

# Rehabilitation and return to work after cancer — instruments and practices

European Risk Observatory

Report

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## Table of contents

|  |    |
|--|----|
| Executive summary .....  | 4  |
| 1 Background.....  | 12 |
| 2 Objective .....  | 13 |
| 3 Methods .....  | 14 |
| 3.1 Literature review .....  | 14 |
| 3.2 Detailed descriptions of policies, systems, programmes and instruments in the field of rehabilitation and RTW after a cancer diagnosis ..... | 14 |
| 3.3 Company case studies .....   | 14 |
| 3.4 Focus groups with stakeholders .....   | 15 |
| 3.5 EU-OSHA seminar to discuss the findings .....  | 15 |
| 4 Results .....  | 16 |
| 4.1 Literature review .....  | 16 |
| 4.2 Detailed description of policies, systems, programmes and instruments.....   | 21 |
| 4.3 Company case studies .....   | 24 |
| 4.4 Focus groups with stakeholders .....   | 32 |
| 5 Discussion of findings .....   | 37 |
| 5.1 Policy and strategy options and recommendations .....  | 37 |
| 5.2 Comparison of approaches, taking into account aspects of national contexts.....  | 40 |
| 5.3 Challenges in and success factors of the implementation of instruments and practices .....   | 41 |
| 5.4 Transferability of instruments and practices .....   | 43 |
| 5.5 Assessment of elements considered essential in an OSH system .....   | 43 |
| 6 Conclusions .....  | 45 |
| 7 References.....  | 46 |
| 8 Annex.....   | 48 |

## List of tables

|         |   |    |
|---------|---|----|
| Table 1 | In-hospital rehabilitation intervention (the Netherlands) .....                                   | 48 |
| Table 2 | Work reintegration agency Rentree (Belgium) .....   | 55 |
| Table 3 | Municipality-based occupational rehabilitation programme (Denmark).....                           | 61 |
| Table 4 | Work reintegration agency oPuce (the Netherlands).....  | 69 |
| Table 5 | Macmillan Cancer Support — cross-organisational working through a cancer programme (the UK) ..... | 76 |
| Table 6 | Work reintegration agency Re-turn (the Netherlands).....  | 84 |
| Table 7 | Booklet/guide developed by the Irish Congress of Trade Unions (Ireland) .....                     | 90 |

## Executive summary

The ‘Rehabilitation and return to work after cancer — instruments and practices’ project provides an insight into the issues surrounding rehabilitation and return to work (RTW) after a cancer diagnosis and the problems encountered by workers affected by cancer and their employers. Furthermore, the report presents recommendations for instruments, practices, policies and interventions to successfully support the RTW of workers affected by cancer.

Each year, an estimated 3.4 million new cases of cancer are diagnosed in Europe. About half of the people diagnosed with cancer are of working age. Although cancer occurrence differs from one region to another in Europe, the most frequent forms of cancer are breast, colorectal, prostate and lung cancer. These types of cancer were estimated to account for over half of the overall burden of cancer in Europe in 2012.

The impact of cancer on a person’s daily life is immediate and striking. The diagnosis usually results in long periods of sickness absence because of medical treatments and functional restrictions. Although, in general, cancer management has improved over the past three decades and the overall number of people who survive cancer is increasing, many cancer survivors still face long-term symptoms and impairments after their treatment ends, such as fatigue.

These symptoms and impairments can affect the work ability of cancer survivors, making it more difficult to remain in or re-enter the job market. Research shows that most cancer survivors are able to remain in or return to work, but that overall the risk of unemployment among cancer survivors is 1.4 times higher than among people who have never been diagnosed with cancer.

Optimising the rehabilitation and RTW of workers affected by cancer is therefore important to both improve the well-being of this vulnerable group and reduce the societal and financial impacts of cancer on European enterprises and society at large.

Instruments, practices, policies and interventions aimed at the promotion of rehabilitation and RTW are clearly important.

- This ‘Rehabilitation and return to work after cancer — instruments and practices’ project reports on the emerging issue of rehabilitation and RTW after cancer and provides national examples of successful instruments, practices, policies and interventions to prevent long-term sickness absences and unemployment.

The project is divided into the following main tasks:

- a literature review on rehabilitation and RTW after a cancer diagnosis;
- detailed descriptions of instruments, practices, policies and interventions to support rehabilitation and RTW after a cancer diagnosis;
- company case studies;
- qualitative research with experts and intermediaries;
- support for the EU-OSHA stakeholder seminar.

## Rehabilitation and RTW after a cancer diagnosis

### *Health and safety implications for workers affected by cancer*

Workers affected by cancer report various effects of cancer and its treatment on their health, including mental, cognitive and physical symptoms. The most frequently reported symptom is a diminished level of energy, described as fatigue or exhaustion, and emotional strain due to the ongoing battle with the illness. Other implications of cancer and its treatment that are reported to have an effect on occupational safety and health (OSH) are diminished mental health, including depression and anxiety, diminished physical functioning and symptoms such as pain and diminished cognitive capacities, including attention and memory problems.

The explicit occupational implications are diminished work productivity, work ability impairments and reduced functioning at work. This means that, due to one or more of these implications, workers treated

for cancer are likely to have to take sick leave because their work capacity is diminished and they can no longer carry out their usual tasks. These implications can occur early in the treatment process or can last years after diagnosis, when they are especially problematic. For example, workers with cancer can be hindered by fatigue or cognitive problems several years after diagnosis and treatment.

### ***Costs for workers, employers and society***

The RTW of cancer survivors is economically important. Not returning to work during or after treatment leads to a financial loss for the worker, the employer and society. Adapting the work environment may enable RTW. This may come with costs for the company and the worker but, in the long run, these may be less than the costs of long-term sick leave.

Little is reported about the costs of cancer for workers, employers or society and, within the little that is reported, there are no consistent results. No reports exist on the costs to companies of workers being diagnosed with cancer. The total economic loss to the European Union (EU) due to lost working days as a result of cancer was estimated to be EUR 9.5 billion in 2009, but this is not all related to unsuccessful RTW.

### ***Work-related and occupational cancer***

The development of cancer may be caused by work and its environment. Occupational cancer can be defined as cancer that is mainly caused by exposure at work, whereas work-related cancer is considered multifactorial and exposure at work plays a smaller role, among other factors, than in occupational cancer.

No studies were found that focus on the RTW of workers with occupational or work-related cancer. This could mean either that RTW is not a problem that needs examining separately in these types of cancer or that the problem simply has not been studied. As most occupational cancers have long latency and occur after working life, or the prognosis is too severe, it could be that RTW is not a desired outcome. For other work-related cancers, exposure to carcinogens at work may go unnoticed and thus the RTW issues are no different from those of other non-work-related cancers.

During the EU-OSHA stakeholder seminar, the European Commission underlined the importance of the tertiary prevention of occupational diseases and outlined the difference between work-related and occupational diseases. The importance of performing risk assessments was also highlighted. Due to the long latency and sensitivity of work-related cancer, risk assessments are needed to allow working conditions to be adjusted in time. Furthermore, in the case of work-related cancer, it is important to talk about the risks (risk communication), so that both the employer and the worker are informed of the risks that RTW poses to health.

### ***Small and medium-sized enterprises (SMEs)***

The size of a company seems to have an impact on cancer survivors' possibilities for returning to work. Companies with fewer than 250 workers (SMEs) lack information and resources for RTW strategies or programmes, and support and education for such enterprises are needed. These problems seem to be especially apparent in small enterprises (fewer than 50 workers) and micro enterprises (fewer than 10 workers).

It has been reported that the RTW of cancer survivors seems to be more problematic for the self-employed and those working in small enterprises. This is because being off work for treatment and necessary rest is more difficult in small companies, as such companies have limited access to occupational health services and they lack experience in the management of sickness absence.

During the EU-OSHA seminar, stakeholders indicated the importance of making straightforward recommendations to stakeholders in companies. Recommendations for how cancer and RTW issues can be integrated into more general RTW programmes are especially important. For SMEs, this is vital because they most likely need intermediaries or consultants to supply these programmes. In addition,

grouping SMEs for OSH information/assistance is valuable because SMEs could learn from each other and together it is easier to access this kind of help from occupational health services.

However, stakeholders also saw the small size of SMEs as an advantage, as such companies provide a more family-like atmosphere, which may create a more supportive environment for workers with cancer returning to work. However, very little has been reported in the literature and the conclusions are weak due to the small evidence base.

## **Instruments, practices, policies and interventions to support rehabilitation and RTW after a cancer diagnosis**

The terms instruments, practices, policies and interventions in this report are understood broadly and include both very active approaches of support, such as training, and less active approaches, such as information provided over the phone, online or on paper.

A limited number of scientific studies have evaluated the effect of interventions to help cancer survivors return to work. Results from the scientific literature show that only multidisciplinary interventions that combine vocational counselling with patient counselling and physical training have increased RTW rates, although only to a small extent.

In the scientific and grey literature, and through contacting experts, a total of 78 instruments, practices, policies and interventions addressing rehabilitation and RTW were found. These examples were collected from 13 EU countries, the USA and Australia. Some interventions were described as workplace accommodations and these were mostly meant to accommodate fatigue and provide more flexibility in working times or a reduction in working time, which could also take the form of paid leave for healthcare appointments. Interventions included proposals for adjustments to workload, modifications to duties, the provision of assistance and changes in personnel.

An extensive number of psycho-educational interventions, such as advising cancer survivors by telephone or providing information on a dedicated website, were also found to be used in practice. Available interventions include information and training on cancer and RTW issues, rehabilitation services, guidelines and workplace accommodations.

For employers, support interventions can help them to construct RTW plans for employees with cancer, create ideas for workplace accommodations to facilitate RTW and improve communication with the employee and co-workers; they can also provide factual information about the diagnosis and treatment of cancer.

### ***Description of good practice examples***

The following seven innovative good practice examples were identified from five Member States:

- Cross-organisational working in Macmillan Cancer Support's 'Working Through Cancer' programme (the UK): the programme provides support to different stakeholders — people with cancer and their carers, health and social care professionals and employers — in helping people with cancer to remain in and/or return to work and in influencing government policy and service commissioners. The programme provides a range of information resources, training materials and guidance for employers; information and helpline employment advice for employees affected by cancer and carers, with specific advice for the self-employed; and resources for health and social care professionals.
- Municipality-based occupational rehabilitation programme (Denmark): the programme involves different stakeholders, namely the hospital (nurses), the employer, a job consultant and the employee. One of the innovative elements of this intervention is the timing and early onset of the occupational rehabilitation. The job consultant acts as an intermediary between the employer and employee.

- In-hospital rehabilitation intervention (the Netherlands): this intervention involves an oncological nurse, an occupational health physician (OHP), a supervisor and the employee. This hospital-based intervention opts for early intervention, as most cancer patients otherwise have no contact with their supervisor or OHP during the early phases of their cancer treatment.
- Work reintegration agency Rentree (Belgium): the agency involves different stakeholders and, from among these, the worker chooses the ones that he or she would like to be involved in his/her personal RTW process. Therefore, the programme is tailored to the user.
- Work reintegration agency Re-turn (the Netherlands): the agency covers issues regarding work, home, family, relationships and the physical and mental effects of treatment and RTW. Re-turn also involves different stakeholders.
- Work reintegration agency oPuce (the Netherlands): the agency provides help to unemployed cancer patients. Working together with large companies and many other stakeholders, including the worker, results in new job opportunities for unemployed cancer survivors.
- Booklet of the Irish Congress of Trade Unions (Ireland): the aim of this booklet is to break down the stigma associated with cancer and RTW, to encourage good conversations between employers and employees, and to provide assistance to unions that represent members diagnosed with breast cancer who are returning to work.

Overall, it seems that RTW is influenced by the institutional context of a country, especially the length of paid sick leave. In addition, early intervention or paying attention to RTW early in the illness process appears to be important in every programme.

Working together with different stakeholders, including the worker and his/her family, the employer, healthcare professionals and occupational rehabilitation experts, seems important in all good practice examples and has a positive impact on the RTW process.

## Policies and interventions in companies to support RTW after a diagnosis of cancer

Employers are key stakeholders in the RTW process because they are in a position to create good working conditions, reduce discrimination and stigmatisation, help minimise the economic impact of a cancer diagnosis, and ensure workers' well-being. Furthermore, employers must have a positive attitude and a good understanding.

We collected examples of enterprises that have implemented interventions for managing the RTW of employees diagnosed with cancer. As far as possible, they represent different types of cancer, cover a variety of workplace sizes, activity sectors and locations, and include medium-sized companies, lower socioeconomic groups and both genders, i.e. a variety of professions:

- A large conglomerate with multiple companies (the Netherlands) has a programme in place that includes a 'Tailored Sport Plan' aimed at sports, rehabilitation and RTW.
- A medium-sized enterprise (the Netherlands) provides an external sports, rehabilitation and RTW programme for its employees diagnosed with cancer.
- A company (the UK) has a programme in place that includes numerous modules of support, information, absence management policy and sick pay, as well as the involvement of a general practitioner.
- A department store (the Netherlands) provides the work reintegration agency Re-turn's programme for its employees diagnosed with cancer.
- A hospital (Belgium) offers a programme aimed at promoting communication between different stakeholders (the employer, an OHP, the human resources (HR) director, the HR assistant and the division manager) on the RTW of employees with a long-term illness. Supervisors are trained in communicating with employees about RTW after a long period of sickness.

- A banking organisation (the Netherlands) provides its employees that have been diagnosed with cancer with information via an intranet and trains supervisors in communicating with employees about RTW after cancer.
- An independent not-for-profit healthcare provider (Ireland) liaises with its members of staff regarding RTW on an ongoing basis during and after treatment for cancer.
- A manufacturing company (Belgium) applies a 'relocation policy' within the company, i.e. workers are given a temporary job with adjusted tasks before they return to their original job.
- A banking organisation (Belgium) has a unique policy regarding communication with employees with a long-term illness.
- 

### ***Experiences of stakeholders in companies***

We interviewed different stakeholders about a worker's RTW process in their company, e.g. workers, employers, OHPs and representatives of trade unions.

The content of the programmes and the people involved in the programmes differed. Multidisciplinary programmes involving several stakeholders from both inside and outside the company were most common. Some programmes included psychosocial support and others offered exercise programmes; some multidisciplinary programmes combined physical support with social support through collaboration in mini-teams and some programmes included the support of only an OHP. We also found that about half of the companies implementing successful programmes had put in place their own RTW programmes and measures, while the other half collaborated with external agencies and programmes to facilitate successful RTW. Not all of the programmes focused solely on workers diagnosed with cancer; some were intended for a wider range of workers with other (serious) illnesses.

The extent to which companies provided support to the worker varied. Most workers felt supported by their supervisors but, in a few cases, external programmes or the OHP had to intervene to establish adequate support from the workplace.

In addition, the communication of the possibilities of engaging in the programmes, initiatives and policies was different, depending on the size of the company. In smaller companies, the communication lines seemed to be shorter and therefore the worker was likely to be informed sooner. The uptake of the programmes provided depended on the situation of the worker, including the severity of the medical diagnosis and personal preferences.

The views of employers differed regarding budgeting for additional help for workers diagnosed with cancer. Most employers had no financial incentives to begin the RTW process for workers diagnosed with cancer, but considered it part of good employment practice. Employers who themselves needed to pay for the long-term absence of employees did, however, indicate that financial motivation might be an incentive to put more effort into RTW.

The most successful programmes were those that were multidisciplinary — including psychosocial and physical aspects — and flexible (tailored to the worker's situation), and those that involved good communication, knowledge of cancer-specific RTW processes and information being made available on the company intranet.

The project organisation within the companies was very diverse and no conclusion can be drawn regarding the most effective form of project organisation. Some programmes were actual policies within the companies, while others were organised by external agencies; some had teams within the company that organised the project and others had no project organisation at all.

As regards transferability, all the interviewees considered that their programme would be transferable if companies were willing to support and finance the programmes. However, for small companies, this might be more difficult due to costs and flexibility needs.



## Barriers to and facilitators of the successful implementation of instruments, practices, policies and interventions for the RTW of employees diagnosed with cancer

Most employers and HR personnel considered that legislation was highly important for (successfully) implementing programmes. Due to differences in legislation, the incentives and possibilities of an employer to provide workers with programmes were different among the countries. The majority of stakeholders indicated that communication with the worker diagnosed with cancer throughout the sickness period was an important facilitator of a successful programme. Furthermore, communication between the stakeholders (HR, the employer, the supervisor and actors from external agencies) was also essential for facilitating the programmes.

Some facilitators provided knowledge to HR personnel and supervisors on cancer and work via, for instance, workshops. Finally, a positive company policy and attitude towards workers with a serious illness returning to work was a prerequisite for successful RTW.

A barrier to the implementation of the RTW programmes seemed to be the inability of some companies to provide the worker with the required work adjustments. This was the case when, for instance, the company had only a specific type of (hard) work. Another barrier was that physical and psychosocial care were often not covered in the treatment phase.

To further explore the barriers to and facilitators of the successful implementation of the policies, systems, programmes and instruments in the field of rehabilitation and RTW of workers diagnosed with cancer in various countries and companies, we arranged focus group sessions in four countries: Belgium, Ireland, the Netherlands and the UK. The stakeholders, experts and intermediaries in the focus groups came from different backgrounds. In addition, the results of the project were presented and discussed in a one-day EU-OSHA stakeholder seminar in October 2017.

On a macro-system level (societal context, culture and politics), one barrier to successfully implementing RTW programmes was the lack of clarity as to who was responsible for supporting workers in their RTW. It should therefore always be made clear to employers, workers and other stakeholders who is responsible for the RTW of workers diagnosed with cancer. In addition, the cultural stigma of a cancer diagnosis and the (cultural) misconceptions about the possibilities of working after a cancer diagnosis were considered important barriers to implementing RTW programmes. It is hence necessary to address these misconceptions and remove the stigma that is associated with the diagnosis of cancer on a societal level. The participants of the seminar discussed how important it would be for physicians to consider 'work' as a health outcome for the future. Increasing the importance of work could start by including 'participation in work' as a health outcome for physicians in research and practice.

The facilitators for implementing successful programmes were the legal possibilities of offering part-time work and incentives for the employer to support RTW, both of which are given as recommendations for legislation. An important factor that hampers RTW is privacy legislation, which hinders open communication. This is nevertheless the statutory right of patients. As the privacy rights of patients are of the utmost importance and are constitutional, stakeholders working in RTW programmes should be trained in how to accomplish open communication without the disclosure of the diagnosis.

To implement successful RTW programmes, society needs better knowledge regarding side effects and regarding RTW opportunities and limitations. The EU and/or national government could play a role in providing this information. Although the findings of this project could be applicable to all Member States, national-level differences should be taken into account in the process of implementing successful RTW programmes in other countries.

On a meso-system level (company, healthcare, legislative and insurance system), the structural implementation of an RTW programme or RTW policy within a company is an important facilitator of its success. Consequently, it is recommended that companies willing to implement RTW programmes make the implementation a structural part of their policies throughout the company. In addition, it is crucial to train supervisors, HR personnel and case managers in cancer and work aspects such as long-term side effects, in communication with the worker with cancer and in the elements of the RTW programme.

At the workplace level, it is essential that colleagues are involved in the RTW process. The importance of practical tools was stressed during the seminar: spreading knowledge to HR personnel and

supervisors on cancer and work via, for instance, workshops, would be of added value. EU-OSHA could possibly take a role in promoting best practices on how sharing information at the workplace level could be achieved: this was discussed during the seminar. Barriers to the implementation of RTW included a lack of time, financial difficulties, a lack of knowledge and insufficient skills at the workplace to support the RTW of the worker with cancer. Consequently, for the implementation of the programmes to be successful, companies should allocate enough time and finances and provide training on the knowledge and skills required. Effective, successful programmes must also be multidisciplinary, timely and tailor made. Furthermore, successful programmes should target not only RTW but also remaining in work once a worker has returned. When companies consider an RTW programme, these aspects should be incorporated into it.

Finally, for successful programmes, it is of the utmost importance that the OHP has access to and can support both the worker and the employer early in the diagnosis and treatment process. Furthermore, practical information is needed regarding, for example, reasonable accommodation within the organisation. Hence, it is essential that companies involve an OHP as soon as the diagnosis has been disclosed. Significant barriers to the implementation of programmes are the failure to address work immediately from the start of the treatment and the fact that attending physicians are too protective regarding RTW or have a negative view of it. Ideally, physicians should be educated during their medical training on the effects of a disease on a worker's involvement in work, the importance of work for the quality of a patient's life and the effect of RTW advice from an attending physician. The participants of the seminar discussed that it is important for physicians to be trained to address RTW issues. The health insurer should play a role in this by funding time for healthcare professionals to do this.

For SMEs, it is considered very difficult to implement RTW programmes because it is harder for them to accommodate work modifications and provide gradual RTW, as they have less flexibility. The seminar participants discussed how information and resources for RTW strategies or programmes are lacking in SMEs, and how support and education are needed. The larger a company is, the more likely it is to have the resources to support and keep an employee with reduced work ability at work or on long-term sick leave. SMEs should therefore receive help in making work requirements more flexible or in aligning themselves with other companies that are more flexible.

On the micro-system level of the worker, it was concluded that early intervention or paying attention to RTW early in the illness process is essential. Communication with the worker diagnosed with cancer throughout the sickness period is another important facilitator of a successful programme. The worker should remain in contact with the workplace during his/her sick leave, especially in the early phases of diagnosis and treatment. Successful implementation is further facilitated by the worker being highly motivated to return to work, taking responsibility for him- or herself and realising that he or she has to plan RTW. These aspects should therefore be part of a successful RTW programme. Furthermore, there is a need for tailor-made programmes for workers diagnosed with cancer; tailoring the programme to suit the worker's preferences could complement the use of a framework for the RTW of workers diagnosed with cancer.

Issues regarding work-related cancer were not mentioned in the focus groups. It was considered as an inappropriate environment for employers or other stakeholders to discuss the RTW of workers with work-related cancer mostly because of legal issues (e.g. the possibility that employers might be legally liable for not preventing work-related cancer). These legal issues regarding work-related cancer for employers might also have been the reason why the subject was not spontaneously mentioned during the focus groups.

To make RTW programmes more successful, there is a further need for RTW policies for cancer and for legislation for self-employed workers affected by cancer.

## Conclusion

Surviving cancer can limit one's work ability for various reasons. The implications of cancer and its treatment can affect all aspects of human health and well-being, including physical, mental and cognitive symptoms. These implications can be either short or long term. When returning to work, survivors may face difficulties in balancing work and treatment demands, including negative attitudes or behaviours

among their colleagues and employers. All of this may lead to a reassessment of work and life goals, and thus may hinder RTW.

With the rising number of cancer survivors, effective interventions are needed to enable RTW and to reduce the costs to individuals, companies and society at large. The only scientific evidence for RTW having been improved is in comparison between multidisciplinary interventions and usual care. These interventions include physiotherapy, occupational therapy, speech therapy, vocational rehabilitation and psychology in relation to RTW (delivery of, for example, education, counselling and training).

We found 78 good practice examples of rehabilitation or RTW support through instruments, practices, policies and interventions for people diagnosed with cancer. Subsequently, seven good practice examples from five Member States (Belgium, Denmark, Ireland, the Netherlands and the UK) demonstrated that working together with different stakeholders — including the workers and their family, the employer, healthcare professionals and occupational rehabilitation experts — was important in having a positive impact on the RTW process. In addition, early intervention or paying attention to RTW early in the treatment phase also appeared to be important in every programme.

We interviewed stakeholders from companies that had a variety of programmes, initiatives and policies in place to support the RTW of workers diagnosed with cancer. The content of the programmes and the people involved in the programmes differed. Multidisciplinary programmes involving several stakeholders from both inside and outside the company were the most common. The facilitators of successful execution of the programmes were legislation encouraging RTW, communication between stakeholders, knowledge of cancer and work and of RTW processes, and positive attitudes towards workers returning to work after a serious illness. The perceived barriers to successful implementation were an inability to implement work adjustments and insurance issues. Overall, the stakeholders were enthusiastic about their programmes, initiatives and policies and believed that these could be transferred to other companies.

The experts and intermediaries in the focus groups indicated a range of barriers to and facilitators of the successful implementation of policies, systems, programmes and instruments in the field of rehabilitation and RTW for workers diagnosed with cancer in their various countries and within their companies. Furthermore, they discussed the requirements for and obstacles to implementing programmes and initiatives for rehabilitation and RTW after cancer. Important barriers were the lack of clarity regarding who is responsible for supporting workers in their RTW, the cultural stigma of a cancer diagnosis, issues around disclosure and privacy, a lack of involvement of OHPs or experts, the inability to provide work accommodations and failures to address RTW issues in the healthcare setting. Success factors for organisations included structural implementation of the RTW programme or RTW policy, communication between all stakeholders and supportive legislation.

In the EU-OSHA seminar for stakeholders, the importance of making straightforward recommendations to stakeholders in companies was discussed. Recommendations for how cancer and RTW issues should be integrated into more general RTW programmes are especially important. For SMEs, this is vital because they most likely need intermediaries or consultants to supply these programmes. During the EU-OSHA stakeholder seminar, the European Commission further underlined the importance of the tertiary prevention of occupational diseases. The participants of the seminar also discussed how important it would be for physicians to consider ‘work’ as a health outcome for the future. Increasing the importance of work could start by including ‘participation in work’ as a health outcome for physicians in research and practice.

In conclusion, a range of RTW instruments, practices, policies and interventions exist for workers with cancer, and these are considered essential for improving the work outcomes of those diagnosed with cancer. To develop effective, efficient RTW interventions, the facilitators for executing successful programmes seem to be legislation that encourages RTW, communication between stakeholders, knowledge of cancer and work and of RTW processes, and positive attitudes towards workers returning to work after a serious illness.

# 1 Background

Each year, an estimated 3.4 million new cases of cancer are diagnosed in Europe. About half of the people diagnosed with cancer are of working age. The number of people diagnosed with cancer in the workplace will steadily increase in the near future. Although cancer occurrence differs among regions in Europe, the most frequent forms of cancer are breast, colorectal, prostate and lung cancer. In 2012, it was estimated that these types of cancer account for over half of the overall burden of cancer in Europe.

The impact of cancer on a person's daily life is immediate and striking. The diagnosis is usually accompanied by long periods of sickness absence due to medical treatments and functional restrictions. Although, in general, cancer management has improved over the past three decades and the overall number of people who survive cancer is increasing, many cancer survivors still face long-term symptoms and impairments, such as fatigue, after treatment ends.

These symptoms and impairments can affect the work ability of cancer survivors, making it more difficult to remain in or re-enter the job market. Research shows that most cancer survivors are able to remain in or return to work, but that overall the risk of unemployment among cancer survivors is 1.4 times higher than among people who have never been diagnosed with cancer (de Boer, 2009).

Optimising the rehabilitation and return to work (RTW) of workers with cancer is important for improving the well-being of this vulnerable group and for reducing the societal and financial impacts of cancer diagnoses on European society at large (EMHF, 2017). Instruments, practices, policies and interventions aimed at the promotion of rehabilitation and RTW are clearly important. These are needed to improve the RTW of workers diagnosed with cancer and to provide employers with advice for assisting the worker affected by cancer while returning to work.

EU-OSHA commissioned projects to review the current research, policies and practices on the following three topics: (1) rehabilitation and RTW after cancer, (2) work-related diseases due to exposure to biological agents and (3) sentinel and alert systems for occupational diseases. These topics were considered important for health and safety at work and are part of EU-OSHA's 2014-2020 strategy<sup>1</sup>. These projects provide an evidence base for prevention policy and practice in the European Union (EU). Cancer and RTW is an occupational safety and health (OSH) problem of increasing importance.

This report concerns rehabilitation and RTW after cancer. The combined review of literature, policy and practice made this project unique. The inclusion of both literature and the opinions and practices of workers, employers and OSH experts was therefore extremely valuable in obtaining a complete picture of the evidence available. This review on rehabilitation and RTW measures for workers affected by cancer provides an insight into the problems encountered by both workers affected by cancer and their employers, and provides recommendations for enterprises, building on examples of policies already in place.

The project covers the current knowledge on workplace adaptations and RTW measures for workers affected by cancer. It outlines the existing views on and conclusions regarding OSH and RTW strategies and the findings of any partnerships and examples of cooperation across policy areas.

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<sup>1</sup> See <https://osha.europa.eu/en/tools-and-publications/publications/corporate/eu-osha-multi-annual-strategic-programme-2014-2020/view>

## 2 Objective

Building on previous EU-OSHA work on rehabilitation and work health promotion and its multiannual project on older workers<sup>2</sup>, the objective of the ‘Rehabilitation and return to work after cancer — instruments and practices’ project is to raise awareness and provide more insight into the problems encountered by workers affected by cancer and their employers. Furthermore, it aims to present enterprises with recommendations and guidance on successful instruments, interventions, programmes and practices to support the RTW of workers affected by cancer, including policy and strategy options for different levels and actors, including those at the EU level.

This project targets:

- employers of workers affected by cancer, including small and medium-sized enterprises (SMEs);
- workers affected by cancer, including those with work-related cancer;
- enterprise actors and intermediaries involved in setting up company policies;
- policy makers at national and EU level, including social partners;
- legislators;
- researchers;
- policy makers in other related areas, including social security and public health;
- actors in occupational diseases recognition, rehabilitation and statistical data collection.

This project aims to help them to:

- have a better understanding of what the issues are and what could be done, the advantages and disadvantages of options, and the drivers and obstacles to effective implementation;
- better assess what decisions they need to consider and with whom they need to cooperate to implement and benefit from a successful RTW and/or integration policy.

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<sup>2</sup> See <https://osha.europa.eu/en/themes/osh-management-context-ageing-workforce/ep-osh-project>

## 3 Methods

To meet the objective of the project, different methodological approaches were used:

- a literature review;
- detailed descriptions of policies, systems, programmes and instruments in the field of rehabilitation and RTW after a cancer diagnosis;
- company case studies;
- focus groups;
- an EU-OSHA seminar to discuss the findings.

More information can be found in a separate document: “Methodological annexes”; available at: <https://osha.europa.eu/en/tools-and-publications/publications/rehabilitation-and-return-work-after-cancer-instruments-and-0/view>.

### 3.1 Literature review

We used three different methods to search for, appraise and collect evidence for this literature review (EU-OSHA, 2017).

First, scientific evidence was searched for and systematic reviews were selected that reported on:

- the health and economic impacts of cancer on the employee and the employer;
- interventions and examples of how to facilitate RTW.

Second, as a lack of systematic reviews was anticipated in the field of occupational cancer and SMEs, a literature search was performed to identify qualitative and quantitative studies that complemented the results of the systematic reviews.

Third, we searched the grey literature (e.g. publications from non-governmental organisations (NGOs) or EU-OSHA) to compile a broad overview of existing programmes and interventions.

In addition, we collected data via an online questionnaire to complement the list of interventions and to identify unpublished programmes and interventions.

It is possible that more literature on RTW after cancer exists than that published in this report, as the research team of this project lacked the language skills to check literature in other languages.

### 3.2 Detailed descriptions of policies, systems, programmes and instruments in the field of rehabilitation and RTW after a cancer diagnosis

To collect information on good practice examples in Europe of rehabilitation or RTW support policies, systems, programmes and instruments for people diagnosed with cancer, we used different methods.

After we had collected this information, we selected seven good practice examples to be described in detail, in agreement with EU-OSHA. An online questionnaire targeting the project leaders of the selected examples of good practice was sent out to generate information for a comparative analysis of the examples, including factors that contributed to their success and transferability.

### 3.3 Company case studies

We used different methods to collect information on examples of enterprises and to briefly describe them. After we had collected this information, eight good practice examples were selected from three different countries: Belgium, Ireland and the Netherlands. Each company case study was elaborated further by interviews covering four different stakeholder groups:

- human resources (HR) personnel;

- workers affected by cancer;
- the trade union representative or works council representative; and/or
- the occupational health physician (OHP).

The interviews were audiotaped, after which a comparative analysis was performed by grouping the companies' answers regarding the different themes of the interview guide; this provided an overview of the similarities and contradictions between these companies.

### 3.4 Focus groups with stakeholders

The results of the detailed descriptions and case studies served as input for the focus groups with stakeholders, in which qualitative research was carried out with experts and intermediaries regarding policies, strategies and programmes aimed at managing the RTW of workers with cancer.

Four countries were selected for the focus groups. The same countries were selected as those selected for the detailed descriptions and/or company cases studies: Belgium, Ireland, the Netherlands and the UK. The countries were selected because their policies, systems, programmes or instruments for rehabilitation and RTW for cancer patients were considered representative and covered a wide range of (work-related) cancers and enterprises (including SMEs). The research question of each focus group was: 'What are the barriers to and facilitators of an RTW programme for workers diagnosed with cancer, and what are the requirements for the success of these programmes?'

### 3.5 EU-OSHA seminar to discuss the findings

In a one-day EU-OSHA stakeholder seminar, the project was explained and the draft final findings were presented and discussed with 35 participants.

The different approaches, instruments and practices were compared, challenges and success factors were examined, and the transferability of the examples of instruments and practices was discussed.

## 4 Results

### 4.1 Literature review

This section summarises the detailed published literature review (EU-OSHA, 2017).

#### 4.1.1 Health and safety implications for workers

Work can be physically, cognitively, emotionally and interpersonally demanding, and workers need to have sufficient work capacity to be able to meet these demands. Disease can affect this capacity, making it impossible to meet demands and lowering a worker's functioning at work. As long as work capacity is reduced, RTW will be impeded. Cancer survivors, in particular, may have long-term or even permanent health complaints that can have implications for their personal ability to return to work.

This section covers the impact of cancer diagnosis and treatment on the work ability of survivors during or after treatment (e.g. the ability to concentrate or to cope with stress) and the factors related to sociodemographics, job characteristics and the disease that influence the RTW process (e.g. age, physical job demands and tumour site). It describes cancer survivors' personal capacity to meet work demands, prognostic factors for RTW after cancer, differences according to selected factors and individual-level economic costs.

##### ▪ Cancer survivors' personal capacity to meet work demands

The literature shows that survivors report various effects of cancer and its treatment on their physical, cognitive and mental health (EU-OSHA, 2017).

Some cancer survivors may be symptom free, while others have to live with cancer-related symptoms and impairments for years after their treatment ends (Feuerstein et al., 2010; Silver et al., 2013). In these cases, symptoms can be long term and can interfere with work performance for 10 years or more after the initial diagnosis (Silver et al., 2013).

Some reviews reported that health implications may result in the termination of employment, an increase in the amount of sick leave and a diminished ability to meet work demands (EU-OSHA, 2017). Any of the reported symptoms and impairments may therefore reduce a cancer survivor's personal capacity to meet work demands, although not all of the reviews explicitly reported a decrease in cancer survivors' work ability.

The most frequently reported symptom in the reviews was a diminished level of energy, described as fatigue or exhaustion, and emotional strain due to the ongoing battle with cancer. This was common across cancer types (EU-OSHA, 2017). The next most commonly reported consequences were other physical, mental and cognitive health implications.

The physical health implications of cancer were described in the literature as either diminished physical and functional capacity or physical problems, impairment or even disability (EU-OSHA, 2017). The specific examples of decreased physical capacity were related to particular types of cancer and its location in the body. The problems were described as limitations in upper body movements, hot flushes, bladder and bowel problems and nausea. The most frequently reported difficulty was (chronic) pain (EU-OSHA, 2017).

Mental health implications were described as diminished mental health, psychological symptoms or mental disorders. Specific examples of mental health problems were depression, lower stress thresholds, anxiety, distress, fear of recurrence, sleep problems, loss of confidence, feelings of inadequacy and limitations regarding re-employability (EU-OSHA, 2017).

Cognitive implications were described by the review authors as diminished cognitive capacities; problems, limitations, difficulties or impairments in cognitive functioning; or even cognitive disability (EU-OSHA, 2017). These problems were attributed to cancer treatments such as chemotherapy and radiotherapy across cancer types. Specific examples included problems with focusing and memorising (Fitch, 2013; Fitch and Nicoll, 2014).



The explicit occupational implications that the review authors reported were diminished work productivity, work ability impairments and reduced functioning at work. However, these were not described in any further detail, except by saying that the symptoms interacted with cognitive, physical and mental work ability or functioning at work (EU-OSHA, 2017).

None of the reviews reported implications for safety issues at work as a result of cancer diagnosis or treatment. It is, however, possible that symptoms such as a lower level of energy, fatigue or a diminished cognitive, physical or mental health status could affect the safety of workers and others and increase the risk of accidents. This might be relevant for professions such as bus drivers, pilots, surgeons and security guards.

#### ▪ Prognostic factors

The review authors used qualitative methods to synthesise studies (EU-OSHA, 2017) or presented a narrative of the study results (EU-OSHA, 2017). This provided an overview of factors that could possibly influence the success of an RTW process after cancer. The following five groups of factors were reported as influencing the RTW process:

1. sociodemographic;
2. work-related;
3. disease-related;
4. treatment-related;
5. other.

The sociodemographic factors associated with RTW included age, gender, educational level, occupational status, marital status and income. Older females with a lower income and a lower level of education seemed less likely to return to work than younger males and survivors with higher levels of education and income (EU-OSHA, 2017). This evidence is not strong, however, and reviews provide conflicting results. Only age can be significantly associated with RTW (Horsboel et al., 2012; Spelten et al., 2002).

Examples of work-related factors were the size of the organisation; physical and emotional job demands; working hours; the possibility of job, health insurance and disability pension coverage loss; attitudes of colleagues; and union membership. Physically demanding jobs were negatively associated with RTW, unlike less demanding jobs which were associated positively with RTW (EU-OSHA, 2017). A supportive work environment (including attitudes of colleagues and perceived employer accommodation) was positively associated with RTW, while a non-supportive social work environment was considered a barrier to RTW, although discrimination at the workplace was not found to be significantly related to RTW (Spelten et al., 2002).

Disease-related factors included cancer type, site, stage and symptoms. Treatment-related factors included the type of treatment received (e.g. aggressive versus less aggressive), treatment length and treatment side effects. The review authors concluded that RTW was negatively associated with survivors of more aggressive cancer types, less favourable prognoses and more intense and longer treatments. Intervention studies have shown that aggressive and less aggressive treatments for the same cancer type result in similar RTW rates, although better quality studies are still needed to confirm this result (de Boer et al., 2015a). This could mean that the type of treatment might not be a relevant prognostic factor, but could instead be an indication of the cancer type and stage.

Other possible factors that the literature regarded as hindering RTW were fear of unemployment, low quality of life scores, changed attitudes to work such as reduced importance or decreased work aspiration and changes in emotional states, such as depression, worry, frustration, fear or guilt. Time is considered a facilitator of RTW, with the likelihood of RTW increasing over time (Steiner et al., 2010). Other factors that were considered facilitators were having private health insurance, receiving advice from one's doctor regarding work and psychological factors (life satisfaction, willingness or self-motivation, normalcy and acceptance of maintaining a normal environment at work). Another factor that was discussed in the literature as influencing RTW was the personal perception of one's illness, as this determines further behaviour concerning managing one's disease (Hoving et al., 2010). However, the

results are based on studies on somatic diseases and the extent to which the findings are relevant for cancer survivors remains unclear.

#### ▪ Differences according to selected factors

Some research evidence suggests that differences in RTW outcomes are due to differences in professions, occupational sectors, enterprise size, gender, age and income.

It is, however, uncertain to what extent these factors influence RTW and how they relate to other factors (such as treatment, diagnosis and psychological factors), because good-quality evidence and multivariate analysis data are lacking.

The influence of the size of the enterprise is even less clear. Only one review identified the size of the organisation as an important factor, but it failed to provide references to primary studies or to specify the direction of the influence (Wells et al., 2013).

Thus, it is uncertain whether the following suggested relationships are actually significant:

- cancer survivors employed in manual labour might be less likely to return to work than survivors with less physically demanding jobs;
- the size of the organisation might be an important factor for RTW (direction unknown);
- female cancer survivors might be less likely to return to work than male survivors;
- older cancer survivors might be less likely to return to work than younger survivors;
- cancer survivors with lower incomes might be less likely to return to work than survivors with higher incomes.

It is difficult to draw firm conclusions about the influence of prognostic factors on RTW because the evidence is mainly from qualitative and cross-sectional studies. Even though these studies indicate possible valuable factors, to be more certain we need more longitudinal studies that indicate how strongly the factor is related to RTW.

Ideally, evidence regarding prognostic factors should be based on primary studies with a longitudinal design to minimise bias and identify relevant factors that predict work status over time. Furthermore, no reviews had numerically combined the results of prognostic factors in a meta-analysis.

This means that no convincing conclusions could be drawn from the review regarding the significance of the identified prognostic factors. For example, no information was available on how well factors predict RTW outcomes or how different factors are related. We cannot determine, for example, the extent to which age increases the risk of not returning to work.

### **4.1.2 Cost to employers, workers and society**

The RTW of cancer survivors is economically important. Cancer survivors who do not return to work during or after treatment inflict a financial cost on the employee, the employer and society. Adapting the work environment may enable RTW. This may come with costs for the company and the employee but, in the end, these costs may be less than those of long-term sick leave.

Most of the scientific literature shows that individuals experience financial loss when they are not able to return to work after cancer. Most commonly, cancer changes the economic status of survivors and imposes economic difficulties on them and their family. Reviews reported economic loss for the individual as a result of reduced wages related to, for example, delayed RTW, exhaustion of paid sick leave or unemployment. Further additional costs due to cancer and its treatment were also reported.

The systematic reviews yielded no results regarding the economic impact on companies.

Only one review reported economic loss to society due to cancer-related loss of productivity and working days. These costs to the EU were estimated to be EUR 9.5 billion in 2009 (Aaronson et al., 2014). None of the reviews reported additional costs to society due to RTW interventions for cancer survivors. Some

individual studies, however, evaluate the costs of single interventions (e.g. Mewes et al., 2015; Tamminga et al., 2012).

- **Individual level**

Systematic reviews identified that the financial impact on the cancer survivor is a combination of the additional costs of having cancer (e.g. travel and medical bills), gradual exhaustion of paid sick leave and a change in occupational status (reduced wages, unemployment or delayed RTW) (EU-OSHA, 2017).

This can pose a serious challenge not only to the individual but also to a family's budget (Wells et al., 2013). Some argue that it is unclear whether the financial status of cancer survivors is different from that of individuals without cancer (Mehnert, 2011; Steiner et al., 2004).

- **Societal level**

It has been argued elsewhere that the economic consequences of cancer-related lost productivity are significant (Wells et al., 2014). The economic costs of cancer and RTW for the EU in 2009 have been estimated to be in the billions (Aaronson et al., 2014).

### **4.1.3 Wider issues that may affect the worker**

- **Meaning of work and motivation to work**

The meaning of work and motivation to work are factors that influence RTW decisions. From the scientific literature, four intrinsic and two extrinsic factors were identified that are related to motivation to work, which either support or discourage RTW decisions.

Most of the factors that facilitate RTW are internally driven. Cancer survivors perceived work as (1) socially important, (2) a marker of health, (3) a marker of normality and (4) important to one's identity. Regaining normality and structure in everyday life was reported as both the motive to return to work and the meaning of work in itself. Cancer survivors valued, for example, the possibility of returning to 'default' and perceived work as a distraction from cancer. They also valued relationships with co-workers and did not want to miss out on the social aspects of work. Others understood work as a marker of well-being and reported that working and being at work made them feel healthy. Work was also reported as being important to one's identity and survivors returned to work to regain a sense of their former self and identity, to adjust to bodily changes or because work meant validation and achievement.

Other potential factors for enhancing RTW were externally driven. Survivors understood work as an economic necessity to protect lifestyle aspirations or support the family or returned to work for insurance reasons. In one review, some men reported feeling pressure from the workplace to return to work (Handberg et al., 2014).

In contrast, some cancer survivors choose not to return to work or choose to reduce working hours. Factors that hindered RTW were described when survivors reported a change in the meaning and importance of work after their cancer diagnosis. Others felt too ill to work, perceived the workplace as discouraging or simply preferred the opportunity to take a break. The reviews did not describe the characteristics that made the workplace a discouraging place.

- **Attitudes and behaviour of employees and colleagues**

The behaviour and attitudes of others can either support or discourage cancer survivors' RTW decisions and can influence organisational structures and interpersonal relationships. The scientific literature mainly describes the attitudes and behaviours of others from the perspective of the cancer survivor: studies describe cancer survivors' positive and negative experiences of workplace accommodations, support from healthcare professionals and support from colleagues and employers.

The negative experiences reported included unwanted workplace accommodations, a lack of support from health professionals, employers and colleagues, and facing discrimination and misconceptions regarding the impact of cancer. In contrast, positive experiences were related to receiving appropriate workplace accommodations and adjustments, organisational communication between healthcare professionals and employers, legal protection and support from healthcare professionals, colleagues and employers.

Neither communication between healthcare professionals and employers nor the type and content of support from professionals, colleagues and employers was very well described in the scientific literature. However, a lack of support was detailed as not receiving work-related guidance from professionals or receiving insincere or only short-lived support from colleagues and employers. Examples of support that resulted in positive experiences were receiving advice from medical practitioners regarding RTW (Amir and Brocky, 2009) and consistent personal and emotional support from colleagues and employers (e.g. empathy, dignity, contact during and after treatment, help to manage symptoms and help to generate a greater understanding of the illness at the workplace) (Wells et al., 2013).

Cancer survivors experienced discrimination in the form of forced changes, refusal of modifications, unfair dismissal, employment discrimination or insensitive and stigmatising behaviour. They also reported that employers did not always realise how long side effects can last.

The type of workplace accommodations and whether they were perceived as wanted or unwanted were not described in detail. Examples of accommodations that were received positively included adaptations to counteract reduced work ability, such as reduced demands or shorter working hours.

#### ▪ **Difficulties in balancing demands of work and treatment**

Cancer survivors face difficulties in balancing the conflicting demands of work and treatment, such as the need for sick leave during treatment and the obligation to be at work (Wells et al., 2013). Scientific literature describing these difficulties in more detail is lacking.

### **4.1.4 Work-related and occupational cancer**

Regarding RTW after cancer, there is a lack of systematic reviews and primary studies on work-related and occupational cancer. It is unclear whether the findings regarding non-occupational or non-work-related cancers are applicable when the cancer is due to workplace exposure.

### **4.1.5 Aspects relevant to SMEs**

The size of the company seems to have an impact on cancer survivors' possibilities for returning to work (Wells et al., 2013). In SMEs (companies with fewer than 250 workers), information and resources for RTW strategies or programmes are lacking and support and education are needed (EU-OSHA, 2017). These problems seem to be particularly prominent in small enterprises (with fewer than 50 workers) and micro enterprises (with fewer than 10 workers) (EU-OSHA, 2016).

### **4.1.6 Interventions and resources**

The overview shows that only a few scientific studies describe the available interventions and resources relevant for cancer and RTW, and that only a few scientific reviews report their effectiveness for RTW. Most information on the available interventions was found in the grey literature.

Most interventions have been developed for cancer survivors, but some interventions specifically target employers, HR professionals, line managers or healthcare professionals. Only a few interventions are available for SMEs and those who are self-employed and affected by cancer.

The interventions described in the scientific literature focus on rehabilitation, guidelines and workplace accommodations. Rehabilitation services for cancer survivors aim to improve their work ability and

include vocational, medical, physical, psycho-educational and multidisciplinary interventions. A positive influence on RTW could be shown only for multidisciplinary interventions (de Boer et al., 2015a; de Boer et al., 2015b). The effect of the other interventions is uncertain.

Results from the grey literature show that many additional interventions are available that provide information, training and assistance related to employment after cancer diagnosis and treatment. However, none of these has been evaluated and the effect on RTW is unknown. Most services are provided by NGOs and focus mainly on providing information and consultancy regarding cancer and RTW. The interventions available are in the form of webinars, seminars, lectures, online material, videos, printed material (posters and brochures), telephone and email support and personal consultancy meetings. Other interventions enable the exchange of experiences, ideas and communication between those affected by cancer or working with cancer survivors via membership in networks and support groups.

#### **4.1.7 Synergies and roles of policy areas and (enterprise) actors**

The actors that are frequently mentioned in the literature as influencing RTW decisions, in addition to the cancer survivors themselves, are healthcare professionals, employers including workers in HR departments, colleagues and trade unions. The grey literature also mentions other actors as providing support to employers and workers: employment and social services, professionals in the area of legal protection and NGOs.

## **4.2 Detailed description of policies, systems, programmes and instruments**

### **4.2.1 Specific examples of rehabilitation programmes after cancer**

In this project, 78 good practice examples of rehabilitation or RTW support policies, systems, programmes and instruments for people diagnosed with cancer were found. The examples were collected from 13 EU countries, the USA and Australia.

The examples were found in the following countries:

|                      |    |
|----------------------|----|
| Australia:           | 2  |
| Austria:             | 1  |
| Belgium:             | 4  |
| Denmark:             | 2  |
| Finland:             | 2  |
| France:              | 1  |
| Germany:             | 11 |
| Ireland:             | 2  |
| Netherlands:         | 14 |
| Scotland:            | 2  |
| Slovenia:            | 1  |
| Spain:               | 1  |
| Sweden:              | 1  |
| UK                   | 26 |
| Both UK and Ireland: | 1  |
| USA:                 | 7  |

Appendix section 9.1, 'Policies, systems, programmes and instruments in the field of rehabilitation and RTW after a cancer diagnosis: 78 programmes found', describes all of the examples found.

## 4.2.2 Seven good practice examples

The 10 most interesting good practice examples were:

- **Macmillan Cancer Support, ‘Working Through Cancer’ programme, the UK.** This programme takes a particularly comprehensive approach, with different resources targeted at multiple stakeholders, including employees, employers, the self-employed, HR managers and healthcare providers. It has multiple modalities, including online information, information in tool kits, consultation, e-learning modules, expert advice, (telephone) support and in-company training courses. The programme is for patients, healthcare providers and companies.
- **Municipality-based occupational rehabilitation programme, Denmark.** This Danish intervention is specifically targeted at seven different types of cancer, including more neglected diagnoses such as head and neck cancer and thyroid cancer. The programme is individual and tailored to the patient’s needs and is carried out by a job consultant.
- **Working Health Services, Scotland.** This programme is specifically aimed at patients with breast cancer; this is by far the largest group of cancer patients of working age. It shows a particularly comprehensive approach, with a multidisciplinary intervention including different modules targeted at multiple stakeholders, including physiotherapists, OHPs and nurses, psychologists and counsellors. It is tailored to the patient’s needs after an intake consultation. It encompasses vocational rehabilitation, telephone and face-to-face support and referrals to supportive services.
- **In-hospital rehabilitation intervention, the Netherlands.** This programme takes a particularly comprehensive approach, with different modules targeted at multiple stakeholders, including employees, OHPs and employers. It has multiple modalities, including face-to-face counselling and information, patient education, enhancing communication between treating physicians and OHPs, and collaboration between the employer, employees and the OHP. It is executed by an oncology nurse trained in occupational issues.
- **Cancer Society Finland, ‘Return back to work’, Finland.** This intervention targets both employees and their family members, as the latter can be very important in the RTW process. The programme has multiple modalities, including counselling, online information, information packages, inpatient and outpatient RTW courses and a helpline.
- **Work reintegration agency Rentree, Belgium.** This agency takes a comprehensive approach, with different modules targeting the employee, but also includes the employer and the patient’s colleagues. It has multiple modalities, including consultation, individual coaching and group coaching. The programme involves patients and companies.
- **Work reintegration agency Re-turn, the Netherlands.** This agency takes a particularly comprehensive approach, with different modules targeted at multiple stakeholders: employees, companies and the self-employed. The programme has multiple modalities, including online information, consultation, expert counselling and in-company training courses. It involves the patients and the companies, with the latter having job coaches. The measure targets and is tailored to both patients and companies.
- **Maggie’s, the UK.** Both employees and employers are involved in this programme. Several aids are provided, including toolkits, webinars and guidance articles. The programme involves patients and employers.
- **Work reintegration agency oPuce, the Netherlands.** This agency is innovative because it focuses on the vulnerable and neglected group of unemployed cancer survivors. oPuce works closely with enterprises that are willing to place these unemployed people. The programme has several modalities, including coaching, counselling and on-the-job support. The programme involves patients and companies, with the latter having job coaches.
- **Booklet of the Irish Congress of Trade Unions, Ireland.** The Irish Congress of Trade Unions provides an overview, in booklet form, of the best processes and policies for those affected by breast cancer and other illnesses. Union representatives, union members and employees have worked together on this booklet and it is an example of an interesting innovative initiative.

The selection of the following seven good practice examples to be described in more detail was made in agreement with EU-OSHA.

Overall, it was found that RTW is influenced by the institutional context of a country.

- Macmillan Cancer Support, 'Working Through Cancer' programme (UK)

The 'Working Through Cancer' programme in the UK provides support to different stakeholders — people with cancer and their carers, health and social care professionals and employers — to support people with cancer to remain in or return to work and influences government policy and service commissioners. The intervention was developed by the charitable organisation Macmillan. Macmillan is a charity in the UK with independent funding; it is building up a basis of good evidence from a wide range of experts and stakeholders. The 'Working Through Cancer' programme includes several stakeholders: people with cancer and their carers, health and social care professionals, employers, and government and service commissioners. The programme includes several resources, with separate resources for the worker, employers and healthcare professionals. It also covers various organisations and companies. Such cross-organisational programmes do not currently exist in other countries.

- Municipality-based occupational rehabilitation programme (Denmark)

According to the Danish Sickness Benefit Act, in Denmark, municipal job centres are responsible for paying sickness benefits and initiating occupational/vocational rehabilitation to help sick-listed people return to work. According to the law, the employer pays sickness benefits for the first four weeks, after which the municipality refunds the employer's wage expenses for a maximum period. This programme was the initiative of one municipality. It involves different stakeholders: the hospital (nurses), the employer, a job consultant and the employee. The job consultant acts as an intermediary between the employer and employee. It was surprising that the job consultants were not wanted at the hospital; the nurses in particular were reluctant to be involved because they felt that patients needed protection from the outside with regards to demands/pressure, etc. One of the innovative elements of this intervention was the timing and much earlier onset of occupational rehabilitation than usual. The evaluation of this intervention will determine whether or not this approach increases the likelihood of RTW compared with the control municipalities.

- In-hospital rehabilitation intervention (Netherlands)

This in-hospital rehabilitation intervention was developed in consistency with the Dutch social security system. In the Netherlands, a sick-listed employee receives at least 70% of his/her wage, which is paid by the employer. Both the employer and the employee have responsibilities as regards the RTW process. The sick-listed employee cannot be dismissed because of his/her illness during the first two years of sickness absence (Improved Gatekeeper Act). This programme seems to be a good way to introduce early intervention, as most cancer patients have no contact with their supervisor or OHP during the early phases of their cancer treatment. In addition, this in-hospital rehabilitation intervention involved different stakeholders: the OHP, the supervisor and the employee. Overall, patients were highly satisfied and nurses found the intervention feasible. Results showed that the programme led to very high RTW rates.

- Work reintegration agency Rentree (Belgium)

In Belgium, disability leave (sick leave) is paid for one month by the employer and thereafter is paid by the social insurance provider. The Rentree programme was a social insurance (sickness and disability insurance) initiative named 'Fight against cancer' (in Dutch 'Kom op tegen Kanker'). Rentree involves different stakeholders, from among which the worker chooses those that are involved in his/her personal RTW process. Hence, the programme is tailored to the user. Since Rentree is a recent pilot (March 2015-March 2017), its results are yet to be analysed to determine whether or not this programme increases the chance of RTW. A preliminary result shows that the sooner the user comes into contact with Rentree during the treatment period or rehabilitation process, the greater the benefits.

- Work reintegration agency Re-turn (Netherlands)

The Re-turn work reintegration agency is the initiative of a cancer survivor. In the Netherlands, it is more financially detrimental to the employer when a worker becomes ill than, for example, in Belgium and Denmark, where the employer must pay a sick-listed employee for one month. Initiatives for cancer patient programmes are therefore a logical consequence of this legislation in the Netherlands.

Rehabilitation with the help of Re-turn includes issues regarding home, family, relationships and the physical/mental effects of treatment on RTW; the programme therefore involves different stakeholders. Re-turn is most effective when it comes into contact with the worker with a cancer diagnosis relatively early in the treatment process. It was determined that early onset of an intervention or programme is important.

- Work reintegration agency oPuce (Netherlands)

oPuce is a work reintegration agency in the Netherlands that was started by a cancer survivor. It provides unemployed cancer patients with help. It is very hard for unemployed cancer patients to apply for and get a job. This might be because unemployed cancer survivors impose a financial risk to their new employers, especially in the Netherlands, because employers must pay employees' salary for two years if they fall ill again. The oPuce programme involves many stakeholders. Working together with large companies, mainly multinationals and corporate businesses and involving many other stakeholders including the worker successfully results in solutions and new jobs for unemployed cancer survivors.

- Booklet of the Irish Congress of Trade Unions (Ireland)

The guide developed by the Irish Congress of Trade Unions is also a rather unique programme. In Ireland, the way in which an employee's sick pay is arranged depends on the employer. The idea for the guide came from a conversation between a nurse (a breast cancer specialist) and a representative of the Irish Congress of Trade Unions. The consensus was that there was a gap between the needs of employees with breast cancer and the help they receive, and that this gap had to be filled. The Irish Congress of Trade Unions is a national trade union centre, an umbrella organisation with which trade unions in both Ireland and Northern Ireland are affiliated. Fifty-five trade unions are currently members of the Irish Congress, representing 35.1% of Ireland's workforce. This guide aims to break down the stigma of cancer and RTW, to encourage good conversations between employers and employees and to provide assistance to unions that represent members diagnosed with breast cancer returning to work.

The tables in the annex provide detailed descriptions of the seven programmes.

### 4.2.3 Conclusions

We found 78 good practice examples of rehabilitation or RTW support policies, systems, programmes and instruments for people diagnosed with cancer. The examples were collected from 13 EU countries, the USA and Australia. We then selected seven good practice examples from this long list; the reason that we selected these was because they fulfilled the selection criteria. The seven selected examples were from Belgium, Denmark, Ireland, the Netherlands and the UK; these countries have differences in their OSH systems and approaches.

These initiatives in the different Member States showed that RTW is influenced by the institutional context of a country, especially the length of paid sick leave. In addition, an early intervention or paying attention to RTW early in the illness process appeared to be important in every programme.

Working together with different stakeholders, including the worker and his/her family, the employer, healthcare professionals and occupational rehabilitation experts, seemed to be important in all good practice examples for creating a positive impact on the RTW process. Therefore, it is important to discuss with these different stakeholders the issues with and possible improvements to the RTW of cancer patients.

## 4.3 Company case studies

### 4.3.1 Examples of enterprises that have implemented successful measures for managing the RTW of employees with cancer

We found 28 examples of enterprises that have implemented successful measures for managing the RTW of employees with cancer. These examples were collected from seven European countries.

The examples were found in the following countries:



|              |    |
|--------------|----|
| Belgium:     | 7  |
| Denmark:     | 1  |
| Ireland:     | 1  |
| Spain:       | 2  |
| France:      | 2  |
| Netherlands: | 12 |
| UK:          | 3  |

Appendix section 9.2, 'Examples of enterprises: 28 enterprises found', describes these examples.

### 4.3.2 Company cases

Nine companies were selected, in agreement with EU-OSHA, according to pre-defined criteria.

- C2, the Netherlands. This company has a programme in place that is innovative because it includes a 'Tailored Sport Plan' aimed at sports, rehabilitation and RTW. Furthermore, it has multiple stakeholders, including the employer, the employee and the HR manager, as well as a psychosocial programme provided by Human Support and a physical programme from the Tegenkracht Foundation. C2.1 and C2.2 have the same company name and programmes, but are independent companies (i.e. have their own HR policies, etc.).
- C8, the Netherlands. This is a medium-sized enterprise that provides the Tegenkracht programme for its employees diagnosed with cancer.
- C10, the Netherlands. This is a banking organisation that provides its employees diagnosed with cancer with information via an intranet and trains supervisors in communicating with employees about RTW after cancer.
- C14, Ireland. This is an independent, not-for-profit healthcare provider that liaises with members of staff on an ongoing basis during and after treatment for cancer.
- C16, the UK. This company has a programme in place that includes multiple modules of support, information, absence management policy, sick pay and the involvement of a general practitioner (GP).
- C25, the Netherlands. This is a Dutch department store that provides the Re-turn programme for its employees diagnosed with cancer.
- C29, Belgium. This is a banking organisation. It has no special policy for workers diagnosed with cancer, but has a unique policy regarding communication with employees with a long-term illness.
- C31, Belgium. This is a hospital that employs a unique concept with respect to communication between different stakeholders as regards the RTW of employees with a long-term illness. The employer, OHP, HR director, HR assistant and division manager (of the department in which the worker is employed) hold a meeting once every 14 days to discuss the RTW of the worker diagnosed with cancer. In addition, supervisors are trained in communicating with employees about RTW after a long period of sickness.
- C34, Belgium. This is a company that manufactures cars. It applies a 'relocation policy' within the company, i.e. workers are given a temporary job with adjusted (less intensive) tasks before they return to their original job. If it is possible and the worker wants to return to work, the company provides opportunities for temporary and/or modified work.

### 4.3.3 Data collection (company cases)

Each company decided which stakeholders would be interviewed. This resulted in the following face-to-face or phone interviews:

C2.1, the Netherlands

- HR director (face-to-face)
- Worker (face-to-face)
- OHP (face-to-face)

C2.2, the Netherlands

- Worker (face-to-face)
- Works council representative ('Ondernemingsraad' - OR) (face-to-face)

C8, the Netherlands

- Representative OHP (by phone)

C16, the UK

- HR manager (by phone)

C25, the Netherlands

- HR manager (by phone)
- Worker (by phone)
- OHP (by phone)

C31, Belgium

- HR director (face-to-face)
- HR assistant (face-to-face)
- Division manager (face-to-face)
- Worker (face-to-face)
- OHP (by phone)

C10, the Netherlands

- HR advisor (by phone)
- Worker (face-to-face)
- OHP (by phone)

C14, Ireland

- Employer (by phone)
- Worker (by phone)
- HR person (by phone)

C34, Belgium

- Supervisor 1 (face-to-face)
- Supervisor 2 (face-to-face)
- Worker (face-to-face)
- OHP (face-to-face)
- Trade union representative (face-to-face)

C29, Belgium

- Worker (by phone)
- HR Business partner (by phone)
- OHP (by phone)
- Trade union representative (by phone)

Appendix 9.3, 'Examples of enterprises: interviews', details the content of the interviews in each company (except for C8 and C16, as these are not complete cases).

#### **4.3.4 Comparative analysis**

The comparative analysis involved comparing the programmes in place in the companies with respect to practice, support, advice and information, potential barriers and facilitators of implementation, financial incentives, success factors, organisation, transferability and cooperation.

#### ▪ **Practices**

Both C2.1 and C2.2 provided a physical and psycho-oncological programme for workers diagnosed with cancer. In C25, an RTW programme from Re-turn was provided for the worker. In C10, extra help for workers diagnosed with cancer was provided via the organisation's intranet, but the worker did not use this. In addition, the supervisors and HR managers were able to attend a meeting about cancer and work that was organised by the OHP and the Dutch Cancer Society (KWF).

In the Belgian company cases (C29, C31 and C34), no specific programmes were in place to support workers diagnosed with cancer. Before 1 January 2017, it was not mandatory to create an RTW environment for people who wanted to return to work after a long period of absence. In C31, mini-teams of different stakeholders discussed the RTW of workers. In C34, different stakeholders collaborated to create opportunities for RTW. C29 had no specific programme for workers, but a well-being team mediated between the OHP and the manager/supervisor of the worker in the RTW process. The trade union was involved when problems or issues needed to be solved between a worker and his/her manager/supervisor.

In C14, a general programme concentrating on the workers' RTW process was provided, in addition to external counselling ('Employee Assistance Programme') being available for every worker with personal problems. The HR representative kept in touch with workers diagnosed with cancer through both phone calls and personal visits.

#### ▪ **Support**

The worker in C2.1 did use the programme and was very pleased with the company's support, but this contrasted with the worker in C2.2, who did not feel supported by the company. In C2.1, both the worker and the employer considered that the worker's supervisor contributed positively to the RTW process if communication was good. The worker in C25 felt very much unsupported by the supervisor and thus the OHP proposed a collaboration with Re-turn to mediate between the worker and supervisor. In C10, the worker felt supported by the supervisor. In C31 and C34, the workers were very happy that they were given the opportunity to reintegrate, which is not typical in companies in Belgium. In C14, employees were made aware of the company's programme through the 'Employee Assistance Programme'. However, the worker believed that the help and support she received was the outcome of her friendly relationship with the head of HR. In C29, during the treatment period, both the worker's colleagues and the supervisor kept in touch with the worker.

#### ▪ **Advice and information**

C2.1 had 100 employees and so was much smaller than C2.2, which had 1,200 employees. Communication lines were short in C2.1 and the help given to workers diagnosed with cancer was more structured in C2.1 than in C2.2. In addition, the person with overall responsibility for the C2 'Vitality' programme was located in the C2.1 offices, which could be the reason why workers in C2.1 were better informed than those in C2.2. In both C2.1 and C2.2, no one person was responsible for giving the workers information about the programmes. In C2.1, the worker would have liked to have been informed of the programme content; in C2.2, the worker would have liked to have had someone clearly responsible for giving information about the programmes. In C2.1, the OHP was the mediator between the employer and the worker regarding the programmes; however, there was no fixed policy with clear steps. C2.2 had no policy at all and, having cancer without a long-term period of illness, the worker in C2.2 had no contact with the OHP, although the mental side to the illness was a continuous problem for the worker. The healthcare manager informed C2.2's works council representative (OR) of the C2 'Vitality' programme at the annual meeting.

In C25, no information was provided to the worker or the supervisor about what constitutes a good RTW process. The OHP in C25 needed approval from C25's HR department to collaborate with Re-turn. In C10, the worker was advised about the RTW possibilities, but did not take up these options. Because, in C31 and C34, there were no specific programmes on cancer and work, workers were not provided

with information about any programmes. They received information about the plan and the tasks of their modified job as part of their RTW, which was provided in C31 by mini-teams and in C34 by a group of different stakeholders. In C29, information about RTW was sent to the worker by the well-being team, and this information was very comprehensive. Furthermore, information was provided via C29's intranet. In C14, no official information about the programme was provided.

- **Potential barriers and facilitators**

C2 is a family business with one shareholder. The company's vision of caring for its family (workers) was a facilitating factor in the provision of RTW programmes. In C2, these programmes must always take into account reintegration as well as 'disintegration' (when a worker's situation deteriorates and he/she has to work less or leave work, e.g. diagnosis of metastases). The OHP in C2.1 played no active role in suggesting programmes to the employer, but the OR in C2.2 suggested improvements and additions to the programme to the employer. The OR of C2.2 felt that HR should be more involved in the programme (HR is overloaded with other tasks).

The worker in C25 thought it would be very important to collaborate with Re-turn at an early phase, and the OHP wanted more structured feedback and support from Re-turn to improve communication with the social security office (UWV).

In C10, it was not mandatory for the HR manager and supervisors to join the workshops on cancer and work, which resulted in these workshops needing to be run again when the HR manager and supervisor were confronted with a worker diagnosed with cancer. The worker in C10 thought that the legislation in the Netherlands, which obligates the employer to pay two years' sick leave in cases of long-term sickness, was not equal to that concerning other diseases or accidents that have a shorter recovery period than cancer.

The perceived barriers to the RTW of the workers in C31 included the employer's inability to provide the worker with adjusted working conditions. The worker mentioned that it would be valuable to keep in touch with the employer, although this was not mandatory according to Belgian legislation. In C34, the perceived barriers to a successful RTW depended on the profession of the worker. The employers could not ensure that every worker who needed modified work could get it.

In C14, the company's thinking about employees who come back to work after serious illness shifted to a position of being empathetic with the person who is ill, and this was a significant facilitator to RTW. One of the barriers in C14, however, was the nature of the company (a hospital), which had no 'light' duties, making phased return problematic.

In C29, the trade unions were very aware of the importance of a worker not being pushed to return to work.

- **Financial incentives and information**

Although C2 had a budget for the company's 'Vitality' programme, the worker in C2.1 and the OHP and the OR of C2.2 had not heard of any financial limits to providing these programmes. Offering such a programme may positively influence the attitude of the worker towards the employer, which could result in a better and/or faster RTW processes and lower absenteeism rates. The employer in C25 noted that it would suggest collaborating with Re-turn if the worker had a leading role or significant responsibility (as, in that case, it would be financially attractive for the employer). Because C10 extended the two-year paid sick leave of the worker. Thus, it could be that this employer put more effort into the RTW of its workers than other companies, namely those that do not extend the two-year paid sick leave. In C31 and C34, the employer had no financial incentives to begin an RTW plan for the worker. The following factors made it financially and practically feasible to reintegrate workers: the worker could return to work and temporarily have no assigned tasks, the worker could return to work for only half of the initial contract hours and the employer could receive compensation for the worker's loss in productivity (VOP-premium: Flemish support grant). Budgeting money for reintegration is not mandatory for the employer, but since new legislation has been implemented in Belgium it is now mandatory to set up an RTW plan. In C14, there was no defined proportion of the budget for the programme. However, this process in C14 is only at its beginning and so, when it increases, C14 will need to look at having a certain amount of money each year for this programme. C29 had no financial incentives to work with a well-being team; the

company believed in the good atmosphere on the work floor created by the support and information provided by the well-being team.

- **Factors that contribute to the success of the programme**

In C2, taking into account both the psychosocial and the physical side to the illness was extremely valuable for the worker, as was the fact that the programme was tailored to cancer patients. If the worker in C2.2 did not use the programmes of C2, he/she was provided with the help of another organisation that also combined these types of support. The employer in C2.1 felt that it being a family business, in addition to the prevention and fun sections of the company's 'Vitality' programme, resulted in it having a good RTW process and a good relationship with the worker. The flexibility of and knowledge provided within the cancer-specific RTW processes of Re-turn were rated by the OHP as very valuable. Both the employer and the worker in C25 noted that helping the worker to accept things and helping to improve communication between the worker and employer were extremely important. The HR manager of C10 was content with the possibilities offered to the worker on the intranet. One of the factors that contributed to the success of the workshop given by the OHP to HR and supervisors in C10 was that it explored the difficulties encountered in the support given to the worker diagnosed with cancer. In C31, one of the success factors of organising mini-teams for the RTW of workers was that the good communication between all of the different stakeholders ensured that there were no misunderstandings. In both C31 and C34, keeping in contact was the most important factor in feeling supported and preparing for a good RTW process. In C34, the mind-set of the employer was to put effort into the RTW of workers diagnosed with a disease that could cause long-term side effects and possibly negatively influence work ability. In C14, the flexible approach taken contributed to the programme's success. In C29, good provision of information to the worker, good communication, tailoring work circumstances in the process of RTW and the positive attitude of the worker towards RTW all contributed to the success of RTW.

- **Project organisation**

In C2.1, the OHP informed the worker of the programme. The programme was coordinated by a healthcare manager and executed by two external organisations. The OR of C2.2 was aware of the programme and could make suggestions. Although it appeared to have a policy, the employer in C2.1 claimed that it had no fixed policy. C2.2 lacked a good policy. The OR of C2.2 was not aware of where and how things were organised if help from Human Support and/or Tegenkracht was applied for. In C10, HR was involved in difficult RTW cases, the supervisor supported the worker and the OHP organised workshops for HR and supervisors. In C31, mini-team meetings were arranged by the HR assistant. Subsequent actions were coordinated by the team. In Belgium, since 1 January 2017, it has been mandatory for the employer to set up an RTW plan for the worker. C14 had no specific project organisation. In C29, the well-being team represented the worker and the OHP was the person who approved the RTW and gave the worker's manager/supervisor a proposal regarding how to begin the RTW process. In difficult cases, HR and the trade union representatives were involved in giving advice on the RTW process.

- **Transferability to other enterprises**

The programme in C2 could be universally applicable. It could also be useful for unemployed people. However, every company has its own HR policy, etc., and how responsible the employer feels for the worker also depends on budget and legislation. Both the employer and the worker in C25 felt that the transfer of the programme to large or small companies was equally possible, but that it was important for the worker to receive assistance from someone who understands the situation. The OHP in C25 mentioned that, in larger companies, the OHP may play a larger role in the RTW process than in smaller companies. Transferring the workshop organised by OHPs in C10 to other (smaller) enterprises would be difficult. The workshop is linked to a sponsor contract with the Dutch Cancer Society (KWF), which means that this workshop depends on the budget of the employer and the incentives to arrange it.

In C31, if the programme were transferred to another company, whether or not the company would work in mini-teams would depend on that company's policy. In addition, the employer would need to believe in open communication regarding RTW with other stakeholders. In C31 and C34, whether or not a company put much effort into the RTW of workers would depend on the view of the company. However, it is now mandatory for an employer to set up an RTW plan.

In C14, both the employer and the HR representative felt that the programme was definitely transferable to other companies. Small companies might have some issues in terms of longer term payment or flexibility around payment, but with good intentions, this should be manageable. In C29, having a well-being team or simply a contact person who arranged everything for the worker was perceived to be a good initiative and transferable. However, success would depend on the view of the company towards well-being and its budget for working with a well-being team.

#### ▪ **Cooperation with other partners and organisations**

No extra cooperation was needed by the employer in C2.1 or by the OR of C2.2. The worker in C2.1 received external support and did not feel unsupported by his employer. The OHP in C2.1 mentioned that, if the company had not had the 'Vitality' programme, the OHP would have cooperated with the GP to meet the (unmet) needs of the worker regarding RTW. The worker in C2.2 said that physical and psycho-oncological care should have been more integrated in the curative treatment phase, and should have been covered by the health insurer.

The employer in C25 mentioned that cooperation with other partners was not needed, since the treating physician provided a great deal of advice. The OHP in C25 mentioned that organisations that combine the psycho-oncological and physical parts of rehabilitation are lacking.

In C10, the HR manager thought it would be valuable to collaborate with experts who could help in the acceptance process of possible dysfunctions among workers recovering from cancer. The OHP in C10 mentioned that it would be useful to centralise all of the available information regarding the RTW of workers diagnosed with cancer.

In C31, more cooperation between all of the involved physicians with respect to the RTW of workers would be valuable. The OHP in C34 mentioned that collaboration with the social insurance provider was difficult and could be better. C29 worked in collaboration with a company that provided an 'Employee Assistance Programme' (six sessions) for its worker and/or the relatives (the worker could discuss personal problems). In C14 there was no specific cooperation.

### **4.3.5 Conclusions**

We found several programmes, initiatives and policies in place in Europe, and these varied in the types of support given. As far as possible, they represented different types of cancer, covered a variety of workplace sizes, activity sectors and locations, and included medium-sized companies, lower socioeconomic groups and both genders, which meant a variety of professions were covered. These programmes have the potential to be transferable to other circumstances (e.g. to other countries, sectors and size classes).

Some programmes included psychosocial support and others offered physical support. Multidisciplinary programmes combined physical support with social support through collaboration in mini-teams, and some programmes included the support of only an OHP. We also found that about half of the companies implementing successful programmes had put in place their own RTW programmes and measures, whereas the other half collaborated with external agencies and programmes to facilitate successful RTW. Not all of the programmes focused solely on workers diagnosed with cancer; some were intended for a wider range of workers with other (serious) illnesses.

The extent to which companies provided support for the worker varied. Most workers felt supported by their supervisors but, in a few cases, external programmes or the OHP had to intervene to establish adequate support from the workplace.

In addition, the communication of the possibilities of engaging in the programmes, initiatives and policies was different, depending on the size of the company. In smaller companies, the communication lines seemed to be shorter and therefore the worker was likely to be informed sooner. The uptake of the programmes provided depended on the situation of the worker, including the severity of the medical diagnosis and his/her personal preferences.

The stakeholders in the companies reported various potential barriers to and facilitators of implementation. Most employers and HR personnel considered that legislation was very important in the

(successful) implementation of the programmes. Due to differences in legislation, the incentives and possibilities of an employer to provide workers with programmes were different among the countries. The majority of stakeholders indicated that communication with the worker diagnosed with cancer throughout the sickness period was an important facilitator of a successful programme. Furthermore, communication between the stakeholders (HR, the employer, the supervisor and actors from external agencies) was also essential for facilitating the programmes.

Other facilitators included spreading knowledge to HR personnel and supervisors on cancer and work, via, for instance, workshops. Finally, a company having a positive policy and attitude towards workers with a serious illness returning to work was a significant prerequisite for successful RTW.

A barrier to the implementation of the RTW programmes was the inability of some companies to provide the worker with the required work adjustments. This was the case when, for instance, the company had only a specific type of (hard) work. Another barrier was that physical and psychosocial care in the treatment phase were often not covered by the health insurer.

The views of the employers differed regarding budgeting for additional help for workers diagnosed with cancer. Most employers had no financial incentives to begin an RTW process for workers diagnosed with cancer, but they considered it part of good employment practice. The employers who themselves needed to pay for the long-term absence of employees did, however, indicate that financial motivation might be an incentive to put more effort into RTW.

The most successful programmes were those that were multidisciplinary — including psychosocial and physical aspects — and flexible (tailored to the worker's situation), and those that involved good communication, knowledge of cancer-specific RTW processes and information being made available on the company intranet.

The project organisation in the company cases was very diverse and no conclusion can be drawn regarding the most effective form of project organisation. Some programmes are actual policies within the companies, whereas others had external agencies that organised the project; some programmes involved teams within the company that organised the project and others had no project organisation at all.

As regards transferability, all the interviewees considered that their programmes would be transferable if the companies were willing to support and finance the programmes. However, for small companies, this might be more difficult due to costs and flexibility needs.

There is still some room for improvement as regards cooperation with other partners and organisations, and some companies do not collaborate with other partners at all. Curative treatment care includes some physical and psychosocial care, and this should be integrated and covered by the health insurer. Furthermore, organisations that combine the psycho-oncological and physical parts of rehabilitation are lacking. There is a need to centralise all of the available information regarding the RTW of workers diagnosed with cancer. More cooperation between all of the involved physicians with respect to the RTW of workers would be valuable.

In conclusion, we interviewed stakeholders from companies that had a variety of programmes, initiatives and policies in place to support the RTW of workers diagnosed with cancer. The content of the programmes and the people involved in the programmes differed. Multidisciplinary programmes involving several stakeholders from both inside and outside the company were most common. The facilitators of successful execution of the programmes were legislation encouraging RTW, communication between stakeholders, knowledge of cancer and work and of RTW processes, and positive attitudes towards workers returning to work after a serious illness. The perceived barriers included the inability to implement work adjustments and insurance issues.

Overall, the stakeholders were enthusiastic about their programmes, initiatives and policies and believed that their programmes could be transferred to other companies.

## 4.4 Focus groups with stakeholders

### 4.4.1 Focus group participants

The focus group sessions were held in the following four countries:

#### ▪ Belgium

In Belgium, the focus group consisted of the following participants:

- a researcher in occupational and environmental medicine;
- a project coordinator of a rehabilitation programme;
- a government representative;
- a professor in RTW after cancer;
- a representative of the Fund for Occupational Diseases;
- an employer (within HR) in a care company;
- an employer (a manager) in a large bank;
- a trade union representative for a factory.

#### ▪ Ireland

In Ireland, the focus group consisted of the following participants:

- a representative of the National HR Division, Specialist Registrar in Occupational Medicine;
- a trade union representative;
- a second trade union representative;
- a representative of the Irish Cancer Society;
- a second representative of the Irish Cancer Society;
- an occupational health nurse.

#### ▪ The Netherlands

In the Netherlands, the focus group consisted of the following participants:

- an employer in a large manufacturing company;
- a project leader for the rehabilitation of unemployed cancer survivors;
- a project leader for the rehabilitation of workers diagnosed with cancer;
- a government representative;
- a workers' representative;
- an OHP experienced in oncology;
- a nurse specialised in RTW and cancer;
- a representative of the OSH research institute.

#### ▪ The UK

In the UK, the focus group consisted of the following participants:

- a research fellow from a university;
- a vocational rehabilitation assistant;
- a research scientist in occupational medicine;
- a representative of Breast Cancer Care.

### 4.4.2 Data collection (focus groups)

#### ▪ Facilitators of and barriers to implementing programmes

Appendix section 9.4, 'Focus groups: facilitators of and barriers to implementing programmes', describes the content of the focus groups regarding the facilitators and barriers to implementing programmes.



- **Requirements for and obstacles to the success of programmes and initiatives for rehabilitation and RTW after cancer**

Appendix section 9.5, 'Focus groups: requirements for and obstacles to the success of programmes and initiatives for rehabilitation and RTW', describes the content of the focus groups regarding the requirements for and obstacles to the success of programmes and initiatives for rehabilitation and RTW after cancer.

#### **4.4.3 Comparative analysis**

The experts and intermediaries in the focus groups highlighted a range of barriers to and facilitators of the successful implementation of policies, systems, programmes and instruments in the field of rehabilitation or RTW for workers diagnosed with cancer in their various countries and within their companies. Furthermore, they discussed the requirements for and obstacles to the implementation of programmes and initiatives for rehabilitation and RTW after cancer. In this comparative analysis, we summarise the most important findings of the focus groups and compare their outcomes.

- **Facilitators of and barriers to implementing programmes**

The experts and intermediaries in the focus groups discussed a variety of potential barriers to and facilitators of implementation of RTW. On the macro-system level (societal context, culture and politics), one barrier to initiating RTW programmes was the lack of clarity regarding who was responsible for supporting workers in their RTW. As a result, neither the worker nor the employer wanted to take the initiative in RTW, there was a gap in support between the hospital and the workplace, and it was difficult for workers to move from job to job. If it was clear who was responsible for supporting a worker with cancer, both the worker and the employer would understand the RTW process and this would facilitate the implementation of RTW programmes.

In all four focus groups, the cultural stigma of a cancer diagnosis and the (cultural) misconceptions about the possibilities of working after a diagnosis of cancer were considered important barriers to implementing RTW programmes. In contrast, disclosure of a cancer diagnosis — or a culture in which it was possible to disclose a diagnosis — was seen as a facilitator. However, this disclosure can also lead to stigma. Given these specific issues for cancer patients, it was interesting that one focus group reported that programmes promoting effective RTW need to be specific to workers with cancer. A culture of sharing best practices and cooperation between stakeholders was considered a facilitator.

Most of the focus group discussions concerned the meso-system level (company, healthcare, legislative and insurance system). The lack of involvement of an OHP and of preventive consultations with an OHP at the workplace, due to limited time or financial resources, was a common theme in three of the groups.

An important success factor for the organisations was the structural implementation of the RTW programme or RTW policy within the company, which was mentioned in three of the focus groups. Again, stigma experienced at the workplace regarding having a disability or work accommodations was considered a barrier. If the employer believed that the worker diagnosed with cancer would be sick-listed again very soon, this was a barrier. However, an employer who wanted to act and who had a positive view of employability was a facilitator. Lack of time, financial difficulties, lack of knowledge and insufficient skills at the workplace to support the RTW of a worker with cancer were seen as barriers. The participants of two focus groups claimed that training supervisors, HR personnel and case managers to execute the programmes facilitated the programmes' implementation.

It is considered very difficult for SMEs to implement programmes because it is harder for them to accommodate work modifications and to provide gradual RTW because they have less flexibility. Difficulty in accommodating, or an inability to accommodate, the work of the worker diagnosed with cancer was seen as a barrier.

With regard to the legislative and insurance system, most participants of the focus groups considered legislation very important for (successfully) implementing programmes. Due to differences in legislation, the incentives and options for employers to provide workers with programmes were different among the groups. There was a great deal of discussion on this issue in the Belgian focus group because of the

country's recent change in legislation<sup>3</sup>. Facilitators for implementing programmes included the employer's legal options for offering part-time work, incentives for employers to support RTW to avoid their premium rising and the employer not having to pay the worker's salary during RTW. An important factor hampering RTW was privacy legislation, as this prevents open communication.

With regard to the healthcare system, the greatest barriers to the implementation of RTW programmes were failing to address work from the start of the treatment and the fact that attending physicians were too protective about RTW or had a negative view of it. Furthermore, work was not considered a clinical outcome and was not structurally assessed in medical files. Other barriers to the implementation of programmes were the limited availability of oncological rehabilitation programmes, insufficient communication between physicians and different stakeholders, and other healthcare professionals not being aware of the importance of RTW advice or feeling insecure about RTW. The involvement of paramedical staff in the RTW process was seen as a facilitator.

On the micro-system level (the worker), it was reported that successful implementation was facilitated by the worker's own motivation to return to work, namely workers taking responsibility and realising that they have to plan their RTW. In contrast, a perceived barrier to implementation was a worker who was not ready to discuss RTW, who could not reach people and who was uncertain about the side effects of their treatment.

#### ▪ **Successful programmes: what is needed?**

The experts and intermediaries in the focus groups discussed a variety of issues regarding what is needed for successful programmes (i.e. the content and timing of the programmes). On the macro-system level (societal context, culture and politics), two of the focus groups claimed that society should have better knowledge of the long-term side effects of cancer and the possibilities of working after cancer. Informing employers of a worker's limitations, rather than of the diagnosis, and the option of a government-provided online platform for cancer and RTW were suggested.

The majority of the discussions in the focus groups concerned the meso-system level (company, healthcare, legislative and insurance system). As regards the workplace, effective and successful programmes should be multidisciplinary, timely and tailor made. Different programmes should be provided for unemployed cancer survivors and self-employed cancer survivors. Two focus groups mentioned that successful programmes should target not only RTW but also remaining in work once a worker has returned.

For successful programmes, it is of the utmost importance that the OHP has access to and can support both the worker and the employer early in the diagnosis and treatment process. Furthermore, practical information is needed regarding, for example, reasonable accommodation within the organisation and there is a need for trainee posts for unemployed cancer survivors. Effective communication and clearly implemented policies are considered essential.

All four focus groups found that training, information and support from ones' supervisor regarding, for example, long-term side effects and communication were crucial.

On a department level, it was essential that colleagues were involved, especially concerning communication, disclosure and the alignment of tasks. Furthermore, staying in contact with workers affected by a cancer diagnosis and providing an RTW plan that includes the option of accommodations if needed, or working part-time, were mentioned as needs.

As regards the legislative and insurance system, there is a need for RTW policies for cancer, surveillance of awarded social insurance premiums and legislation for self-employed workers affected by cancer. Furthermore, social insurance should benefit the employer of a worker with cancer and patients should be better informed of their privacy rights.

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<sup>3</sup> Since 1 January 2017, in Belgium, employers may begin an RTW plan after four months of a worker's absence. Furthermore, the employer is required to set out an RTW plan. A second important difference from the former legislation is the role of the advisory physician of sickness and invalidity insurance. The physician assesses possible progressive job resumption or disability and can autonomously initiate an RTW process.

With regard to the healthcare system, oncological rehabilitation is needed that includes work issues and care pathways and that addresses work as early as possible. Advice and referral by the nurse, GP or attending physician, as well as convalescence recommendations, are necessary.

On the micro-system level (the worker), tailor-made programmes are needed for workers diagnosed with cancer, and workers should stay in contact with the workplace during their sick leave, especially in the early phases of diagnosis and treatment.

#### **4.4.4 Conclusions**

The specific objectives of the focus groups were to collect and analyse the views of experts and intermediaries on the facilitators of and barriers to promoting effective RTW programmes, on the one hand, and to identify the requirements for and obstacles to the implementation of programmes and initiatives for rehabilitation and RTW after cancer, on the other. We discussed these topics in four focus groups in Belgium, Ireland, the Netherlands and the UK, and performed qualitative analyses by themes of the results of these focus groups, using the Sherbrooke model of RTW (Loisel et al., 2005).

On a macro-system level (societal context, culture and politics), one barrier to implementing RTW programmes was the lack of clarity as to who was responsible for supporting workers in their RTW. It should therefore always be made clear to employers, workers and other stakeholders who is responsible for the RTW of workers diagnosed with cancer. In addition, the cultural stigma of a cancer diagnosis and the (cultural) misconceptions about the possibilities of working after a cancer diagnosis were considered important barriers to implementing RTW programmes. It is thus necessary to address these misconceptions and to remove the stigma that is associated with the diagnosis of cancer on a societal level. To implement successful RTW programmes, society needs better knowledge regarding side effects and regarding RTW opportunities and limitations. The EU and/or national government could play a role in providing this information via, for instance, online platforms.

On a meso-system level (company, healthcare, legislative and insurance system), the structural implementation of an RTW programme or RTW policy within a company is an important facilitator of its success. Consequently, it is recommended that companies willing to implement RTW programmes make the implementation a structural part of their policies throughout the company. In addition, it was indicated that, to make the implementation of the programme successful, it is crucial to train supervisors, HR personnel and case managers in cancer and work aspects such as long-term side effects, in communication with the worker with cancer and in the elements of the RTW programme. At the workplace level, it is essential that colleagues are involved in the RTW process.

A lack of time, financial difficulties, a lack of knowledge and insufficient skills at the workplace to support the RTW of the worker with cancer were seen as barriers. As a consequence, for the implementation of the programmes to be successful, companies should allocate enough time and finances and provide training on the knowledge and skills required.

Effective, successful programmes need to be multidisciplinary, timely and tailor made. Furthermore, they should target not only RTW but also remaining in work once a worker has returned. When companies consider an RTW programme, these aspects should be incorporated into the programme.

Finally, for successful programmes, it is of the utmost importance that the OHP has access to and can support both the worker and the employer early in the diagnosis and treatment process. Practical information is also needed regarding, for example, reasonable accommodation within the organisation. Hence, it is essential that companies involve an OHP as soon as the diagnosis has been disclosed. The OHP can also provide the necessary information regarding reasonable accommodation.

For SMEs, it is considered very difficult to implement RTW programmes because it is harder for them to accommodate work modifications and provide gradual RTW, as they have less flexibility. SMEs should therefore receive help in making work requirements more flexible or in aligning themselves with other companies that have more flexible jobs.

Issues regarding work-related cancer were not mentioned in the focus groups. No specific questions regarding this topic were prepared beforehand because of employers' legal issues regarding the liability

of work-related cancer at the workplace. These legal issues might also have been the reason that the subject was not mentioned during the focus groups.

The facilitators for implementing successful programmes were the legal possibilities of offering part-time work and incentives for the employer to support RTW, both of which are given as recommendations for legislation. An important factor that hampers RTW is privacy legislation, which hinders open communication. This is nevertheless the statutory right of patients. As the privacy rights of patients are of the utmost importance and are constitutional, stakeholders working in RTW programmes should be trained in how to accomplish open communication without the disclosure of the diagnosis.

RTW policies for cancer and legislation for self-employed workers affected by cancer are needed to make RTW programmes successful.

Important barriers to the implementation of programmes are the failure to address work from the start of the treatment and the fact that attending physicians are too protective regarding RTW or have a negative view of it. Ideally, physicians should be educated during their medical training on the effects of a disease on a worker's involvement at work, the importance of work for the quality of the patient's life and the positive effect of RTW advice from an attending physician.

On the micro-system level of the worker, it was concluded that successful implementation is facilitated by the worker being highly motivated to return to work by taking responsibility for him- /herself and realising that he/she has to plan RTW. These aspects should therefore be part of a successful RTW programme. Furthermore, there is a need for tailor-made programmes for workers diagnosed with cancer; in addition, the worker should stay in contact with the workplace during sick leave, especially in the early phase of diagnosis and treatment.

Overall, the participants of the focus groups were enthusiastic about the RTW programmes, initiatives and policies for workers with cancer, and considered that these programmes are essential for improving the work outcomes of those diagnosed with cancer. They were also of the opinion that these programmes could be implemented in other companies.

## 5 Discussion of findings

### 5.1 Policy and strategy options and recommendations

#### 5.1.1 Workers affected by cancer

This project shows that survivors report various effects of cancer and its treatment on their physical, cognitive and mental health. The explicit occupational implications reported were diminished work productivity, work ability impairments and reduced functioning at work.

Several factors were found that could influence a successful RTW process after cancer: sociodemographic, work-related and treatment-related factors. There are large differences between workers affected by cancer in terms of long-term side effects and/or work-related problems after treatment. Of the work-related factors, the type of work, the work setting, the social factors of work and other work-related factors may possibly influence successful RTW, but more research is needed to confirm this.

Depending on the country, cancer survivors have access to different rehabilitation services and information sources from the social and healthcare sector. These can include vocational, medical, physical, psycho-educational and multidisciplinary interventions.

Survivors can find further support from NGOs. The services provided by these organisations are mostly informative and do not include rehabilitation. The aim of these interventions is to enable cancer survivors to adapt to their new situations and make informed decisions regarding their RTW. The information is disseminated in printed form (e.g. brochures), personally (e.g. in-house counselling and over the telephone) or on the internet (e.g. online articles, videos and webinars).

Some cancer survivors receive support from their employers in the RTW process when, for example, the company has RTW programmes and policies in place that can assist cancer survivors with workplace concerns. It is uncertain if the RTW implications and interventions for occupational and work-related cancers and those for non-work-related cancers differ. However, the possible implications for survivors' psychological health and the risk of recurrence differ among work-related and non-work-related cancers, and therefore the RTW process or RTW interventions are, or should be, different. Occupational or work-related cancer might call for other psychological interventions and more drastic vocational rehabilitation services (such as enabling entry into a new job market) in comparison with non-work-related cancer. In addition, to prevent work-related cancer, sanctions and claims should be imposed if an employer does not meet preventive measures. At the workplace, close collaboration is needed between different stakeholders, as RTW can best be regarded as a multidisciplinary process involving several stakeholders in addition to the employee and the employer. When stakeholders are motivated, they find ways in which to support RTW. Therefore, clarification regarding bottlenecks and contributing factors, and the relationship between policy and practice regarding the RTW perceived by stakeholders, would be of added value in all cases.

#### 5.1.2 Employers and the workplace

In some countries, employers are bound by law to make reasonable adjustments for people with disabilities. Examples of these are reducing working days, altering working hours and altering the work environment.

Support for employers, line managers and HR professionals focuses on managing sick employees and helping their RTW (e.g. appropriate workplace accommodation). For the employer, it is important to stay in contact with the worker during the whole treatment process. This helps to get the worker back into the workplace and could thus facilitate their RTW. It is also important to create real tools for the employer to help cancer patients' RTW. An offer of workplace accommodation from the side of the employer shows that the employer is committed to getting the worker back. An intervention or RTW programme should be mandatory for the employer. In addition, the employer should be willing to help the cancer patient and should be provided with resources to help the worker.

The interventions available for employers are mainly informative and can include counselling or in-house training courses. Topics include general information on cancer, legislation and finances, as well as on the role and support needs of staff and cancer carers. Information is available on how cancer and its treatment affects people and how this may affect a person's work. Employers can learn about common myths and facts and about death and bereavement. Further information is available on the legal background to work and cancer, the financial support available to employees and the role of the employer.

Other topics include communication with survivors and their colleagues on how to practically support cancer survivors' RTW and how to support them in remaining in work. The employer can learn about confidentiality issues, managing absences, workplace policies, creating an RTW plan and possible changes in work arrangements (workplace accommodation and adjustments). Possible workplace accommodations include, for example, paid working time for medical appointments, reduced working hours and RTW meetings.

The size of the organisation might be an important factor for RTW. In SMEs, information and resources for RTW strategies or programmes are lacking, and support and education are needed. The larger a company is, the more likely it is to have the resources to support and keep an employee with reduced work ability at work or on long-term sick leave. In contrast, workers in SMEs might have a closer relationship with their employers than those in larger companies, and so keeping in contact during treatment may be easier, which might in turn facilitates RTW. For SMEs, it is considered very difficult to implement RTW programmes, because it is harder for them to accommodate work modifications and provide gradual RTW, as they have less flexibility. SMEs should therefore receive help in making work requirements more flexible or in aligning themselves with other companies that have more flexible jobs. Interventions that are tailored for small business owners are lacking. For example, it might be useful to provide access to financial aid during the first five years after diagnosis to prevent the risk of these businesses closing down. Further support might also be needed in drawing up policies that regulate and assist in the management of issues such as time off and bereavement.

In the EU-OSHA seminar for stakeholders, the importance of making straightforward recommendations to stakeholders in companies was discussed. Recommendations on how cancer and RTW issues should be integrated into more general RTW programmes are especially important. In addition, it is important to indicate what resources are needed for a new RTW after cancer programme and where companies can obtain these resources. For SMEs this is vital and they most likely need intermediaries or consultants who can supply these resources. In addition, grouping SMEs for OSH information/assistance is valuable. SMEs could learn from each other and together it is easier to access this kind of help from occupational health services. It is also more financially attractive to SMEs in a group, and collaborating with business incubators could help SMEs to develop by providing services such as management training, as business incubators support (small) start-up companies. Business incubators could also act as forums for the main occupational issues encountered.

In conclusion, effective employer-employee communication was suggested as a prerequisite for successful RTW, but employers felt uncertain about how and when to communicate and therefore often avoided cancer-related discussions. Employers were also perceived as lacking knowledge on cancer and its treatment, which might influence their ability to support employees with cancer. Employers felt that they needed supporting information and tools for improving the participation of employees with cancer at work. In addition, close collaboration is needed between different stakeholders in the RTW process.

### **5.1.3 Healthcare professionals**

Healthcare professionals can support cancer survivors' RTW. Interventions to improve healthcare professionals' skills and expertise may include information on how to communicate about employment issues with people affected by cancer, how to develop and deliver care and services, and information on their roles and responsibilities.

Guidelines are also available that provide advice on, for example, workplace accommodations, communication between healthcare professionals, and communication with cancer survivors. One example is an intervention that took place in a hospital in the Netherlands. Participants were given advice on how to communicate about the cancer diagnosis, the treatment plan and its outcome. Cancer survivors and physicians received an additional leaflet that described a detailed 10-step plan for returning to work, which included an activity plan and goals.

In addition, oncological rehabilitation is needed, which includes work issues and care pathways and involves addressing work as early as possible. Advice and referral by the nurse, GP or attending physician, as well as convalescence recommendations, are necessary.

Because of the different healthcare systems and thus roles of healthcare professionals, the role of the OHP differs among companies, and it is not possible to provide one general recommendation. In the seminar it emerged that a great deal of misconceptions exist about not being able to work during and/or after cancer. These misconceptions may possibly be caused by different cultural views regarding whether or not someone is able to work during cancer treatment. It was discussed that the worker's ability to work, rather than her/his inability, should be decided by the worker him- or herself. With regard to physicians, it is important to train them to address RTW issues. The health insurer should play a role in this by funding time for training healthcare professionals.

The importance of considering 'work' as a health outcome was also discussed. Increasing the importance of work could start by including 'participation in work' as a health outcome for physicians.

#### **5.1.4 Stakeholders — national level**

The initiatives in different Member States showed that RTW is influenced by the institutional context of a country, especially the length of paid sick leave, the responsibility of the employer and the financial incentive of the employer.

Developing and implementing efficient, effective interventions to promote RTW may require close collaboration between the government, stakeholders and practitioners. To build this relationship, a comprehensive overview of relevant stakeholders and their roles is still needed. The key actors who need to communicate to develop and implement interventions are the workers diagnosed with cancer themselves, healthcare professionals, employers and workers in HR departments, colleagues, professionals in legal rights, employment and social services, trade unions, NGOs and the government.

In this project, we found different interactions, roles and synergies between policy areas and (enterprise) actors in awareness raising, information provision and support for cancer survivors in their RTW. Actors in this process vary. Even though the types of actors across countries may be similar, their responsibilities, their ability to influence the RTW process and the way in which they communicate differ significantly. These differences, as well as the similarities, seemed to be crucial when developing and implementing interventions to promote RTW among workers diagnosed with cancer. Therefore, it is important to discuss issues and improvements in the RTW of workers diagnosed with cancer with these different stakeholders. Because of the influence of a country's context, the length of paid sick leave and the responsibility of the employer, the transfer of the programmes from one country to another country needs considerable adjustments and tailoring.

Legislation can prescribe or allow for RTW support and can offer the means to increase facilities for support. Therefore, it is necessary to explore the tension between policy and practice in its specific context. Legislation on sick leave and RTW may focus on, for example, the provision of information and the control of sicknesses, which differs among the countries in Europe. Greatly varying social security practices in Europe make RTW for cancer survivors difficult in some places. It was argued in the seminar that employers should have greater incentives to take workers back. However, this process requires the patient to disclose his or her diagnosis, because without disclosure it is difficult to access rights to, for example, workplace accommodations. This contrasts with the right to privacy that exists in many countries, which means that the employer does not have the right to know an employee's diagnosis. In any case, recommendations should respect national legislation.

### **5.1.5 Stakeholders — EU level**

The European Commission's perspective was highlighted during the EU-OSHA stakeholder seminar. The European Commission acknowledged how the demographics of an ageing population affect society and make RTW after cancer an important European topic. European legislation could help solve this issue, since not all Member States have a well-defined legislation system for RTW. In addition, a bridge is needed between results and actions. Solutions vary between different countries due to cultural differences, costs, inequalities in treatment and the programmes already in place.

The European e-Business support network (EBSN) could provide workers diagnosed with cancer with valuable information on RTW through e-business practices. EBSN is a platform and network that provides coordination and support for SMEs in e-business practices. European funding is granted for programmes that stimulate the exchange and transfer of knowledge regarding e-business practices, bringing together e-business experts in Europe, and sharing e-business experiences and good practices among SMEs.

Regarding work-related cancer, the European Commission underlined the importance of the tertiary prevention of occupational diseases and outlined the difference between work-related and occupational diseases. In addition, the importance of performing risk assessments was highlighted. Due to the long latency and sensitivity of work-related cancer, risk assessments are needed to allow working conditions to be adjusted in time. Furthermore, in cases of work-related cancer, it is important to talk about the risks (risk communication), so that both the employer and the worker are informed of the risks that RTW may pose to health.

## **5.2 Comparison of approaches, taking into account aspects of national contexts**

### **5.2.1 National regulatory and advisory systems related to OSH**

With regard to the legislative and insurance system, legislation was considered very important for (successfully) implementing programmes. Due to differences in legislation, the incentives and options of employers to provide workers with programmes varied among the countries. There was a great deal of discussion on this issue in the Belgian focus group because of the country's recent change in legislation<sup>4</sup>. Facilitators for implementing programmes were the legal options of offering part-time work and incentives for employers to support RTW to avoid their premiums rising, or employers not having to pay the worker's salary during RTW. An important factor hampering RTW is privacy legislation, as it prevents open communication.

### **5.2.2 Socioeconomic aspects**

The RTW of cancer survivors is economically important. Cancer survivors who do not return to work during or after treatment inflict a financial cost on the employee, the employer and society. Adapting the work environment may enable RTW. This may come with costs for the company and the employee but, in the end, these may be less than the costs of long-term sick leave.

The views of employers differ regarding budgeting for additional help for workers diagnosed with cancer. Most employers had no financial incentives to begin an RTW process for workers diagnosed with cancer, but considered it part of good employment practice. The employers who themselves needed to pay for the long-term absence of employees, however, indicated that financial motivation might be an incentive to put more effort into RTW.

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<sup>4</sup> Since 1 January 2017, in Belgium, employers may begin an RTW plan after four months of a worker's absence. Furthermore, the employer is required to set out an RTW plan. A second important difference from the former legislation is the role of the advisory physician in sickness and invalidity insurance. The physician assesses the possible progressive job resumption or disability and can autonomously initiate an RTW process.



It is therefore likely that national economic situations and financial incentives have an impact on the possibilities of workers with cancer returning to work. Our earlier research showed that, in times of economic hardship and higher national unemployment rates, the economic impact on workers diagnosed with cancer is stronger than that on the general population, because their chances of becoming unemployed increase faster (de Boer, 2009). It is therefore recommended that, especially in hard economic times, financial incentives for the RTW of workers diagnosed with cancer are available to employers.

### **5.3 Challenges in and success factors of the implementation of instruments and practices**

Barriers to and facilitators for the successful implementation of instruments, interventions, programmes and practices for rehabilitation and RTW after cancer will be discussed at the following different levels: workers affected by cancer, the employer and the workplace, healthcare professionals and other stakeholders.

#### **5.3.1 Workers affected by cancer**

In this project, we found that the extent to which companies provided support to workers varied. Most workers felt supported by their supervisors, but in a few cases the external programmes or the OHP had to intervene to establish adequate support from the workplace.

In addition, communication about the possibilities of engaging in the programmes, initiatives and policies were different depending on the size of the company. In smaller companies, the communication lines seemed to be shorter and therefore the worker was likely to be informed sooner. The uptake of the provided programmes depended on the situation of the worker, including the severity of the medical diagnosis and his/her personal preferences.

The results from the EU-OSHA stakeholder seminar included the importance of early intervention for workers: early intervention or paying attention to RTW early in the illness process is essential. Communication with the worker diagnosed with cancer throughout the sickness period is another important facilitator of a successful programme. Moreover, tailoring the programme to suit the worker's preferences could complement the use of a framework for the RTW of workers diagnosed with cancer.

Successful implementation was facilitated by the worker's own motivation to return to work, namely workers taking responsibility and realising that they have to plan their RTW. In contrast, a perceived barrier to implementation was a worker who was not ready to discuss RTW or was uncertain of the side effects of their treatment and who could not discuss RTW with the supervisor.

#### **5.3.2 Employers and the workplace**

The stakeholders in this project highlighted various potential barriers to and facilitators of implementation in companies. Most employers and HR personnel considered legislation to be very important for the (successful) implementation of a programme. Due to differences in legislation, the incentives and possibilities of an employer to provide workers with programmes differed among the countries.

The majority of stakeholders indicated that communication with the worker diagnosed with cancer throughout the sickness period was an important facilitator of a successful programme. In addition the programme should be flexible and should facilitate adjustments according to the situation of the worker. Furthermore, communication between the stakeholders (HR, the employer, the supervisor and actors from external agencies) was also essential. Another facilitator was spreading knowledge to HR personnel and supervisors regarding cancer and work via, for instance, workshops. Finally, a company having a positive policy and attitude towards workers with a serious illness returning to work was a prerequisite for successful RTW.

A barrier to the implementation of RTW programmes was the inability of some companies to provide the work adjustments that the worker required. This was the case when, for instance, the company had only a certain type of (hard) work.

The most successful programmes were those that were multidisciplinary — including psychosocial and physical aspects — and flexible (tailored to the worker's situation), and those that involved good communication, knowledge of cancer-specific RTW processes and information being made available on the company intranet.

The project organisation in the company cases was very diverse and no conclusion can be drawn regarding the most effective form of project organisation. Some companies' programmes were actual policies, while other companies had external agencies that organised the project; some had internal teams that organised the project and others had no project organisation at all.

The worker's colleagues should also be taken into account, as was discussed during the seminar. If their role in the RTW process is unclear to them, they might not know how to communicate with the worker diagnosed with cancer and they might not understand this worker's adjusted tasks. This could cause conflict, which may have a negative impact on the RTW of the worker and on the implementation of the programme.

### **5.3.3 Healthcare professionals**

For successful programmes, it is of the utmost importance that the OHP has access to and can support both the worker and the employer early in the diagnosis and treatment process. In the cases considered in this project, sometimes the OHP was kept away by the employers, which made it difficult for the worker to obtain access to occupational healthcare. Furthermore, practical information is needed regarding, for example, reasonable accommodation within the organisation, as are work placement opportunities for unemployed cancer survivors. Effective communication and clearly implemented policies were considered essential.

With regard to the healthcare system, oncological rehabilitation is needed, which includes work issues and care pathways; it must also address work as early as possible. Advice and referral by the nurse, GP or attending physician, as well as convalescence recommendations, are also necessary and should be included in guidelines for healthcare professionals. The OHP should be provided with special courses on RTW and cancer. During the seminar, participants discussed the Dutch initiative to train OHPs to become oncological occupational physicians, which has had positive results, but also some financial implications for implementation. It was also mentioned that RTW opportunities depend on whether the treatment is intended to be curative or palliative. The participants discussed that one way of helping the implementation of these programmes would be disability management, which already exists in educational programmes in Austria, Belgium and Canada.

### **5.3.4 Stakeholders — national level**

Another barrier is that physical care and psychosocial care in the treatment phase are often not covered by the health insurer.

There is still some room for improvement as regards cooperation with other partners and organisations, and some companies do not collaborate with other partners at all. Curative treatment care involves some physical and psychosocial care, and this should be integrated at the beginning of the treatment phase and covered by the health insurer. Furthermore, organisations that combine the psycho-oncological and physical parts of rehabilitation are lacking. All the available information regarding the RTW of workers diagnosed with cancer should be centralised. More cooperation between all the involved physicians with respect to the RTW of workers would be valuable.

### **5.3.5 Stakeholders — EU level**

During the seminar, the European Commission stressed the importance of disseminating easily available information, such as the recent new infographic produced within the framework of the Online interactive Risk Assessment (OiRA) or the International Labour Organisation (ILO) app<sup>5</sup> to support social dialogue (InfoStories).

The most important recommendation for all stakeholders is to ‘talk about work’. This is based on the notion that RTW can be helpful and can help in the ‘fight’ against the disease. Too often, people believe that it is best for cancer survivors not to work, and this belief is the result of this topic not being talked about with and among stakeholders. Talking about work is a good start, and this could be supported by, for example, an EU-OSHA communication that stresses that ‘you can often work despite being diagnosed with cancer’. In addition, an RTW programme similar to that of Macmillan Cancer Support would be beneficial in all EU countries. Ensuring that the various stakeholders obtain the material could be a task for public health or social security authorities. Macmillan has successfully reached out to HR managers and OSH professionals in the UK. Thus, it is possible to create a network of involved people.

## **5.4 Transferability of instruments and practices**

As regards transferability, programmes are considered transferable if companies are willing to support and finance them in combination with the legislation of the country. However, for small companies, this might be more difficult due to costs and flexibility needs.

Participants of the EU-OSHA stakeholder seminar also discussed how national-level differences should be taken into account, although the findings of this project could be applicable to all Member States.

## **5.5 Assessment of elements considered essential in an OSH system**

### **5.5.1 Information and support for workers**

The cultural stigma of a cancer diagnosis and the (cultural) misconceptions about the possibilities of working after a diagnosis of cancer were considered important barriers to implementing RTW programmes. In contrast, disclosure of a cancer diagnosis — or a culture in which it was possible to disclose a diagnosis — was seen as a facilitator. However, this disclosure can also lead to stigma. Given these specific issues for cancer patients, programmes promoting effective RTW need not be specific to workers with cancer. A culture of sharing best practices and cooperation between stakeholders was considered a facilitator.

In addition, it was felt that society should have better knowledge of the long-term side effects of cancer and the possibilities of working after cancer. Informing employers of a worker’s limitations, rather than of the diagnosis, and the option of a government-provided online platform for cancer and RTW were suggested.

### **5.5.2 Support and needs of workplaces**

With regard to the workplace, the lack of involvement of an OHP or of preventive consultations with an OHP, due to limited time or financial resources, was seen as a hindering factor.

Training, information and support from the manager regarding, for example, long-term side effects and communication are crucial.

At the workplace level, it was essential that colleagues were involved, especially in communication, disclosure and taking over tasks of the sick worker. Staying in contact with workers affected by a cancer

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<sup>5</sup> See [http://www.ilo.org/global/publications/WCMS\\_461341/lang--en/index.htm](http://www.ilo.org/global/publications/WCMS_461341/lang--en/index.htm)

diagnosis and providing an RTW plan that includes the option of accommodations if needed, or of working part-time, were also identified as needs.

The seminar participants stressed the importance of practical tools: spreading knowledge to HR personnel and supervisors on cancer and work via, for instance, workshops, would be of added value. EU-OSHA could possibly take a role in promoting best practices on how sharing information at the workplace level could be achieved.

### **5.5.3 Cooperation across policy areas**

The experts and intermediaries in the focus groups discussed a variety of potential barriers to and facilitators of implementation. On the macro-system level (societal context, culture and politics), one barrier to initiating RTW programmes was the lack of clarity regarding who is responsible for supporting workers in their RTW. As a result, neither the worker nor the employer wants to take the initiative in RTW; there was a gap in support between the hospital and the workplace and it was difficult for workers to move from job to job. If it was clear who was responsible for supporting a worker with cancer, both the worker and the employer would understand the RTW process, and this would facilitate the implementation of RTW programmes.

## 6 Conclusions

In conclusion, surviving cancer can limit one's work ability for various reasons. The implications of cancer and its treatment can affect all aspects of human health and well-being, including physical, mental and cognitive symptoms. These implications can be either long or short term. Having cancer may also lead to a reassessment of one's life and the meaning of work. Survivors may be highly motivated to return to work to regain normality and control over their lives, or they may decide not to return to work at all. When returning to work, survivors may face difficulties in balancing work and treatment demands or may face negative attitudes or behaviours among their colleagues and employers. All of this may lead to a reassessment of work and life goals, and thus may hinder RTW.

There is a gap between what is available in practice and the descriptions and evaluations of interventions that aim to enhance RTW in the scientific literature. What is available is, for example, information or training on cancer and RTW issues. Other types of interventions include rehabilitation services, guidelines and workplace accommodations. Most interventions have been developed primarily for cancer survivors, followed by interventions for employers and healthcare professionals. Very few interventions are available that are specifically for self-employed workers or SMEs.

With the rising number of cancer survivors, effective interventions are essential to enable RTW and to reduce the costs to individuals and society at large. But, to date, little is known about the effectiveness of these interventions, making it difficult to recommend 'best practices'; more research on the effectiveness of these interventions is needed.

Developing and implementing efficient, effective interventions to promote RTW may require closer collaboration between stakeholders. Communication between stakeholders (HR, the employer, the supervisor and actors from external agencies) is also essential for facilitating programmes. To build this relationship, a comprehensive overview of relevant stakeholders and their roles is needed. The key actors who need to communicate to develop and implement interventions are the cancer survivors themselves, healthcare professionals, employers and workers in HR departments, colleagues, professionals in legal rights, employment and social services, trade unions, NGOs and the government.

RTW is influenced by the institutional context of a country, especially the length of paid sick leave. Due to differences in legislation, the incentives and possibilities of an employer to provide workers with programmes differ among countries.

To facilitate programmes, it is important to take into account the support provided by companies. In addition, communication about the possibilities of engaging in the programmes, initiatives and policies, as well as early intervention or paying attention to RTW early in the illness process, also appeared to be important. Communication with the worker diagnosed with cancer throughout the sickness period is another important facilitator of a successful programme. Spreading knowledge to HR personnel and supervisors on cancer and work via, for instance, workshops, is of added value. Finally, a company having a positive policy and attitude towards workers with a serious illness returning to work is a prerequisite for successful RTW.

A barrier to the implementation of the RTW programmes is the inability of some companies to provide the worker with the required work adjustments. This is the case when, for instance, the company has only a specific type of (hard) work. Another barrier is that physical care and psychosocial care in the treatment phase are often not covered by the health insurer.

In conclusion, among the countries, the content of the programmes and the people involved in the programmes differed. The following were identified as facilitators for executing effective, efficient RTW interventions: legislation encouraging RTW, communication between stakeholders, knowledge of cancer and work and of RTW processes, and positive attitudes towards workers returning to work after a serious illness. The perceived barriers were an inability to implement work adjustments and insurance issues.

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## 8 Annex

Table 1 In-hospital rehabilitation intervention (the Netherlands)

|   |   |
|---|---|
| <b>1) Country and context</b>                               |   |
| a) Population   | 16.9 million  |
| b) Employment rate (percentage)                             | 73.1 ( <a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a> , 2014)  |
| c) Official retirement age (years)                          | 65.5 ( <a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view</a> , 2016)  |
| <b>2) Legislation regarding sickness in the Netherlands</b> | <p>No special legal rights of workers diagnosed with cancer are formulated. Improved gatekeeper law that applies to all workers who report sick:</p> <ul style="list-style-type: none"> <li>▪ problem analysis (sickness of worker) by an OHP within six weeks;</li> <li>▪ plan of action based on problem analysis by the employer and employee within eight weeks;</li> <li>▪ guidance including RTW support (paid) by the employer for two years and, after this, referral for disability pension assessment.</li> </ul> <p>Extended paying of income act:</p> <ul style="list-style-type: none"> <li>▪ at least 70% of former income (minimum wage guaranteed and not above a certain maximum) for two years;</li> <li>▪ employee has to show willingness to recover and return to work.</li> </ul> |



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| <p><b>3) Detailed description of programme</b></p> | <p>The in-hospital RTW intervention, aimed at enhancing RTW, was carried out by the research leader in a multi-centre randomised controlled trial, which is a trial conducted at more than one medical centre or clinic. A randomised controlled trial is a type of scientific (often medical) experiment that aims to reduce bias when testing a new treatment. The people participating in the trial are randomly allocated to either a group receiving the treatment under investigation or a group receiving standard treatment (or placebo treatment) as the control.</p> <p>The effectiveness of the intervention compared with usual care for female cancer patients was studied. The intervention involved:</p> <ul style="list-style-type: none"> <li>▪ patient education and support at the hospital (as part of usual psycho-oncology care);</li> <li>▪ improvement of communication between the treating physicians and OHPs; and</li> <li>▪ the patient’s OHP being asked to organise a meeting with the patient and the employer to make a gradual RTW plan.</li> </ul> |
| <p><b>4) Target group of programme</b></p>         |   |
| <p>a) Targeting cancer type</p>                    | <p>Breast and gynaecological cancer patients between 18 and 60 years who were treated with curative intent (one-year survival rate of 80%), had paid work and were on sick leave. The reason that only breast and gynaecological cancers were included in this intervention is that a specialised nurse (e.g. breast care nurse) who could take RTW into account as part of the psycho-oncological care was available for only these cancer types. In total, 133 patients were included in the study; 65 were assigned to the intervention group and 68 were assigned to the control group. Breast cancer was the most common diagnosis (62%), followed by cancer of the female reproductive system (34%).</p>  |
| <p>b) Targeting specific workers</p>               | <p>The programme did not target any specific type of workers.</p>   |
| <p>c) Targeting specific enterprises</p>           | <p>-</p>  |
| <p>d) Gender</p>                                   | <p>Women</p>  |
| <p>e) Programme applied in practice</p>            | <p>In eight departments from six hospitals (breast care and gynaecological care departments) in the Netherlands.</p>  |

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| <p>5) Development of the programme</p>              |   |
| <p>a) Development of the programme</p>              | <p>The development of the work-directed intervention was based on the following:</p> <ul style="list-style-type: none"> <li>▪ a systematic review concerning the content of work-directed interventions for cancer patients;</li> <li>▪ factors reported by cancer survivors as helping or hindering their RTW;</li> <li>▪ focus group data of cancer survivors and of supervisors regarding RTW after cancer;</li> <li>▪ vocational rehabilitation literature;</li> <li>▪ semi-structured interviews with healthcare professionals.</li> </ul>   |
| <p>b) Partners and actors involved</p>              | <p>Cancer patients, supervisors, healthcare professionals</p>   |
| <p>c) Financial costs of the development</p>        | <p>Stichting Instituut Gak (<a href="http://www.instituutgak.nl/">http://www.instituutgak.nl/</a>) financed the development of the programme. Institute Gak is a fund that provides grants for projects in the fields of social security and the labour market in the Netherlands.</p> <p>The costs to implement the intervention were determined by combining the training costs and the costs of implementation. They consisted of:</p> <ul style="list-style-type: none"> <li>▪ the average hours of investment multiplied by the average nurse wage, subsequently multiplied by 42% overhead costs;</li> <li>▪ the secretary's average hours for sending letters to OHPs, which were copies of the letters sent to the GP;</li> <li>▪ no additional costs for the treating physician to produce these letters were taken into account.</li> </ul> |
| <p>d) Objectives of the programme</p>               | <p>To determine the effect of a hospital-based work support intervention for cancer patients on RTW and quality of life (QoL).</p>  |
| <p>e) Were the objectives of the programme met?</p> | <p>The intervention was easily implemented into usual psycho-oncological care and showed high RTW rates. No differences were seen between intervention and control groups as regards RTW and QoL outcomes.</p>  |

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| <p><b>6) Interesting or innovative features</b></p>   | <p>Patient education and support at the hospital (as part of usual psycho-oncology care): four 15-minute meetings with an oncology nurse or medical social worker.</p> <p>Improvement of communication between treating physicians and OHPs: a letter was sent to the OHP (when patients gave consent to allow medical information to be sent to the OHP).</p>  |
| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |   |
| <p><b>a) Strengths of the programme</b></p>   | <p>The use of a low-cost intervention that could be implemented without substantially increasing the time required.</p> <p>Easily adapted to the existing variation in usual psycho-oncological care, which yields high external validity.</p>  |
| <p><b>b) Weaknesses of the programme</b></p>  | <p>It is difficult to inform the OHP of specific illness-related features as formulated by the treating physician (first, not all patients know who their OHP is and, second, patients have to provide their consent to allow the treating physician’s medical information to be sent to the OHP).</p> <p>There is a gap between curative care and occupational healthcare in the Netherlands. There is no advantage to the health insurer in financing interventions aimed at RTW after cancer, because the health insurer will not pay if an employee remains sick (the costs of absenteeism, disability pension and loss of productivity lie with the employer). However, in the literature, returning to work is a key aspect of survivorship because it is often experienced as an important part of recovery (in addition to physical and psychological recovery, which is what the health insurer is paying for). The employer/occupational healthcare physician has to take these interventions regarding RTW into account.</p> |

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| c) Success factors (financial incentives)                        | It is a low-cost intervention.   |
| d) Facilitators for implementation (including awareness raising) | There are no facilitators for implementation available.  |
| <b>8) Transferability</b>  |  |
| a) Other groups of workers                                       | It is feasible to involve a specialised nurse into any psycho-oncological care and to take RTW into account.   |
| b) Countries   | The results and conclusions of this intervention are relevant for the Netherlands due to its social security legislation. The intervention, integrated into usual psycho-oncological care, could be adapted and generalised to other countries if cancer patients in other countries experience a lack of support from the hospital for their RTW as often as patients in the Netherlands. |
| c) Companies   |  |
| d) Other circumstances   | The programme was targeted at breast cancer patients, as psycho-oncological care is well suited to this target group (during the development of this intervention). The programme is transferable to other cancer types for which a rehabilitation programme has also been developed in which psycho-oncological care is deeply involved.  |
| <b>9) Parties and actors involved</b>                            |  |
| a) Parties and actors involved                                   | The project leader is responsible for the programme. The programme involved an OHP, an oncology nurse, a medical social worker, the employer, the treating physician and the patient.  |

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| <p>b) Role of parties and actors involved</p>    | <p>OHP: was informed by the treating physician by letter.</p> <p>Oncology nurse/medical social worker: delivered patient education and support at the hospital. They were trained by a labour and organisational psychologist.</p> <p>Employer: made a gradual RTW plan in collaboration with the cancer patient and the OHP.</p> <p>Treating physician: sent a letter to the OHP (a copy of the letter sent to the GP).</p> <p>Patient: was trained by the oncology nurse/medical social worker and was involved in developing a gradual RTW plan in collaboration with the employer and the OHP.</p>  |
| <p>c) Cooperation with other partners</p>        | <p>The different hospitals did not interact. The programme was run in different hospitals that did not communicate regarding their experiences. The only interaction was a newsletter, which was sent to the hospitals a few times by the project leader.</p>   |
| <p>d) Interaction between different partners</p> | <p>-</p>  |
| <p><b>10) Assessment of success</b></p>          |   |
| <p>a) Results of the programme</p>               | <p>Questionnaires were administered to the patients by the project leader at the beginning of the intervention and at the six- and 12-month follow-ups.</p> <p>The intervention was easily implemented into usual psycho-oncological care and showed high RTW rates. RTW rates were 86% and 83% for the intervention and control group, respectively. Median time from initial sick leave to partial RTW was 194 days versus 192 days, for the intervention and control group, respectively. QoL and work ability improved statistically over time but did not differ statistically between the intervention group and the control group (assumption of the project leader: work ability could have been improved by providing patient education and support that addressed misconceptions concerning RTW).</p> |

b) Improvements and future developments

Future developments

- To develop a clinical prediction rule for work outcomes (identifying patients that are at risk of a lower RTW rate).
- To develop an intervention more tailored to patients' needs through a stepped care model. Stepped care is a system of delivering and monitoring treatments, so that the most effective yet least resource-intensive treatment is delivered to patients first; patients only 'step up' to intensive/specialist services as clinically required.
- To develop an e-health intervention (internet-based intervention) for employers. Employers are key stakeholders in the RTW process of cancer survivors. Their positive understanding is essential and they are in the position to create work accommodations. However, employers express a need for support. The purpose of this study is to optimise the RTW of employees with cancer by supporting employers.
- To continue to develop an intervention (e-health/website) in which the patient is able to invite the employer, the OHP and the treating physician to get in contact with each other (this is currently ongoing).

Improvements

- To improve the incentives of the OHP and the employer to participate in such programmes.
- To embed structural financial compensation of RTW in psycho-oncological care.
- To improve the addressing of misconceptions (about cancer and work).
- To improve the instructions for nurses (a number of nurses mentioned that they were not completely convinced of their competence to deliver RTW advice). The half-day training course was too short to enable nurses to gain the knowledge required to adequately address patients' misconceptions about RTW.

Table 2 Work reintegration agency Rentree (Belgium)

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| <b>1) Country and context</b>                       |  |
| a) Population                                       | 11.3 million   |
| b) Employment rate (percentage)                     | 61.9 ( <a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a> , 2014)   |
| c) Official retirement age (years)                  | 65 ( <a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-belgium/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-belgium/view</a> , 2016)   |
| <b>2) Legislation regarding sickness in Belgium</b> | <ol style="list-style-type: none"> <li>1) Disability leave (sick leave): one month paid by the employer and thereafter paid by the social insurance provider without time limits.</li> <li>2) Legal options for gradual RTW have recently been implemented.</li> <li>3) The OHP legally supervises RTW for all employees and thus also for cancer survivors.</li> </ol> <p>The Belgian legislation on sick leave and RTW focuses on the ‘provision of information’ and ‘control of sicknesses’. The treating physician, the employer and the social security physician are the most important stakeholders. The treating physician provides the sickness certificate. The employer pays the sick leave benefit for the first two to four weeks. After that, sick leave wages are automatically offered by the national healthcare and benefit insurance service. Benefit recipients are regularly examined by the social security physician, who evaluates the patient’s inability to work. The physician assesses the patient’s access to sick leave benefits and gives advice on RTW possibilities. Both the social security physician and the employer need to authorise gradual work resumption during sick leave. In Belgium, every employer is obliged by law to organise occupational healthcare for the employee. Most employers hire the services of an external occupational healthcare service. A few large companies have an internal occupational healthcare service. The main role of the OHP is to prevent occupational diseases and accidents. The OHP is hardly involved in the sick leave process. It is only recently that employees on sick leave have been legally entitled to contact the OHP to discuss RTW options. In fact, the move from the protection of income to activation has been made to only a limited extent in Belgium.</p> |

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| <p><b>3) Detailed description of the programme</b></p> | <p>Rentree is part of the organisation Jobcentrum and provides coping techniques for the long-term side effects of cancer during the diagnosis and treatment period. Rentree also provides education for employees on legislation, including help with a RTW plan, involving the employer and colleagues. Admission to the programme was free.</p>   |
| <p><b>4) Target group of the programme</b></p>         |  |
| <p>a) Targeting cancer type</p>                        | <p>Employees diagnosed with cancer or patients diagnosed with cancer who become unemployed during cancer treatment.</p> <p>Rentree found that those contacting the organisation were mainly breast cancer patients and men with leukaemia or colorectal cancer who had a heavy physical job and would not be able to return to their original job in the future due to the effects of the cancer treatment. Men who will be reintegrating into their original job do not normally seek Rentree's help.</p> |
| <p>b) Targeting specific workers</p>                   | <p>-</p>   |
| <p>c) Targeting specific enterprises</p>               | <p>-</p>   |
| <p>d) Gender</p>                                       | <p>-</p>   |
| <p>e) Programme applied in practice</p>                | <p>Rentree is offered in the West Flanders (in Dutch 'West Vlaanderen') area. Rentree is also becoming well known outside this area and is receiving many requests from people outside this area.</p>  |
| <p><b>5) Development of the programme</b></p>          |  |



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| <p>a) Development of the programme</p>              | <p>Rentree is subsidised by a two-year project grant from 'Kom op tegen Kanker', which is the National Cancer Foundation (March 2015-April 2017); the initiative to start this project came from professionals in the areas of social services and cancer rehabilitation. The project proposal was submitted in March 2015, with the aim of helping people who were suffering from chronic diseases and who had become restricted in the labour market; there was no programme in place for cancer patients in particular and therefore social services and cancer rehabilitation professionals came up with the initiative to start this project. First, Rentree looked at what already existed and was offered. Rentree visited several oncological departments and obtained advice from OHPs (in Dutch 'arbeidsgeneesheer'), who recommended that the intervention should not be a group programme because of the mind-set that survivors of cancer (in general) want to focus on their own rehabilitation and do not want to be confronted with other people's problems. There are four training and mediation centres, namely in Bruges, Kortrijk, Ostend and Roeselare. Rentree has put a great deal of effort into campaigns to raise awareness of its programme. After a year, mainly by word of mouth, Rentree has received a lot of attention. The programme does not work with a waiting list, instead it is accessible at any moment. The first contact a patient has with Rentree is when they call up on the phone. A face-to-face consultation is the next step. After this, the interested person decides on the degree of counselling.</p> |
| <p>b) Partners and actors involved</p>              | <p>CM West Vlaanderen, various employers (HR Renson and capital Blankenbergem), a trade union (ABVV), Borstkliniek Waregem, CM (medical expert), Koninklijke Villa (rehabilitation physician), Provikmo (OHP), Kom op tegen kanker (representative), dienst arbeidsintegratie (representative), GTB West Vlaanderen (representative) and Jobcentrum (project team and project coordinator at Rentree). All of these organisations have been working together to create the Rentree programme and to provide input for the programme. These organisations did not have specific roles.</p>   |
| <p>c) Financial costs of the development</p>        | <p>No information was provided.</p>   |
| <p>d) Objectives of the programme</p>               | <p>To get at least one new case per week (as proof of the level of awareness raising).</p>  |
| <p>e) Were the objectives of the programme met?</p> | <p>In 1.5 years, 117 people signed up for Rentree. Of these 117 people, 104 have completed a programme or are currently following a programme. Thirteen people signed up but, after the intake consultation (face-to-face), decided not to follow the programme because they felt that just talking with the Rentree representative was of enough value to independently start the RTW process without further help. To monitor possible upcoming issues, Rentree contacted these people a few times. Consultations vary from</p>   |

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|   | <p>weekly to monthly. The frequency changes if the employee is going back to work and is tailored to the preferences of the employee. An employee has the option of seven months of counselling from Rentree.</p>  |
| <p><b>6) Interesting or innovative features</b></p>   | <p>Rentree provides three different pathways:</p> <p>Rentree<sup>2</sup>, which provides support and assistance in finding a new job.</p> <p>Rentree Plus, which provides support and assistance in RTW (the employee and Rentree together create a RTW plan), with many communication sessions with Rentree.</p> <p>Solo Rentree, which provides support and assistance in RTW (the employee and Rentree together create a RTW plan), but with no communication sessions with Rentree (the employee returns to work independently).</p>   |
| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |  |
| <p>a) Strengths of the programme</p>  | <p>Rentree has built up a large network in the field of cancer and rehabilitation: CM West Vlaanderen, various employers (HR Renson and capital Blankenbergen), a trade union (ABVV), Borstkliniek Waregem, CM (medical expert), Koninlijke Villa (rehabilitation physician), Provikmo (OHP), Kom op tegen kanker (representative), dienst arbeidsintegratie (representative), GTB West Vlaanderen (representative) and Jobcentrum (project team and project coordinator at Rentree). All of these organisations have been working together to create the Rentree programme and to provide input for the programme. These organisations did not have specific roles.</p> |
| <p>b) Weaknesses of the programme</p>   | <p>Rentree is regionally oriented (but wants to expand to the provincial level) and wants to guarantee the same quality in a larger area, which means that adaptations in the organisation must be made and the Rentree team must be extended. New members of the team must guarantee the same quality of service that Rentree is currently offering.</p>  |

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| c) Success factors (financial incentives)                        | -   |
| d) Facilitators for implementation (including awareness raising) | -   |
| <b>8) Transferability</b>  |   |
| a) Other groups of workers                                       | -   |
| b) Countries   | Yes, it is feasible. The findings of Rentree particularly underlined the stakeholders' wish to know each other and to cooperate to achieve a qualitatively good RTW and to share responsibility for the RTW process. However, Rentree noticed that successful RTW in West Vlaanderen largely depends on employers' goodwill and the employers' relationship with the OHP and the employee. Therefore, employers have to make efforts to create acceptable RTW conditions.   |
| c) Companies   | -   |
| d) Other circumstances   | -   |
| <b>9) Parties and actors involved</b>                            |   |
| a) Parties and actors involved                                   | CM West Vlaanderen, various employers (HR Renson and capital Blankenbergem), a trade union (ABVV), Borstkliniek Waregem, CM (medical expert), Koninlijke Villa (rehabilitation physician), Provikmo (OHP), Kom op tegen kanker (representative), dienst arbeidsintegratie (representative), GTB West Vlaanderen (representative) and Jobcentrum (project team and project coordinator at Rentree). All of these organisations have been working together to create the Rentree programme and to provide input for the programme. These organisations did not have specific roles. |

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| <p>b) Role of parties and actors involved</p>    | <p>Support tailored to the needs of the participant, the OHP, the employer, caregivers and the family will be involved in the Rentree programme.</p> <p>At the workplace: workplace adjustments will be implemented (as feasible) in consultation with both the employer and the employee; this will be different in each case.</p>  |
| <p>c) Cooperation with other partners</p>        | <p>-</p>   |
| <p>d) Interaction between different partners</p> | <p>-</p>   |
| <p><b>10) Assessment of success</b></p>          |  |
| <p>a) Results of the programme</p>               | <p>In April 2017, the programme will be evaluated. A Rentree steering group is analysing the results and monitoring the progress of the project, as well as making suggestions (for the future at the policy level).</p> <p>Rentree has developed a questionnaire for participants to evaluate the programme. This questionnaire deals with oncological problems, experiences with respect to Rentree, the coping styles of the participant and the company that was involved. Rentree is interested in using a questionnaire from Denmark; it is currently using it as an evaluation form, but this questionnaire has so far not been validated in Dutch.</p> |
| <p>b) Improvements and future developments</p>   | <p>The aims are to offer Rentree to all cancer survivors in Flanders, together with 'Kom op tegen Kanker', and to develop policy recommendations and provide a permanent service and a structural service by Rentree.</p> <p>In addition, there is room to improve the method of providing information by providing good-quality assistance to the Rentree team by a psychologist and during existing study-days. These study-days are organised by Rentree. The organisations are looking into the needs of the Rentree team and possible solutions.</p>  |

**Table 3 Municipality-based occupational rehabilitation programme (Denmark)**

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|---|--|
| <b>1) Country and context</b>                       |  |
| a) Population                                       | 5.7 million  |
| b) Employment rate (percentage)                     | 73.2 ( <a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a> , 2014)   |
| c) Official retirement age (years)                  | 65.5 ( <a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-denmark/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-denmark/view</a> , 2014)   |
| <b>2) Legislation regarding sickness in Denmark</b> | <p>During absence, the following people are entitled to receive their full salary from their employer without any time limit:</p> <ul style="list-style-type: none"> <li>▪ salaried employees (Salaried Employees Act);</li> <li>▪ employees covered by certain Collective Bargaining Agreements.</li> </ul> <p>Other employees are entitled to statutory sickness benefits from the following (Sickness Benefits Act (Consolidated Act No 653 of 26 June 2012)):</p> <ul style="list-style-type: none"> <li>▪ The employer for the first three weeks if the employee has worked with the employer for a period of eight weeks or more before the sick leave and has worked at least 74 hours during this period. It is generally not possible for the employer to recover these payments from the state or local authority.</li> <li>▪ The local authority for the remaining period, if one of various occupational conditions is met (for example, that the employee has been employed with one or more employers for a continuous period of at least 13 weeks before the sick leave and has worked at least 120 hours in total during the past 13 weeks). This also applies to the first three weeks of sickness if employees do not fulfil the conditions entitling them to statutory sickness benefits from their employer during this period (see above). Statutory sickness benefits cannot generally be paid for more than 52 weeks during a period of 18 months. The amount of benefit depends on the employee's hourly pay and weekly working hours. In 2012, it could not exceed DKK 106.49 per hour and DKK 3,940 per week.</li> </ul> |

### 3) Detailed description of the programme

In a controlled trial, municipal job consultants used acceptance and commitment therapy (ACT) dialogue with cancer survivors (to enhance commitment and change behaviour towards RTW, the survivors, through dialogue with their job consultant, were confronted with the following six core subjects: acceptance, cognitive fusion, being present, self as a context, values and committed action).

In addition, individual placement and support (IPS)-inspired tools were used with cancer survivors to engage them in behaviour changes towards readiness for RTW (R-RTW). The workplace (the employer and colleagues) was involved in the RTW process. In this intervention, the individualised support was 'operationalised' in a number of phases, which corresponded to the R-RTW stages of change obtained, i.e. a set of IPS-inspired actions were initiated according to the defined stage in which the survivor perceived him- or herself to be.

The individual rehabilitation plan was tailored according to different stages of R-RTW and the corresponding IPS actions that the job consultant initiated, accompanied by ACT-inspired dialogue that should enhance commitment and change behaviour towards RTW.

Job consultants did not entirely follow the programme (i.e. the IPS actions) because similar actions were already implemented in their workplace. IPS is similar to the way job consultants are already trained in dealing with RTW with clients (so they used IPS but in a slightly different way from in their training, and at times they did more). However, they did use ACT-inspired dialogue, and this was the unique part of the interventions.

The individual rehabilitation plan is tailored according to different stages of R-RTW and the corresponding IPS actions that the job consultant initiates, accompanied by ACT-inspired dialogue that should enhance commitment and change behaviour towards RTW.

Consultants documented exactly what they were doing online via a computer programme in which the job consultants ticked off the actions they had taken. This was routinely done for each patient. For some patients, there was only one page of information because only one meeting took place (as they did not need further support from the job consultants because they had a plan they could easily follow). Others had more pages because several meetings took place, as they needed more support. This is the tailored part of the intervention.

The patients had access to this online computer programme only at the baseline, after three months and after 12 months, when they filled out the questionnaires. The job consultants had access to the patients' responses, but the patients did not have access to what the job consultant wrote.

### 4) Target group of the programme

|   |   |
|---|---|
| <p>a) Targeting cancer type</p>               | <p>Patients referred to surgery, radiotherapy or chemotherapy at the Oncology Department, Aarhus University Hospital, Denmark (and residents in the municipalities of Silkeborg or Randers) for the following cancer diagnoses: breast, colorectal, head and neck, thyroid gland, testicular, ovarian or cervical. Patients are 18-60 years of age with permanent or temporary employment (with at least six months left of their contract).</p> <p>All diagnoses were included, but patients without breast cancer were so few that it was decided that 90 patients with breast cancer and 20 patients with other cancers would be included, so that a sub-group analysis of breast cancer could be done.</p>  |
| <p>b) Targeting specific workers</p>          | <p>-</p>  |
| <p>c) Targeting specific enterprises</p>      | <p>-</p>  |
| <p>d) Gender</p>                              | <p>-</p>  |
| <p>e) Programme applied in practice</p>       | <p>Not yet applied in practice, as it is still an intervention project. It could be implemented on a larger scale, but this will depend on the results.</p>   |
| <p><b>5) Development of the programme</b></p> |   |
| <p>a) Development of the programme</p>        | <p>RTW after long-term sickness absence can be seen as a behavioural change or a process with several stages; a person's own RTW perceptions are predictive of future work participation.</p> <p>The R-RTW scale is based on the original stages of change model, which has been applied to various behaviours and across diverse disorders. The R-RTW model addresses the motivational and social factors contributing to RTW behaviour and the maintenance of work participation. According to this model, the person progresses through stages of behaviour change, i.e. RTW after sickness absence, shifting from the intention not to engage in RTW behaviour in the foreseeable future to a stage of initiating behaviour change, maintaining behaviour change and returning to work in a sustainable fashion. Based on a person's score on the R-RTW scale, it is possible to identify that person's stage of readiness for change with regard to RTW, which allows professionals, e.g. job consultants, to tailor effective and individual support.</p> |

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| <p>b) Partners and actors involved</p>              | <p>In both intervention municipalities, the two job consultants attended a four-day course during which they were specially trained by a psychologist to use elements of ACT and the IPS model. During the inclusion and intervention period, the job consultants received supervision from the psychologist once a month to secure a high degree of compliance with the intervention protocol.</p>  |
| <p>c) Financial costs of the development</p>        | <p>The Danish Cancer Society funded the majority of the study. Funding also came from one of the five regions in Denmark and from the Danish Health Foundation. Thus, funding came from three different sources.</p> <p>There is no cost-effectiveness analysis in the programme. However, the hours spent by the consultants on this programme were recorded (the consultants had other main roles in their daily jobs). The accountant from the research department will calculate the exact cost of their time input. One municipality joined the programme for free, but the other municipality is being paid for their job consultants in terms of hours spent.</p>   |
| <p>d) Objectives of the programme</p>               | <p>To apply an early, individually tailored occupational rehabilitation intervention for cancer survivors in two municipalities in parallel with cancer treatment focusing on enhancing R-RTW.</p>   |
| <p>e) Were the objectives of the programme met?</p> | <p>The research team succeeded in involving two municipalities and the hospital. However, the hospital did not want the job consultants to come to the hospital and deliver the intervention. Therefore, patients went to the municipality and this was successful. It was surprising that the job consultants were not wanted at the hospital. It turned out that the hospital wanted to protect its patients. The project leader is about to submit a qualitative article about the professionals' perspective on the intervention project. The healthcare personnel and the job consultants (both recruiting patients for the intervention) have very distinct values and goals regarding the patients.</p> <p>One municipality was paid; one was doing it for free. A medical professor and two research nurses from the hospital were involved but they did not receive any funds for planning the project. There may have been an opportunity to pay a salary to a member of staff in the hospital for recruitment purposes, but the medical professor and research nurses did not think it was necessary because the effort of recruiting patients was quite small. The project leader does not think that payment would have improved the recruitment process or cooperation between the hospital and job consultants, as the nurses in particular were reluctant to be involved because they felt that patients needed protection from the outside with regards to demands/pressure, etc.</p> |



**6) Interesting or innovative features**

The intervention will also be evaluated through qualitative interviews in terms of its acceptability to stakeholders, whether or not the existing setting is appropriate and whether or not the job consultants are capable of this task. There are currently no results about this.

The innovative element of this intervention was the timing of the occupational rehabilitation, which was initiated much earlier than usual, and the active involvement of the workplace (the employer and colleagues). We anticipate that vulnerable cancer survivors will benefit from this approach, which could reduce the effects of social inequality on work ability.

The ACT dialogue was the most innovative and successful part of the intervention, which was partly due to the supervision that job consultants received once a month from a psychologist (see Figure 1 above). However, the dialogue was not recorded during the sessions or reflected upon by the patients after the session. The job consultants might do this as part of their work anyway, as they are obliged to take notes. The project leader needs to follow this up. However, notes were made on any dialogue challenges so that the job consultant could discuss them with the supervisor.

The programme also allowed patients to receive information on RTW before their treatment was over and before their sickness benefits ran out. This was innovative, as otherwise patients do not receive RTW information or support until their sickness benefits are about to run out.

**7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)**

|   |   |
|---|---|
| <p>a) Strengths of the programme</p>                                    | <p>The timing of the occupational rehabilitation and the active involvement of the workplace (the employer and colleagues) were strengths. In addition, the ACT dialogue was a successful part of the intervention, which was partly due to the supervision that job consultants received once a month from a psychologist.</p> <p>The programme also allowed patients to receive information on RTW before their treatment was over and before their sickness benefits ran out, which was a strength because, otherwise, patients do not receive RTW information or support until their sickness benefits are about to run out.</p> <p>Another strength was the cooperation with the employer. The job consultant encouraged the patients to set up a round table meeting between the employer, themselves and the consultant to discuss what work adjustments/modifications were required on the employee's return to work. There was also an opportunity for the employer to discuss what refunds they could get for implementing work modifications. This information was provided by the job consultant.</p> |
| <p>b) Weaknesses of the programme</p>                                   | <p>The involvement of the hospital was a weakness of the programme. There was little communication between the hospital and the municipality. Therefore, the patient was the carrier of information between the two. This is unfortunate, as patients with a low socioeconomic status would have benefited from the hospital providing this link (this is the project-leader's hypothesis).</p>   |
| <p>c) Success factors (financial incentives)</p>                        | <p>The ACT dialogue was a success factor, as was the fact that the job consultants were offered supervision, which helped them to adhere to the protocol. The dialogue is very new to the consultants.</p>  |
| <p>d) Facilitators for implementation (including awareness raising)</p> | <p>A lot of awareness has been raised as a result of the intervention. There have been interviews published in newspapers and the Danish Cancer Society had a week of raising awareness on TV, including a fundraising show. One of the job consultants was filmed and appeared on TV.</p>  |
| <p>8) Transferability</p>   |   |

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| <p>e) Other groups of workers</p>            | <p>The intervention could be applied to other types of physical illnesses (e.g. heart disease) but perhaps not to mental health issues, as the stigma of such issues needs to be addressed and employers may be less likely to want to help/support such employees (although this is anecdotal).</p> <p>The theory behind the hypothesis that the intervention will increase RTW rates originates from the stages of change model. The R-RTW model addresses the motivational factors of behaviour change towards RTW and the maintenance of work and was validated in a population of claimants with musculoskeletal disorders. The scale has been translated to Norwegian and was validated in a Norwegian inpatient occupational rehabilitation programme in sick-listed people. The scale was reliable and was found to be a valid tool for RTW prognosis. In Denmark, the R-RTW scale is currently being validated.</p> <p>If there are comparable social security schemes, as in other Nordic countries, then yes, this intervention is easily transferable. However, in countries where employers are more responsible for RTW, the intervention may not be transferable without modifications. The project leader thinks that a tailored intervention approach is crucial, regardless of the country it is implemented in.</p> |
| <p>f) Countries</p>                          |  |
| <p>g) Companies</p>                          | -  |
| <p>h) Other circumstances</p>                | -  |
| <p><b>9) Parties and actors involved</b></p> |  |
| <p>a) Parties and actors involved</p>        | <p>Job consultants, employers (colleagues should have been involved but, to date, employees have not involved them), family members and GPs (sometimes patients are encouraged to go to their GP by their job consultant if they feel the patient is developing depression).</p> <p>The municipality and hospital did not interact, as the hospital did not want to take part. When the employee involved the employer, as recommended, the job consultant interacted with the employer. Sometimes the job consultant referred the patient to other departments in the municipality for rehabilitation, e.g. physical activity, support groups, etc. On some occasions, the job consultants became emotionally involved during their close dialogue with the patients and, in such situations, unusual tasks (for a job consultant) may be done, e.g. will writing.</p>  |

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| b) Role of parties and actors involved    |  |
| c) Cooperation with other partners        | -  |
| d) Interaction between different partners | -  |
| <b>10) Assessment of success</b>          |  |
| a) Results of the programme               | <p>It is too early yet for results.</p> <p>Results are regularly reported but the intervention has not yet been evaluated, as recruitment and intervention is ongoing until November 2016. The aim is to recruit 90 breast cancer patients and currently 86 have been recruited. Recruitment will end on 1 November 2016 or when the other four participants have been recruited.</p>  |
| b) Improvements and future developments   | <p>The recruitment period has been prolonged, so perhaps more municipalities should be included so that more cancer types can be included. There is only one large hospital in the region (this is where the project leader is employed) where cancer is treated and so perhaps more regions could have been involved.</p> <p>It is a little too early to comment on the future. The project leader wants to look at the R-RTW data first to see what actions have been put into place and whether or not these actions correspond with the hypotheses as regards when they should be put in place and for what cancer stage. However, further funding is required to do this (using the stages of change approach).</p> |

Table 4 Work reintegration agency oPuce (the Netherlands)

|  |   |
|--|---|
| <p><b>1) Country and context</b></p>                               |   |
| <p>a) Population</p>   | <p>16.9 million</p>   |
| <p>b) Employment rate (percentage)</p>                             | <p>73.1 (<a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a>, 2014)</p>   |
| <p>c) Official retirement age (years)</p>                          | <p>65.5 (<a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view</a>, 2016)</p>   |
| <p><b>2) Legislation regarding sickness in the Netherlands</b></p> | <p>The legal rights of workers diagnosed with cancer are outlined below.</p> <p>Improved gatekeeper law that applies to all workers who report sick:</p> <ul style="list-style-type: none"> <li>▪ problem analysis (sickness of the worker) by an OHP within six weeks;</li> <li>▪ plan of action based on problem analysis by the employer and employee within eight weeks;</li> <li>▪ guidance including RTW support (paid) by the employer for two years and, after this, referral for disability pension assessment.</li> </ul> <p>Extended paying of income act:</p> <ul style="list-style-type: none"> <li>▪ at least 70% of former income (minimum wage guaranteed and not above a certain maximum) for two years;</li> <li>▪ employee has to show willingness to recover and return to work.</li> </ul> |

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| <p><b>3) Detailed description of the programme</b></p> | <p>oPuce is a social enterprise focusing on finding jobs for unemployed cancer survivors, on the one hand, and on putting ‘cancer and work’ on the political and societal agenda, on the other hand.</p> <p>oPuce consists of the social enterprise oPuce and the oPuce Foundation.</p> <p>The social enterprise oPuce focuses on businesses. It focuses on finding work for unemployed people who have recovered from cancer and on coaching them in their new job for one year.</p> <p>The oPuce Foundation focuses on politics and society. It sets societal issues such as the burdens of cancer survivorship on the political and societal agenda. It also seeks solutions for the burdens that arise in life — and especially at work — after cancer.</p> <p>At this moment, oPuce is creating an ecosystem (in an ecosystem, all stakeholders are included and play an equal role in finding solutions and making an impact) for cancer and work, inspired by Prof. Dr Annemieke JM Roobeek. Twenty large employers (mainly multinationals and corporate businesses) will look for solutions and help make an impact. The main activities of the ecosystem are sharing knowledge and creating best practices, and helping create jobs for unemployed cancer survivors.</p> <p>The Deloitte Impact Foundation is helping this ecosystem.</p> <p>Companies such as Manpower, a multinational HR consulting firm, help oPuce with scaling up. By creating an ecosystem with large employers, it is possible to find better solutions and make a larger impact. It is an ecosystem ‘by and for companies’. This means it is important to involve the employers to make them aware of the urgency in helping unemployed cancer patients to find a job.</p> |
| <p><b>4) Target group of the programme</b></p>         |  |
| <p>a) Targeting cancer type</p>                        | <p>oPuce focuses on unemployed recovered cancer survivors. The cancer types we often see are Hodgkin’s lymphoma, breast cancer and leukaemia. The goal is to create a showcase that can be shared with other European countries.</p>   |
| <p>b) Targeting specific workers</p>                   | <p>Unemployed.</p>   |
| <p>c) Targeting specific enterprises</p>               | <p>As it is important to have an impact, oPuce focuses on multinational companies and large employers.</p>   |

|  |   |
|--|---|
| d) Gender                              | -   |
| e) Programme applied in practice       | The programme is applied in all companies that are members of the oPuce ecosystem. As previously explained, job retention is stimulated by sharing knowledge and best practices among employers. In addition to this, employers help RTW by creating jobs for recovered cancer survivors.   |
| <b>5) Development of the programme</b> |   |
| a) Development of the programme        | <p>oPuce was founded in 2012 by Isabelle Lebrocqy.</p> <p>In 2011, Isabelle lost her job during colon cancer. Once recovered, she discovered how difficult it is to find a job after cancer. To change this, she founded the social enterprise oPuce.</p> <p>oPuce focuses on finding work for unemployed people who have recovered from cancer and on coaching them in their work for one year. To this end, oPuce established an ecosystem with multinational and large employers.</p> <p>To gain more insight into the problems cancer survivors are facing when they apply for new jobs, the project leader decided to start an online survey: 1,000 cancer survivors participated. The results were overwhelming: 25% lost their jobs and 61% remained unemployed and were not able to find a new job. The project leader asked other patient associations and the Dutch news programme 'Eén Vandaag' to also carry out surveys. They all got the same results. With these results, the project leader convinced a member of the Dutch Parliament to put the difficulties and problems regarding 'cancer and work' on the political agenda. The Minister of Social Affairs and Employment (L. Asscher) is now working on a plan of action for 'cancer and work' and on a pilot for no-risk insurance. (Minister Asscher wants to experiment with the so-called no-risk policy. Employers will run no risk, which might increase the likelihood of them hiring someone with cancer and of deploying better reintegration.) To continue this work, the oPuce Foundation was founded. The oPuce Foundation helps raise awareness of the burdens of cancer survivorship by setting these issues on national and international governmental agendas. In addition, oPuce wants to remove the stigma of cancer by creating a positive and powerful image of cancer survivors.</p> |

## Rehabilitation and return to work after cancer — instruments and practices

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|---|---|
| <p>b) Partners and actors involved</p>              | <p>Philips helped oPuce during piloting to discover what was needed and what was feasible.</p> <p>In addition, the 1,000 respondents of the oPuce survey, and the hundreds of patients/survivors with whom Isabelle Lebrocqy spoke, helped by giving insights into the burdens, challenges and possibilities for ‘cancer and work’.</p> <p>In the oPuce ecosystem, employers share their experience, knowledge and best practices. This information will be shared in the future.</p>   |
| <p>c) Financial costs of the development</p>        | <p>Own funding.</p>   |
| <p>d) Objectives of the programme</p>               | <p>The objective of the oPuce programme is to provide work for unemployed cancer survivors.</p> <p>oPuce does this through an ecosystem for ‘cancer and work’. In this ecosystem, knowledge and best practices are shared between employers. The Philips WGP programme is one of these best practices. In this programme, people learn new skills while working.</p> <p>The oPuce programme is tailor made and adapted to the needs of the cancer survivor and the employer. If someone needs redirection in his or her career, oPuce looks for the right training and finds the job that goes with it.</p>   |
| <p>e) Were the objectives of the programme met?</p> | <p>At this moment, the oPuce ecosystem is setting goals in brainstorm sessions. Now that ‘cancer and work’ stands on the Dutch governmental agenda, oPuce wants to create a best practice as a showcase for employers in the Netherlands and later for those in Europe as a whole.</p>  |
| <p><b>6) Interesting or innovative features</b></p> | <p>oPuce targets unemployed cancer survivors: in the Netherlands, 25% of employed cancer patients lose their job due to cancer and 61% will never work again because they will not be approved for a new job. By creating an ecosystem with large employers, social innovations are possible and are in line with the needs of the recovered cancer survivors and their employers. In an ecosystem, all stakeholders are included and play an equal role in finding solutions and making an impact. In the oPuce ecosystem, sharing knowledge and best practices between employers also stimulates job retention. Moreover, employers foster RTW by creating jobs for recovered cancer survivors.</p> |



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| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |  |
| <p>a) Strengths of the programme</p>  | <p>The strengths of oPuce are its focus on the possibilities rather than on the impossibilities. In addition, the oPuce ecosystem includes the opinion of employers in RTW after recovering from cancer.</p>   |
| <p>b) Weaknesses of the programme</p>   | <p>At this moment, the ‘cancer stigma’ and the Dutch social system are problems for employed and unemployed cancer survivors. Under Dutch law, employers are obliged to continue paying a sick employee 70% of his or her salary over the first two years of illness. This makes unemployed cancer survivors a financial risk to their new employers. Of survivors, 25% lose their job and 61% will never work again. The Dutch government is set to launch a pilot of no-risk insurance. The minister of Social Affairs and Employment (L. Asscher) wants to experiment with the so-called no-risk policy. Employers will run no risk, which might increase the likelihood of them hiring someone with cancer and of deploying better reintegration.</p> <p>By creating an ecosystem, the greatest barriers for ‘cancer and work’ are tackled. As previously noted, it is important to remove the stigma associated with cancer and adapt social legislation.</p> |
| <p>c) Success factors (financial incentives)</p>  | <p>Incentives could be governmental, such as financial incentives: employers could be financially supported in job retention and RTW for employees diagnosed with cancer.</p>  |
| <p>d) Facilitators for implementation (including awareness raising)</p>   | <p>Including cancer survivors in the RTW programmes could enhance the general understanding of what it is like to have cancer when working. By creating ecosystems that include all stakeholders and experts, implementations, successes and impacts will be bigger and better.</p>  |
| <p><b>8) Transferability</b></p>  |  |
| <p>a) Other group of workers</p>  | <p>The oPuce programme is transferable, as it is created with employers. It is about finding work and coaching people while working and learning.</p>  |

## Rehabilitation and return to work after cancer — instruments and practices

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|---|--|
| b) Countries                              | <p>At the moment, oPuce is creating a best practice in the Netherlands but wants to extend it to Europe. Manpower and other multinational employers have been asked to help in this.</p> <p>By creating an ecosystem that co-creates and by sharing knowledge, the programme is comprehensive and easily transferable.</p> |
| c) Companies                              | -  |
| d) Other circumstances                    | -  |
| <b>9) Parties and actors involved</b>     |  |
| a) Parties and actors involved            | <p>All stakeholders are directly or indirectly included. For the assessment, a psychologist is included and the coaching is done by qualified job coaches. When needed, external experts are consulted and involved.</p>   |
| b) Role of parties and actors involved    | <p>Stakeholders and employers have started sharing knowledge in brainstorming sessions. Employers guarantee two to five jobs per year for recovered cancer survivors.</p>  |
| c) Cooperation with other partners        | <p>Yes, all stakeholders cooperate. The principle of an ecosystem is co-creation and interaction.</p>  |
| d) Interaction between different partners |  |
| <b>10) Assessment of success</b>          |  |

a) Results of the programme

For four years, at least three to five employed and unemployed cancer patients and survivors have called oPuce on a weekly basis. Now, employers are also starting to ask for advice. The hundreds of cancer patients and survivors that have received assistance from oPuce 'behind the scenes' have helped oPuce obtain an insight into employees' and their employers' obstacles during and after cancer. It has also clarified what should be done for unemployed cancer survivors. When cancer patients or survivors want to remain anonymous, oPuce advises them on how to deal with job interviews. All of this information helps the oPuce ecosystem, which was set up in 2015. Twenty large employers will help find solutions and make an impact in job retention and RTW.

In addition, setting 'cancer and work' on the Dutch political agenda resulted in a plan of action for 'cancer and work' and in a pilot for no-risk insurance. Many stakeholders are now working nationally on solutions.

b) Improvements and future developments

Improvements

One suggestion is to set up ecosystems with stakeholders to solve the problems of 'cancer and work'.

In addition, it is crucial that organisations increase job retention, especially for patients with chronic and fatal diagnoses, both for reintegration and for patients and survivors who have difficulties finding work because of, for example, age discrimination.

Future developments

Sharing knowledge on and developing best practices can become showcases to teach other employers what to do in 'cancer and work'.

**Table 5 Macmillan Cancer Support — cross-organisational working through a cancer programme (the UK)**

|  |  |
|--|--|
| <b>1) Country and context</b>                      |  |
| a) Population                                      | 64.1 million   |
| b) Employment rate (percentage)                    | 72.0 ( <a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a> , 2014)   |
| c) Official retirement age (years)                 | 65 (for men) and 62 (for women) ( <a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-united-kingdom/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-united-kingdom/view</a> , 2016)  |
| <b>2) Legislation regarding sickness in the UK</b> | <p>Employees can get GBP 88.45 per week statutory sick pay (SSP) if they are too ill to work, which is paid by the employer for up to 28 weeks. Employees need to qualify for SSP and must have been off work sick for four or more days in a row (including non-working days).</p> <p>Employees cannot get less than the statutory amount. They can get more if their company has a sick pay scheme (or ‘occupational scheme’).</p> <p>Employers should make changes to an employee’s working conditions if they become disabled because of their sickness. These changes are known as ‘reasonable adjustments’ and could include shorter working hours or adaptations to the equipment that the employee uses at work.</p> |
| <b>3) Detailed description of the programme</b>    | <p>The ‘Working Through Cancer’ programme is a cross-organisational initiative at Macmillan Cancer Support aimed at supporting people affected by cancer to remain in or return to work after treatment.</p> <p><b>Overview</b></p> <p>The programme’s vision is to ensure that people living with cancer and their carers (family) feel confident and supported in remaining in or returning to work, if that is their wish.</p> <p>The programme has four key priority outcomes:</p> <p>1) <b>People with cancer and their carers</b> are informed and supported so that they can make work choices that are right for them and can enjoy a positive change in their quality of life, health and well-being.</p>           |

2) **Health and social care professionals** understand the benefits and importance of work to the health and well-being of people with cancer and confidently support them and point them in the direction of appropriate services from diagnosis onwards.

3) **Employers** actively help employees living with cancer and their carers to remain in or return to work and to understand the benefits to their business of doing so.

4) **Government and service commissioners** recognise work as a health outcome and ensure everyone living with cancer has access to appropriate work support services, including case-managed vocational rehabilitation for those with the most complex needs.

Within each area, the programme carries out a range of activities including for:

#### 1) **People with cancer and their carers**

- Providing information and support via online and offline resources, through awareness campaigns (e.g. on rights at work) and through Macmillan's online communities.
- Providing a telephone helpline service called 'Work Support' that provides guidance on employment issues and referrals to legal advice when required. Legal advice is provided via a partnership with a charity providing pro bono legal support to people who cannot afford to pay for legal advice.

Macmillan Cancer Support also runs a range of other services to which people affected by cancer can be referred, such as financial support (welfare advice, financial guidance and debt advice) and clinical and emotional support services.

#### 2) **Health and social care professionals**

- Developing the knowledge and capacities of health professionals to help them understand the importance of work and how to have conversations about work issues with patients. This activity is delivered through the development of guidance tools, e-learning on work and cancer, face-to-face training and awareness campaigns for health and social care professionals.

This programme links with other wider initiatives in Macmillan that focus on the development of workforce capabilities and ensuring that everyone with a cancer diagnosis in the UK gets access to a holistic needs assessment and care plan during and after treatment, including access to health and well-being clinics (otherwise known as the 'Recovery Package').

#### 3) **Employers**

|   |  |
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|   | <ul style="list-style-type: none"> <li>▪ Awareness raising to shift the perceptions of employers regarding cancer and survival and the ability of people living with cancer to return to work. This includes direct marketing campaigns, articles in trade publications, presentations at relevant conferences and the use of social media.</li> <li>▪ Delivering the ‘Macmillan at Work’ (MAW) programme for employers, which launched in July 2014. MAW provides employers with information, guidance and training. Over 4,000 employers have signed up since its launch. Once employers register, they automatically get access to the ‘Essential Work and Cancer’ toolkit (a package of resources for employers), free quarterly e-newsletters and a range of free e-learning for managers, trade union representatives and occupational health professionals. MAW also delivers employer training for those needing more bespoke support. Training is delivered in various ways, e.g. through open workshops at Macmillan or in-house training at the employer’s site. The methods used include ‘train the trainer’ and consultancy advice to support the review of policies and practices.</li> </ul> <p>The programme also offers specific support for SMEs online (e.g. online video case studies) and for the self-employed.</p> <p><b>4) Government and commissioners</b></p> <p>The key activity here focuses on influencing policy, e.g. making sure that there is a focus on cancer in health and work initiatives and policies and in cancer policies.</p> |
| <p><b>4) Target group of the programme</b></p> <p>a) Targeting cancer type</p> <p>b) Targeting specific workers</p> <p>c) Targeting specific enterprises</p> <p>d) Gender</p> | <p>The programme targets patients with cancer and their carers, regardless of their cancer type and their stage in their cancer journey. However, there is a particular focus on supporting people who survive cancer and who want to return to work after treatment.</p> <p>-</p> <p>-</p> <p>-</p>   |

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| e) Programme applied in practice             | UK wide.  |
| <b>5) Development of the programme</b>       |   |
| a) Development of the programme              | See MacMillan website for more information ( <a href="https://www.macmillan.org.uk/about-us/who-we-are/organisation-history.html">https://www.macmillan.org.uk/about-us/who-we-are/organisation-history.html</a> )  |
| b) Partners and actors involved              | <p>Many expert advisors were involved in developing the programme. These included researchers on work and cancer, employers, HR experts, occupational health professionals, occupational therapists and others. The National Cancer Survivorship Initiative (NCSI) initially supported the research and piloting activities that underpin the programme (NCSI partnership included Macmillan, National Health Service (NHS) Improvement and the Department of Health).</p> <p>Macmillan also brought together a forum of employers to advise the project team on the development of the employer programme.</p> <p>Currently, Macmillan is delivering the 'Work Support' service on the 'Macmillan Support' line in partnership with a pro bono charity called LawWorks, which matches volunteer lawyers with clients who cannot afford legal advice or who do not qualify for legal aid.</p> |
| c) Financial costs of the development        | Macmillan funds this programme.   |
| d) Objectives of the programme               | <p>Macmillan's ambition is to reach and improve the lives of everyone living with cancer and to inspire millions of others to do the same.</p> <p>The vision of the programme is to ensure that people affected by cancer in the UK and feel confident and supported in remaining in or returning to work, if they wish to do so. This includes using a range of activities as described above to deliver outcomes.</p>   |
| e) Were the objectives of the programme met? | To date, over 4,000 employers have signed up the MAW programme; Macmillan trained over 800 line managers in 2015.   |

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|   | <p>The programme has been successful in influencing policy, such as the Cancer Strategy for England, which included recommendations on how the NHS in England could support people with cancer in returning to work.</p> <p>Although still a pilot, the helpline takes at least 200 calls a month on employment issues. In the evaluation of the service, 25% of customers reported that they would not have been able to return to work without the support of the helpline, 30% reported a reduced loss of income and 22% reported that they had left work on satisfactory terms as a result of the support received.</p> <p>The 'Working Through Cancer' awareness campaigns have also been very successful. For example, the website of the 'Rights at Work' campaign had over 113,000 visitors over a period of 11 weeks in 2015, and 15,000 copies of the resources were downloaded, indicating a high demand for information on this issue.</p> |
| <p><b>6) Interesting or innovative features</b></p>   | <p>The holistic approach is taken to remove the barriers that patients with cancer face. This is done through the four outcomes outlined above.</p>  |
| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |  |
| <p>a) Strengths of the programme</p>  | <p>One strength is that Macmillan is a UK-wide programme with independent funding that is building up a good evidence base; a wide range of experts and stakeholders are inputting into the programme; Macmillan is a well-recognised charity and brand that has helped to influence policy and to leverage support from stakeholders.</p>   |



## Rehabilitation and return to work after cancer — instruments and practices

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| <p>b) Weaknesses of the programme</p>                                   | <p>The programme's weaknesses are that a charitable organisation cannot deliver everything for everybody. The 'Working Through Cancer' programme is a small dedicated team of five full-time staff and there are four staff members on the 'Work Support' helpline (in total, there are nine staff members). The team is supported by 15 volunteers and five freelance trainers who help deliver the MAW employer programme.</p> <p>The greatest barrier faced is the lack of understanding of the changing nature of cancer, particularly on the part of employers, but also within society in general. There is a poor understanding of cancer; it is not one but 200 diseases and no two people have the same experience. In addition, more people are surviving the disease and are wanting to remain in or return to work after their treatment.</p> |
| <p>c) Success factors (financial incentives)</p>                        | <p>Macmillan Cancer Support is registered as a charity with the Charity Commission and as a company limited by guarantee with the Registrar of Companies.</p> <p>One strength is that Macmillan is a UK-wide programme with independent funding that is building up a good evidence base; a wide range of experts and stakeholders are inputting into the programme; Macmillan is a well-recognised charity and brand that has helped to influence policy and to leverage support from stakeholders.</p>  |
| <p>d) Facilitators for implementation (including awareness raising)</p> | <p>Macmillan is continually raising awareness of the resources that Macmillan offers through, for example, its awareness campaigns.</p>   |
| <p><b>8) Transferability</b></p>  |   |
| <p>a) Other group of workers</p>  | <p>-</p>  |
| <p>b) Countries</p>   | <p>-</p>  |
| <p>c) Companies</p>   | <p>-</p>  |
| <p>d) Other circumstances</p>   | <p>Yes, other charities could potentially replicate what Macmillan is doing. However, it does require the investment of both time and resources.</p>  |

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| <p><b>9) Parties and actors involved</b></p>  |  |
| <p>a) Parties and actors involved</p>         | <ol style="list-style-type: none"> <li>1) People with cancer and their carers</li> <li>2) Health and social care professionals</li> <li>3) Employers</li> <li>4) Government and service commissioners</li> </ol>   |
| <p>b) Role of parties and actors involved</p> | <p><b>3) Employers</b></p> <ul style="list-style-type: none"> <li>▪ Awareness raising to shift the perceptions of employers regarding cancer and survival and the ability of people living with cancer to return to work. This includes direct marketing campaigns, articles in trade publications, presentations at relevant conferences and the use of social media.</li> <li>▪ The delivery of the MAW programme for employers, which launched in July 2014. MAW provides employers with information, guidance and training. Over 4,000 employers have signed up since its launch. Once employers register, they automatically get access to the ‘Essential Work and Cancer’ toolkit (a package of resources for employers), free quarterly e-newsletters and a range of free e-learning for managers, trade union representatives and occupational health professionals. MAW also delivers employer training for those needing more bespoke support. Training is delivered in various ways, e.g. through open workshops at Macmillan or in-house training at the employer’s site. The methods used include ‘train the trainer’ and consultancy advice to support the review of policies and practices.</li> </ul> <p>The programme also offers specific support for SMEs online (e.g. online video case studies) and for the self-employed.</p> <p><b>4) Government and commissioners</b></p> <p>The key activity here focuses on influencing policy, e.g. making sure that there is a focus on cancer in health and work initiatives and policies and in cancer policies.</p> |
| <p>c) Cooperation with other partners</p>     | <p>The vocational rehabilitation pilots had partners such as employment services, the NHS, etc. However, the pilots were discontinued after initial investment, as there was no pick-up funding from the NHS or other partners. This is primarily because, in the UK, work is not yet seen as a clinical outcome of care and, as a result, it is difficult to get commissioners to invest in the delivery of work or vocational rehabilitation services.</p>   |



Table 6 Work reintegration agency Re-turn (the Netherlands)

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| <b>1) Country and context</b>                               |  |
| a) Population   | 16.9 million   |
| b) Employment rate (percentage)                             | 73.1 ( <a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a> , 2014)   |
| d) Official retirement age (years)                          | 65.5 ( <a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-netherlands/view</a> , 2016)   |
| <b>2) Legislation regarding sickness in the Netherlands</b> | <p>The legal rights of workers diagnosed with cancer are outlined below.</p> <p>Improved gatekeeper law that applies to all workers who report sick:</p> <ul style="list-style-type: none"> <li>▪ problem analysis (sickness of the worker) by an OHP within six weeks;</li> <li>▪ plan of action based on problem analysis by the employer and employee within eight weeks;</li> <li>▪ guidance including RTW support (paid) by the employer for two years and, after this, referral for disability pension assessment.</li> </ul> <p>Extended paying of income act:</p> <ul style="list-style-type: none"> <li>▪ at least 70% of former income (minimum wage guaranteed and not above a certain maximum) for two years;</li> <li>▪ employee has to show willingness to recover and return to work.</li> </ul>                        |
| <b>3) Detailed description of the programme</b>             | <p>Re-turn supports employees with cancer and their employers (preferably at the same time) with absenteeism through help with reintegration. In addition, Re-turn provides process support. The Re-turn programme is called 'Werkkracht bij kanker'. 'Werkkracht bij kanker' is a modular and scalable programme that provides a clear structure through which both the employer and the employee can plot their future path, supported by the knowledge of what happens in relation to work when someone is diagnosed with cancer. This knowledge relates to personal characteristics, disease-related (long-term) consequences and the impact of cancer on the work environment (including colleagues). Constructing these custom-made routes using the programme requires highly skilled, trained and experienced specialists.</p> |

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| <b>4) Target group of the programme</b> |  |
| a) Targeting cancer type                | Re-turn is accessible to everyone. However, breast cancer is a commonly encountered cancer type in the programme due to its high survival rates and thus a large number of people needing support.   |
| b) Targeting specific workers           | -  |
| c) Targeting specific enterprises       | -  |
| d) Gender                               | -  |
| e) Programme applied in practice        | Re-turn works together with employers from different sectors (e.g. KPN Corporate Market BV, Capgemini Nederland, Bijenkorf, Municipality Groningen, Department of Justice, Boskalis, Movir, A.S.R.). The programme is incorporated in collective damage insurance by a health insurer (in Dutch 'Zilveren Kruis').   |
| <b>5) Development of the programme</b>  |  |
| a) Development of the programme         | The project leader has herself suffered from breast cancer and was a volunteer in a Dutch breast cancer organisation. She decided to set up Re-turn because, at that time, many cancer patients had questions about work. For the first two years, she put a lot of effort into developing a methodology (not into directly offering a programme or service to employees). A great deal of information has been put together obtained from, for example, OHPs. Together with these collaborators, questionnaires were created and validated (which are used during the intake consultation). The three steps of the methodology of Re-turn are (1) structuring the current work situation, (2) coaching through the RTW process (stepped care and evidence based) and (3) the actual reintegration (evidence based). In addition, the experience and network of collaborators was important for building a good methodology. |
| b) Partners and actors involved         | A network that consists of scientists, specialised OHPs, labour experts, rehabilitation specialists and medical professionals.   |

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| <p>c) Financial costs of the development</p>        | <p>Own funding. At this moment, Re-turn is a privately held company. In addition, Re-turn could be considered a social enterprise because it provides a lot of information for free in various fields (i.e. for patients, research and policy).</p>  |
| <p>d) Objectives of the programme</p>               | <p>The mission of Re-turn is to retain work, work ability and employability among workers with cancer. The intrinsic motivation of a patient to contact Re-turn is based on three aspects of quality of life: private conditions (home, family and relationships), the effects of treatment (physical and mental effects) and questions regarding work. Re-turn provides help with and will take all three of these aspects into account because a good RTW process consists of a balance between them all.</p>  |
| <p>e) Were the objectives of the programme met?</p> | <p>Re-turn aims to reach many more people and considers that it is very important to provide a tailored (customised) programme. The average duration of absenteeism decreases among employees who work together with Re-turn. Re-turn wants to help reduce absenteeism and job loss and increase quality of life.</p>  |
| <p><b>6) Interesting or innovative features</b></p> | <p>The most interesting factor is that the three main aspects of quality of life are involved throughout the rehabilitation programme.</p> <p>Another innovative factor is that Re-turn has been able to name and position various different disease-related phases and determine their implications for work. The focus in disease-related problems is generally patients' recognition of their own feelings and experiences, rather than the direct implications of these for work.</p> <p>The following are the three main aspects considered in the programme: private conditions (home, family and relationships; in Dutch 'Privé'), the effects of treatment (physical and mental effects; in Dutch 'Behandeling/revalidatie') and questions regarding work (in Dutch 'Werk'). The employer is not allowed to ask the worker about the effects of their private conditions (home, family and relationships) and the effects of treatment (physical and mental effects) on RTW.</p> |

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| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |   |
| <p>a) Strengths of the programme</p>  | <p>The main strength of Re-turn is that it involves the three main aspects of quality of life throughout the rehabilitation programme.</p> <p>Another strength is that Re-turn has been able to name and position various different disease-related phases and determine their implications for work. The focus in disease-related problems is generally patients' recognition of their own feelings and experiences, rather than the direct implications of these for work.</p>  |
| <p>b) Weaknesses of the programme</p>   | <p>Weaknesses of Re-turn include that it is dependent on others to provide 'Werkkracht bij kanker' to employees diagnosed with cancer. The information provided in 'Werkkracht bij kanker' could be provided by OHPs, HR departments, oncological nurses, physiotherapists, health insurers or occupational health services. If an employee contacts Re-turn in sufficient time, Re-turn is able to offer a good programme for the employee.</p> <p>Working together with other disciplines as Re-turn does has the potential to make it difficult to get in touch with employees, as the primary concern of other stakeholders is not connecting employees with Re-turn, since 'work' is not considered an objective in their treatment plans.</p> <p>Re-turn cannot provide employees diagnosed with cancer with help without insurance. Jobs in the market place that allow people to slowly build up hours are also rare, so those who are unemployed and receive sick benefits find it is difficult to return to work. An experiment with a no-risk policy will soon be under way in the Netherlands (led by Minister Asscher, who is the Minister for Social Affairs and Employment).</p> |
| <p>c) Success factors (financial incentives)</p>  | <p>The programme would be as effective in other countries as it is in the Netherlands with respect to its content (which is applicable to cancer patients in many countries). However, due to the law in the Netherlands, there are incentives for both the employer and the employee to focus on RTW: employers must keep paying the employee's salary during sick leave and, if an employee does not work, his/her salary will decrease (both of which work as stimuli for RTW).</p>  |

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| d) Facilitators for implementation (including awareness raising) | <p>Sometimes, Re-turn is asked to fulfil a consultancy role (e.g. what would Re-turn recommend for a large company and how these recommendations could become part of the large company's organisational structure).</p> <p>Awareness raising is conducted through conferences and by word of mouth.</p>  |
| <b>8) Transferability</b>  |   |
| a) Other group of workers  | -   |
| b) Countries   | <p>The content of the programme is transferable to other countries. However, in the Netherlands, the legal context has made developing this intervention possible, in line with 'cancer and work', which has become a hot topic in the last 10 years in the Netherlands.</p>  |
| c) Companies   | -   |
| d) Other circumstances   | -   |
| <b>9) Parties and actors involved</b>                            |   |
| a) Parties and actors involved                                   | <p>The employee, the employer, an OHP and a HR professional.</p>  |
| b) Role of parties and actors involved                           | <p>The programme is all about customisation. The employer is involved in a tripartite conversation (in Dutch '3-gesprek') and first must fill in an employer questionnaire. Re-turn also provides information to the employer. The outcomes of the questionnaires (filled out by both the employer and the employee) and the provision of information to the employer will result in a tripartite conversation, which will be repeated during the involvement of Re-turn. Another part of this '3-gesprek' is the information provided by the OHP. The results of the '3-gesprek' will be put to the HR professional.</p> |
| c) Cooperation with other partners                               | <p>There is cooperation with providers of physical strength programmes and sometimes with psychologists who specialise in oncology.</p>   |



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| <p>d) Interaction between different partners</p> | <p>95% of the employees in the programme are also involved in a physical exercise programme.</p> <p>10% of the employees in the programme are involved in a psychosocial programme. Re-turn refers employees to different programmes and is always looking for customised solutions (including group and individual therapy). These programmes can be attended in parallel to Re-turn.</p>  |
| <p><b>10) Assessment of success</b></p>          | <p>The employee starts by filling in an inventory (questionnaire) that identifies his/her positive and negative predictors of RTW. This questionnaire will be filled in again in the middle and at the end of the programme. The employee's progress is monitored through these questionnaires and through employee self-reports. In addition, there is also an overall evaluation of the employee. Based on these three aspects of assessment, progress and final reports are created. Descriptive statistics are also obtained from information provided by management.</p> |
| <p>c) Results of the programme</p>               | <p>Re-turn reports on the progress and the employer can refer to these reports in the context of the gatekeeper law. Social law is an integral element of the methodology of Re-turn.</p>   |
| <p>d) Improvements and future developments</p>   | <p><b>Improvements</b></p> <p>To get in touch with employers and employees at the right moment during the diagnosis, treatment and recovery process.</p> <p>To reach more employees diagnosed with cancer and to focus on small enterprises (e.g. the bakery around the corner).</p> <p>To go abroad with the programme (implementation in Europe).</p>   |

Table 7 Booklet/guide developed by the Irish Congress of Trade Unions (Ireland)

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| <p><b>1) Country and context</b></p>                       |  |
| <p>a) Population</p>                                       | <p>4.6 million</p>   |
| <p>b) Employment rate (percentage)</p>                     | <p>61.9 (<a href="https://data.oecd.org/emp/employment-rate.htm">https://data.oecd.org/emp/employment-rate.htm</a>, 2014)</p>  |
| <p>c) Official retirement age (years)</p>                  | <p>66 (<a href="https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-ireland/view">https://osha.europa.eu/en/tools-and-publications/publications/safer-and-healthier-work-any-age-country-inventory-ireland/view</a>, 2016)</p>  |
| <p><b>2) Legislation regarding sickness in Ireland</b></p> | <p>An employee might need to take some time off work for tests, treatment and recovery afterward a cancer diagnosis. How much time taken will depend on the type of cancer and the treatment.</p> <p>In general, an employee has no right under Irish employment law to be paid while on sick leave. It is usually up to the employer to decide its own policy on sick pay and sick leave, so it will all depend on the employees' contract or terms of employment.</p> <p>If an employee is entitled to sick pay, an employer will usually ask the employee to send in a medical certificate from the GP or family doctor when he/she is on sick leave. For example, employees may have to send in a medical certificate if they are off sick for more than two consecutive days. The medical certificate should state the date that the employee is likely to return to work. If an employee is likely to be off sick for a long period, the employer may ask the employee to send in a medical certificate every week. If employees are entitled to sick pay, the employer will probably ask the employee to sign over any illness benefit payment from the Department of Social Protection to the employer for as long as the sick pay continues. Usually, the contract of employment will place a maximum period of sick pay entitlement in a stated period. For example, one month's sick pay in any 12-month period. If employees are not entitled to sick pay, they can apply for illness benefit if they make sufficient social insurance contributions. If they do not make sufficient contributions, they should contact their local social welfare office or health centre for advice.</p> |

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| <p><b>2) Legislation regarding sickness in Ireland (Cont.)</b></p> | <p>If an employee is a public servant, for example, he/she could get certified sick leave for six months on full pay and a further six months on half pay, followed by the pension rate of pay for an unspecified length of time. However, these periods were halved from 2014 for non-critical illnesses. Employees with such illnesses are entitled to three months on full pay and three months on half pay in any rolling four-year period. In public services, the uncertified sick allowance of seven days per year was stretched to seven days over a two-year period. Employees may get similar benefits as public servants if they are employed by a large company. Other employers might pay for a shorter period of sick leave, while some do not pay for sick leave at all.</p> |
| <p><b>3) Detailed description of the programme</b></p>             | <p>The guide provides assistance to union representatives who are representing members diagnosed with breast cancer and returning to work following diagnosis and treatment. Many of the recommendations would also apply to other forms of cancer and illness.</p> <p>The guide sets out the key stages in the process, covering topics such as informing colleagues, negotiating a ‘time off work plan’ and what to bear in mind when returning to work.</p> <p>The guide serves as assistance; it is only a guide and should not be considered legal advice.</p> <p>Regarding extra information in addition to the guide, there are a number of other documents referred to in the guide, but there is no extra information to provide.</p>  |
| <p><b>4) Target group of the programme</b></p>                     |   |
| <p>a) Targeting cancer type</p>                                    | <p>The booklet targets union representatives and workers affected by breast cancer.</p>   |
| <p>b) Targeting specific workers</p>                               | <p>-</p>  |
| <p>c) Targeting specific enterprises</p>                           | <p>-</p>  |
| <p>d) Gender</p>   | <p>Women.</p>   |

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| <p>e) Programme applied in practice</p>       | <p>Union representatives and members are the target group. The Nurses Union was also very involved in the production of the guide. Breast cancer nurses are using the guide and regularly come back for more copies. The programme leader recalls there were 5,000 copies printed. Physicians and GPs might also be using the guide, but they were not directly targeted.</p>  |
| <p><b>5) Development of the programme</b></p> |  |
| <p>a) Development of the programme</p>        | <p>The idea for the guide came about from a chance conversation the programme leader had with a representative at a Union day. The lady introduced herself as a breast cancer specialist explaining that she worked in the Nurses Union representing nurses. In their discussions, she said that it would be helpful to have advice in a situation where an employee was affected by breast cancer.</p> <p>The programme leader identified a gap in the information provided to the workers in question and that thought she could address this with the support of the Union Congress.</p>  |
| <p>b) Partners and actors involved</p>        | <p>The programme leader produced and launched the booklet with the same theme and in the same manner as other Union publications and it was treated as another Union issue guide. The programme leader did not want it to become a health and safety or legal piece of work. It was something that, in the hands of a union official, would be a document that could be used and put into action. Due to this requirement for the booklet to lead to actions, models were included that could be followed. The programme leader found that including sample clauses and models was hugely helpful to representatives, as it generated discussion, even if the guidance was not followed.</p> <p>The programme leader drafted the booklet. The programme leader gave it to practising officials and asked them for comments; specifically she asked them that, if on reading it, they would know what to do. The programme leader also gave it to breast cancer nurses and asked them if it felt right. Two officials in the Nurses Union had had breast cancer themselves, and they gave their informed views on the guide. This confirmed that it was something useful and would be helpful to produce.</p> |
| <p>c) Financial costs of the development</p>  | <p>The Irish Congress of Trade Unions financed the booklet.</p>  |

d) Objectives of the programme

There were two main objectives:

- To make it very clear that people do recover from cancer and return to work and that we do not have to whisper about cancer. This is something that union representatives can do something about; they can also help the employee to negotiate time off when needed. The hope was that the guide would encourage people to have a conversation with their employer in sufficient time and when time off was needed.
- The guide needed to be written using accessible language. It needed to be a publication that did not require a legal representative to interpret it. It also needed to be something that could be used as a tool so the advice needed to be very matter of fact and honest, as well as easy to understand. It needed to point people in the right direction while being matter of fact.

It is important to make sure that 'helping people who have an illness at work' is not a medical issue but instead concerned the 'organisation of work'. The guide was about providing information to help this category of workers to normalise their situation. Breast cancer is normal; it happens in all workplaces. The guide was about outlining the ways in which a union could help, highlighting flexible rules in how a union can accommodate the worker and his/her situation.

e) Were the objectives of the programme met?

The objectives were met and awareness was raised. The programme leader received two complaints: one was from someone saying the guide should not focus only on women and the other asking why the guide focused only on breast cancer. The reason for the focus on women with breast cancer was the significant proportion of women who are diagnosed with breast cancer and the need identified for these people to recover and return to work.

The aim of the guide was to enable a union official to make the best decision in the workplace and to help the people who are helping others to do their jobs better.

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| <p><b>6) Interesting or innovative features</b></p>   | <p>The fact that the guide presented a model for a time off work plan put this idea into the collective imagination and made this idea real for people.</p> <p>The guide focused on a particular group of workers, namely those affected by breast cancer; this helped union representatives to negotiate meaningful outcomes for workers. Without the guide, and despite best intentions, they might not have been able to support workers in the most effective way.</p> <p>Interestingly, with many people being diagnosed with breast cancer, there might be important workplace factors contributing to these diagnoses that need to be taken into account. At the end, the guide prompts for such considerations to be made.</p> |
| <p><b>7) Success factors (including financial incentives) and facilitators for implementation (including awareness raising)</b></p> |  |
| <p><b>a) Strengths of the programme</b></p>   | <p>The strengths of this booklet include the model presented for a time off plan, as well as the fact that it talks about human interaction in the workplace. This is the significant aspect of unions that people do not always understand. Unions understand that you need to be able to manage on your own, if you aren't going to be supported by someone else, and that the impacts of the cancer on everybody else also need to be considered. The guide takes a holistic perspective on the relationships in the workplace that are often affected by cancer and it begins to deal with these relationships, providing the language and a structure that can be used to discuss the cancer.</p>                                 |

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| <p>a) Weaknesses of the programme</p>                                   | <p>The weaknesses of the booklet include the ongoing disappointment the Congress experienced with employers not being more positive about the guide. Although disappointing, the programme leader believes this is more of a cultural factor associated with employers. At the same time, the programme leader provided advice to hospices on how to break the news of a death at work; the programme leader believes that employers can be overly cautious about differentiating between a reasonable way to behave and situations in which there is a minimum legal requirement. This might have been part of the problem, namely that employers would not say anything good about a non-legal minimum requirement.</p> <p>The guide could have been better designed, namely in its look and feel. The intention was for it to look like something comfortable to read. It did not look like a medical text; it looked like something you could have in your handbag.</p>  |
| <p>b) Success factors (financial incentives)</p>                        | <p>The guide targets the Union official with the aim of ensuring that people then get the support that they need. Making the guide widely available was a key facilitator in awareness raising; the guide was available online — you did not need to go out and buy a hard copy.</p> <p>General success factors included the facts that the guide was written using everyday language and that it was not a generic book but it instead targeted a particular group. The unions engaged positively with the programme leader about the guide.</p>  |
| <p>c) Facilitators for implementation (including awareness raising)</p> | <p>First, although not necessarily negative, the programme leader was often asked the following questions about the guide: why this booklet, why is it a priority and why not something else?</p> <p>To raise awareness of the booklet, the Minister of Social Welfare and the deputy prime minister were involved with the launch, which took place in the Nurses Union premises. A number of people spoke at the launch about breast cancer and shared their stories, talking about how a guide like this would have helped them.</p> <p>Although not explicitly set out, the programme leader made sure that all the cancer nurses involved knew about the booklet, hence why we launched it at the Nurses Union premises. Very often, workers' main point of advice is a cancer nurse, who will help the patient prepare properly for the situation. The programme leader wanted to make sure that the cancer nurses knew about the guide so that they could mention it to patients to raise awareness. Although aimed at union representatives, the objective of the guide was to inform. Unions in the field of health and safety and women's unions in Ireland were invited to comment.</p> |
| <p>8) Transferability</p>   |  |

## Rehabilitation and return to work after cancer — instruments and practices

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| a) Other group of workers              | The booklet would be easily transferable to other workers affected by cancer, but some changes might need to be made. If targeted at men, for example, some of the language might need to be amended and some areas re-written.  |
| b) Countries                           | No information about this.   |
| c) Companies                           | -  |
| d) Other circumstances                 | -  |
| <b>9) Parties and actors involved</b>  |  |
| a) Parties and actors involved         | <p>The programme leader did not know who else was/is using the guide in addition to union representatives and members, the Nurses Union, breast cancer nurses and doctors.</p> <p>The Union committee included various types of health and safety experts, occupational health therapists, occupational health specialists and nurses. Several HR managers were also on the committee, although they were there as union representatives, not HR professionals. The role of the committee was to question the guide: does it work and would you know what to do with it? No physicians were directly involved.</p> |
| b) Role of parties and actors involved | -  |
| c) Cooperation with other partners     | Some of the people on the committee worked at a hospital. No hospitals signed up to receiving the booklet and there was no institutional involvement. The programme leader did send the booklet to the Department of Social Welfare and asked if the booklet seemed fitting. They confirmed it was.  |



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| <p>d) Interaction between different partners</p> | <p>There was no interaction between the workplace and the health system. The role of a union representative is to interact with the employee and the employer. Such representatives would never interact with a hospital, for example. They are concerned with the workplace and making sure the workplace is not part of the problem in cases of breast cancer, that a worker can return to work as soon as possible and that a worker can remain as long as possible in the workplace; a representative's roles include negotiating those arrangements and having a framework in place to begin the discussion with the employer; they do not contact the hospital.</p>   |
| <p><b>10) Assessment of success</b></p>          |   |
| <p>a) Results of the programme</p>               | <p>There was (and is) no planned assessment or evaluation of the guide.</p> <p>The Congress typically evaluates and updates documents every few years, in the ordinary course of events. If a significant strategic case came up that had implications for the guide, this would be an impetus to update the guide. It has not been updated since 2015.</p>   |
| <p>Improvements and future developments</p>      | <p>In the workplace, there is currently a need for help with how to have a conversation with somebody about terminal illness. Prostate cancer/terminal cancer are areas that could be looked at in the future.</p> <p>After the guide came out, a general conversation began about the risks of night work with regard to breast cancer. Including something in the guide about night shift working risks would be the main change the programme leader would make to the guide. At the time the guide was being created, there was some indication of the risks of night work, but it was after publishing that the evidence surfaced. Although the programme leader is aware of that the link between night work and breast cancer, the programme leader is not aware of the measures that would need to be put in place to mitigate these risks, and how any measures might work in terms of shift planning and staff scheduling.</p> <p>The programme leader would also probably make the cancer prevention section of the guide clearer. The programme leader would improve it by talking about shifts and providing more information on how to do a risk assessment, how to organise work, substances being used in the workplace, etc.</p> |

**Improvements and future developments**

The programme leader thinks that a new and different guide would be useful for situations in which the patient was not going to get better. There are those for whom there is no recovery but who are making the choice to either remain in or leave work, but are indecisive about when the optimal point for them to leave work might be.

The programme leader is not aware of any further planned developments at this time.

**The European Agency for Safety and Health at Work (EU-OSHA)** contributes to making Europe a safer, healthier and more productive place to work. The Agency researches, develops, and distributes reliable, balanced, and impartial safety and health information and organises pan-European awareness raising campaigns. Set up by the European Union in 1994 and based in Bilbao, Spain, the Agency brings together representatives from the European Commission, Member State governments, employers' and workers' organisations, as well as leading experts in each of the EU Member States and beyond.

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