**Record of Wellbeing Meeting**

To be completed by the Manager conducting the wellbeing meeting, in discussion with the employee. All sections **must** be completed and the record kept on the employee’s personal file. A copy **must** be provided to the employee immediately after the meeting.

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| **Section 1 - Personal Details** | | | |
| **Date, time and venue of meeting** | |  | |
| **Name of employee** | |  | |
| **Job Title of employee** | |  | |
| **Name of Manager conducting meeting** | |  | |
| **Name of HR Support** | |  | |
| **Name of Support:**  *Union Rep, Colleague, Relative* | |  | |
| **Half Pay Date:** | **Nil Pay Date:** | | **SSP:** |
| **First Date of Absence** | |  | |
| **Reason for Absence**  *(as documented on medical certificate)* | |  | |
| **Has the employee kept all medical certification up to date? YES/NO** | |  | |
| **When does the current medical certificate expire?** | |  | |
| **Section 2 - Wellbeing Update** | | | |
| **How is the employee at present?**  *(Document any progress including improvements/deterioration)* | |  | |
| **What specialist input/advice is the employee receiving?** *(GP/Consultant, outcome of recent/upcoming appointments)* | |  | |
| **Does the employee need help accessing appropriate support/ treatment?** | |  | |
| **What is the employee doing to manage their own health & wellbeing to facilitate a return to work?** | |  | |
| **Is the employee able to return to work in some capacity?** *(within team, on a short term basis until health improves, regardless of how limited)* | |  | |
| **Is there anything preventing a return to work on the expiration of the current Medical certificate?** | |  | |
| **Section 3 – Occupational Health** | | | |
| **Has Occupational Health input been sought?** | | **YES NO\***  *(\*If absent for 4 week+ please complete an OH referral if applicable)* | |
| **If yes, please document the date of the referral and the outcome/advice provided.**  *(Adjustments, phased return, redeployment etc.)* | |  | |
| **With the recommended adjustments in place could this facilitate a return to work in their current role? YES/NO** | |  | |
| **Section 4 – Is the Employee able to Return to Work? (if not go to section 5)** | | | |
| **Is the employee planning to return to work on expiration of their current medical certificate? YES/NO** | |  | |
| **If yes, confirm date of planned return to work including return to work details e.g. phased return** | |  | |
| **Section 5 - Employee NOT fit to Return to Work** | | | |
| **What is the treatment plan/prognosis?** *(Next steps, treatment plan, timescales)* | |  | |
| **Would a case conference with Occupational Health help? YES/NO** | |  | |
| **If the episode has exceeded 6 months with no return to work identified in the near future, please document any discussion that has taken place regarding capability moving forward?** | |  | |
| **Any other notes/comments/considerations/actions:** | |  | |

***This is an accurate record of the discussion that has taken place***

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| --- | --- | --- | --- |
| **Employee Signature:** |  | **Date:** |  |
| **Manager Signature:** |  | **Date:** |  |