Managing sickness absence

Part 1: the business case

Introduction

Underpinning efforts to improve sickness absence management is the legal duty placed on employers under The Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999. Employers are responsible for health, safety and welfare of their staff at work and carrying out appropriate risk assessments to identify and alleviate risks to their staff.

The cost of sickness absence in England is estimated at £12 billion. Of this, £4 billion is estimated to be in the public sector, and £1 billion in the NHS.

The ministerial taskforce on health, safety and productivity, set up by the Government in the summer of 2004, called for continuing reductions in levels of absence among all staff in the public sector. It also looked at the impact on absence rates of:

• effective health and safety management
• better access to rehabilitation for those who have been long-term sick
• improved management of workplace stress.

The NHS is now working towards targets set as part of the Revitalising Health and Safety strategy, with the aim that by 2010 working days lost to work-related injury and ill health will have been reduced by 30 per cent.

This section is intended to provide managers at all levels of an organisation with the background, business case and political imperative for addressing current levels of sickness absence, alongside a detailed description of how to manage sickness absence effectively.

It is presented in three sections:

• the business case – including the government, business and trade union view - the ‘high level’ view
• effective management of sickness absence – the template for managing sickness absence
• line managers’ toolkit – checklists and flow charts to assist line managers, HR and occupational health professionals.

The advice in this document is drawn from previous documents published by the Department of Health and NHS Employers, plus publications from the Department for Work and Pensions, the Health and Safety Executive (HSE) Advisory, Conciliation and Arbitration Service (ACAS) and the Chartered Institute of Personnel and Development (CIPD).
Current thinking

Changes in both the public and private sectors are taking place against a background of renewed government interest in improving the health and well-being of the working population.

Both the Government and the private sector are beginning to address the demographic changes that are taking place and the impact they will have on the working population.

Some of the main influences on current thinking are covered below.

The NHS Health and Well-being Review

In the interim report of the NHS Health and Well-being Review, Dr Steve Boorman looked at staff absence through illness and found that despite reporting generally good health, NHS employees have high levels of sickness absence. NHS staff take, on average 10.7 days sick leave a year which has been compared unfavourably with other public sector organisations.

The introduction of the Electronic Staff Record has resulted in improvements in recorded attendance but Boorman believes that this can be improved upon.

The report identified a greater propensity in NHS staff to incur a work-related illness or accident than other comparative groups of workers. The probability of an NHS worker having an illness is 1.491 times greater than a non-health worker and the probability of having an accident is 1.731 times greater.

Boorman also identified a number of factors that may help to account for these figures. NHS work is often more physically and psychologically demanding and this increases the risk of ill health or of injury. The NHS also has a diverse workforce in terms of occupation and skills and staff are involved in a wide range of activities some of which, such as manual handling, carry higher risks of injury than other employment. The large numbers of female staff and staff in their late 40s and 50s, traditionally high risk groups for sickness absence, also impacts on NHS sickness absence rates.

Major causes of absence identified in the report are musculoskeletal disorders, which account for over 45 per cent of absence and 25 per cent related to stress, anxiety and depression.

A key influencer on the effective management of sickness absence that is identified by the report is the role of line and senior managers and their engagement with managing absence and the health and welfare of their staff.

NHS Staff Council Agreement

In 2008 the NHS Staff Council agreed arrangements intended to supplement statutory sick pay to provide additional payment during absence due to illness, injury or other disability. This was supplemented by an annex to the Staff Handbook which sets out a framework to support employers and staff in the management of sickness absence and manage the risk of premature and unnecessary ill health retirements.

This document is intended to support the framework set out in the Annex to the Staff Handbook which can be found at the end of this chapter.
Reform of incapacity benefit

The Government has set a target as part of the Department for Work and Pensions’ five-year strategy (published February 2005) of moving towards an employment rate of 80 per cent of the working age population. This takes the Government “beyond helping the unemployed, to helping those who are further from the labour market – who have more complex and substantial barriers to overcome.”

To reach the 80 per cent target could mean helping as many as one million people on incapacity benefit into work. To this end, incapacity benefit has been reformed and the Government has introduced better rehabilitation back into work for those who have been out of work for a long time.

Alongside this reform, since its introduction in 2001 the New Deal for Disabled People has seen over 45,000 jobs created, including posts in the NHS.

The well-managed organisation

Promoting board level leadership on the issue of sickness absence has been a focus for the Ministerial Taskforce on Health, Safety and Productivity.

At its request, The Work Foundation, HSE and an advisory group worked together to develop a profile for the ‘Well-managed organisation’ and identified four elements that the strategy should concentrate on:

- monitoring, measuring and understanding
- managing sickness absence when it happens
- tackling the underlying causes of absence
- a culture that encourages attendance.

The Work Foundation has produced a suite of three products aimed at different levels of the management chain.

- Guidelines for boards: aimed at chief executives and board members. Intended to support boards as they address sickness absence and promote a healthy workplace, they are designed to be part of a ‘whole systems’ approach that:
  - links top level commitment to operational delivery
  - tackles problems that are organisational rather than individual
  - involves employees and their representatives.

- Guidelines for HR directors and senior managers: supplement the guidelines for boards. They provide a framework for considering the reduction of absence and the promotion of healthy attendance and sources of further expertise.

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1 Rt Hon Alan Johnson MP Secretary of State for Work and Pensions speech to CIPD 9 February 2005
Diagnostic tools for handling sickness absence: supplements the guidance for boards and HR directors. It is aimed at practitioners and will help them to:

(a) identify management skills and training needs
(b) assess underlying causes of absence, especially where they might be improved through better work organisation and job design
(c) implement best practice in engaging the workforce. It includes pointers to further sources of help and advice.

The publications can be found at [www.hse.gov.uk/wellmanaged](http://www.hse.gov.uk/wellmanaged)

Rehabilitation and early intervention

The statistics alone present a strong case for tackling sickness absence:

- every week in the UK, around one million people report sick
- 3,000 of those will remain off at six months, 2,400 will not work again in the next five years
- after two years on incapacity benefit an individual is more likely to retire or die than return to work
- 40 million working days are lost each year to occupational ill health and injury, costing the economy an estimated £12 billion.

People who are out of work experience poorer mental health than those in employment. They make increased use of GP and hospital services and use more prescribed medication.

Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury is important if we are to reduce absence and prevent people becoming dependent on benefits. The workplace also provides an environment where people can be provided with the support and encouragement to take responsibility for improving their own health.

The National Audit Office report, *A safer place to work: improving the management of health and safety risks to staff in NHS trusts*, found that the NHS was not taking advantage of its own services for rehabilitation, such as physiotherapy.

As a result, much NHS sickness absence is long term and is caused by stress and musculoskeletal disorders that should have been dealt with at a much earlier stage.

The report said:

“Staff absence has a direct impact on the ability of NHS trusts to treat patients, and can increase costs through the use of bank or agency staff. There is therefore a strong incentive for trusts to ensure effective and speedy rehabilitation of staff.”

Research also shows that the longer an employee takes off work to recover from sickness, the lower the chances of them ever returning to work.
Early intervention such as occupational therapy, physiotherapy or counselling is important for preventing acute conditions becoming chronic and securing successful rehabilitation. The independent report, Is Work Good for your Health and Well-being?\(^2\) shows that being out of work is bad for both mind and body – progressively damaging health and decreasing life expectancy.

Its comprehensive review of more than 400 pieces of scientific evidence concludes that being in work is good for physical and mental health, boosting self-esteem and quality of life.

The issue of rehabilitation has also risen up the policy agenda of private sector organisations. A survey of employers carried out in 2001\(^3\) indicates that the reasons for the increased interest in rehabilitation include:

- increased concern for the general well-being of employees
- part of the process of improvement of general management
- growing concerns over both the numbers of long-term absences and number of ill health early retirements
- concerns about rising employment liability of insurance claims and premia
- part of the policy on the treatment of disabled workers.

Evidence from clinical studies suggests that, at four weeks, patients are still sufficiently engaged with their workplace to be anxious to return to work, while at two or three months they have begun the process of mental disengagement that makes a successful return more difficult to achieve.

Increasingly, evidence suggests that earlier interventions in a period of sickness absence are more effective than waiting for the four-week indicator to trigger action. For example, in cases where it is appropriate, referral to physiotherapy in the first week of sickness can have the employee rehabilitated back into work at the time when normally they would have been having the first review of their case – triggered by the four-week indicator.

The benefits of rehabilitation are twofold:

- for the trust’s management, they have a member of staff back earlier than expected, performing at least some of their duties. The organisation has shown that it cares for the member of staff and values their contribution
- the member of staff feels valued by a caring employer and will, in all probability, recover more quickly when back in the working environment, than at home.

Research in the US and UK has shown that staff rehabilitated into work recover more quickly than those left at home.\(^4\)

**Disability Discrimination Act**

\(^2\) Waddell, G and Burton, K (2006), *Is work good for your health and well-being?* DWP

\(^3\) Rehabilitation: Return to Work Policies and Practices. IRS Employment Review Vol 74

\(^4\) Swansbro (1997), *Absenteeism – at issue in the American workplace*, Business Topics
The Disability Discrimination Act lays a duty upon employers to “look at what changes or reasonable adjustments they could make to the workplace or the way the work is done which would overcome the effects of disability.”

In returning members of staff into work, it may be necessary to treat them as if they were suffering from a disability, for the sake of making reasonable adjustments.

Reasonable adjustments to a job can include:

- changes to duties, shifts or hours
- changes to the place of work
- adjusting the features of a building or access to it, including its fixtures, fittings and design.

See the chapter on The Disability Discrimination Act for further details.

The union perspective

In its July 2002 report on rehabilitation, the Trades Union Congress (TUC) identified a growing acceptance that greater effort is needed to retain employees who have been affected by poor health, injury or disability.

It also identified a key role for employers in achieving this and indicated that this is best done where they:

- make rehabilitation a policy goal
- invest in employees’ health, providing access to good occupational health facilities and workplace health initiatives
- are responsive to absence: monitoring health, keeping in touch with sick employees, responding early with referral for medical checks, being alert to disability issues, and applying practical rehabilitation measures
- do not make health a disciplinary matter
- investigate work-related health problems
- involve all levels of management in rehabilitation, including line managers, personnel/human resources managers, occupational health and senior managers
- work with unions and their members, being open on health and absence issues, and involving them fully in the development of relevant policies.

5 Rehabilitation and Retention: the workplace view (2002), a Trades Union Congress report
Part 2: managing sickness absence effectively

Systems and structures

In its survey of 2000 large and small workplaces the TUC Labour Research Department (LRD) found that in good practice employers there was more consistency about the implementation of management systems for dealing with employee health and issues of absence.

Employers identified as following good practice were more likely to do so through a formal policy and effective management was found to be an essential part of good rehabilitation.

Good co-operation between line managers, HR, occupational health staff and senior management was more important than having just one manager in charge. Having a single person responsible for dealing with employees whose employment is at risk due to illness or disability did not emerge strongly as a distinction between good practice and other workplaces.

It found there was no single best practice pattern to follow regarding who takes the lead on dealing with this issue. This ties in quite closely with findings from the Employers’ Forum on Disability, which show best results in decision-making on adjustments for disabled staff come from joint decision-making with no single final responsible party.

Rehabilitation

The TUC survey identified a number of rehabilitation measures that employers might undertake.

The results show that employers who are successful at rehabilitation are much more likely to use all of the measures identified but that in particular they were most likely to:

- adapt equipment and workplace
- change hours of work and reduce tempo
- encourage visits
- provide mobility/transport.

The full list of rehabilitation measures used in the report are defined as follows:

- change the employee’s tasks or work content, for example, change in work activities, variation in tasks, move to another job with same employer (redemption)
- allow a staged/phased return to work

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6 Rehabilitation and Retention: the workplace view (2002), a Trades Union Congress report

• change their working hours for example, reduce or stop night working, more regular working hours, reduce working day or week, shift changes or different rest periods

• encourage them to visit the workplace to keep in touch

• provide training (vocational training, on the job training, job coaching)

• adapt tools/equipment (adapt machines, chairs, computers, telephones and so on)

• adapt the workplace (work station/site design, access to buildings, accommodation, lighting, temperature/working conditions)

• reduce the tempo or speed of their work (reduce productivity targets or customer contacts, get colleagues to provide help, allow employees to adjust own work patterns)

• provide for mobility/transport (mobility within the workplace such as wheelchairs, transport to and from the workplace).

**Approachability of management and self-referral**

Absence monitoring is not the only route to identifying potential rehabilitation cases. The survey shows that in the good practice employers, managers are more approachable, there are more levels of management that staff can approach and they are well informed about the policies and help available to employees.

The evidence suggests that managers in good practice workplaces are more likely to have received training in counselling, disability matters and management practices.

Due to the confidential nature of individual health problems and subsequent rehabilitation, it is likely that the wider workforce will be unaware of the full extent of what is available to them. The most successful organisations surveyed entered into open discussions with employees and their representatives and developed a joint approach to rehabilitation and its supporting policies that was then owned by all of the parties involved.

**HSE Framework**

The Health and Safety Executive (HSE)\(^8\) suggests seven sets of management processes and practices that contribute to the development and operation of effective workplace rehabilitation programmes. These are:

• early and timely identification of vulnerable workers through information obtained via such means as recruitment and selection procedures, health checks and medicals, staff appraisals and other performance measures, absence statistics, the maintenance of regular contact with absent workers and return to work interviews and fitness for work assessments

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\(^8\) *Job retention and vocational rehabilitation: The development and evaluation of a conceptual framework* (2003), Middlesex University Business School and the University of Strathclyde, research report 106
• provision of rehabilitation support in the form of medical treatment and the provision of various 'vocational services' such as functional evaluations, training, 'social support' and workplace adjustments

• co-ordination of the rehabilitation process by the creation of systems that facilitate sufficient communication, discussion and ‘joined up’ action between all potentially relevant factors, human resource staff, safety practitioners, occupational physicians and nurses, psychologists, disability advisers, equal opportunities personnel, trade union and other workplace representatives and external medical personnel

• access to worker representation as a means of ensuring that attempts at rehabilitation are made in an environment of openness and trust

• establishment of policy frameworks that clearly detail what can and should be done to support the rehabilitation of workers and also make clear who is responsible and accountable for carrying out the various laid down requirements

• systematic action, including the provision of required training, to ensure that any laid down policy frameworks are implemented properly and hence do, in practice, influence how particular cases are handled

• adoption of mechanisms that enable any weaknesses in the content and operation of established policy frameworks to be identified and addressed.

A variety of internal and external influences can facilitate or hinder the nature and impact of the rehabilitation processes and practices of employers. These include:

• organisational commitment and culture, including the attitudes and values of senior management

• availability of specialist advice, required financial resources and line management, as well as general workforce awareness and support of organisational policies and objectives

• nature of work tasks and processes, as well as surrounding pay and grading systems

• extent to which workers have access to systems of worker representation that provide them with an independent and meaningful ‘voice’ in discussions over rehabilitation issues

• external guidance, support and financial incentives provided to employers

• nature of surrounding legal frameworks, including those relating to unfair dismissal, disability discrimination, health and safety at work and personal injury litigation

• employer access to healthcare and specialist rehabilitative expertise

• worker access to various forms of external support, such as public transport, social security benefits, relevant training and educational opportunities and medical care and rehabilitative support.
Developing an absence management policy

All of the research into absence management carried out over the last ten years shows that the first action to be taken in successfully addressing the issue is the development of an absence management policy.

This can be quite a simple and short document and should include the following:

1. The standards of attendance expected of the employee:
   • employees are paid to attend work – this is accepted as the norm
   • unplanned absence is a cost in terms of efficiency, replacement staff and impact on patients
   • limited absence is inevitable and the organisation will support employees who are absent for good reason in returning to work as early as is appropriate.

2. A statement of the process to be undertaken in relation to absences:
   • how to notify the employer about an absence
   • how to keep line managers informed of the expected duration of the absence and return date
   • what level of certification is required and when
   • any potential effect on pay
   • what support an employee can expect from their line manager, HR, occupational health, under what circumstances, and when this might be expected
   • what actions should be taken before and after an employees return to work
   • whether there will be a return to work interview.

3. A statement that responsibility for some of these actions lies with the employee and that failure to carry them out without good reason may result in disciplinary action.

Managerial adequacy and responsibility

Managers need to be trained to manage staff and to raise their skills to ensure that they can manage sickness absence. There may be an issue concerning the areas of responsibility that managers are being asked to assume and how best to explain them to the staff they are managing.

Managers will need to be made aware of:
• the process for managing sickness absence
• the costs to the organisation
• the effects it has upon the organisation.
They will need to be able to pass this information on to their staff as part of the management process. They must be trained in return-to-work interview techniques together with management and time management training.

**Role of the line manager**

The role of the line manager is to ensure regular contact is maintained with staff when they go on long-term sick leave. Advice should always be sought at an early stage from human resources and the occupational health department when managing individual cases of employee ill health.

Line managers should be involved closely in the decision making process relating to specific cases, as well as the development of strategies to counter the operational impact of sickness absence. It is therefore essential to ensure that line managers have the appropriate training in staff management so that they know how to manage sickness absence and return-to-work issues correctly.

**Role of occupational health**

Occupational health and safety professionals also have a major role to play in reducing sickness absence in the NHS. Reductions in the levels of accidents and of violence and aggression to staff, together with action to tackle workplace stress, can significantly reduce absence levels. These are areas where occupational health and safety professionals may influence policies.

Management referrals can be made to the occupational health department. The role of occupational health is to advise the line manager and human resources on the long-term effects of the employee’s job performance and attendance at work. It is also to advise whether the health problem is related to work and whether there any reasonable adjustments or modifications that can be made to their duties or work environment to allow them to return to their current post, or where this is not a considered option, help with identifying criteria which would allow them to return to an alternative post. They also provide advice as to whether the person is eligible to qualify for incapacity benefit or ill health retirement.

It is considered good practice to ensure that the employee is given a copy of the letter of referral.

In order to make recommendations and facilitate a return to work, the occupational health professional will need to be in possession of all the facts; where it is considered useful, information may be sought about their illness from the employee’s GP and/or consultant.

Written informed consent must be obtained from the employee when an occupational health professional wishes to contact their GP or consultant for information regarding them. The employee must be told what information is being sought about them and why, and should be advised of their rights under the Access to Medical Records Act 1998.

Confidentiality of any clinical information obtained must be respected.
Reasonable adjustments

It is important that the employee is fully consulted throughout the process and that their medical position is ascertained as early as possible. Where the ill health, injury, or other impairment meets the relevant criteria under the Disability Discrimination Act, discrimination is prohibited and ‘reasonable adjustments’ to working arrangements must be considered. It is important that advice is sought from occupational health and human resources when determining whether any reasonable adjustments or modifications can be made to the existing workplace, and/or duties, a risk assessment should be carried out as appropriate. Some examples include:

- allowing an employee time off to attend medical appointments
- modifying a job description to take away tasks that cause particular difficulty
- offering flexibility in working hours/patterns, ie reduced hours, working from home or a phased return
- transfer of work place
- acquiring or modifying equipment and ensuring suitable access to premises for people using wheelchairs or crutches, providing taxi to and from workplace or giving access to on-site parking
- social or cognitive support
- training
- providing support to overcome barriers to returning to the workplace.

The process

Definitions

Absence

A common definition of absence needs to be used across the organisation and must be based on the equation: hours lost compared with hours available.

It is important that all staff involved in managing sickness absence are made aware of what the term covers.

It should not cover:

- maternity leave
- carer’s leave
- any periods of absence agreed under family-friendly policies.

It should cover:

- all unauthorised absence from work due to sickness

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Use of the equation of hours lost compared to hours available allows for the calculation of percentage of time lost and also for aggregating days lost for comparison with most public sector bodies. This method also circumvents the confusion caused by calculations using shifts (which may vary in length), days (which may vary considerably), or part days/shifts – all of which are currently used in the NHS.
• long-term sickness (see next page for definition).

All staff must be included in the reporting system (from chief executive to cleaner and including all grades of staff) and this should include medical staff.

**Long-term absence**

Long-term sickness has been defined in the NHS as being any sickness absence longer than four weeks. It was also considered good practice for NHS employers to trigger a review of the case at this stage. This may involve contacting the patient’s GP to discuss the course of action to rehabilitate the employee back into work.

Evidence from government research suggests that the businesses dealing most effectively with their long-term sickness absence problems now assess each individual case on its merits and, where appropriate, take action at the earliest possible opportunity.

**Reporting**

It is important that the reporting system, by which staff report their absence and by which managers record and pass the information up the line, is set out clearly and maintained across the organisation by all staff.

Responsibilities must be made clear to all involved and, where necessary, training should be given to managers on how to fulfil their role.

For a sickness absence policy to be successful management should take the following steps.

1. Set a time by which staff should report in – good practice suggests within one hour of the shift starting.

2. Nominate a person to report sickness to, by telephone – good practice suggests the line manager. If the line manager works away from site or on a different shift pattern, then nominate a single person for all staff in that unit to report to. They will be responsible for reporting up line, and may be responsible for carrying out return-to-work interviews.

3. Ensure that staff know that:
   - they should report in or it will be assumed they are absent without leave (a relative or friend may phone in if necessary)
   - they should report to the nominated person – not a friend on the same shift
   - they should provide brief details of their ailment and how long they expect to be absent
   - they should provide a certificate if they are absent for more than one week
   - they will have a return-to-work interview with their line manager or the nominated person on their return – even if they are absent for only one day.

4. Ensure that line managers (or nominated persons) know that:
   - they should note details of absent staff when they report in
   - they should note the expected date of return
   - they should note the reason for absence
• it is advised that a return-to-work interview is carried out for all staff when they return – even after one day

• they should keep accurate and up-to-date records of sickness absence for all the staff they are responsible for

• they should pass information on absent staff to the central collating point, as soon as it is available. If possible this should be done daily, but where this is not possible, then on a weekly basis. Monthly absence returns are not acceptable.

Reasons for absence should be collected in categories that are simple but meaningful\textsuperscript{10}. These might be:

• short-term acute medical conditions (cold, influenza and so on)

• musculoskeletal injuries

• stress related

• long-term chronic illness

• work-related injury

• other.

In collecting this data employers must be careful to comply with the Data Protection Act 1998 and remember that this information is categorised as ‘sensitive personal data’ under the Act. Staff should know what information is being collected and recorded and why.

**Information systems**

An important part of keeping track of sickness absence levels is the quick reporting of data up to the central collection point. Data should be recorded daily and ideally reports should be made on a daily basis\textsuperscript{11}. This is easier where there is widespread use of IT and departments are linked to central functions by computer. Reporting weekly is acceptable, provided data is recorded on a daily basis.

The central data collection point/HR must ensure that all staff are aware of the importance of collecting accurate data. Data that is only collected from part of an organisation – for example, data that leaves out doctors or is only collected for a percentage of staff – is of no use.

Aggregating data to allow for under-collection provides a false picture of the state of the organisation.

**Monitoring**

The most successful sickness absence management includes a high level of monitoring, both by the HR and/or Payroll function and by first-line managers. It is advised that the process includes the following provisions:

• there should be clear lines for reporting absence so that it is recorded centrally – this may be by Payroll or by HR

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\textsuperscript{10} Absence management – do you have a problem? (2006), CIPD, ACAS, HSE

\textsuperscript{11} Managing best practice – maximising attendance (1997), IRS
• senior managers should set a level of absence after which further action – usually involving a senior manager or HR department – needs to be taken

• at any given time, first-line managers should be aware of who is absent and why

• first-line managers should keep their own records so that they can refer back to them

• if appropriate, line managers should discuss the use of the occupational health service or referral to the employee’s own GP as a means of dealing with underlying health problems

• line managers should look for patterns of absence to enable them to approach staff if a pattern is apparent

• line managers should be aware of the number and length of absences that staff have, before the problem is referred to more senior managers or personnel

• the central data collection point/HR should be able to identify trends among those staff who have passed the agreed cut-off point for a review of sickness and should bring these to the attention of line managers

• first-line managers should conduct return-to-work interviews and find out the reason for absence and if there is an underlying health problem.

Analysing trends
Data collected on reasons for staff absence, together with data on individual and team absences, is useful for analysing trends and identifying individuals and teams where a problem may be developing. The appropriate analysis will allow for identification of:

• overall levels of sickness absence

• incidence of absence. Are a small number of staff responsible for most of the sickness absence? Why and what action needs to be taken?

• the ratio of long-term absence to short-term absence

• whether absence levels are higher in one part of the organisation than another – this might lead to interviews with managers in that area to drill down for the reasons behind the high levels of absence.

Analysing trends and having robust data at hand will also allow for benchmarking against similar organisations in the area or within the sector.

Information on sickness absence trends can be found on the websites of both the Confederation of British Industry (CBI) and CIPD and in the quarterly Labour Force Survey.

Guidance issued by the HSE, ACAS and CIPD\textsuperscript{12} includes useful information on ways of drilling down into absence data to look for characteristics and causes that may not be obvious at first sight. The ways suggested include interviews, focus groups and surveys and they provide frameworks for management and staff interviews together with advice on conducting surveys.

\textsuperscript{12} Absence management: Do you have an absence problem? (2006), CIPD, ACAS, HSE
Trigger points
One of the main uses of sickness absence data is to help identify any staff who need attention from management. Setting parameters or triggers can help to determine where and when action is needed. The attendance records of individual employees can then be monitored against these criteria.

Triggers fall into two broad categories:

- informal arrangements where periodic reviews of an employee’s sickness absence pattern are carried out and it is left to the manager to determine whether action is required
- more tightly-specified absence thresholds, which are used to identify when managers should introduce a formal review, counselling, reference to occupational health service or the taking of disciplinary action.

Typical triggers may be:

- cumulative number of days absent in a set period
- number of spells of absence in a set period
- combination of days and spells
- pattern-related absences.

Efficient and careful collection of sickness absence data will allow feedback to line managers, and give them sufficient information on trigger points, or allow the recording department to notify them if a trigger point has been reached.

This will support managers in taking action to review the absence record with the member of staff concerned, or to make a referral to the occupational health service.

Organisations may want to consider having a range of trigger points that are used for recurrent short-term absence or to initiate action by individuals or departments in longer-term absences.

Potential causes of absence
When reviewing data it may be useful to consider the causes of sickness absence. These can be influenced by organisational and role issues, medical factors and by external or social factors.

It is important that all data is considered carefully to allow for what is often a complicated picture. Older staff may, for instance, suffer more from ill health, but they are generally more responsible in their attitude to sickness absence and attendance.

The new guidance from HSE, ACAS and CIPD sets out a number of role and organisational factors that managers may find it useful to look at. These include:

- work and role design
- workload and stress
- organisational team size
- occupational sick pay
• organisational culture
• medical factors
• injuries at work
• lifestyle
• persistent or recurrent conditions
• external and social factors
• family, carer or other domestic commitments
• travel difficulties.

There are also suggestions for further investigation and possible solutions offered.

Costing sickness absence
Sharing the costs of sickness absence with line managers who have responsibility for budgets has been found to be an effective way of engaging them more positively in managing the problem.

There are a number of models available for costing sickness absence but one of the simplest, devised by Hugo Fair\textsuperscript{13}, is:

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\begin{align*}
\text{Average weekly wage} (a) \\
\text{Total absence in days per year} (b) \\
\text{Total number of working days per year} (c) \\
[(b) \times 100] / (c) = \text{absence rate \%} (d) \\
[(a)/5 \times (b)] = \text{absence cost per year} (e)
\end{align*}
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Using the above formula an organisation with 100 staff, earnings of £250 per week (a), average working days 228, and a sickness absence level of ten days per year would give:

\[
250/5 \times 1000 = £50,000 \text{ direct annual cost}
\]

A reduction in sickness absence per employee of two days per year would save £10,000.

This calculation can be done at department or directorate level, or smaller.

Rehabilitation and redeployment
Research carried out by HSE\textsuperscript{14} sets out current good practice that can be applied to every stage of an employee’s rehabilitation and return to work following illness:

• early contact with the employee
• early health assessment

\textsuperscript{13} Personnel and Profit. Hugo Fair (1992)

\textsuperscript{14} Best Practice in rehabilitating employees following absence due to work related stress (2003), IES/HSE research report 138
• quality of the health assessment
• development of an agreed rehabilitation plan
• availability of therapeutic interventions
• flexible return to work options
• work adaptations and adjustment.

Where rehabilitation is considered possible, the occupational health service and human resources will plan to manage the return in whatever manner is considered best for the individual. In most cases, this is likely to be in a staged manner, with a change of duties if this is considered necessary.

Pay issues relating to the phased return to work will need to be decided locally, but it would seem reasonable that the patient should remain on full sick pay, if they are entitled to it, as they would be entitled to full pay at home.

Phased rehabilitation allows the member of staff to start contributing to the smooth running of the organisation at an early stage, and research suggests that it also aids recovery.

Time allowed for rehabilitation varies from trust to trust, but the accepted time across the service seems to be two months on full pay, working up to a full return to work at the end of this period. Of course, this depends on the original cause of absence and will need to be decided on a case-by-case basis.

**Staged/phased return**

Phased rehabilitation allows the member of staff to start contributing to the smooth running of the organisation at an early stage and research suggests that it also aids recovery. Times allowed for rehabilitation vary from trust to trust, but the accepted time across the service seems to be two months on full pay, working up to a full return to work at the end of this period. This does, of course, depend upon the original cause of the absence and will need to be decided on a case-by-case basis.

Line managers and occupational health professionals should discuss the best course of action with the employee, considering:

• the nature of the condition the employee is suffering from
• what level of work they can do
• how many hours they are reasonably capable of doing
• over what period of time they should work towards achieving a full-time return to work
• any modifications that would help them return to work faster, including special equipment or re-training
• time needed to continue any ongoing medical treatment such as physiotherapy, counselling, hospital/GP visits
• regular reviews of the situation
• compliance with the Disability Discrimination Act 2005.
Redeployment on health grounds
Many trusts using rehabilitation as part of their sickness absence management policies have found that it is not always possible to rehabilitate staff back into their original post in the short term.

This may be due to job loading or to the nature of their illness. For instance, musculoskeletal problems need time to heal without the risk of further damage.

In these circumstances, an alternative that is widely used is that of redeployment.

Redeployment is seen as an important mechanism that can assist in the retention of experienced and skilled staff in the NHS. An effective redeployment policy can help minimise the need for redundancies, not only as a result of organisational change, but to help retain staff unable to do their own job through ill health or injury.

This can be used in the short term, while an employee is recovering from the ailment before returning to their usual job full time, or permanently for staff who have no likelihood of returning to their original role.

In some cases, redeployment requires re-training, and it is good practice for this to be provided as part of a package devised and managed by the occupational health service and human resources.

Work-related ill health
If there is any possibility that ill health may have been caused or exacerbated by work, or working arrangements (including, for example, conditions such as asthma, musculoskeletal disorders or stress-related illnesses), advice should be sought from occupational health and referral to the service considered. Certain accidents, incidents and absences from work are reportable to the Health & Safety Executive under statutory health and safety regulations.

Occupational health assessment
Staff should only be placed on the redeployment register once occupational health has certified them as fit for redeployment. Redeployment on health grounds will always be based on occupational health approval/advice. Where redeployment is being considered for a member of staff, it is important to ensure that an occupational health assessment is carried out.

This can include a variety of elements and consideration should be given to ensuring the most appropriate elements are used for the individual case in question. The more elements used, the more informed the decision-making process will be.

Seeking suitable employment
The NHS Terms and Conditions handbook (section 16.15) states that suitable employment is determined by reference to sections 138 and 141 of the Employment Rights Act 1996.

If, after following advice and recommendations from occupational health, the range of duties cannot be reasonably accommodated within the employee’s current job, the department should consult with the employee (and if the employee wishes, a staff representative), and an attempt to identify alternative work within the organisation should be sought. This should take into consideration the operational requirements and the employee’s skills,
capabilities and personal circumstances. Employees will be expected to show some flexibility.

The procedure should be designed to ensure that decisions on the most suitable alternative post for an employee maximises their skills and expertise. It is essential that the Disability Discrimination Act 1995 (as amended), along with policies on equality and diversity, are taken into account to ensure fair and consistent treatment of all staff.

An assessment should be made to ensure that the new post will not aggravate the existing medical condition and that taking up this position will assist the employee to be rehabilitated back into work. If alternative employment is identified, then human resources should meet with the manager to establish the employee’s suitability for the post. If the employee meets the essential criteria or can meet the essential criteria with a reasonable level of re-training, or any reasonable adjustments/modifications to the work environment, then this will be considered to be a suitable alternative employment.

An informal meeting with the employee and human resources should be arranged to discuss the suitability of the post and a letter should be sent to the employee outlining start date, job description, additional information about the directorate and a training plan, if applicable.

In the case of an employee becoming disabled, it is important that advice is sought from a Health and Safety adviser and relevant external agencies or government bodies on any equipment or adjustments to the work environment.

Where an individual is suitable for a vacancy, it is appropriate for the vacancy to be offered to them without the need for advertising.

**Review**

Where suitable employment is found, a review period should be agreed ideally four weeks from the employee first taking up the new post. The purpose of the review meeting is to establish that appropriate training has been highlighted and completed to address any minor training or knowledge gaps, along with an assessment of any new reasonable adjustments required.

**Refusal of suitable employment**

If the employee refuses an offer of suitable employment then they must provide written confirmation of the reasons for this decision to human resources within one week of the letter of offer.

Employees should be reminded that if no other suitable alternative vacancies arise, and all options are exhausted, they may be dismissed on the grounds of lack of capability or ill health. Advice must be sought from human resources and the Pensions Agency.

**Ill health retirement**

An employee may be referred for retirement on the grounds of ill health following examination by the organisation’s occupational health service. This referral follows either:

- a period of ill health where suitable alternative employment cannot be sourced
• an employee request, in writing, to human resources to be considered for ill health retirement. This will be dependent on meeting criteria from the appropriate pension funds.

**Dismissal on the grounds of ill health**
Dismissal on the grounds of ill health occurs when an employee doesn't meet the ill health retirement criteria. It is important that a clear audit trail is kept to support any outcomes that end in dismissal to ensure that the organisation can confirm that the most appropriate exit route has been used.
Managing sickness absence – manager’s toolkit

This section provides a series of factsheets providing advice for line managers, occupational health and human resources managers on a range of issues related to the effective management of sickness absence.

The factsheets cover:

• contacting staff – issues to consider
• return to work interviews
• investigation
• absence review meetings
• confidentiality
• handling short-term absence
• the statutory framework
• Disability Discrimination Act
• pregnancy
• role of the manager in managing long-term sickness absence
• role of occupational health in managing long-term sickness absence
• assisting an employee’s return to work
• implementing a return to work plan
• risk assessment.
Factsheet: Contacting staff – issues to consider

All contact between managers and staff relating to sickness absence should be documented.

Without seeking personal or confidential details, line managers should discuss with their staff member the nature of their illness and its likely duration. Ideally, this conversation should take place when the member of staff reports their absence from work. If the line manager does not take the call they should contact the employee at the earliest opportunity.

Weekly contact is recommended for staff who are likely to be off for a number of weeks.

Line managers should consider the following and discuss with the employee:

- are they making progress?
- are they receiving the appropriate support?
- are they waiting for physiotherapy, counselling, outpatient appointments, inpatient services?
- what parts of the current job could the employee not carry out?
- what could the manager do for the employee?
  - facilitate easier access to physiotherapy, counselling and so on
  - adjustments to hours or duties
  - aids/equipment that might help
  - exploring possibilities for temporary redeployment
- when might the employee feel ready to start on a return-to-work package?
- what is stopping them starting a package now?

Managers should always remind the employee that they will be keeping in contact with them during their absence and that they are there to help facilitate the quick return to work.

Line managers are responsible for:

- monitoring the situation
- contacting occupational health and HR when necessary
- acting upon the information received from the absent employee.
Factsheet: Return-to-work interviews

Return-to-work interviews have proved to be the single most effective measure for reducing short-term sickness absence. They indicate to employees that their absence was noticed and that they were missed. They are also an indication that managing sickness absence is a priority for the employer.

The interview helps identify the cause of any short-term sickness absence and also gives line managers the opportunity to discuss with the employee whether there are any particular problems the employee might have.

The interviews should be carried out after every instance of sickness absence – even one day.

Managers should have received training to assist them in carrying out interviews in a fair and consistent way.

The interview should:

• consider the reason for the absence
• discuss whether the reasons for the absence are consistent with other evidence
• allow the line manager to express any doubts to the member of staff
• allow the member of staff to explain the absence.

The line manager should keep a brief note of the interview, which should be agreed with the employee and signed off by both of them as a fair record of what was discussed.

Line managers have many competing claims on their time and may be tempted to miss out return to work interviews. However, documentary evidence that return to work interviews were carried out, and their content, may prove useful should any further action be required at a later date.
Factsheet: Investigation

When an employee’s sickness absence reaches a trigger point it should also trigger an investigation into the nature and causes of the absence. This will allow the line manager to pull together all of the available data to allow them to hold an absence review meeting.

It is important to remember that each case is different and will require different treatment.

It is also important to approach each investigation with an open mind and no preconceptions.

Reviewing the data should allow the line manager to answer the following questions:

• are there any patterns to the absence – Friday/Mondays?
• how much of the absence is certified and how much uncertified or self-certified?
• what reasons have been given for previous absences at return-to-work interviews?
• is there a link between previous absences or were they all for different reasons?
• is there any other evidence about possible underlying causes of absence?\(^{15}\)

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\(^{15}\) Absence management: How do you deal with short-term recurrent absence? (2006), CIPD
**Factsheet: Absence review meetings**

Ideally, managers should receive appropriate training to give them the skills to conduct positive and effective absence review meetings.

The absence review meeting is intended to offer the line manager and the employee the opportunity to discuss the sickness absence record in a positive way.

It is also an opportunity for the line manager to explain to the employee the impact their sickness absence has on the organisation, or their part of it, and what that impact means for colleagues.

Managers and staff need to be aware that although this interview is likely to take longer than a return-to-work interview it is not part of the disciplinary process and should not be seen this way by either party.

The line manager should try to ensure an air of openness and support and encourage the employee to bring forward any concerns that might be affecting attendance.

Appropriate training will assist line managers in being able to identify symptoms that might be affecting attendance and how to help draw the employee into discussing these.

Managers will need to adapt their approach depending on the evidence they have collected. They may have concluded that there are domestic issues, rather than illness, that have affected absence and in this case they will need to offer the employee the opportunity to raise these issues and to be prepared to consider ways in which they can be helped to deal with them.

If absences appear to have been caused by a number of opportunistic illnesses the line manager may decide to refer the employee to the occupational health service. This must be done with the approval of the employee who must be told the reason for the referral and receive a copy of the referral letter.

No employee should be referred to occupational health without a clear understanding of the reasons why.

Experience will help managers identify what they believe are the issues involved in the employee’s sickness absence but they need to remember that the reasons can be very complex. They should be made aware, through training, of the variety of causes of sickness absence. These may include drug or alcohol dependency, domestic violence, stress, carer responsibilities or underlying medical issues.
Factsheet: Confidentiality

Line managers need to be aware that confidentiality principles place constraints on occupational health professionals in regard to the release of the personal medical information of staff. These apply in all cases. The General Medical Council principles are:

- staff have a right to expect that OH professionals will not disclose any personal information which is learned during the course of their professional duties, unless they give permission
- when OH professionals are responsible for confidential information they must make sure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received
- when staff give consent to the disclosure of information about them, OH professionals must make sure the employee understands what will be disclosed, the reasons for disclosure and the likely consequences
- OH professionals must respect staff requests that information not be disclosed to third parties, apart from in exceptional circumstances (for example, where the health or safety of others would otherwise be at serious risk)
- if OH professionals disclose confidential information they should release only as much as is necessary for the stated purposes
- OH professionals must make sure that the people receiving the information understand that it is given to them in confidence
- if OH professionals decide to disclose confidential information they must be prepared to explain and justify their decision.

Further guidance on confidentiality can be obtained in Duties of a Doctor. Guidance from the General Medical Council\textsuperscript{16} published by the GMC and in the Faculty of Occupational Medicine’s Guidance on Ethics\textsuperscript{17}.

\textsuperscript{16} Duties of a Doctor (2006), General Medical Council
\textsuperscript{17} Guidance on Ethics for Occupational Physicians - 6th Edition (2006), Faculty of Occupational Medicine
**Factsheet: Handling short-term absence**

ACAS has produced an advisory handbook, which is a useful starting point for handling short-term absence. The recommended steps are:

- prompt investigation of absences and an opportunity for the employee to explain them
- referral to OH to see if there is an underlying health problem
- when there is no obvious medical evidence to support frequent short-term absences
- if, after investigation and referral to OH, there is no health reason for the absences the matter should be treated under the normal disciplinary procedure
- if the absences have a domestic cause the line manager, often assisted by HR, will want to consider whether assistance can be offered to help alleviate the problem. This may be a change of duties or hours, referral to counselling services or some other action
- the employee must be told that there is an expectation of improvement in their attendance and what the consequences might be if that improvement does not happen.

In the event of the above not producing an improvement then the line manager, with HR, will need to consider what other action to take given performance, length of service, effect on the work and other issues.

Key steps given by the Employment Appeals Tribunal (EAT) in a case in 1980 were:

- a fair review by the employer of the employee’s attendance record and reasons for absence
- an opportunity for the employee to make representations
- appropriate warnings of dismissal if the situation doesn’t improve.

The EAT concluded that if no adequate improvement took place after this procedure, dismissal would be appropriate.

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18 *Discipline and grievances at work – dealing with absence, ACAS*

19 *ibid*
**Factsheet: The statutory framework**

While it is not essential for line managers to know the statutory framework under which employees may be dismissed for poor attendance, they should be aware of the impact their actions may have on the process.

The Employment Rights Act and subsequent statutes set out the right not to be unfairly dismissed and require tribunals to consider two points when dealing with unfair dismissal claims:

- is there a potentially fair reason for dismissal established by the employer?
- has the employer acted reasonably in all circumstances and did they use the proper procedures?

In the case of short-term repeated absences, the potentially fair reasons for dismissal are likely to be capability, where some underlying medical condition has been found, or misconduct where no medical reason has been found. The burden of proving that one of these potentially fair reasons exists lies with the employer and so it is essential that line managers keep good records of all absences, return-to-work interviews and reviews.

In the case of long-term absence the potentially fair reason will be based on the capacity of the employee to carry out the work they were employed to do. There is an expectation that the employer will have taken steps to offer a suitable alternative to the usual work. This is why line managers should be aware of the potential to offer alternative duties or a change of post if it would facilitate a return to work and improved attendance.

In deciding whether an employer acted reasonably or unreasonably in dismissing an employee, the Employment Tribunal will consider whether proper procedures were followed, if the decision was consistent with previous dismissal cases and whether other mitigating circumstances were taken into consideration.

The role of the line manager in ensuring that all procedures are followed properly is important to provide the evidence for any case that should, ultimately, result in a decision to dismiss.
Factsheet: Disability Discrimination Act 1995

Line managers need to be aware of the rights afforded to employees who have a “physical or mental impairment” that has a “substantial” and “long-term adverse effect” on their ability to carry out “normal day to day activities”.

Managers should receive suitable training in equality and diversity issues in order to be able to recognise when they impact on sickness absence management.

Further, comprehensive advice on the effects of the Disability Discrimination Act 1995 can be found in:

- Disability and Employment, CIPD
- The healthy workplaces handbook, NHS Employers 2007
Factsheet: Pregnancy

The law requires that a pregnant woman is not to be subject to ‘detriment’ either directly or indirectly due to her pregnancy.

Line managers should take extra care when dealing with absences taken during pregnancy and may wish to take advice from HR colleagues on how to address any issues that arise.

Generally, it should be assumed that any dismissal arising out of pregnancy would be considered unfair.

It should also be noted that absences incurred after a return from maternity leave, which could be considered to be related to pregnancy or childbirth, may also be considered as normal by an Employment Tribunal should they result in a dismissal.

Line managers should seek further advice from both occupational health and HR when dealing with cases of sickness absence during pregnancy or on return from maternity leave.

Further advice can be found in:

• *The healthy workplaces handbook*, NHS Employers 2007
Factsheet: Role of the manager in managing long-term sickness absence

The primary role of the line manager in cases of long-term sickness absence is the same as in managing short-term absences – to remain in contact with the employee and to keep open discussions about the progress of their illness.

They are also the first point of contact when discussions take place about the possibility of rehabilitation back into work, phased return, redeployment or access to occupational health services.

They should be involved with the occupational health service and HR in formulating a plan for the return to work, should involve the employee in all stages of formulating it, and be there for the employee to contact if they have any concerns.

Most importantly they have a role in maintaining records of previous sickness absences and any interviews that have taken place following those absences.

In many cases they will be the person referring the employee to occupational health, if it is considered necessary, although in some cases, depending upon local practice, this will be done by HR.

Line managers often feel awkward maintaining contact with absent employees during a long period of absence but much of this can be dealt with through training and through encouraging a workplace ethos where regular contact under these circumstances is seen as the norm.

If an employee is being treated at home it may be advisable to contact a relative or carer to agree the best time to call. Remaining in contact and building up a relationship in this way will make the discussion of returning to work and how it is to be facilitated much easier.

Further advice on maintaining contact is available in:

• *Managing sickness absence and return to work* – HSE
• *Absence management: How do you deal with long-term absence?* (2006), CIPD
Factsheet: Role of occupational health in managing long-term absence

The CIPD Annual Absence Management Survey 2006 found that referral to occupational health services was considered the most effective way to manage long-term sickness absence.

A line manager can seek an independent medical opinion from a qualified occupational health professional to assist with health-related management issues. These may include:

- frequent short-spell absences attributed to sickness or injury
- long-term sickness absence
- altered or impaired work performance without absence, including behavioural problems
- concern by management about an employee’s ability to work before his or her return to work
- the monitoring of a member of staff who is suspected of drug or alcohol misuse
- concern regarding an infection control issue
- ill health retirement.

OH professionals may advise on issues relating to job redesign, rehabilitation, access to services such as physiotherapy, the need for redeployment, assessing the risks involved in return to work, phasing of return to work.

When an employee has been absent due to sickness for a long period, OH should be involved in preparing the return-to-work plan with both the line manager and HR so as to ensure the employee’s health is not put at further risk.
Factsheet: Potential steps in assisting an employee’s return to work

The HSE suggests that the following work adjustments can be made to assist an employee’s return to work:

- provide new or modify existing equipment and tools, including IT, modified keyboards and so on
- modify workstations, furniture, movement patterns
- provide additional training such as refresher courses
- modify instructions and manuals
- modify work patterns or management systems and style to reduce pressure and give the employee more control
- modify procedures for testing, assessment and appraisal
- provide the employee with a mentor or ‘buddy’ while they regain confidence in the workplace
- provide supervision
- reallocate work within the team
- provide alternative work.

Line managers, HR and occupational health will also want to consider the following:

- can an earlier return to work be accomplished through providing access to occupational health, counselling or physiotherapy?
- can a phased return to work be agreed?
- can this be agreed without affecting pay?
- is it possible to return on a part-time basis?
- can extra support be offered in the first weeks back – such as extra supervision?
- can the job be altered either on a temporary basis or permanently?
- can the job be altered to remove the most physically demanding work until the employee is completely rehabilitated back into the workplace?

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20 Managing sickness absence and return to work, HSE
Factsheet: Implementing a return-to-work plan

When a line manager, in collaboration with the employee, HR and occupational health, has identified all of the ways in which the employee can be assisted back into the workplace they need to agree a return-to-work plan.

The time at which this plan should be formulated will vary with the individual concerned but it should be based on the expected date of return and reflect any medical and safety advice that has been received. A good time to start thinking about producing the plan might be around four weeks into the absence but, again, this will depend upon the nature of the illness and the ease of making the arrangements necessary to facilitate the return to the workplace.

A return-to-work plan might include:

• the expected date of return
• the agreed intention of having the plan – for instance it might be a phased return over four weeks allowing the member of staff to return to their old post fully recovered
• the period of time covered by the plan
• whether the plan will be reviewed and if so, when and by who
• will the plan have any effect on the terms and conditions of the employee and is there any change to their pay
• who has been involved in drawing up the plan.21

It is important for all parties to keep the plan under review to ensure that it delivers what is intended and to allow for agreed changes to be made if it is found to be failing in some way.

Lessons learned from implementing return-to-work plans should be shared with other managers, OH and HR in order to learn the lessons and improve the process for other employees in the future.

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21 Absence management: How do you deal with long-term absence (2006), CIPD
**Factsheet: Risk assessment**

Health and Safety legislation requires that a risk assessment is carried out on an employee’s job to ensure that it will not be harmful to them.

All existing jobs should already have been subject to a risk assessment and these should be reviewed regularly.

If an employee is returning to work after an extended period of absence and their job has been adjusted to facilitate the return it should be subject to a new risk assessment before they start it.

If the returning employee is now disabled or there have been significant changes due to their illness or injury, the job should be subject to a new risk assessment before they start it.

Line managers should take expert advice from a qualified health and safety professional to ensure that the risk assessment is carried out in compliance with current health and safety legislation and takes into account, where necessary, the Disability Discrimination Act 1995.

Further advice on risk assessments is available from:

- [www.hse.gov.uk](http://www.hse.gov.uk)
- *The healthy workplaces handbook*, chapter on risk assessment
NHS Staff Council Agreement – Annex Z to the Staff Handbook

Managing sickness absences – developing local policies and procedures

The management of ill health within the NHS is challenging, but provides opportunities to improve the overall health and wellbeing in the workplace, which will ultimately boost organisational productivity and support service improvements for patients.

The arrangements set out in this annex are intended to support employers and staff in the management of sickness absence and in managing the risk of premature and unnecessary ill health retirements. It is intended that employers will amend, in partnership with local staff sides, their local policies and procedures consistent with the provisions of this agreement.

This agreement details the responsibilities of both staff and employers in the management of ill health in the NHS.

This annex should be read in conjunction with the NHS Staff Handbook:
Section 14  Sickness Absence
Section 30  General statement on Equality and Diversity
Section 32  Dignity at Work
Section 34  Flexible working arrangements

Local sickness absence procedures

Effective partnership working is crucial in achieving the effective management of sickness absences. Employers therefore, in partnership with local staff side representatives, should ensure that their local sickness absence procedure and working arrangements incorporate the minimum standards set out below to minimise the risk of premature and unnecessary ill health retirements. This will ensure that, where possible, staff are able to continue working despite experiencing periods of ill health or disability.

- **legal responsibilities** including mutual responsibilities of employers and staff to comply with health and safety requirements, reporting of injuries and dangerous occurrences (RIDDOR), disability discrimination and other relevant legislation.

- **key employer responsibilities;** employers are expected to:
  - communicate appropriately with absent staff
  - manage absences under the locally agreed sickness absence procedure
  - provide support and advice through the use of occupational health services where appropriate
- develop reporting arrangements, recognising that high levels of sickness absence are a financial risk to the organisation
- have appropriate management systems in place to collect good quality data on sickness absence.
- in partnership with Trade Union representatives, regularly monitor and review arrangements to identify where and how policies can be improved.

**key employee responsibilities:** employees are expected to:
- ensure regular attendance at work
- communicate appropriately with employer when absent from work
- co-operate fully in the use of the locally agreed sickness absence procedures

Partnership arrangements should also ensure the regular monitoring and review of local policies and procedures is undertaken, to identify where and how policies can be improved.

**The key elements of local procedure will include:**

**A structured review process**
Regular reviews should be carried out to assess and monitor staff when they are off sick, and determine what action is needed at each stage. Where a member of staff is unlikely to return to work this would culminate in a final review where a decision on the appropriate way forward is made i.e. return to substantive employment/redeployment/termination of contract. It is assumed that as part of this process that reasonable adjustments have been considered. Medical evidence should be made available to support the review process and occupational health advice should be sought on the likelihood of:
- the prospects of a likely return to the previous employment with or without adjustments
- a phased return with or without a need for adjustments
- redeployment
- a successful ill health retirement application.

**Early interventions**
In order to avoid premature and unnecessary ill health retirements employers should also consider the following interventions as early as is practically possible and at the latest within one month of an employee going sick:

*Rehabilitation* – identifying appropriate ways of supporting staff to remain in work or return to work at the earliest opportunity through intervention with appropriate treatment. This will mean providing staff with direct access through appropriate dedicated resources, such as physiotherapy and cognitive behavioural therapy.
Phased return - enabling staff to work towards fulfilling all their duties and responsibilities within a defined and appropriate time period, through interim flexible working arrangements whilst receiving their normal pay.

Redeployment - enabling the retention of staff unable to do their own job through ill health or injury as an alternative to ill health retirement or termination. Staff should be made aware of the provisions within the NHS Pension scheme to assist this process through “step down and wind down” arrangements.

Sick pay entitlements – review and decision dates should be determined taking account of the individual’s sick pay entitlements and there should be a review before their sick pay ends. Procedures should make reference to the NHS Injury Benefit Scheme and in particular the circumstances when NHS Temporary Injury Allowance should be paid.

Occupational health support – Occupational health services have a responsibility to provide advice and support to both the individual and the employer. Line managers should seek advice on long term sickness cases from their occupational health service as early as reasonably practical. Individuals may also self-refer for advice and support about the best way of seeking a return to work.

Termination
Where termination of the contract of employment on the grounds of incapacity is considered, all reasonable efforts should be made to obtain appropriate medical evidence via the occupational health service, including occupational health advice on the likely outcome of a successful ill health retirement application. Before a decision to terminate is made all other options should meaningfully be considered, including:

- Rehabilitation
- Phased return
- A return to work with or without adjustments.
- Redeployment with or without adjustments

Contractual notice must be given to a member of staff whose contract is being terminated on grounds of ill health.