Fitness for work

**Introduction**

Fitness for work is an issue that can arise for any employee – whether because of a change of job or because they are returning to work after sickness.

In the NHS, employees should be subject to a pre-employment health assessment (see the chapter on health assessments). This will ascertain whether there is any medical reason why the employee should not be appointed to a particular post.

But the question of whether they are able to do a particular job may come up at other points in their career. An assessment should be made if they change their job to one with substantially different duties – for example, involving more physical exertion or exposure to potentially hazardous working conditions. A deteriorating medical condition or the development of a condition which is related to their work may also mean their GP or occupational health team need to become involved.

And if an employee is off sick for longer than seven days, their GP normally has to make a decision about their fitness for work.

It should be remembered that fitness for work is about both the functional capability of the employee to do the work in question and the risk involved to them and others of them doing the work. Saying an employee is not fit for a particular job does not mean they are not fit to do any job.

**The legal position**

There are potential legal hazards in deciding that any employee is not capable of doing a particular job, if that ultimately leads to the end of their employment.

Employees will want to be aware of the requirements of the Disability Discrimination Act.

However, dismissal because an employee is not fit to do their job will also need to be in accordance with other employment legislation and capable of withstanding examination at an employment tribunal. It is important to follow procedures and to show what options, such as alternative work, were made available to the employee at each stage.

At the same time, employers have a duty to protect the health and safety of other employees and patients.
It is likely that in many cases employers will simply accept a GP’s judgement on when an employee is able to return. But there may be some cases when occupational health becomes involved earlier on – for example, where there has been an outbreak of an infectious disease – and may want a longer period before the employee returns to the workplace, especially if the GP is not fully aware or familiar with the nature of the work.

A GP can recommend a period of rehabilitation on a medical certificate. This could include an employee returning to work on shorter hours or in a less demanding role for a period of up to three months.

In many cases where an employee is off work for a substantial length of time, their occupational health service is likely to become involved and, with the patient’s consent, will contact their GP. This can lead to more information being shared about the patient’s condition and its interaction with their work, and potentially to changes in their working life which will enable them to return to work.

**Issues which may need to be looked at include:**

- the chances of the employee recovering from the condition
- whether there is any prospect of improvement in their abilities
- whether the work they do will make the condition worse
- the extent to which the worker is unable to do the job – and whether any adaptations could be made
- the employee’s ability to do other jobs within the organisation
- the employee’s views.

**Making adaptations**

In many cases, the worker may be fit to work but not fit for a particular job or task within that job. Some of these issues may be overcome by offering the worker alternative employment or by redesigning the job they do. An occupational health department can assist in this.

**Occupational health specialists can assist by:**

- assessing the functional capability of an employee against the demands of the job
- advising what duties the employee would be able to cope with
- devising a rehabilitation programme aimed at returning the employee to work.

www.nhsemployers.org has a useful checklist on addressing issues around employees’ health, including some organisations who may be able to offer advice.
It is likely that any discussion around possible adaptations will involve:

- the worker
- their manager
- occupational health advisers
- the HR department
- potentially the worker’s own GP or specialist.

In some cases, it will be necessary to seek other specialist advice. Some workers with hazardous substances may be having regular health surveillance anyway which can be both a trigger for a fitness to work examination and can provide useful additional information.

The requirements of the Disability Discrimination Act need to be borne in mind. If the employee has a disability, as defined by the Act, there is a requirement to make ‘reasonable adjustment’ for them.

This could include:

- physical adjustments
- allocation of some of their duties to another employee
- transferring the disabled person to a vacant post in the same organisation
- changes to working hours which may enable them to return to work or continue working – this could include working shorter hours, job-sharing and so on
- providing equipment to assist them in their job, for example voice recognition software.


In many other cases, the NHS may have invested many thousands of pounds in an employee’s training. If the employee can continue in a modified job, this investment need not be lost.

But any decisions will also need to bear in mind:

- any additional risk to patients by allowing the employee to continue
- risks to the employee themselves from continuing
- the effect on their fellow workers – both in terms of infection or other risks, and the impact on them on a redesigned job for a colleague which may put additional duties on others. This needs to be addressed as a separate issue.

More information
The Society of Occupational Medical publishes a health and work handbook which can be downloaded at www.som.org.uk

The regulations and guidance covering doctors certifying a patient unfit for work are covered by a Department for Work and Pensions booklet IB204 – a guide for registered medical practitioners, available at www.dwp.gov.uk

Chartered Institute of Personnel and Development – www.cipd.org.uk
Health and Safety Executive – www.hse.gov.uk
NHS Employers – www.nhsemployers.org
Advisory, Conciliation and Arbitration Service – www.acas.org.uk

**Helping your workforce to a healthy lifestyle**

The days when an employer would remain detached from a worker’s lifestyle are fast disappearing. Many employers are realising they can influence the future health of their employees for the better.

Changes in workforce demographics and increases in the prevalence of obesity are likely to move workplace health higher up employers’ agendas, with financial and non-financial incentives for organisations to maintain the physical capacity of the workforce.

Employers are currently faced with the challenge of managing an ageing workforce, with experts predicting that by 2030 half the UK population will be over 50 and a third over the age of 60. Furthermore, the number of younger workers entering the workforce each year is set to decline.

These changes will require employers to give greater consideration to how they can ensure that they employ staff who are fit for work, both at the recruitment stage and throughout their employment.

It is likely that, in the past, employers have not felt it was their place to become involved in the health issues of their staff. They now need to take a more hands on approach by providing access to information on good health and encouraging staff to access it.

This chapter sets out some of the costs and effects of the greatest causes of ill health (other than stress and musculoskeletal problems) in the workplace and offers some suggestions for action that employers can take. The issues covered are:

- obesity
- alcohol
- diabetes
- smoking
- promoting healthy eating
- promoting active transport
• promoting active recreation health in the workplace
• fitness testing.

Background

1. Research suggests that muscle strength, heart and lung function and some mental capacity does decline with age. In addition, older workers are statistically more likely to suffer from conditions such as heart disease and arthritis.

2. Health problems in the UK workforce may also be triggered by increases in the prevalence of obesity. Obesity is believed to put individuals at greater risk of contracting a number of illnesses including diabetes, gall bladder disease and certain types of cancer.

3. The NAO report *Tackling Obesity in England* estimated that the indirect costs of obesity in England in 1998 were £2.1 billion. Indirect costs refer to loss output in the economy due to sickness absence or death of workers. As the largest employer in the UK this would be a significant burden to the NHS.

Obesity

Definition

The Royal College of Physicians defines obesity as ‘a disorder in which excess fat has accumulated to an extent that health may be adversely affected’. To be termed obese, people must have a body mass index (BMI) which exceeds 30kg/m².

Prevalence of obesity

The results of the Health Survey for England 2004 indicated an increase in the proportion of obese adults. Between 1993 and 2004 the proportion of obese men increased from 13.2 per cent to 23.6 per cent and from 16.4 per cent to 23.8 per cent of women.

Strong regional variations in obesity levels were revealed in the results of the Health Survey for England. Based on figures for 2002, County Durham and Tees Valley SHA had the highest level of obesity at 27.3 per cent compared with Avon, Gloucestershire and Wiltshire who had the lowest levels at 17.3 per cent. The select Committee on Public Accounts noted that there has been very little research conducted to investigate the causes of regional variations.

The Government’s white paper, *Choosing Health: making healthy choices easier* used data from the Health Survey for England to indicate a rise in obesity levels among children aged two to ten, from 9.6 per cent in 1995 to 15.5 per cent in 2002. There is a robust evidence base linking obesity in childhood to an increased risk of obesity in adulthood, and this has serious implications for the future prevalence of obesity in the adult population.
Cost of obesity

Obesity is known to be a substantial and ever-growing burden on the UK’s economy. *Tackling Obesity in England* estimated that the healthcare cost to the NHS of treating obesity was in excess of £0.5 billion in 1998 (1.5 per cent of total NHS expenditure).

This is thought to be an underestimate with the real cost for 1998 ranging between £0.7 billion and £2.1 billion. These figures are based on international research which estimates that, in countries with prevalence of obesity similar to England, the direct costs of obesity range between 2 per cent and 6 per cent of national healthcare costs.

NAO also estimated the indirect costs of obesity to be £2.1 billion in 1998. Based on current trends the total cost of obesity could rise to £3.6 billion by 2010, when levels of obesity in the UK would approach those presently seen in the United States.

Health implications

Obesity can have detrimental effects on the health of adults. The World Health Organisation (1998) identified physical health problems that obese individuals are at an increased risk of developing.

Greatly increased risk:
- type 2 diabetes
- gall bladder diseases
- dyslipidemia
- metabolic syndrome
- breathlessness
- sleep apnoea.

Moderately increased:
- coronary heart disease
- hypertension
- osteoarthritis (knees and hip)
- hyperuriecima and gout.

Slightly increased:
- cancer (breast cancer in postmenopausal women, endometrial cancer, colon cancer)
- reproductive hormone abnormalities
- polycystic ovary syndrome
• impaired fertility
• low back pain
• increased risk of anaesthetic complications
• foetal defects associated with obesity.

Obesity can also cause psychological problems including social isolation, low self-esteem and depression as identified by the Scottish Intercollegiate Guidelines Network (1996).

See the chapter on obesity.

**Alcohol**

Average alcohol consumption levels rose marginally between 1993 and 2004, from 17.2 units to 18.1 units in men and from 6.2 units to 7.4 units in women. However, increases in alcohol consumption were more significant for young men and women. Between 1993 and 2002, the proportion of men aged 16-24 consuming more than 28 units per week increased from 22 per cent to 34 per cent. The proportion of women consuming more than 21 units per week increased from 9 per cent to 21 per cent.

Excessive alcohol consumption is a form of substance abuse and can harm the user both physically and mentally and, through actions, other people and the environment. More specifically substance misuse:

• represents a hazard to the health and safety of patients, staff and visitors to the NHS
• influences the quality of the service provided by the NHS
• impairs an employee’s work performance
• affects the welfare of employees by impairing their physical and psychological health, thereby contributing to social, economic and domestic problems.

Guidance for developing a substance misuse policy is available in the chapter on alcohol and drugs.

**Diabetes**

The 2004 Health Survey for England 2004 revealed increases in the prevalence of diabetes in all age groups from 35 upwards in men and age 25 upwards in women. This resulted in an overall increase in the proportion of the population with the disease between 1994 and 2003, increasing from 2.9 per cent to 4.8 per cent of men and from 1.9 per cent to 3.6 per cent of women. The survey also estimated that 3 per cent of men and 0.7 per cent of women suffered from undiagnosed diabetes in 2003.
By manipulating data from the Health Survey for England, the British Heart Foundation has estimated that the prevalence of diabetes in the UK will rise to 7 per cent of men and 5 per cent of women by 2010. The increase of type 2 diabetes has been strongly linked to rising obesity levels, poor diet and low activity levels.

The Ambulance Service Association (ASA), working jointly with NHS Employers has produced guidance on managing diabetes in the ambulance service, entitled *Diabetes in the Workplace: a guide for managers in the Ambulance Service*. The guidance encourages organisations to find “creative ways to make reasonable adjustments to working arrangements so that staff with diabetes can be employed in a way that uses their skills and talents without creating undue risk.”

Further guidance on diabetes in the workplace can be found in the chapter on diabetes.

**Smoking**

The Health Survey for England reported a decrease in the total number of smokers among adults in England. Between 1993 and 2004 the proportion of male smokers decreased from 28 per cent to 22 per cent and the proportion of female smokers decreased from 26 per cent in 1993 to 23 per cent in 2004.

The proportion of boys who had reported smoking at least once decreased from 22 per cent in 1995 to 16 per cent in 2004. The proportion of girls who had smoked remained constant.

Despite decreasing numbers of smokers, smoking still remains the largest single cause of death and disease in England and the harm caused by passive smoking, a proven carcinogenic, is well established.

Smoking has now been banned in all workplaces and enclosed public places in the UK, including NHS premises. The health benefits of enforcing smoke-free workplaces in England have been widely recognised and Secretary of State for Health, Alan Johnson announced that, over time, the legislation was expected to result in 600,000 fewer smokers and save thousands of lives.

See the chapter on smoking.

**Government initiatives**

**Promoting healthy eating**

Encouraging healthy eating is a key component of the Government’s campaign to address the rising prevalence of obesity. In 2003 the Government launched its ‘five a day campaign’. The aim of the campaign was to encourage individuals to eat at least five portions of fruit and vegetables a day. They planned to do this by raising the awareness of the health benefits of eating fruit and vegetables and by improving access to fruit and vegetables by targeted action.
At the time of launching the campaign, fruit and vegetable consumption among the population of England was less than three portions a day, with consumption tending to be lower among children and people on low incomes. The health survey indicated the number of people consuming five portions of fruit and vegetables a day increased from 22 per cent to 23 per cent of men and from 26 per cent to 27 per cent of women from 2003 to 2004. There were no changes in the number of portions of fruit and vegetables consumed by children.

To achieve the priorities identified in Choosing Health the Department has published Choosing a better diet: A food and health action plan. The action plan aims to improve health in England by reducing the prevalence of diet-related disease, and to reduce obesity in England by improving the nutritional balance of the average diet. The plan outlines an extensive range of initiatives, including a commitment to build on the ‘five a day’ campaign by targeting those groups with the lowest fruit and vegetable intake and by clarifying what a portion means for adults and children.

**Promoting active transport**

The Walking and Cycling Action Plan reported that the number of journeys on foot, except for those purely for recreational purposes, has fallen consistently for the last 20 years. The number of cycling journeys has remained fairly constant, despite the national cycling strategy setting an ambitious target of quadrupling the number of cycle trips between 1996 and 2012.

The Government has introduced an initiative to encourage people to cycle to work. The scheme allows the employee to benefit from a long-term loan of a bicycle and safety equipment free from tax. This provides the employee with all the benefits associated with cycling, and also creates benefits for the employer.

Employers need to take steps to provide facilities to safely store employee’s bicycles during working hours, which may further encourage cycling as a mode of transport.

Based on evidence of what works, the walking and cycling action plan aims to combine improvements to the environment and facilities for walkers and cyclists with carefully targeted information about travel choices, health benefits and recreation opportunities. The plan proposes to do this by:

- creating places in which people want to walk and cycle
- providing high-quality facilities for safe walking and cycling, such as secure shelters to lock up cycles during the working hours
- influencing travel behaviour, through education, training, marketing and promotion
- building skills and capacity
- monitoring success through better targets and indicators.

**Promoting active recreation**
In the chief medical officer’s report *At least five a week*, it is recommended that adults should exercise for a minimum of 30 minutes a day, at no lower than a moderate intensity level, five times a week.

Currently only 37 per cent of men and 24 per cent of women meet the chief medical officer’s recommendations. With research suggesting that activity levels decline with age and are lowest among individuals with low educational attainment, the *Choosing health: choosing activity* action plan outlines the government strategy to encourage higher activity levels. A main focus of the action plan is to educate people of the links between better health and activity and as to where the opportunities in life exist to be active.

**Promoting health in the workplace**

The workplace is increasingly being recognised as a key setting for health promotion. Rationales for the workplace as an advantageous site for the efficient delivery of health promotion include:

- the working population spends a large amount of their time there
- incentives for employers, both financial and non-financial
- the opportunity to mobilise peer pressure to help employees make desirable changes in health habits.

The benefits for employers and employees of employee health promotion are identified in the government white paper *Choosing Health: making healthier choices easier*. The report said:

“Many employers recognise that they have a direct interest in creating an environment that helps people make healthy choices: because of corporate social responsibility or because a healthier, more engaged workforce makes good business sense. A motivated, healthy workforce is more likely to perform well. Employers and employees benefit through improved morale, reduced absenteeism, increased retention and improved productivity.”

The report also identified opportunities for the NHS to work in partnership with employers to improve the health of their employees. An example of NHS health trainers or NHS stop smoking services promoting access to their services is provided.

Despite the NHS occupying a key role in health promotion, the House of Commons Health Select Committee Inquiry on Obesity (2003) questioned how many NHS organisations offer their large staff opportunities to improve their diet and increase their physical activity.

Research is currently being conducted to develop the evidence base for the effectiveness of promoting health and well-being in the workplace. This will aid individuals in developing a strong business case for health promotion in the workplace.
Investors in People (IiP) have agreed to develop a new healthy business assessment into the IiP standard. This will identify the advantages for business and employees in investing in staff health and building on mechanisms already available to businesses from IiP covering issues such as work-life balance. NHS organisations wishing to achieve the IiP standard will need to visibly take steps to promote the health of the workforce.

**Fitness testing in the workplace**

The use of pre-employment physical capacity tests for jobs with significant physical demands is becoming increasingly necessary as a way to address the growing problem of worker injury. Musculoskeletal-related injuries are most common in the NHS, accounting for 40 per cent of all sickness absence and costing the NHS somewhere in the region of £400 million a year.

Physical capacity testing ensures individuals are matched with the physical demands of the job. This is contrary to the traditional approach to tackling workplace injuries by organisations such as The National Institute for Occupational Safety and Health (NIOSH), who have traditionally involved engineering the workplace to accommodate the worker. While the ergonomic approach is important it does not appear to be a complete solution.

Research into the effects of pre-employment physical capacity screening of MSDs in a labour intensive work environment found that employees who have been effectively matched to the physical demands of their jobs may be at significantly lesser risk of injury and disability from both musculoskeletal and non-musculoskeletal disorders.

Fit individuals who are capable of meeting the physical demands tend to be injured less often than unfit counterparts. Their injuries are also generally less severe and they recover more rapidly. This could have cost-saving implications for the NHS.

**Fitness testing in the ambulance service**

The ambulance service has relatively high levels of sickness absence at 6.2 per cent. The ambulance service is also known to have relatively high rates of ill health retirement. These statistics are partly attributed to the physical and psychological demands of the job.

To protect the health and well-being of staff the ASA launched the “Fit for Work” (F4W) test in 1997. Fitness testing is widespread in the Ambulance Service, with an estimated 74 per cent of trusts making use of testing, although only 31 per cent of those trusts use the ASA test.

Research undertaken by Vince Clarke as part of his BSc (Hons) Paramedic Sciences degree in May 2004, “Investigation into the Introduction and Implementation of Fitness Tests within UK Ambulance Services”, revealed that the two main reasons for the use of
the current fitness tests were that it was a good/proven indicator of physical fitness and reflected the job requirements.

The ASA are currently developing guidance on physical and psychological fitness requirements for operational ambulance work.

**Chronic Fatigue Syndrome**

Chronic fatigue syndrome (CFS) is a medically unexplained illness characterised by severe, disabling fatigue and other symptoms. There have been a number of studies of CFS dealing with its treatment but few that have looked at the employment outcomes for sufferers. However, new guidance from the Department of Health and NHS Plus summarises current evidence and is intended to assist occupational health professionals, managers and others in providing advice on fitness for work of individuals with CFS.

This short section is intended only as a signpost to the research which can be obtained from the Department of Health and to highlight the key findings.

The review found:

- cognitive behavioural therapy and graded exercise therapy have been shown to be effective in restoring the ability to work in those who are currently absent from work

- concurrent depression in individuals with CFS is associated with poorer work outcomes. Therefore psychiatric conditions such as depression should be treated, if present. Other factors which predict poor work outcomes include a greater number of physical symptoms and signs, and older age at presentation

- there is some evidence that individuals treated with cognitive behavioural therapy have a lower risk of relapse than a control group five years after presentation

- there is a lack of published primary research on the best way to manage return to work in individuals with CFS

- employers and occupational health professionals should be aware that most individuals with CFS are likely to fall under the remit of the Disability Discrimination Act 1995.

Further information, including findings for occupational health managers and suggested audit criteria, can be found in the publication *Occupational aspects of the management of chronic fatigue syndrome: a national guideline*. It is available from the DH Publications Orderline, PO Box 777, London SE16XH or on dh@prolog.uk.com, quoting the title and reference 273539.
**Good Practice**

The Nottingham University Hospitals NHS Trust – Q-Active Scheme

The Nottingham University Hospital NHS trust has made yoga, Pilates, salsa dancing and Nordic classes available to its staff as part of its Q-Active scheme. Classes fit around shift times and allocated break times, and provide staff with an opportunity to socialise outside their normal working unit.

A number of further developments are planned as part of the three-year programme, including the development of an attractive perimeter path to encourage staff to take exercise and fresh air during their breaks.

The scheme was set up in response to the Government’s 2004 white paper *Choosing Health*, which identified strong links between employment, individual health and the health of local communities.

The primary aim of the scheme is:

‘To change the health culture at Nottingham University Hospitals NHS trust to a health-promoting organisation where staff lead by example being actively encouraged and empowered to make healthy choices at work.’

The trust anticipates that this will result in decreased sickness absence, turnover and increased morale and productivity, as well as improving the reputation of the organisation among staff and the local community.

The scheme is accompanied by a research programme which aims to create a robust evidence base for health promotion initiatives in healthcare settings.

More information can be found on the Q-Active website, www.qactive.co.uk.

**More information**

www.diabetes.org.uk – provides information on diabetes, and how to deal with it

www.hda.nhs.uk – provides information on a range of issues, including smoking

www.nao.org – gives information about obesity

www.dh.gov.uk – gives information on promoting health in the workplace and also provides information on transport

www.qactive.co.uk – gives more details on the Nottingham University Hospitals NHS trust scheme