

**LEAD EMPLOYER**

**Return to Work Toolkit**

A Return to work discussion needs to be completed following all periods of absence. The return to work discussion should take place within 5 working days of the trainee / student physician associate’s return date. The Lead Employer self-certificate should be completed by the trainee / student physician associate and can be completed prior to the meeting.

The discussion should take place between the trainee/ student physician associate and their supervisor/ practice manager/ university lead. The date of the discussion needs to be recorded on the form and entered onto ESR.

The aim of this meeting is to ensure that the trainee/ student physician associate has recovered from their illness and to ascertain whether any support is needed from HWWB. If the trainee confirms they need additional support please contact Lead Employer and this will be facilitated by a HR Advisor.

Provision should be made to ensure the return to work interview is carried out in a sympathetic and structured way and in consideration of the employee’s capabilities and it should be agreed how progress will be monitored and recorded during the first few weeks of the return.

**Once the discussion has taken place please forward all documentation to Lead Employer**

**Cheshire and Mersey:** **lead.employer@sthk.nhs.uk**

**West Midlands:** **leademployerwestmids@sthk.nhs.uk**

**East of England:** **leademployerEOE@sthk.nhs.uk**

**East Midlands:** **leademployer.eastmids@sthk.nhs.uk**

GP Trainees can now access the GP Health Service which offers support for trainees suffering mental ill-health and addiction. Further information about this service can be found by visiting the website [www.england.nhs.uk/gphealthservice](http://www.england.nhs.uk/gphealthservice)

|  |
| --- |
| **LEAD EMPLOYER SERVCE - SELF CERTIFICATE**This certificate is to be completed by the Trainee to cover:- 1. Absences lasting 7 calendar days or less. 2. The first 7 days of any absence lasting 8 or more days (This form must be returned with your Certificate of Fitness). **NB** If absence is expected to last longer than 7 days this form **MUST** be completed before your return to work**NB** Failure to complete and submit this form to the designated person could result in the loss of sick pay and statutory sick pay, and may lead to disciplinary action being taken including a referral to the Trust's Local Counter Fraud Specialist where potential concerns are identified. |
| **Please Use Block Capitals** |
| **First Name** |  | **Surname** |  |
| **Specialty** |  | **Placement** |  |
| **Assignment Number:** *(this can be found on your payslip)* |  |
| **National Insurance Number** |  |  |  |  |  |  |  |  |  |
| **Commencement of Illness** | **Date:** | **Time: AM** [ ]  **PM** [ ]   |
| **First Working Day of Absence** | **Date:** | **Time: AM** [ ]  **PM** [ ]  |
| **Last Working Day of Absence**  | **Date:** | **Time: AM** [ ]  **PM** [ ]   |
| **Last Day of Sickness** | **Date:** | **Finish Time:**  |
| **Actual Date of Return to Work** | **Date:** | **Start Time:**  |
| **Total** | **Working Days:** | **Working Hours:**   |
| **Absence Reason:**Back Condition **[ ]** Skin Disorders **[ ]** Other (Mental Health) **[ ]** Swine Flu  **[ ]** Arms/Shoulders Condition **[ ]** Headache/Migraine **[ ]** Stress/Anxiety/Depression **[ ]** Legs/Knees Condition **[ ]** Cold/Flu **[ ]** Gastric Condition **[ ]** Respiratory Condition **[ ]** Disability Related **[ ]** Other **[ ]  Please specify what other ……………………………………………………………..** |
| **Type of Absence:** Work Injury **[ ]** Work Related Sickness **[ ]**  Pregnancy Related Absence **[ ]**  Other Sickness **[ ]** Accident Outside of Work **[ ]** Did this accidentcause you to consult a medical practitioner or attend hospital? **[ ]** Was your injury due to an accident involving a third party, e.g. road traffic accident **[ ]  NB** *If the answer is ‘yes’ and damages are received from third party you will not be entitled to occupational sick pay and would be expected to return the net pay to the Trust.* |
| **Trainee Declaration** |
| I confirm that the above information is accurate and that (tick as appropriate) |
| I confirm that during the period of being unfit for work I did not undertake any unpaid or paid work, study or training which was not approved in advance and in writing by my line manager.**or** |
| I confirm that during the period of being unfit for work I undertook unpaid or paid work, study or training which was not approved in advance and in writing by my line manager.Please provide details; |
| **NB** Failure to declare accurate and truthful information on this form may lead to disciplinary action and result in matters being referred to the Trust's Local Counter Fraud Specialist to investigate. |
| Trainee Signature |  | Date |  |

**THIS FORM SHOULD BE SENT TO THE DESIGNATED PERSON WITHIN YOUR HOST TRUST WITHIN 3 DAYS OF YOUR RETURN FROM ABSENCE**

**DESIGNATED AUTHORITY SIGNATURE (Sign if form is satisfactory completed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**N.B DESIGNATED OFFICER: A copy of this form should be sent to the Lead Employer by email to Cheshire and Mersey:** **lead.employer@sthk.nhs.uk****, West Midlands:** **leademployerwestmids@sthk.nhs.uk****, East of England:** **leademployerEOE@sthk.nhs.uk, East Mids:** **leademployer.eastmids@sthk.nhs.uk**

**RETURN TO WORK INTERVIEW GUIDE FOR DESIGNATED OFFICER**

|  |
| --- |
| This form is to be completed by the Designated Officer and Trainee/ Student Physician Associate as soon as possible following a return to work interview. On completion they must ensure the date of this interview is entered on ESR. By completing this form you are confirming that the Trainee has fully completed and returned to you the Trust Self Certificate (Appendix 2).  |
| **Trainee Name** |  | **Reviewing Manager** |  |
| **Specialty** |  | **Date**  |  |
| **Placement** |  | **Location** |  |
| **Absence Start date** |  | **Date returned to work** |  |
| **Specific Reason for Absence** |  |
| Total absence during last 12 months…………………….days on ………………… occasions  |
| **If you are a clinician explain that you are seeing the Trainee in your role as their manager not their clinician** |
| Did the Trainee comply with the Sickness Absence Reporting and Certification Procedures? Yes/No (if No refer to HR) |  |
| Has the Trainee completed and signed the Trust Self Certificate to your complete satisfaction? Yes/No(If No ensure that this is done) |  |
| On the Trust Self Certificate has the Trainee declared that they have worked during their absence? Yes/No (if Yes refer to HR) |  |
| Ensure that the absence triggers are explained to the Trainee so they are fully aware of policy implications. *i.e. 3 instances in 12 months/since last review, 10 days or more since last review over 2 occasions or 2 instances in 13 weeks since last review.* Has this been done?Yes/No |  |
| Has the Trainee hit a trigger point? Yes/No N.B If yes do not discuss this in detail, refer to HR |  |
| Explain that any confidential information made known will be not be disclosed other than to the Trainee’s line management and HR/ Health, Work and Wellbeing. Has this been done? Yes/No |  |
| **GENERAL QUESTIONS** |
| Has the Trainee fully recovered? Yes/No If No what are the continuing effects of their illness (detail)? |
|  |
| Is the individual to continue to receive treatment for this problem (detail)? Yes/No  |
|  |
| Does the Trainee need any support, e.g. referral to Wellbeing Service? Yes/No (If Yes please detail) |
|  |
| Does the Trainee consider it likely that they will have further absences due to their medical condition? Yes/No If yes detail below, discuss with HR & obtain advice from the Work, Health & Wellbeing Service |
|  |
| Does the Trainee consider themselves to have a disability under the Equality Act? Yes/No If yes detail & consult HR |
|  |
| Does the Trainee consider themselves to have an underlying medical condition? Yes/ No if yes detail and consult HR |
|  |
| Date for review (if appropriate) |  |
| **If absence was stress related, musculo-skeletal or pregnancy related has a risk assessment been completed? Yes/No** |  |
| If no, please complete a risk assessment, forward a copy of all risk assessments to the Lead Employer HR Team leademployer.casemanagement@sthk.nhs.uk  |
| Additional notes or comments please put below *(including agreed action points from above)* |
|  |
| **NB: Please remind the Trainee that they can obtain further advice relating to the impact of their absence on their training programme and pastoral support from HEE.** |
| **Interviewer Signature** |  | **Date** |  |
| **Trainee Declaration** |
| I confirm that the above information is accurate and that (tick as appropriate) |
| I confirm that during the period of being unfit for work I did not undertake any unpaid or paid work, study or training which was not approved in advance and in writing by my line manager.**or** |
| I confirm that during the period of being unfit for work I undertook unpaid or paid work, study or training which was not approved in advance and in writing by my line manager. Please provide details; |
| **NB** Failure to declare accurate and truthful information on this form may lead to disciplinary action and result in matters being referred to the Trust's Local Counter Fraud Specialist to investigate.**NB** GP Trainees can now access the GP Health Service which offers support for trainees suffering mental ill-heal and addiction. Further information about this service can be found by visiting the website [www.england.nhs.uk/gphealthservice](http://www.england.nhs.uk/gphealthservice) |
| Trainee Signature |  | Date |  |

**GUIDE TO CONDUCT RETURN TO WORK**