King Edward's Hospital Fund for London

King's Fund Centre

REHABILITATION AND RESETTLEMENT OF NHS EMPLOYEES

Report of a Conference held at the King's Fund Centre

on Tuesday 16 October 1979

Report by K Annette Barfield

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The King's Fund Centre
126 Albert Street
LONDON NW1 7NF

HOFE Bar

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Tuesday 16 October 1979

Chairman: Miss Audrey Prime OBE, Chairman, Enfield and Haringey Area Health /Authority

PROGRAMME

10.00 a.m.	Registration and Coffee
10.30	Welcome to the Centre Mr W G Cannon, Director
10.35	Chairman's Introduction
10.40	The Employers Responsibility - Legal Framework and Personnel Policy Mr Max Millett, District Personnel Officer St Mary's Hospital, Portsmouth
10. 55	Questions
11.00	Present Practices and Future Trends Mrs Rose Lambie, National Officer, COHSE
11.10	Questions
11.15	The Role of the National Employment Service in Helping with Resettlement of NHS Employees Mr A Edgerton, Disablement Resettlement Officer, Employment Service Division, Manpower Services Commission
11.30	Questions
11.35	Highlighting the Problem and Some Solutions Mrs Gillian Myers, Occupational Health Nursing Adviser, Mount Vernon Occupational Health Services Mrs K Artus, Senior Nursing Officer, Occupational Health Service, Berkshire Area Health Authority Miss Grace Hammond, Principal Nursing Officer Brent District Occupational Health Service
12.05 p.m.	Questions
12. 10	At the Receiving End - Personal Experiences of Rehabilitation Miss Gillian Clarke and Mrs Jeanne Braybon
12.35	Questions
12.40	Briefing for Group Work
12.45	Lunch

14.00 p.m.	Group Work
15.00	Tea
15.10	Plenary Session - Reporting back from Groups and Questions to Panel
15.50	Proposals for a Funded Establishment for Employment and Rehabilitation of NHS Employees Dr P K Wilson, Staff Medical Officer, Ipswich Health District
16.04	Questions
16.10	In conclusion - the Chairman's summing up
16.30	Conference Ends

The Employers Responsibility - Legal Framework and Personnel Policy
Mr Max Millett, District Personnel Officer, St Mary's Hospital, Portsmouth

In his opening sentence, Mr Millett virtually summed up the recurring theme of the seminar. It is easier to identify and diagnose the problems of long term sickness or disability than it is to come up with an effective cure. He tackled his remit from three main angles:

1. Legal constraints
2. the need for a clear cut personnel policy,
3. the possible scope and content of such a policy.

Legal constraints

Under the Disabled Persons (Employment) Acts 1944 and 1958, the employer has an obligation to employ a quota of registered disabled persons (3% of the work force). Failure by an employer to employ the quota is not in itself an offence. The legal duty imposed on the employer is to allocate vacancies to registered disabled persons as they occur so as to ensure that the quota is maintained. To give effect to this, an employer must not (if below quota):

i. engage a person who is not registered disabled without a permit to do so

ii. discharge a registered disabled person without reasonable cause.

Whilst technically this requirement not to discharge a registered disabled employee relates only to those employees who in fact register as such, there is a broader implied assumption that the employer should give consideration to the retention of employees becoming disabled (for whatever reason) whilst employed.

The termination of an employee's contract of employment following long term sickness and/or disability. Such termination, either by the contract just lapsing, i.e. frustrated by the sickness of the chronically sick employee ('frustration' being the legal term covering the situation where a party to a contract becomes incapable of performing it) - or - by dismissal on grounds of incapacity under Section 57 (2) (a) of the Employment Protection (Consolidation) Act. There is considerable overlap in the criteria used by courts and tribunals in determining frustration or unfair dismissal and it is probably more helpful today to concentrate on the latter.

The Employer needs to demonstrate:

i. that the decision to dismiss is reasonable, given all the circumstances of the case· and

ii. that the procedure used in reaching and implementing this decision was also fair.

As far as (i) is concerned, this is essentially a judgement: a balance between the interests of the employer and the employee. Facts to be considered include:

- employee's age, status, length of service, sickness record
- nature, length and effect of illness or disability
- importance of the job, possibility of temporary cover etc.
- interests of the public or safety factors
- needs of the organisation in maintaining services etc.

As far as (ii) is concerned, several Key Employment Appeal Tribunal cases have established certain guidelines for the employer in how they should be handled:

- the employer must consult the employee on his condition, effects on his job etc. Failure to involve or consult effectively can render an otherwise fair dismissal unfair
- the employer must establish the facts about the employee's state of health ie. adequate medical reports are essential
- the employer must consider the possibility of alternative work for the employee. The employer is not required to create a special job for the employee but, is expected to work hard at finding suitable alternative posts. In practice, the degree to which this is achievable will depend upon the size of the organisation but, clearly, in a large District it can sometimes be difficult to prove that there are no such posts!

The whole emphasis, therefore, is that a reasonable employer will normally treat cases of long term illness or disability very gently and carefully and will resort to dismissal only if all other means have failed. In fact, in most cases unless the employer has made serious attempts at rehabilitating or resettling an employee, the chances are that a claim for unfair dismissal will be upheld. It is clear that a major effect of the way Tribunals are tackling cases of dismissal on the grounds of ill health or disability is to force employers in to giving more thought as to how they deal with their staff whilst they are still employed and to tackle the problem more positively.

Personnel Policy

This positive approach could be achieved by the District Management Team, developing a comprehensive personnel policy for the handling of such cases. This policy is needed:

1. to meet the legal requirements. Districts need an approach to the handling of these cases that will, as a minimum, ensure that a manager's actions in any particular case will stand up to the fairly stiff testing of fairness by an Industrial Tribunal; or more positively, aim to meet the broader requirement for a greater commitment to the retention and resettlement of staff.

2. because the traditional approach to such cases are proving increasingly ineffective. In many Districts, cases are handled in an informal and ad hoc way. Sometimes the problem is ignored· the employee being left in a kind of limbo, uncertain of where he stands; his colleagues in a team being expected to carry him indefinitely. Alternatively, the employee can be pushed out precipitately, generating considerable ill will and possibly, an unfair dismissal claim·

3. to ensure a consistant approach by managers and personnel officers. Without clear guidelines, similar cases can be handled differently by different officers, even within the same unit or function. Managers are too often left coping with the practical problems of ensuring cover, persuading other staff to fill gaps etc. without being clear about what can, or cannot, be done to tackle the problem·

4. to provide a formal framework to encourage more positive attitudes. Attitudes towards rehabilitation and resettlement are often notoriously unsympathetic and sometimes openly hostile amongst managers, staff and trade unions. Many personnel officers too, if they are honest, are luke warm in their commitment to resolving the problem. Such attitudes are not going to change overnight - the policies and procedures a District adopts can help to promote a more positive approach·

5. to face up to a moral responsibility to staff that the NHS has largely shirked in the past. Traditionally, managers have been very task, or service orientated, in their approach, eg. we use an employee for 10 - 20 years and then when he develops a health problem want to get rid of him as soon as possible. The service has a greater obligation to staff than this and we need to arrive at a new balance of obligation to the service and the staff.

A policy needs to cover five broad areas:

- overall aims
- procedure for counselling, consultation and medical investigations
- guidelines for managers on District policy or ways of assisting with the rehabilitation process
- options open to the employee and manager
- handling the resettlement or redeployment of an employee.

Overall aims

An unambiguous statement of the District Management Team's commitment - to give employees every reasonable opportunity to recover and return to work - and, to retain existing staff within the organisation wherever possible.

A clear procedure for counselling, consultation

(with the employee and his representative) and medical investigations.
The aim at this stage being to rehabilitate the employee into his existing job. Since August of last year, St Mary's has been experimenting with a formal procedure on the following lines:

a. every case where an employee's entitlement to full sick pay expires is notified by the Salaries/Wages Department to the Personnel Officer so that the case can be reviewed.

b. The personnel officer discussess it with the manager. If there is any uncertainty about the position, the latter then holds a counselling interview with the employee to establish the facts of his situation.

c. following this the manager and personnel officer meet again to decide the action to be taken. Following this initial assessment the procedure provides for up to three formal interviews between the manager, personnel officer and employee and his representative, with reference to the employee's GP or Specialist or to an independent medical assessor as appropriate.

d. by the time the 3rd formal interview is held, the employee's personal position, wishes and concerns and his medical position are usually reasonably clear.

This procedure is an example, not a blueprint. It needs to be designed to suit the organisation and management style of each District and it will vary according to the availability or otherwise of Occupational Health Services, the role of the Personnel Department etc. Any such procedure also needs to be applied flexibly in practice to meet the needs of each particular case eg. it will clearly be a more extended process in the case of progressive chronic illness than in the case of a sudden obvious disability such as an amputation where the position of the employee in relation to his job will be evident fairly quickly.

Guidelines for managers on the District's policy on certain ways of assisting with the rehabilitation process. This policy may vary from District to District - the key thing is that some guidance is available.

a. part-time working for a limited period as a phase in the return to work - an option available at the manager's discretion.

b. 'Light duties' - what does the manager do when the GP sends an employee back for 'light duties only'? It is not particularly helpful to anyone to accept this too readily. It is up to the manager to state what duties are required, not the GP and then, up to the latter to assess whether or not the employee is fit to do them. The general policy might, therefore, be that there is no such thing as 'light duties', only a range of jobs with differing physical and mental requirements and that an employee should only return when he can undertake the full duties of the job.

b. Contd. On the other hand, in certain situations, it might be possible for the manager to create a less physically demanding job on a temporary basis. This should, however, only be done when the service needs can continue to be met and when no additional workload or stress is placed on other members of the team.

c. continuing to keep the employee on the books even if sick pay has expired. This may assist with recovery and might well be used positively by the manager on occasions.

d. flexibility in the use of establishment control and budgetary procedures to provide for temporary staff to cover absences in order to give the permanent employee longer to recover, or, in situations where there is a need to recruit to a key post (eg. a sister's post in a special unit), flexibility to fill the post but assessing the sick employee for another post in the same grade elsewhere in the Division. In other words, how far is the District prepared to bend the rules to help the manager help the employee.

An indication of the options open to the employee and manager once the rehabilitation process is completed or exhausted, as the case may be. There are five outcomes:

a. the rarest - the employee may choose to resign

b. in certain cases (eg. where the illness becomes terminal) it may be appropriate to take no formal action at all

c. the employee may retire on grounds of incapacity due to ill health and claim superannuation benefits. (As an aside on this one, whilst we are usually only too pleased if this option is available, I have got an uneasy feeling that in some cases this is a way of 'buying off' staff who would perhaps wish for, or even be better off psychologically, placed in another job).

d. the manager may need to consider resettling the employee in suitable alternative employment.

e. consideration may need to be given to dismissal on the grounds of incapacity due to ill health - usually, though not always, following attempts at resettlement.

The handling of the resettlement or redeployment of the employee into a suitable alternative post. In Portsmouth, this is the key problem. A clear policy encouraging the rehabilitation of staff on the lines outlined so far is often of little effect if it comes to a full stop at this stage. We have had little success in persuading managers to help with the resettlement of staff needing alternative employment. The instant a personnel officer mentions an employee needing a different post on health grounds the barriers go up.

- the manager with the vacancy immediately assumes that he is being lumbered with another manager's problem: that the employee represents a high absenteeism risk. He resents interference with his freedom to select the best candidate for the vacancy and has little commitment to the responsibility of the organisation as a whole to the employee in question;

- the staff and their representatives are afraid that the employee will not take his fair share of the workload and will need to be 'carried' and, again, anticipate high absenteeism or sickness.

These same attitudes are found not just when the proposal is redeployment between different Departments but also when it is a matter of redeployment within the same Department.

Content of the Policy

The main elements that need to be included are:

i. a clear objective. This should be to match the employee with a job and not to impose the employee on an unwilling manager and work group just because there happens to be a vaguely suitable vacancy in their department.

ii. adequate assessment. This is essential partly as an aid to effective matching, partly to allay some of the anxieties of the manager and staff on the receiving end. A three fold approach is possible and such assessment could include one or all of the following :

- by the employee's previous manager: an assessment of his performance in that job, his strengths and his weaknesses etc.

- by his doctor: ideally, an occupational health doctor but otherwise one briefed on the physical/mental requirements of the job or job in question. It is essential that the assessment is job related not just a general medical one.

- by a Disablement Resettlement Officer.

Such assessments might well be supplemented by short term placements in other departments within the District.

iii. careful consultation: with the manager and staff of the department with a suitable vacancy.

iv. defined procedure for making the placement itself ie. the mechanics of slotting the employee into a different post. This might provide for a 'guaranteed interview' for the employee along with other applicants on a short list, or might be a more rigorous 'prior consideration' approach, requiring the matching process to be completed before a post can be advertised. It should probably include a 'trial period' with provision for review before the employee or manager have to commit themselves finally to accepting the placement. The manager should be free to reject it at this stage on reasonable grounds.

I am very conscious that compulsion can be counter productive and work against the interests of the employee needing resettlement. On the other hand, I am equally aware of the failure of informal persuasion to-date. A new balance between the two is required.

In conclusion

There is little alternative to developing a comprehensive personnel policy to cover the rehabilitation and resettlement of staff. Such a policy would need to be implemented with the full backing of the District Management Team and following consultation with both managers and trade union representatives, hopefully with some commitment to a fresh approach.

Such a policy would also provide a framework, not just to facilitate the rehabilitation of staff but almost more important, to encourage the changes in attitude that are a prerequisite to achieving any real improvement.

> "I started off by saying that in this area, identifying and diagnosing the problems is easier than finding a cure. I do not pretend that the introduction of clearer personnel policies and procedures will effect an instant cure, but it might constitute a course of treatment leading to some improvement in due course."

Present Practices and Future Trends

Mrs Rose Lambie, National Officer, COHSE

In putting forward the Union's point of view, Mrs Lambie made some interesting and controversial statements which, unfortunately, could not be enlarged upon nor challenged as she was unable to be present at the Questions to Panel session in the afternoon.

In talking about NHS occupational health services, she stated that some schemes are not working as they should. There is a fear amongst union members that if they are referred to the occupational health services, regarding their fitness to return to work, they will be sent back too soon because the doctors have the reputation of being pro-management and in conflict with the general practitioners.

She suggested that it should be the responsibility of management, when they received NHS medical certificates, to see that the section on industrial injuries had been filled in (and filled in correctly). Frequently, the certificate indicated the absence was due to sickness when it was actually due to industrial injury. This meant that the correct benefit entitlement was not being paid to the absentee. She concluded by stating that the only way to achieve an occupational health service, accepted by all as being truly independent, was for it to be administered and funded at Government level through a division/section at the DHSS and, she suggested that funds should also be made available for research into hospital hazards, especially low back pain and its rehabilitation.

The Role of the National Employment Service
in Helping with Resettlement of NHS Employees

Mr A J Egerton, Senior Disablement Resettlement Officer, Employment Service Division, Manpower Services Commission.

Personnel requiring help from the National Employment Service can be divided into three categories:

1. those who have fully recovred from their illness/disability but need a period of re-adjustment before returning to their old employment.

2. those who, for one reason or another, may need to change their employment but, are not substantially disabled.

3. those who are substantially disabled and are therefore severely handicapped in obtaining employment in an open, competitive market.

Facilities available through the Service for the above categories:

1. A period of about six weeks at an Industrial Rehabilitation Centre for general toning up in a disciplined atmosphere, (this does not apply to professional classes) together with an assessment of the individual for alternative employment and occupational guidance on suitable future work. A separate register is kept for certain categories of people eg. nurses and the blind.

2. The Disablement Resettlement Officer, the King pin of the Service, whose main function is to ensure that the severely disabled have equal opportunities for suitable employment in a competitive market. To help him in his objective the following facilities are available:

   a. Quota Scheme - 3% of every work force should be registered disabled persons.

   b. Fares to Work Scheme - up to 75% of taxi fares can be paid.

   c. Special Aid Schemes - the loan of any type of equipment essential to the job.

   d. Job Introduction Scheme - payment to an employer during a trial period (6-12 weeks) to see if the disabled person is suitable for a particular job.

   e. Adaption Scheme - payment of up to £5,000 towards the cost of adapting appropriate machinery, or premises, for the use of a disabled person.

f. Sheltered Workshop Scheme - non-profit making companies can be subsidised for employing severely handicapped people.

g. Business or Own Account - for which, if all else fails, help can be given - to assist a registered disabled person to set up on his own.

Proposals for a Funded Establishment for Employment and Rehabilitation of NHS Employees

Dr P K Wilson, Staff Medical Officer, Ipswich Health District.

The Ipswich, or more precisely, the East Suffolk Health District, covers a geographically large area with some 1,500 of the employees (out of a total of 5,200 in the District) scattered in small hospitals up to 30 miles from Ipswich - the main employment area. This means that rehabilitation has to be considered in a 'local small employment' context very often. Dr Wilson's experience in trying to rehabilitate employees after long sickness absence led him to consider whether posts for this purpose could not be 'funded' at District level for, at the present time, the establishment of departments, their management structure and bonus schemes often militate against the resettlement of the disabled employee.

It has often been found that employees who could give useful service in the District have to spend extra time off sick because their disability precludes them from their usual job. Before the NHS reorganisation, the interdependence of small units with less strict management methods enabled disabled employees to be 'carried' on the establishment and this was done to a large degree. Unfortunately, the present structure does not allow this degree of flexibility, having rigid staff costings. Since management may be bureacratically aesthetic but, the disabled were better off with only a Matron and Hospital Secretary who knew them, to be responsible to.

At the present time, if an employee has to be rehabilitated and his present department is not suitable for his needs, then he has to be 'sold' to another departmental manager for a routine establishment job. Even temporarily disabled people are not a 'saleable' commodity.

In certain areas of employment, bonus schemes militate against the disabled. It is essential for each member of the team to do his fair share of the work and so the less able are not welcomed by their colleagues.

To overcome these problems, Dr Wilson proposes the setting up of a 'central establishment' at District and/or Area level. This establishment would provide for a floating number of people, X per thousand employees. (The exact figure would have to be assessed by all parties in the District depending on their morbidity levels - it is probable that it would have to be higher in the industrial conurbations than it would be in East Suffolk). This figure would include:

a. the long term disabled who become so in their employment with the NHS (not the already registered disabled persons newly taken on for suitable posts) and have a useful contribution to make to the service.

b. those employees who would benefit from a temporary change of work to help with their rehabilitation in the hope that they may be able to resume their previous role. Some of these may have to be dismissed later, retired on health grounds or transferred to the long term disabled list.

It is envisaged in the Ipswich District that, initially, two posts per thousand would be a reasonable figure for a Pilot Scheme for the long term disabled and probably, nearer four per thousand for short term ('temporary' should not be longer than a year).

The scheme would allow departments to take on such people in a supernumerary role but, more important, it would free their original posts (in the long term cases) for a more able bodied employee sooner than is possible now.

The admittance to, and removal from, this 'central funded establishment' would be under the constant review of the Personnel Department aided, of course, by the Staff Health Department of the District.

The costing of such a scheme should not be too much even for present times. Initially, the establishment of departments losing an employee to the 'central fund' might have to be reduced to some extent until such a time as the severe financial stringency can be relaxed. On his preliminary figures, Dr Wilson estimates that there would be ten long term and twenty short term - that is thirty of these posts for his District. By the nature of their establishment a lot of these would be part-time and probably doing as little as twenty hours per week when they were fit.

Highlighting the Problem and Some Solutions

Case histories presented by:

Mrs Gillian Myers, Occupational Health Nursing Adviser,
Mount Vernon Occupational Health Services

Mrs Grace Hammond, Principal Nursing Officer,
Brent District Occupational Health Service

Mrs Karen Artus, Senior Nursing Officer, Occupational Health Service, Berkshire Area Health Authority.

Case 1.

A highly intelligent young woman working as an Acting Nursing Officer in the Regional Burns Unit requested a transfer for personal reasons. She was transferred to another hospital in the Group, where she was a Night Sister on the Intensive Treatment Unit. On her second night on duty there was a cardiac arrest in the Unit which she coped with most competently but, unfortunately, on her own whilst attempting resuscitation she felt a sharp pain in her lower back and on being relieved by the medical officer on duty, she found that she was unable to straighten her back without intense pain. She has not worked as a nurse since that night.

Following a diagnosis of spondylolisthesis complicated by a low back injury, she underwent major surgery three times with only limited success. Apart from being in constant pain, this 30 year old woman suffered from severe emotional problems on learning that she was unlikely to nurse again. Initially, she could not accept that she was to lose the only career which gave her complete satisfaction. Apart from her SRN she had obtained three further postgraduate qualifications and, it was entirely understandable that she should react in this way.

At this point, there was consultation between the patient, the Occupational Health Department, Personnel, Management and the Disablement Resettlement Officer, to discuss the various options which were open to her as a disabled person - these were as follows:

1. A change of job within the NHS (perhaps in teaching or management)

2. A job outside the NHS but using her nursing skills and experience

3. Retraining in an entirely new field.

At this time, through a contact in Marks and Spencer Ltd., she was offered an interview with a view to being trained by them in Personnel Management. They were most helpful and sympathetic but, unfortunately, on the day of her interview she was again admitted to hospital. This was a great blow because her morale on finding someone willing to train her on full salary in a field which appealed to her had at last improved.

Whilst in hospital, a sister from the Occupational Health Department visited her and again broached the subject of her future· quite by chance, the possibility of training as a Speech Therapist was mentioend and greeted with enthusiasm. At this point, all the agencies who could be of help were contacted and brought into action. A place was obtained for her at the National College for Speech Science, a Local Authority Grant was also, miraculously, forthcoming and it was even possible to arrange residential accommodation for her within comfortable walking distance of the College.

It would be pleasant to report that this was the end of an undoubted success story but, alas, it is not possible to do so. Shortly after starting the Course she was again admitted to hospital for further surgery and, at present time, is still under hospital care.

What of the future? The options in this case, are still open and we hope will remain so. However, it must be said that failure in rehabilitation of staff within the NHS far outweigh the successes.

Case 2

This again demonstrates, as in Case 1. what can be achieved in the rehabilitation of staff by effective co-operation and consultation between managers, personnel staff and the Occupational Health Service.

The lady concerned had been a District Nurse for seven years, was in her late 30s and married with two children. In 1975 she complained of headaches, dizziness and double vision. After visiting her GP, who made light of her symptoms and carried out no investigations, she became depressed and convinced that she was neurotic. Her work performance suffered as a result.

Her Senior Nursing Officer became concerned about her and asked the Occupational Health Nurse, because of the established independence of the Occupational Health Service, to see her to establish whether there were any possible underlying problems. Her nurse agreed to this consultation but, before it could take place, she became an emergency admission to hospital in a semi-conscious and partially paralysed state. It was decided to operate and, to re-assure her and as part of her on-going rehabilitation, the Senior Nursing Officer (Theatre) visited her pre-operatively and stayed with her until her pre-medication had taken effect. A benign meningioma was removed successfully. The post operative recovery was uneventful but slow, due to her inability to accept that the diagnosis was non-malignant. She became depressed and required a lot of firm handling, support and encouragement.

Some 4-5 months later, management in consultation with the Personnel Department decided, subject to the approval of the Occupational Health Medical Adviser (to whom a letter was sent asking for his advice as to her fitness for the post described), to offer her a return to work, as a supernumerary, on Out Patients Department for about four months. It might then be considered allowing her to return to district nursing. The Occupational Health Medical Advisor's reply stated that the nurse should be fit to return to some nursing duties but recommended that these should only be clinic work.

During the next four months, her health was monitored at intervals. She complained of dizziness on bending or lifting and gained too much weight. She was advised that unless those symptoms improved, which they eventually did, she might have to give up nursing altogether.

Finally, after further referral and consultation between the Personnel and Occupational Health Departments, she was allowed to return to her original post in district nursing two years after the beginning of her symptoms.

Some four months later, complaints were received of her unsatisfactory work performance and her apparent disinterest in her job. She was counselled by her Senior Nursing Officer and agreed to further referral to the Occupational Health Medical Adviser, to whom a letter was sent regarding the numerous complaints received. Her medical examination report showed ' No evidence of physical disability or post operative condition to account for the poor performance'. Her case load was about 25 per day: she was feeling well and her memory was good. Upon receiving this report the first stage of disciplinary action was put into effect - a verbal warning by the Nursing Personnel Officer in the presence of her Senior Nursing Officer and Trade Union Representative. She accepted this reprimand well.

At the present time her work performance is much improved, she appears happier and has developed a much better attitude towards patients and colleagues. This attitude in the opinion of the Occupational Health Nurse has been achieved because of her final acceptance of the reassurance of her full recovery. This, in turn, has boosted her self-confidence and her competence to carry out the work allocated to her.

Case 3

Nellie, now aged 49, was a mentally subnormal person who had been resident in hospital until aged 24 and had then held several short term posts. She was accepted as a domestic in a small cottage hospital in 1960. She was resident and received care and supervision, on and off duty, from the staff who ensured she washed, bought such clothes as were necessary, cleaned her room etc. Then 18 years later (1978) complaints were received from the staff (via the Unions) that Nellie had a poor work record, poor personal hygiene and was a hazard to the patients.

(There had been recent cuts in the staffing level and a bonus scheme for staff introduced.) She was therefore referred to the Occupational Health Service to rule out any major physical illness. Over the years she had been reasonably well though a constant visitor to her GP and Occupational Health Service with trivial complaints.

Following a negative report from the Occupational Health Medical Adviser, attempts were made to get Nellie to start cooking for herself in the Residents Quarters, instead of her practice of eating in the wards and to encourage a self-care programme.

What should be done about the future? It was finally decided that she should be re-assessed and after this be referred to the Community Nursing Service for them to arrange for a self-care support programme together with placement on a hostel waiting list. The outcome and security of her present position is still in doubt.

Case 4.

Susan aged 31, was referred to the Occupational Health Department in 1978 with the following information.

She had been employed as a Health Visitor for four years but had not been seen by the Occupational Health Service prior to appointment. She had had a severe depressive illness in early 1977 and was an in-patient for four months. She then returned to a clerical position for one month before going off sick again - this time for one month with depression.

Following this second breakdown, she was advised by her Senior Nursing Officer to give up nursing and was offered a permanent clerical position. When she refused this offer she was referred to the Occupational Health Service for advice on the termination of her employment on the grounds of ill health. Her GP had agreed that this was the best course of action for her. As a result of her assessment by the Occupational Health Service and the receipt of detailed reports from a psychiatrist and her GP it was recommended that she be given clerical work for three months before a final assessment be made. When this was made it was advised that she was fit to return to normal duties and she has now been working for well over a year as a Health Visitor.

Arising out of these case histories the following points of interest emerged:

1. Non-nursing personnel are easier to rehabilitate than nursing personnel especially if the latters only interest is in clinical nursing.

2. Successful rehabilitation or resettlement depends on:

   a. effective consultation and co-operation between management, heads of departments and interested outside organisations.

   b. availability of and/or willingness to provide suitable or alternative employment

c. methods of work where a 'carried' employee has no adverse effects on the potential earning capacity of the rest of his colleagues

d. less stringent economic climate in the NHS

At the Receiving End - Personal Experiences of Rehabilitation

Experience 1.

Ms A. was a senior staff nurse working in a London teaching hospital. She was a member of a closely knit family (she has three sisters) but when her father was in and out of hospital with terminal cancer, the full responsibility seemed to devolve on to her. This she accepted as she was the nearest to the family home. During her father's illness a close male friend had a coronary incident and was in hospital but she told none of her family of her emotional problems as she did not wish to impose her personal problems on them.

She had always been apprehensive about the area in which she was forced to live and one night, she was mugged on her way home from work. She spent one night in hospital and then was put off sick by her GP for one week. Subsequently she was terrified of going out but she refused to tell her mother of this fear.

Her father died and as a result she came to a 'full stop'. She felt she just could not go on any longer and so visited the Occupational Health Service for help and advice. As a result of the advice and the support, care and supervision given her she was temporarily removed from her current post. Now, after two years, she is coping satisfactorily with her normal duties and feels in the best of health.

Experience 2.

Ms B. now confined to a wheel chair, in contrast, considers she experienced 'a total lack of help' at the time she needed it though she feels sure things have improved during the past ten years.

On duty in 1969, she was attacked by a drunken patient when she was Senior Night Sister in the Accident and Emergency Department. She was then aged 35 years, married with three school aged children and her husband, a dyslexic was employed as a gardener at the hospital. She was, therefore, the main bread winner of the family.

At the time of the attack she did not consider it serious enough to report her injury but soon became a hospital patient, remained so for 13 months and had three operations. During this period she received 'little sympathy and understanding and no help with the children'. The family was soon in dire financial trouble: she had only paid reduced National Insurance contributions and her salary became non-existent. An appeal for its continuation was refused.

She became very depressed and because of this and the need for money, she was told she could return to work on a trial basis in the Accident and Emergency Department, working four days per week. After one month she was informed she was not fitting into the Department and was transferred to the Special Care Baby Unit. She had had no experience of this type of work and found it impossible to carry out the work satisfactorily, wearing a spinal jacket. She therefore resigned and the family moved to Sussex where her husband had found another job and the cost of living was cheaper.

She was assessed as 80% disabled and with help from the Disabled Income Group, eventually received a pension and compensation for her injury.

In 1975, via the local Job Centre, she was given the task of running a nursing agency from her home. This was of psychological rather than financial benefit. She also started and then became secretary, of the local branch of DIG 'Disablement Income Group) and she now runs an advisory service from her home as well as representing people at tribunals 'following training for this).

She considers she was very badly treated and that her rehabilitation was achieved entirely by her own efforts. At no time did a Disablement Resettlement Officer or anyone from the Social Services visit her until after she had written to Barbara Castle to complain. Her feeling of uselessness and despair at having to give up nursing and the isolation of the life she was forced to live, together with the torment she and her family suffered at being in debt and losing their home are beyond description. Had there been an Occupational Health Service in the Hospital when she had her accident she feels certain she would have been given the help, support and advice she needed.

Group Discussion Report

Four questions were posed as a basis for group discussion:

1. Is there a problem in your Area?

2. How extreme is the problem and is it getting worse?

3. Are there any insoluble problems in your area - if so what are they?

4. Any success stories?

All groups agreed that the problems are universal but no magic solution could be produced nor any positive conclusion reached.

The problems are very real and are becoming more acute due, mainly, to the increasing number of disabled persons, the deplorable staffing levels in the NHS with its inflexibility over the movement of staff and the current policy of certain District Managements Teams to 'freeze' posts.

Many of the problems are due to a lack of understanding on the part of managers and the unions as to the role of the Occupational Health Service and its independence and of its responsibility to participate actively in the problem sharing and the problem solving.

There is evidence of an element of work shyness and lack of work morals creeping in.

Bonus incentive schemes may encourage a worker to hide his disability or to return to work too soon.

Some suggestions made to help ease the problems

1. Financial incentive to management when they employ more than their quota of disabled persons.

2. A pool of money to cope with the problems of long term absences when the employee must be kept on the books.

3. Demonstrate by example and structure the independence of the Occupational Health Service.

4. Setting up a National Occupational Health Service. It was thought this could be cost effective.

5. An NHS Rehabilitation Service along the lines of that set up by the Royal Air Force.

6. The employment of one or two disabled people who will work well and so, 'sell' the feasibility of doing this.

7. More use to be made of the Disablement Resettlement Officer and the nurses in the Employment Services Agency.

8. Disabled persons to be taken on for six weeks trial period after which their health status would be reviewed.

9. The Injury Benefit Scheme to be used more fully and sensibly by attracting workers back to work by allowing them to receive full time pay whilst doing part-time work.

10. The extension (to three months) of full pay for industrial injury.

The key to the problem appeared to be the education of staff and management at all levels as to their responsibility towards rehabilitation and also, what it is possible to achieve through the establishment of good relationships, good lines of communication and the fostering of mutual trust.