

# Guidelines on prevention and management of sickness absence

Updated November 2013

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# Introduction

These guidelines have been developed in partnership between NHS Employers representatives and staff side trade unions through the NHS Staff Council's Health, Safety and Wellbeing Partnership Group (HSWPG) (formerly known as POSHH) to supplement and reinforce Annex Z of the *NHS terms and conditions of service handbook*. They should be implemented in partnership at a local level.

The 2009 Boorman Review<sup>1</sup> of the health and wellbeing of the NHS workforce highlighted the fact that the NHS loses 10 million working days each year to sickness absence. It also, whilst recognising sickness absence is higher in the NHS compared to other sectors, recognised high levels of presenteeism, with many staff reporting that they come to work when they feel sufficiently unwell to justify staying at home. Stress and musculoskeletal disorders were found to be the main causes of absence and ill health. In addition, the average age of the NHS workforce is increasing and this is going to impact on both the physical and mental wellbeing of the workforce.

The review recommended that more could be done to prevent the work-related and lifestyle causes of ill-health and identified the important role the NHS has in promoting the health of its employees. It also recommended the need for interventions to support the recovery and early return to work of staff who were off sick. If interventions to prevent and manage sickness absence are implemented effectively, Boorman estimates that absence could be cut by a third, meaning a cost reduction of £555 million per annum.

The NHS Constitution commits NHS employers to go beyond the legal minimums in managing the health, safety and wellbeing of its workforce, by providing opportunities for staff to improve their health and wellbeing. It also commits the NHS to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements.<sup>2</sup> The NHS Staff Council is committed to partnership working – the *NHS terms and conditions of service handbook* states that: "Effective partnership working is crucial in achieving the effective management of sickness absence."<sup>3</sup>

A variety of information and advice is available to support organisations to implement the wide-ranging recommendations of the Boorman Review. These guidelines outline key principles that NHS organisations should follow to prevent and manage sickness absence, and help signpost readers to sources of further information.

The first section of this guidance looks at prevention through the creation of safe and healthy workplaces. The second section looks at the management of sickness absence.

# Underlying principles

The Health, Safety and Wellbeing Partnership Group has agreed five key principles for the prevention and management of sickness absence:

**1) Partnership working.** Initiatives to create healthy workplaces should be *undertaken with* staff not *done to* staff. Workers affected by programmes to create healthy workplaces must be involved in every step of the process, and their opinions and ideas sought out, listened to and where agreed implemented.

Local sickness absence policies and procedures should be developed and agreed in partnership. In relation to addressing workplace hazards, there is a legal requirement to consult trade union safety representatives.<sup>4</sup>

**2) Leadership.** Commitment from the board is essential. The NHS Health and Wellbeing Improvement Framework outlines five high impact changes for health and wellbeing. One of these five actions is to ensure that health and wellbeing initiatives are backed with strong leadership and visible support at board level.<sup>5</sup> Employers also have a legal duty to manage and assess all health and safety risks,<sup>6</sup> and this includes causes of sickness absence. The Health and Safety Executive (HSE) and the Institute of Directors guidance, *Leading health and safety at work*, recognises that health and safety is critical to organisational success. It adds that board members who do not show leadership in this area are failing in their duty as directors.<sup>7</sup>

**3) Continuous improvement model.** It is important that initiatives to create healthy workplaces and manage sickness absence are monitored and evaluated. Measures should be taken to address gaps in provision and review the effectiveness of initiatives.

**4) Line management support.** A consistent theme in health and wellbeing surveys of healthcare workers is the importance of good line management support. Line managers need to be developed, supported and provided with clear policies and resources for preventing and managing sickness absence.

**5) Competent advice.** Access to competent advice is key. Occupational health advisors, health and safety specialists, re-ablement specialists (for example, physiotherapists, occupational therapists, occupational psychologists), human resource advisers and health promotion experts can all provide advice and support to organisations on creating a healthy workplace and the management of sickness absence, for example, supporting early return to work. Advisers need to work closely together, rather than in silos, and engage with staff side representatives.

# Part 1: Creating healthy workplaces

There are moral, legal and business reasons for creating a healthy workplace:

- society expects good standards of health and safety
- it is the right thing for organisations to do
- there are legal requirements to protect workers from the hazards they face at work
- it makes good business sense.

When an accident occurs there will be direct and indirect costs associated with the event:

- Direct costs include the time lost through sickness absence, including the recruitment and training of temporary staff to cover the injured party, potential NHS Injury Benefit and other compensation claims (See the *NHS terms and conditions of service handbook*<sup>8</sup>), and the subsequent increased insurance premiums (see NHS Litigation Authority Standards<sup>9</sup>).
- Indirect costs, such as the adverse affects on the quality of patient care. A healthy workforce is better able to provide high-quality patient care, and an unhealthy workforce disrupts patient services through high levels of both sickness absence and presenteeism.

The World Health Organization defines a healthy workplace as follows:

“A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace by considering the following, based on identified needs:

- health and safety concerns in the **physical work environment**
- health, safety and wellbeing concerns in the **psychosocial work environment** including organisation of work and workplace culture
- **personal health resources** in the workplace
- ways of **participating in the community** to improve the health of workers, their families and other members of the community.”<sup>10</sup>

The healthy workplace principle is one that actively promotes health, not just prevents ill-health and reduces sickness absence.

## Physical working environment

If not managed, the physical working environment can lead to ill-health. Physical hazards in the NHS are wide ranging, from chemical hazards, such as cytotoxic drugs and cleaning substances, to biological hazards, such as blood-borne viruses; ergonomic hazards, such as heavy lifting and blue light driving, and the hazards associated with radiation.

The physical infrastructure and facilities within a work building can also lead to health problems and low morale. These include working in hot environments, a lack of changing facilities and a lack of access to drinking water.

There is wide ranging legislation which places a duty on employers to take action to eliminate or reduce exposure to physical hazards and reduce the risks to health. There is also a requirement to carry out

proactive checks, known as 'health surveillance' for workers exposed to a number of physical hazards, for example, skin irritants or asthma causing substances.

### **Psychosocial work environment**

The psychosocial work environment includes the organisation of work and the organisation culture; the attitudes, values and beliefs and practices that are demonstrated on a daily basis in the enterprise, and which affect the mental and physical wellbeing of employees.

The HSE recognises a number of factors in the workplace that can lead to poor mental health and stress at work. These include:

- excessive demands
- lack of control
- lack of support
- poor working relationships
- role ambiguity
- organisational change.

Employers have a legal duty to assess the risks from psychosocial workplace hazards in the same way they do with physical hazards. Tools and guidance are available from the HSE to help. The HSE guidance provides a benchmark for organisations to meet in order to continuously improve the psychosocial work environment.

### **Blackpool Flyde and Wyre NHS Foundation Trust**

Blackpool Flyde and Wyre NHS Foundation Trust had a dedicated stress management project worker and a stress management group. A series of focus groups were set up to look at some of the key issues that might be causing stress in the workforce. A series of actions has been taken, which include: revamping training programmes; dedicated courses for line management on supporting staff; improving communication through a magazine for staff who don't sit in front of a computer; and an employee assistance programme for staff and their families.

The interventions have contributed to a 40 per cent reduction in cases of work related stress; sickness absence has improved by over 10 per cent; employee grievances reduced by 50 per cent; and disciplinary action reduced by 25 per cent.

A key message from the work is the importance of listening to the workforce by asking them what they think.

## **Personal health resources**

It is increasingly accepted that organisations have an important role in promoting good health in the workforce and giving staff information, resources and opportunities to improve their own mental and physical health. There is recognition in the Boorman review that the NHS can do more to become an exemplar in this area. Initiatives such as smoking cessation groups for staff, workplace Fit4Life programmes and the NHS Sports and Physical Activity Challenge can support improvements in individual health.

It is important to recognise that work conditions can act as a barrier to improving health, for example, physical inactivity may result from long work hours and poor diet from lack of access to healthy snacks or meals at work or time to take meal breaks.

Health promotion activities should be tailored to the needs of occupational groups and be accessible to staff working shifts.

## **Community participation**

Organisations exist in communities and there are opportunities for initiatives to protect and promote the wellbeing of workers to extend beyond the workplace to community settings.

In some parts of the country the NHS Sport and Physical Activity Challenge which aims to get NHS staff more active has been extended to NHS workers families and the wider community.<sup>11</sup>

# Part 2: Support – what to do when people go off sick

## Introduction

This section outlines what to do when people go off sick. It takes a work-focused approach to managing sickness absence.

A work-focused approach:

- respects employees rights to take paid sick leave, within the scope of the relevant sick leave policy, when they are unable to work due to illness or injury
- recognises that work is generally good for people's physical and mental health and well being
- encourages managers, at their discretion, to make reasonable temporary workplace adaptations to enable employees to work rather than take sick leave and recognises that employees do not always need to be fully fit to undertake work
- ensures that managers make reasonable adjustments under the organisation's reasonable adjustments policy where employees have a disability or serious underlying medical condition.

The work-focused approach differs from previous approaches because it focuses on what the employee can do or might be capable of doing with reasonable help rather than what they cannot do due to illness or injury.

This following pages cover:

- developing policies in partnership
- training
- scope of policy
- documentation and confidentiality
- presenteeism/staff becoming ill at work
- Equality Act and disability discrimination
- entitlements
- certification
- reporting and monitoring
- managing long-term absence
- early interventions
- ill-health retirement and dismissal on the grounds of ill-health
- infection control
- medical suspension.

## Developing policies in partnership

The NHS Constitution commits NHS employers, staff and staff side representatives to work in partnership. This should include procedures and arrangements for managing sickness absence. The effective management of sickness absence is in the interests of both employers and their staff, and robust sickness absence policies can, if implemented, properly help improve attendance at work, the health and wellbeing of staff and ultimately patient services.

By working together, managers and staff and their trade union representatives can identify issues at an early stage whether these are:

- previously undiagnosed systemic causes of sickness absence
- individual members of staff whose attendance record is a cause for concern.

By so doing, both parties can avoid lengthy time consuming procedures.

## Training

In order to comply with both health and safety and equality laws, employers are responsible for having the right policies in place and for ensuring that managers are trained in their successful implementation. Also, as part of their commitment under the NHS Constitution to work in partnership, employers should involve staff side representatives in any training programme. Where possible, managers, safety and industrial relations reps should be trained together as this will ensure successful buy-in to the policies, and all parties will gain a better understanding of each other's different perspectives.

## Scope of policy

Employers have a duty to manage sickness absence, regardless of its duration. Sickness absence can be defined as any absence from work due to sickness or ill-health. Sickness absence policies should not cover:

- maternity leave
- carer's leave
- any periods of absence agreed under family friendly policies
- any pre-agreed periods of absence to receive treatment (see also the section on the [Equality Act and discrimination](#)).

Neither should they cover any unauthorised absence or absence where managers believe staff are abusing sickness absence procedures. These should be managed through disciplinary procedures.

## Documentation and confidentiality

Communication between manager and employee regarding the cause of sickness absence should be considered confidential. Although other staff will need to know that their colleague is off work due to sickness, they are not required to know the cause of the absence. The manager should ensure that only those persons who need to know should be given access to relevant information and they in turn should treat that information as confidential. Information should not be disclosed by the manager to a third

party without the consent of the employee concerned, except where failure to do so would be contrary to the public interest, or a breach of health and safety or other legal obligations. These records should be kept confidential and retained in accordance with the Data Protection Act. Please note that documentation may form part of future procedures, so it is imperative, therefore, that any information is recorded accurately and without prejudice.

## **Presenteeism/staff becoming ill at work**

Although this part of the document is primarily about managing staff who have time off through sickness, it is equally important that trusts develop policies to support staff who attend work when they are too ill or unfit to work. The Work Foundation estimates that presenteeism due to poor mental health leads to a loss of working time nearly 1.5 times that caused by sickness absence due to mental health in the United Kingdom.<sup>12</sup>

If the manager believes the employee may be too ill or unfit to work, they should have a discussion with the employee and risk assess the situation. This assessment should consider the risks to the individual in question, their colleagues, patients and the organisation. It may be concluded that the risks can be managed by a change or an adjustment to the workers duties. If the manager concludes that the employee is too ill to attend work, they should send them home, as their continued attendance at work could put the health and welfare of the employee, their colleagues or patients at risk.

Similarly, if an employee is taken ill or suffers an accident while at work which impacts on their ability to perform their duties, they should whenever possible, inform their immediate supervisor or manager without delay. If, for whatever reason, this is not possible, their colleagues must do so on their behalf. The manager must then risk assess the situation as explained above. If appropriate, the manager should inform the next of kin.

If an employee attends work but then leaves due to sickness, it will be recorded as a full day's attendance and will not count as a sick day, although if it were to happen frequently it would need to be managed, monitored and subjected to absence procedures.

## **The Equality Act & disability discrimination**

The Equality Act says that a person has a disability if they have a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities. As well as previous physical and mental disabilities, this definition includes hidden disabilities (such as diabetes, epilepsy, mental health), and progressive and recurring conditions (such as cancer, HIV and MS).

Guidance on what is defined as a disability can be found on the Equality and Human Rights Commission's (EHRC) website.<sup>13</sup>

The Equality Act defines three types of disability discrimination:

- direct discrimination; that is less favourable treatment on the grounds of disability compared to someone without that disability where other circumstances are comparable. Note such discrimination cannot be justified by the employer

- indirect discrimination through a provision, criterion or practice applied to everyone, but which puts people with a disability at a particular disadvantage
- treating a disabled person unfavourably because of something arising from, as opposed to because of, their disability.

In the case of discrimination “arising from disability” there is no need to compare a disabled person’s treatment with that of another person. It is only necessary to demonstrate that the unfavourable treatment is because of something arising in consequence of their disability. However, unlike with both direct and indirect discrimination, if the employer can show that they did not know that the disabled person had the disability, it will not constitute discrimination arising from disability. As with indirect discrimination, the employer may avoid a claim of discrimination if the treatment can be objectively justified as a proportionate means of achieving a legitimate aim.

## Reasonable adjustment

Discrimination against a disabled person occurs where an employer fails to comply with a duty to make reasonable adjustments imposed on them in relation to that disabled person. The duty to make reasonable adjustments is a cornerstone of the Equality Act and requires employers to take positive steps to ensure that disabled people can access and progress in employment. What is considered reasonable will depend on:

- whether taking any particular steps would be effective in preventing substantial disadvantage
- the practicability of the step
- the type and size of the employer
- the financial and other costs of making the adjustment, compared to the extent of the employer’s resources and disruption caused
- the availability to the employer of financial or other assistance (such as advice through Access to Work<sup>14</sup>) to help make the adjustment.

Examples of reasonable adjustments include:

- adjustments to premises
- allocating some of the disabled person’s duties to another worker
- transferring the disabled worker to fill an existing vacancy
- altering the disabled worker’s hours of work or training
- assigning the disabled worker to a different place of work or training or arranging working from home
- allowing the disabled worker to be absent during working or training hours for rehabilitation, assessment or treatment
- acquiring or modifying equipment

- allowing a period of disability leave
- modifying capability/sickness absence or grievance procedures for a disabled worker
- adjusting redundancy selection criteria for a disabled worker.

Just because an employer has taken one step does not mean they don't have to consider other steps, and it will often be necessary to consider a combination of steps.

## Sickness absence policies and the Equality Act

These policies should not be discriminatory in design<sup>15</sup>. The EHRC says that: "It will often be appropriate to manage disability absence, pregnancy and gender reassignment-related absences differently from other types of absence", and that "recording the reasons for absence should assist that process"<sup>16</sup>. It also advises that although "employers are not automatically obliged to disregard all disability-related sickness absences, they must disregard some or all of the absences by way of an adjustment if this is reasonable", and that "if an employer takes action against a disabled worker for disability-related sickness absence, this may amount to discrimination arising from disability"<sup>17</sup>.

## Entitlements

Employees on NHS terms and conditions absent from work owing to illness will be entitled to receive sick pay in accordance with Section 14 of the NHS terms and conditions handbook<sup>18</sup>.

## Exemptions

Sick pay is not normally payable:

- for an absence caused by an accident due to active participation in sport as a profession
- where contributable negligence is proved
- when an employee is absent as a result of an accident where damages are received from a third party.

## Sickness absence and annual leave

In the event of an employee falling sick whilst on annual leave, annual leave entitlement should be reinstated so long as the appropriate sickness reporting procedures have been followed. Should an employee wish to go on holiday during a period of long-term sickness absence, then they would need to request annual leave in line with their annual leave policy and this would normally be agreed as long as the holiday period does not have a detrimental effect on the employee's rate of recovery.

## Carry forward of annual leave due to sickness absence

In recent years there have been a number of high-profile legal decisions on the relationship between holiday rights and sickness. Details on the decisions and guidance and frequently asked questions can be found on NHS Employers website.<sup>19</sup>

## Time off for medical appointments

Employers should facilitate employees' attendance of all medical appointments, as this is in the interests of all parties.

Time off for antenatal and postnatal care appointments and classes will always be agreed in line with Maternity Policies.

Employees with on-going medical problems which may be defined as a disability under the Equality Act, and require disability leave to attend their appointments, should discuss their requirements with their manager (see [Equality Act and disability discrimination](#)).

Similarly, any other staff who have suffered injury or illness (whether physical or mental) and require rehabilitative therapy should discuss the time required with their line manager. Such time off will bring the employee back to full fitness sooner. However, the timing of appointments needs to be managed against the requirement to provide a service.

Occupational health appointments should be taken in work time where possible. Where this is not possible, employees should be paid for the time taken to attend. This should be claimed via the normal processes for claiming additional hours or overtime.

## Staff awaiting and recovering from operations and other treatments

Once the employee informs the manager of an impending operation or treatment, there should be a discussion as to whether the employee will be incapacitated either before or after the treatment, and where an amendment to duties, working hours, rota or days worked per week will support the employee and ensure they remain in work where possible.

Managers should be sympathetic to staff who are experiencing attendance problems in the run up to treatment and discuss an adjustment of working patterns, duties or taking occasional half days or full days leave in order to ease the situation where possible. For instance, lighter duties may keep the person at work where they cannot perform all of their normal duties as opposed to taking sick leave until the operation, which may exacerbate their condition (see also section under Equality Act and discrimination).

## Time off for treatment for conditions not defined as incapacity

Certain operable conditions such as infertility, are not, in themselves, defined as incapacity, and therefore staff would not be automatically entitled to sick pay as defined by Section 14 of the NHS Terms and Conditions Handbook. However, if staff are, as a consequence of the operation or treatment, incapacitated for work, Section 14 should apply regardless of the original condition (with the exception of exemptions listed above). Similarly, staff would also be entitled to sick pay, if they are incapacitated by some of the causes of infertility, such as ovarian cysts.

Managers should look to support employees during the course of their treatment through regular discussions around, for example, alternative duties to prevent unnecessary stress during the course of treatments.

The following guidance offers a suggested process for doing this:

- Meet with staff member and manager (plus union representative and HR if required) to explore exactly what the staff member is asking for.
- Managers should give appropriate consideration to all requests. In making their decision, managers must act in accordance with the trust's Equal Opportunities policy and ensure each request is treated in a fair and equitable manner and that due consideration is given to the individual circumstances of each application.
- If the request is expected to be over the long term, the manager should consider provisions such as the positive use of the flexi-time scheme or appropriate use of accrued lieu time, use of annual leave, or unpaid leave. Permission must be sought from the manager for requests to reasonable paid time off where deemed appropriate.
- Final agreements should be signed by both the employee and manager and put in the personal file.
- The situation should be reviewed regularly with the employee and support offered.
- A log of cases should be maintained by HR.

## Certification

This section covers the processes for self certification and medical certificates (fit-notes). The employee has a contractual obligation to ensure that sickness absence is certificated appropriately.

The Department of Work and Pensions standard is for self-certification from the third, and medical certification from the eighth day. However, it is the normal practice within most NHS organisations to require self-certification from the first, and medical certification from the eighth day.

## Self-certification

If a period of sickness absence lasts more than three days and up to a maximum of seven days, some employers may ask for a self-certification form. Please note that when calculating the above number of days, these include days not normally rostered or contracted to work (for example, weekends for Monday to Friday workers or 'days off' for shift workers).

Self-certification forms are available from managers, GP surgeries and community pharmacies. Completed forms should be given to relevant managers no later than the employees' first day back at work. Managers will retain a copy of the self certificate on the employee's personal file and forward the original to Paymasters.

## Medical certification fit-notes

The "fit-note" is at the centre of the work-focused approach. The fit-note medical statement issued by the doctor either indicates that a person is not fit for work, or that they might be fit for some work under certain circumstances. The doctor will also be able to suggest changes that would assist a return to work.

On the form, doctors will advise one of two options:

1. not fit for work – this means that the doctor’s assessment is that they have a health condition that prevents them from working for the stated period of time. This is just like on the old ‘sick note’ where the doctor advises the employee to “refrain from work”
2. may be fit for work taking account of the following advice – this means the doctor’s assessment is that although their condition does not necessarily stop them from returning to work, their return is conditional on certain conditions being met.

The form contains the following options:

- a. Phased return to work. A doctor will recommend this where they believe that the employee may benefit from a gradual increase in the intensity of their work duties or their working hours.
- b. Altered hours. A doctor will recommend this where they believe that the employee may be able to return to work, if there is a change to the hours that they work. This may mean either working fewer hours or a change to their working pattern (for example, starting and finishing later to avoid travelling in the rush hour).
- c. Amended duties. A doctor will recommend this where they believe the employee may be able to return to work if their duties are amended to take into account their condition.
- d. Workplace adaptations. A doctor will recommend this where they believe the employee may be able to return to work if their workplace is adapted to take into account their condition.

The manager should contact the employee to discuss the advice on the note and where possible, facilitate return. If it is not possible for the manager to provide the support to return to work, the statement should be regarded as if the doctor had advised ‘not fit for work’.

A fit certificate is required for all periods of sickness absence which exceed seven days.

## **Working for other organisations whilst off sick**

Whilst on sick leave, employees are indicating they are not fit to fulfil their role as an employee, either in full or as adjusted in line with the doctor’s fit note. As such, they should not undertake any paid work elsewhere, including bank or agency work unless given permission by their employer. Where a member of staff is deemed to be sufficiently fit to work elsewhere for their employer, suitable alternative employment should be discussed with their manager in the first instance.

## **Reporting and monitoring**

Managers should keep accurate and up-to-date records of sickness absence for all the staff they are responsible for. It is important that there are clear reporting lines, involving staff, first line managers, HR, payroll and occupational health. 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 set a time by which staff should report in and nominate a person they should report to. Staff should be made aware that:

- they may on return have a return-to-work meeting with their line manager or a nominated person
- they should report in (and to whom) or it will be assumed they are absent without leave (a relative or friend may phone in if necessary). Staff should provide a brief description of their ailment and say how long they expect to be absent. They should provide a certificate if they are absent for more than one week ([see above](#)).

Managers should pass information on absent staff to a 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.

When recording sickness absence, managers should collate their records so as to record:

- causes of absence
- length of absences
- the identity of those who have been absent.

The causes of absence should be classified in accordance with the Electronic Staff Record (ESR) codes. Under the existing ESR codes approved disability leave should be recorded as "Approved - Paid Leave". Managers should consider keeping a record of when absence is disability related for the purposes of demonstrating reasonable adjustments (see page 12).

When analysing sickness absence data, it is important that, as well as identifying who took the time off and for how long, employers should look for patterns such as whether certain parts of the organisation have higher levels of absence than others, and whether there appears to be any underlying causes.

## Other duties and responsibilities

**Managers**, with the support of occupational health services, have a duty to communicate appropriately with absent staff, and provide support and advice for staff when they are off sick, ensuring that appropriate regular contact is maintained with staff for the durations of their absence, and on their return to work.

**Occupational health services** should also be proactive in providing advice on any work-related issues which need to be addressed by management to maintain attendance. This includes monitoring both sickness absence and presenteeism figures to ensure that any underlying causes of ill-health are tackled.

**Employees** in turn are expected to ensure regular attendance at work, communicate appropriately with their employer when absent from work, and cooperate fully in the use of the fully agreed sickness absence procedures.<sup>20</sup>

## Setting indicators

One of the uses of sickness absence data is to help identify any staff that may need support or intervention from management. Setting such indicators can help determine where and when action is needed. The attendance records of individual employees can then be monitored against these criteria. A partnership case/management approach to such situations is recommended. Organisations may wish to set:

- 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
- set 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 further action under the capability procedures.

Indicators may take account of:

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

Absence relating to injury in the workplace or ill health caused by work (for example, sharps injuries) should be excluded from indicators triggering action through capability-related procedures. Healthcare associated infections should not be used to trigger absence management procedures but may be considered when looking at the sustainability of attendance.

Organisations may want to consider having a range of such points that are used for recurrent short-term absence or to initiate action by individuals or departments in longer-term absences. However, whatever indicators employers use, they must ensure it is compliant with the Equality Act.

Such indicators should help identify those cases where the level of sickness absence has reached a point where some type of intervention is deemed necessary. The intervention may include providing additional support for the member of staff in question, a change of duties for example, which may help with addressing an underlying health problem.

It is important that employers act in a consistent manner, and this includes transparent procedures, agreed through partnership working. However these procedures should include a degree of flexibility that takes into account the individual and the nature of their illness.

## Managing long-term absence

In recent years, there has been a focus on managing "short-term" or "occasional" absence", at the expense of managing "long-term" absence. However, research<sup>21</sup> has shown that long-term absence accounts for 56 per cent of working days lost, and 70 per cent of the costs of absence.

NICE (National Institute of Clinical Excellence) guidance defines long-term absence as four or more weeks<sup>22</sup>. However, it concedes there is no consensus on how to define long or short-term sickness absence, and definitions vary between NHS trusts. Evidence from government research suggests that employers deal most effectively with their long-term sickness absence problems if they assess each individual case on its merits and, where appropriate, take action at the earliest possible opportunity.

Research carried out by both HSE<sup>23</sup> and NICE<sup>24</sup> sets out current good practice that can be applied to every stage of an employee's rehabilitation and return to work following illness. These include:

- early contact with the employee
- early and thorough health assessment
- development of an agreed rehabilitation plan
- availability of therapeutic interventions
- flexible return to work options
- work adaptations and adjustments.

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 or graduated fashion, with a change of duties if this is considered necessary.

During the rehabilitation period, employers should allow employees to return to work on reduced hours or work from home without loss of pay<sup>25</sup>. Phased return enables staff to work towards fulfilling all their duties and responsibilities within a defined and appropriate time period, through interim flexible working arrangements, whilst receiving normal pay.<sup>26</sup>The time allowed should be decided on a case by case basis depending on the original cause of absence (See also information on the fit note).

NICE recognises that the workplace may contribute to or cause someone's absence from work due to sickness<sup>27</sup> and that, consequently, both employers and employees have an important role in helping people get back to employment after long-term sickness absence and incapacity. It recommends a partnership/case management approach with managers, occupation health services, employees and their trade union representatives working together in deciding what actions to take in relation to adaptations or adjustments. It is important that occupational health have resources and expertise to provide the appropriate advice. If there are adaptations or changes to an employee's duties, the employer must remember to do a revised risk assessment. If the employee is disabled and covered by the Equality Act then the new "fit note" procedures do not alter the duty on the employer to make reasonable adjustments, regardless of what a GP recommends. The DWP has produced a range of guidance on the fit note for employers, staff and GPs.<sup>28</sup>

## Early interventions

Annex Z of the *NHS terms and conditions handbook* recommends that in order to avoid premature and unnecessary ill-health retirement, employers should consider interventions as early as possible, and at the latest within one month of an employee going off sick.<sup>29</sup>

Together, mental health problems and musculoskeletal disorders make up nearly 80 per cent of all ill-health in the NHS. They are also the main causes of ill-health retirement. Early interventions are key to supporting a timely return to work and most importantly helping to stop conditions such as musculoskeletal disorders worsening or leading to additional health problems such as depression.

In his review of the health and wellbeing of the NHS Workforce, Dr Steve Boorman recommends that there should be “consistent access to early effective interventions for common musculoskeletal and mental health problems in all trusts”<sup>30</sup>, *as they are the major causes of ill health amongst NHS staff*. Dr Boorman argues that by allowing staff to access early interventions, disruption to frontline services and patient care are minimised. The recommendations of the Boorman Review are supported by the Government and NHS organisations should be implementing these recommendations.

The Boorman recommendations add to both Annex Z and NICE guidelines on the management of long-term sickness and incapacity, which both recommend early interventions. Annex Z already states that employers should support return to work by providing staff with direct access through appropriate dedicated resources<sup>31</sup>. The NICE guidelines, which aim to prevent the number of employees moving from short-term to long-term sickness absence and to help employees on long-term absence return to work, says that intervening at an early stage during sickness absence contributes to the success of the intervention<sup>32</sup>. The guidelines in particular recommend targeting those with musculoskeletal disorder and mental health problems.<sup>33</sup>

## **Early interventions in practice**

A number of NHS trusts have seen the business benefits of early intervention and have invested in dedicated services for staff including physiotherapy services and occupational psychologists.

A number of examples of interventions are detailed below.

### **West Suffolk Hospital NHS Trust**

West Suffolk Hospital NHS Trust introduced a system of priority treatment referrals to a local physiotherapist for injured staff. In the first nine months of operating the system, 104 staff were referred, the numbers of days lost to sickness absence was reduced by 40 per cent and the direct costs of musculoskeletal injuries to the trust were reduced by more than £170,000. This was done at a cost of £21,000.

### **Gloucestershire Hospitals NHS Foundation Trust**

Gloucestershire Hospitals NHS Foundation Trust introduced an occupational health department based physiotherapy musculoskeletal assessment service for NHS staff that aimed to provide advice about returning to work. This resulted in a reduction in average sickness absence from 13.6 to 6.8 days per year, a decrease in waiting times for musculoskeletal appointments and the majority of patients being assessed and managed by physiotherapists without the need for medical input, with significant cost savings for the trust.

### **Doncaster and Bassetlaw Hospitals**

A study undertaken at Doncaster and Bassetlaw Hospitals NHS Trust to evaluate the benefits of providing an occupational health physiotherapy service for staff with back pain demonstrated that the potential savings from providing this type of service for staff, was £246,545. The total cost for setting up this service including staff and equipment came to just under £80,000.

### **Worthing and Southlands Hospitals NHS Trust**

Worthing and Southlands Hospitals NHS Trust worked in partnership with West Sussex Primary Care Trust (PCT) to put in place an occupational health physiotherapy service to reduce the level of musculoskeletal related sickness absence amongst the workforce. Staff can be referred to the service via the occupational health team, through their GP or local consultant. In the six months since the service was established sickness absence for musculoskeletal problems had fallen by 25 per cent compared with the previous six months. For the largest single group affected by musculoskeletal injuries, the nurses and midwives, sickness absence fell by 39 per cent since the start of the service. This equates to 195 working days saved over six months.

## **Ill health retirement and dismissal on the grounds of ill health**

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.<sup>34</sup>

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 likelihood of a successful ill-health retirement application.<sup>35</sup> Further details on the process and criteria for ill-health retirement can be found in the NHS terms and conditions handbook<sup>36</sup> and the NHS Business Services Authority factsheet.<sup>37</sup>

## **Medical suspension**

In exceptional circumstances, a manager may be concerned that an employee is unfit on health grounds to undertake the duties of their post. This will normally be on the advice of occupational health.

In these cases, the employee will be suspended on full pay pending action being taken at the earliest opportunity to confirm the sickness absence position by providing a medical certificate or by the individual returning to work.

## **Infection control issues**

In order to comply with infection control guidelines, staff diagnosed with D&V (diarrhoea and vomiting) should not attend work until they are clear for 48 hours in order to prevent the spread of infection. In other examples where an employee is excluded from doing their normal role due to infection control reasons (for example, sores on hands), managers should find suitable alternative duties for a temporary period. Where this is not possible, the employee should not attend work.

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- <sup>1</sup> NHS Health & Wellbeing Interim Report, p2. [www.nhshealthandwellbeing.org](http://www.nhshealthandwellbeing.org)
- <sup>2</sup> Handbook to the NHS Constitution, 2012, p96, 98.  
[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132959.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132959.pdf)
- <sup>3</sup> *NHS terms and conditions of service handbook*, Annex Z, p247  
[www.nhsemployers.org/payandcontracts/agendaforchange/termsandconditionsofservicehandbook/pages/afc-handbookrp.aspx](http://www.nhsemployers.org/payandcontracts/agendaforchange/termsandconditionsofservicehandbook/pages/afc-handbookrp.aspx)
- <sup>4</sup> Safety Representatives and Safety Committees Regulations (1977) and the Health and Safety (Consultation with Employees) Regulations (1996).
- <sup>5</sup> Department of Health (2011) NHS Health & Wellbeing Improvement Framework.  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128691](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691)
- <sup>6</sup> Management of Health and Safety at Work Regulations (1999).
- <sup>7</sup> Institute of Directors and Health and Safety Executive (2007) *Leading health and safety at work*.  
[www.hse.gov.uk/pubns/indg417.pdf](http://www.hse.gov.uk/pubns/indg417.pdf)
- <sup>8</sup> NHS terms and conditions of service handbook, Section 22 and Annex Z para 10  
[http://www.nhsemployers.org/SiteCollectionDocuments/AfC\\_tc\\_of\\_service\\_handbook\\_fb.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf)
- <sup>9</sup> NHLA, *Risk management standards handbook*. <http://www.nhsla.com/Pages/Home.aspx>
- <sup>10</sup> World Health Organization (2010) WHO Healthy Workplace Framework and Model: Background and Supporting Literature and Practices, p3.  
[www.who.int/occupational\\_health/activities/healthy\\_workplaces/en/index.html](http://www.who.int/occupational_health/activities/healthy_workplaces/en/index.html)
- <sup>11</sup> NHS Sports and Physical Activity Challenge. <http://sportandphysicalactivity.nhs.uk/category/case-studies/>
- <sup>12</sup> The Work Foundation, *Health and well-being at work in the United Kingdom*, p8.  
[www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Literature%20Review.pdf](http://www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Literature%20Review.pdf)
- <sup>13</sup> Equality and Human Rights Commission.  
[www.equalityhumanrights.com/uploaded\\_files/EqualityAct/employercode.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/employercode.pdf)
- <sup>14</sup> Access to Work – practical help at work.  
[www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG\\_4000347](http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_4000347)
- <sup>15</sup> Equality and Human Rights Commission, Equality Act 2010 Code of Practice, Employment Statutory Code of Practice [http://www.equalityhumanrights.com/uploaded\\_files/EqualityAct/employercode.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/employercode.pdf) (paragraph 17.16)
- <sup>16</sup> Equality and Human Rights Commission, Equality Act 2010 Code of Practice, Employment Statutory Code of Practice [http://www.equalityhumanrights.com/uploaded\\_files/EqualityAct/employercode.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/employercode.pdf) (paragraph 17:19)

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<sup>17</sup> Equality and Human Rights Commission, Equality Act 2010 Code of Practice, Employment Statutory Code of Practice [http://www.equalityhumanrights.com/uploaded\\_files/EqualityAct/employercode.pdf](http://www.equalityhumanrights.com/uploaded_files/EqualityAct/employercode.pdf) (paragraph 17:20)

<sup>18</sup> *NHS terms and conditions of service handbook*, Section 14, pp59–62.

<sup>19</sup> [www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/Pages/AccrualofStatutoryAnnualLeaveonLongtermSickLeave.aspx](http://www.nhsemployers.org/EmploymentPolicyAndPractice/UKEmploymentPractice/Pages/AccrualofStatutoryAnnualLeaveonLongtermSickLeave.aspx)

<sup>20</sup> *NHS terms and conditions of service handbook*, Annex Z, para 5.

<sup>21</sup> Attendance management by Stephen Bevan, the Work Foundation, 2003.

<sup>22</sup> NICE, *Managing long-term sickness absence and incapacity for work*, p8. [www.nice.org.uk/nicemedia/live/11779/43545/43545.pdf](http://www.nice.org.uk/nicemedia/live/11779/43545/43545.pdf)

<sup>23</sup> *Best practice in rehabilitating employees following absence due to work related stress*. ES/HSE research report 138, 2003.

<sup>24</sup> NICE, *Managing long-term sickness absence and incapacity for work*, pp10–11.

<sup>25</sup> *NHS terms and conditions of service handbook*, section 14, para 14:13.

<sup>26</sup> *NHS terms and conditions of service handbook*, annex Z, para 8.

<sup>27</sup> NICE, *Managing long-term sickness absence and incapacity for work*, p10.

<sup>28</sup> See DWP website: <http://webarchive.nationalarchives.gov.uk/http://www.dwp.gov.uk/healthcare-professional/news/statement-of-fitness-for-work.shtml>

<sup>29</sup> *NHS terms and conditions of service handbook*, annex Z, para 8.

<sup>30</sup> NHS Health & Well-being Final Report, p17. [www.nhshealthandwellbeing.org](http://www.nhshealthandwellbeing.org)

<sup>31</sup> *NHS terms and conditions of service handbook*, annex Z, para 8.

<sup>32</sup> NICE op. cit. p16, para 2.17.

<sup>33</sup> *ibid*, p29.

<sup>34</sup> *NHS terms and conditions of service handbook*, annex Z para 9.

<sup>35</sup> *NHS terms and conditions of service handbook*, para 9.

<sup>36</sup> *NHS terms and conditions of service handbook*, para 16.26–16.28.

<sup>37</sup> <http://www.nhsbsa.nhs.uk/searchpage.aspx?terms=pensions+factsheet>

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