed by clicking on 'jobseekers' and then 'disability', or 'employers' and then 'disability'.

Brenda Heningham JDS2

Ergonomics in the workplace

Both employer and employee have a responsibility to prevent accidents. However, the management of Health & Safety at Work Regulations 1992 places statutory requirements upon all employers to ensure "as far as is reasonably practicable" the health and safety and welfare of all employees. This leaves the initiative with the employer to balance the cost of prevention against the risk of an accident. From an economic viewpoint, an accident or injury can be very expensive once all the costs have been summated, including lost time, replacement labour, compensation, loss of production, etc. Traditionally, emphasis has been placed on the physical environment and equipment design. However, the legislative responsibility for the health and welfare of employees has given recognition to broader aspects of employment, stressing the role of management, especially in training and education. Ergonomics can support management in this role. Briefly this is a process of promoting compatibility between the



worker and their environment or task. Ergonomics affects all our work activities, from sitting and sorting to controlling industrial plant, but while ergonomic principles are often considered in high hazard industries, they are often ignored at the shop floor level, either through fear of cost or ignorance, or problems accessing information. In response to this need, a team of therapists based at the Derbyshire Royal Infirmary have been working with companies to develop methods of managing and preventing musculoskeletal disorders. Through the application of ergonomics principles by people aware of the physiological and biomechanical functions of the human body, many of the problems associated with repetition injury due to handling equipment or working in static or confined postures can be identified and where possible remedied. Specialist expertise is also available in work related upper limb disorders and back care.

Sarah Woodbridge
Work Safe Work Fit
Senior Occupational Therapist/
Ergonomist

Both specialists work together hopefully ensuring a speedy and satisfactory return to work and/or varied work-based solutions, which accommodate the employee's situation.

The economic and operational impact of one employee being absent due to sickness for a number of weeks, though a problem, bears no comparison to the pressures placed on a small company employing a few people.

The benefits of immediate intervention would be both beneficial to employers the DSS budget and the potential employment position of employees. What co-ordinated practical support is currently offered to employers in this major employment area?

It would be great to visualise a country where small employers and their employees automatically receive a localised integrated support service,

embracing occupational health, health and safety and human resource specialists. The opportunity for companies to adopt and follow good practice in terms of practices and procedures, workplace environment and job design.

I wonder how much more successful these companies would be?

G Huckerby