Supporting occupational health and wellbeing professionals

University of Glasgow

COVID-19 return to work in the roadmap out of lockdown:

guidelines for workers, employers and health practitioners

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1. WHY DO WE NEED THIS GUIDANCE NOW?

Never, since records began, have so many people been off work as in this pandemic.

However, in the UK, there have been significant and positive developments since the turn of the year. We have seen a successful and rapid roll-out of the vaccination programme, and in recent weeks, substantial reductions in community transmission and death rates compared to previous months.

Consequently, the UK and devolved Governments have finally been in a position to present their roadmaps out of lockdown. With lockdown measures easing, the challenge now is to get as many workers as possible back to work safely. Some workers were in 'shielded' groups who were advised to 'stay at home', and others chose to self-isolate at home because of a perceived or real increased risk.

At present, over half of the UK population do not have access to occupational health services[1]. Therefore, the task of the return to work (RTW) risk assessment is likely to fall on health practitioners, notably general practitioners (GPs) and potentially employers and workers themselves.

There are multiple factors to consider in the COVID-19 return to work risk assessment[2,3] (see Figure 1 below). In this rapid guide, we describe these factors and present a simple stepwise approach to the risk assessment to inform decisions and facilitate safe return to work.

The health, financial and social consequences of workers not returning to work could be catastrophic and far reaching. Employers, health practitioners, politicians and workers themselves need to recognise that the population health outcomes and effects of potential long-term unemployment / worklessness will be much worse than will occur in this pandemic[4].

2. KEY FACTORS TO CONSIDER IN RETURN TO WORK (RTW)

Figure 1 below presents the key factors to consider in the RTW risk assessment. Each of these are described in more detail in the following section.

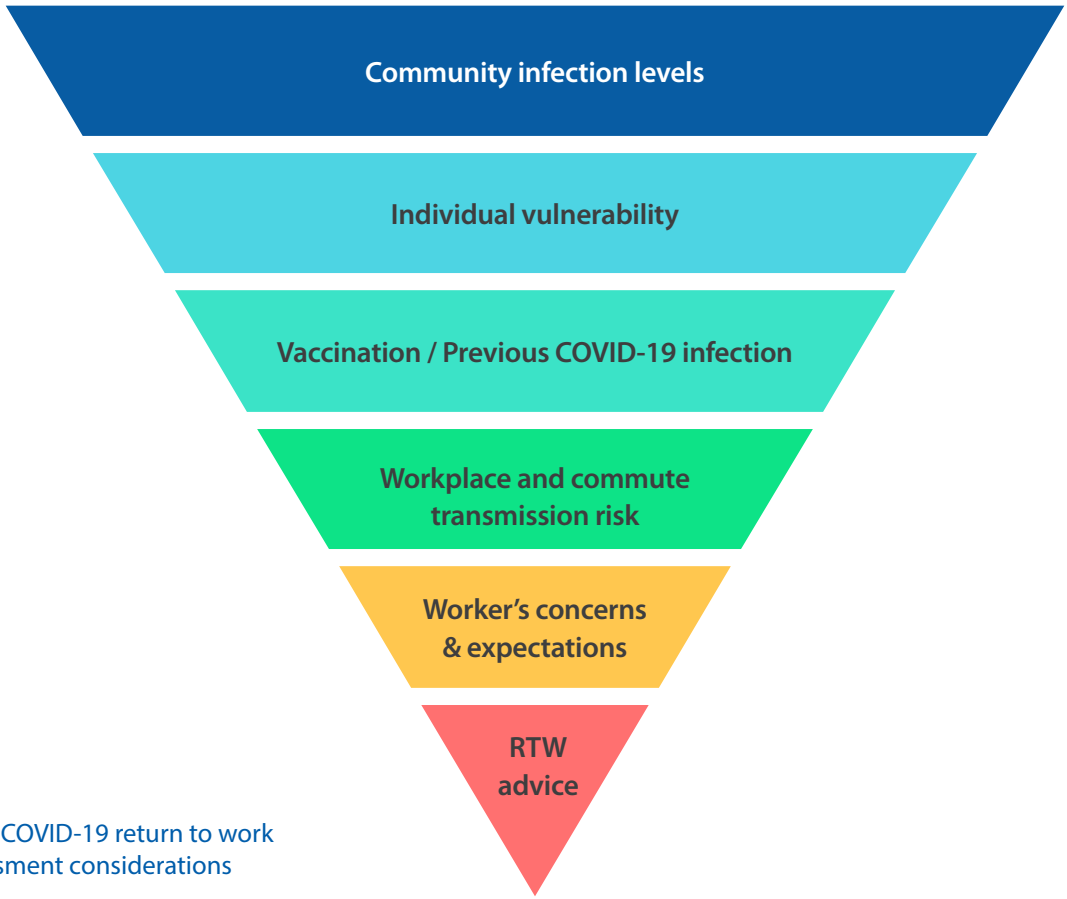


Figure 1. COVID-19 return to work risk assessment considerations

1. Community infection levels

The most important risk factor is the level of infection in the community. In recent weeks, we have seen substantial reductions in community transmission and death rates, together with a successful and rapid roll-out of the UK vaccination programme since the start of the year. Control measures (social distancing, hygiene, face coverings) remain key to maintaining this.

2. Individual vulnerability

Shielding advice was based on an assumption that some conditions and treatments made people more vulnerable to severe illness, hospitalisation and death, and did not account for multi-morbidity (i.e. multiple health conditions and risk factors)[2]. With emerging evidence, we now understand that there are many factors that affect individual vulnerability (e.g. age, ethnicity, BMI as well as medical factors) and the best current tool available to estimate vulnerability is Covid-age[5]. This can be found at: https://alama.org.uk/covid-19-medical-risk-assessment/

(Complete the calculator online and follow the advice on how to interpret the result, using clinical judgement when appropriate.)

3a. Vaccination

Studies of vaccines show that they are effective in preventing infection, hospitalisation, death, and transmission of the infection. The two vaccines being used in the UK currently, are the Pfizer BioNTech and Oxford AstraZeneca vaccines, although other approved vaccines are anticipated in the coming months. Vaccine effectiveness for the Pfizer BioNTech vaccine in those aged 16 years and above is 89% (95% CI 52-97%) from 10 days after the first dose and 95% (95% CI 90-98%) from seven days after the second dose[6].

Vaccine effectiveness for the Oxford AstraZeneca vaccine (based on most recent data) is 76% (CI: 59% to 86%) from 21 days after a first dose, with protection maintained to the second dose. With an inter-dose interval of 12 weeks or more, vaccine efficacy increased to 82% (CI: 63%, 92%)[7].

Current UK vaccine schedules are two doses. However, single dose vaccines are also expected.

We are still learning how effective the vaccines are against variants of the virus. Early research suggests vaccines may work against some variants but could be less effective against others. Early studies have shown that vaccines may also stop people from spreading COVID-19, but we are learning more as more people get vaccinated. We are also still learning how long they offer protection[8]. Some immunosuppressive conditions and treatments may affect the efficacy of vaccines. For individuals with serious immunosuppressive disorders such as HIV, advice should be sought from an occupational health (OH) professional, GP or Consultant before making a discount for vaccination.

3b. Previous COVID-19 infection

For those who have had COVID-19 infection, naturally acquired immunity / antibodies provide 83% protection against reinfection, compared to people who have not had the infection. This protection appears to last for at least five months from first becoming ill. These individuals however, are still able to pass the virus on to others[9].

4. Workplace transmission risk

Occupationally associated severe COVID-19 risk has been evident and concerning in essential workers, notably healthcare workers but also in social care and transport workers (given their higher exposure to the SARS-CoV-2 virus due to the nature of their work)[10,11,12] and individual workplace outbreaks have occurred (particularly in the food production / processing industry)[13]. However, there is little evidence to date that UK workplaces in general are a high source of transmission. Consideration of travel to work is a key factor, notably risks associated with public transport use[14].

We present in Table 1 below a matrix guide to provide an estimation of a worker's overall risk taking into account their workplace risk (including their commute to work), their Covid-age and current viral prevalence rates.

To calculate Covid-age, please go to https://alama.org.uk/covid-19-medical-risk-assessment/

Individual Government websites provide current viral prevalence rates, although this can also be accessed via: https://www.bbc.co.uk/news/uk-51768274

Table 1 below presents the overall risk pre-vaccination / infection.

*** You will drop down to the next lower Covid-age[β] category below your calculated level if:

- You had the infection in the last six months
- You had the first dose of PfizerBioNTech vaccine more than 10 days ago
- You had the first dose of AstraZeneca vaccine more than 21 days ago

Table 1. Matrix guide for estimation of a worker's overall risk pre-and post-vaccination / infection***	
	Overall risk is very high, avoid this activity
	Overall risk is high, only undertake this activity if it is essential and cannot be avoided
	Overall risk is moderate, avoid if the activity is unnecessary
	Overall risk is low, no requirement for any additional adjustments or controls

		Viral prevalence per week [α]			
Workplace Risk	Covid-age [β]	1-9 /100,000	10-99 /100,000	100-999 /100,000	1000+ /100,000
VERY HIGH In rooms, wards or vehicles **caring for COVID-positive patients where full PPE cannot be worn reliably.**	85 and above				
	70-84				
	50-69				
	Under 50				
HIGH In rooms, wards, accommodation buildings or vehicles in **close proximity to people with suspected COVID-19**.	85 and above				
	70-84				
	50-69				
	Under 50				
MEDIUM **High number of different face-to-face contacts** e.g. healthcare, care homes, social care, hairdressing, teaching, police, probation work, supermarket staff. Public transport staff and passengers.	85 and above				
	70-84				
	50-69				
	Under 50				
LOW **Where good social distancing, ventilation and hygiene measures are in place** e.g. call centre work, office work, in-home utility and repair work. Commuting by car, bicycle and walking.	85 and above				
	70-84				
	50-69				
	Under 50				
Working from home	All ages				

α Individual Government websites provide current viral prevalence rates, although this can also be accessed via https://www.bbc.co.uk/news/uk-51768274

β Please note: Covid-age is not the same as actual age and has to be calculated. To calculate Covid-age, please go to https://alama.org.uk/covid-19-medical-risk-assessment/

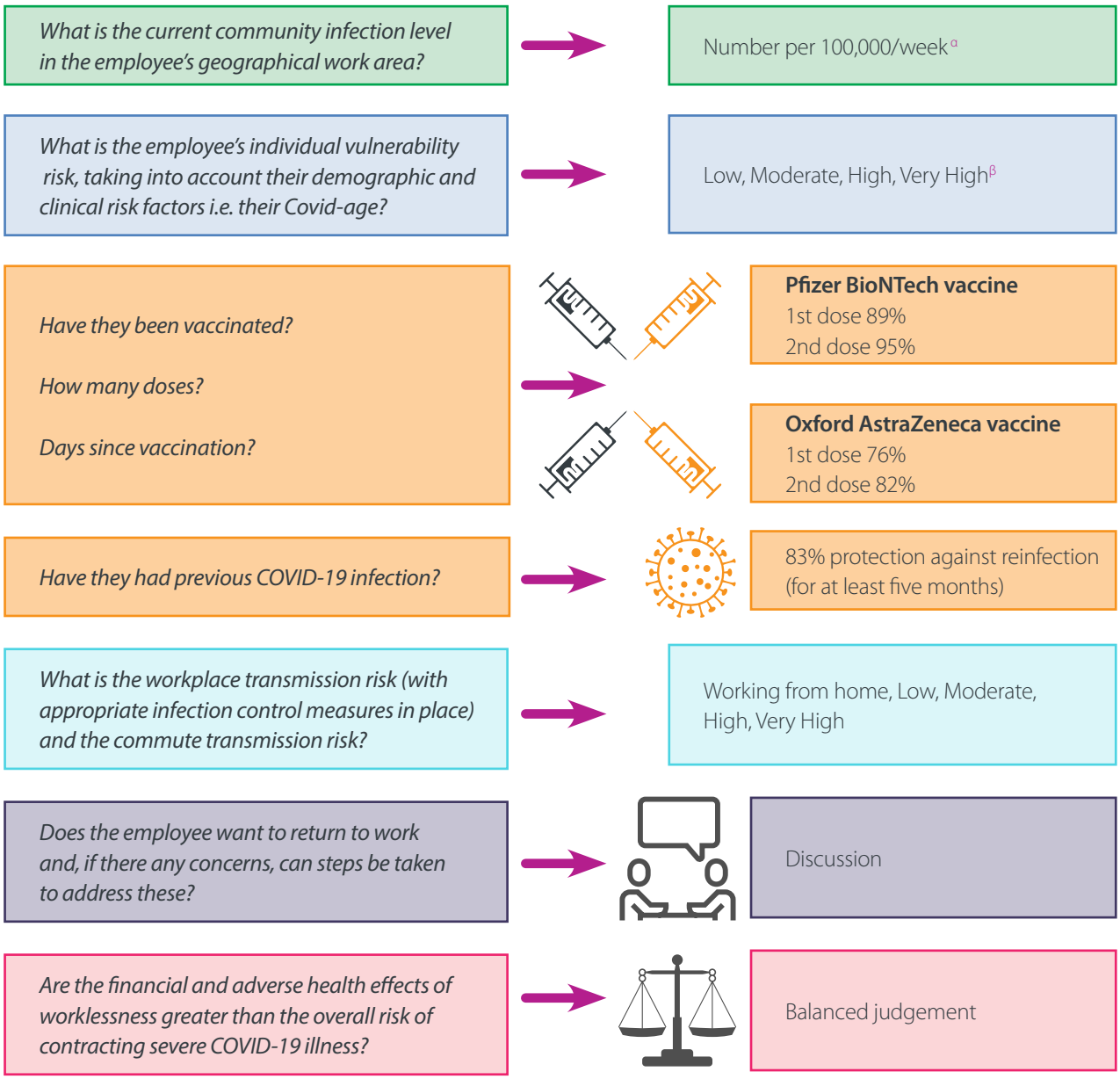
5. Workers' concerns and expectations

While many workers will look forward to the social aspects and the routine of attending their workplace, others may be more apprehensive, particularly those who are clinically vulnerable or perceive themselves to be. The psychological effect of returning to work after extended periods away, including fears of workplace transmission are recognised[15].

It is important therefore in any RTW discussions by employers and health professionals that any psychological barriers are explored and steps that can be taken to address these are considered. Employers who prioritise workers' health and organisational and workplace hygiene measures to reduce risk are both associated with a lower risk of psychological symptoms among returning employees[16].

Figure 2 below presents a summary of the key questions to consider in approaching the RTW risk assessment.

Figure 2. Flow chart summarising the RTW risk assessment steps



α Individual Government websites provide current viral prevalence rates, although this can also be accessed via https://www.bbc.co.uk/news/uk-51768274

β Please note: Covid-age is not the same as actual age and has to be calculated. To calculate Covid-age, please go to https://alama.org.uk/covid-19-medical-risk-assessment/

3. PUTTING THE RTW RISK ASSESSMENT IN CONTEXT

- In this guidance, we are presenting a pragmatic approach based on current evidence. The situation is changing all the time and advice may change depending on community transmission rates. The expectation, however, is of continuing improvement and immunity with ongoing successful vaccine roll-out.
- The decision on RTW for each case should be based on individual risk judgement taking into account all the factors above, including engagement and discussion with the employee / worker.
- For more complex cases, individual RTW advice can be sought from an occupational health (OH) specialist.
- Irrespective of vaccination, continuation of recommended infection control measures (including maintaining social distancing, regular handwashing / hygiene and face covering use) are key to stopping the spread of the virus. These steps remain important, even as vaccines are being rolled out.
- Likewise, it remains imperative that all employers continue to implement and maintain effective workplace infection control measures, to continue to protect their employees.

4. LONG COVID

Some workers who have had COVID-19 illness can experience symptoms that last weeks or months after the infection has gone. This is called post-acute COVID-19 syndrome or Long COVID and can be an important factor in RTW. Please see Appendix 1 for a suggested pragmatic approach to worker rehabilitation.

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APPENDIX 1: LONG COVID

Some workers, who have had COVID-19 illness can experience symptoms that last weeks or months after the infection has gone.

This is called post-acute COVID-19 syndrome or Long COVID and can be an important factor in RTW.

Here is what we know so far relevant to worker rehabilitation:

- The propensity to developing this condition does not appear to be linked with illness severity. Those with mild infection initially can still have long-term problems[1].
- Recovery times will be different for everybody. The majority (around 90%) would be expected to make a full recovery within 12 weeks[2]. But for some people, symptoms can last longer.
- Long COVID can affect a range of different body systems and present with a broad spectrum of symptoms[1,2]. Common symptoms include: extreme tiredness (fatigue), shortness of breath, chest pain or tightness, problems with memory and concentration, difficulty sleeping (insomnia), heart palpitations, dizziness, and depression and anxiety, although this list is not exhaustive, and many other symptoms have been reported.
- Given that this is a new condition, there are currently no established evidence-based treatments to facilitate recovery and rehabilitation. Active research is ongoing.

Worker rehabilitation

In the meantime, a pragmatic approach to worker rehabilitation could include:

1. If not already undertaken, advice to consult their GP to exclude any serious complications and explore symptomatic treatment.
2. Acknowledgement that the condition is 'real', its functional impacts and the unknowns.
3. For fatigue: advice on pacing of activities, setting daily achievable targets and graduated resumption of normal day to day activities / exercise, as they are able to tolerate.
4. Functioning at 70% of what they perceive are their limitations, avoiding becoming exhausted, and being able to take rest as required, is likely to lead to progressive recovery[3].
5. Where appropriate, advice on cognitive-behavioural therapy strategies that may assist.
6. Health promotion advice – maintaining a healthy diet and daily routine, sleep hygiene, weight management, stopping smoking, avoiding alcohol and caffeine.

Return to Work advice

RTW advice should consider:

1. Phased returns (both in terms of their hours of work and the duties / functional demands of their roles). These may need to be longer than standard timescales.
2. Flexibility for increased rest breaks.
3. Continued homeworking, if feasible, to avoid the additional demand of a commute to work, where fatigue or breathlessness are prominent.
4. Consideration of temporary (or permanent) alternative duties and working hours, if feasible and can be accommodated, in those whose symptom profile is not compatible with a return to their normal contractual role.
5. For safety critical roles, advice from an occupational physician or from their treating doctor should be obtained.

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