NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Workplace health: long-term sickness absence and capability to work

Draft for consultation, May 2019

This guideline covers how to help people return to work after long-term sickness absence, reduce recurring sickness absence, and how to prevent people moving from short-term to long-term sickness absence.

Who is it for?

- Employers' representatives including managers, human resource professionals and occupational health professionals
- GPs and secondary care specialists
- Employees and their workplace representatives
- Commissioners of advice and support services for people who are not in work and are receiving benefits because of their health or a disability, and users of these services

This guideline will partially update NICE public health guideline PH19 (published 2009).

We have reviewed the evidence on reducing recurrent short-term sickness absence, preventing or reducing moving from short-term to long-term sickness absence, returning to work after long-term sickness absence, and reducing recurrence of long-term sickness absence. You are invited to comment on the new and updated recommendations. These are marked as **[2019]**.

You are also invited to comment on recommendations that NICE proposes to delete from the 2009 guideline.

We have not reviewed the evidence for the recommendations shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See update information for a full explanation of what is being updated.

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the 2019 recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

Full details of the evidence and the committee's discussion on the 2019 recommendations are in the evidence reviews. Evidence for the 2009 recommendations is in the evidence reviews of the 2009 guideline.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read in conjunction with the NICE guidance on workplace health: management practices, low back pain and sciatica in over 16s and mental wellbeing at work.

The recommendations in sections 1.1 and 1.3 to 1.7 are for employers, senior leadership, managers and human resources personnel.

The recommendations in section 1.2 are for those assessing and certifying fitness for work.

The recommendation in section 1.8 is for those responsible for commissioning and delivering advice and support services for people not in work and who are receiving benefits relating to a health condition or disability.

1.1 Workplace culture and policies

1.1.1 Make health and wellbeing a core priority for the top level of management of the organisation. See the section on organisational commitment in NICE's guideline on workplace health: management practices (this section includes making health and wellbeing a core priority, ensuring the commitment of managers, and the importance of policies and of communication). **[2019]**

1.1.2 Foster a caring and supportive culture that encourages a consistent, proactive approach to all employees' health and wellbeing. **[2019]**

1.1.3 Organisations (for example those with a small number of employees) that do not have formal policies should ensure that clear procedures for reporting and managing sickness are in place and are explained to all new and existing employees. **[2019]**

1.1.4 Ensure all employees know the workplace policies for notifying and managing sickness absence, and for return to work. Make this part of the induction process for new employees. **[2019]**

1.1.5 When developing workplace policies for managing sickness absence and return to work, ensure these are part of a broader, strategically led approach to promoting employees' health and wellbeing. **[2019]**

1.1.6 Consider using an external employee assistance programme and occupational health provider if the organisation does not already do this. **[2019]**

1.1.7 Monitor and regularly review the impact of sickness absence policies and procedures to ensure that they are being implemented fairly and consistently across the organisation and that they are fit for purpose. **[2019]**

1.1.8 Consider collecting data that can enable the sickness absence profile and changing trends to be monitored across the organisation. The data should include information on:

- the cause of absence **and**
- factors that may be associated with sickness absence such as job role, salary band, department and location of workplace.

1.1.9 Regularly review the data on trends in sickness absence to identify:

- areas where intervention may support employees' health and wellbeing **and**

- where policies or procedures may need to be reviewed or amended. **[2019]**

To find out why the committee made the 2019 recommendations on workplace culture and policies and how they might affect practice, see rationale and impact.

1.2 Assessing and certifying fitness for work

1.2.1 The statement of fitness for work ('fit note') should be completed by the medical practitioner with the most relevant recent knowledge of the person's health, reason for absence and prognosis for return to work. This may be a secondary care specialist or GP. **[2019]**

1.2.2 Encourage people who are assessed as not fit for work to maintain regular contact with their workplace. **[2019]**

1.2.3 If the person is likely to be absent from work for more than 4 weeks, consider:

- GP referral to health rehabilitation and support services, such as physiotherapy, counselling or occupational therapy
- signposting them to independent sources of vocational advice and support. **[2019]**

1.2.4 Take account of the fact that reasons for sickness absence can be complex. Encourage the person to:

- reflect on any factors in their work or personal life that may be contributing to their current absence or causing concern about returning to work **and**
- identify any additional support they might need. **[2019]**

1.2.5 Be aware that employers need information on how the employee's health condition or treatment could affect them on their return to work. Use the statement of fitness for work to provide sufficient information in clear, non-technical language. **[2019]**

To find out why the committee made the 2019 recommendations on assessing and certifying fitness for work and how they might affect practice, see rationale and impact.

1.3 Statement of fitness for work

1.3.1 When a statement of fitness for work ('fit note') is received indicating that someone is not fit for work, start and maintain a confidential record. This record should include:

- the reason for absence, the anticipated length of absence and any recurrence of absence (for the same reason) **and**
- any comments from the medical practitioner about how the person's condition or treatment affects their capacity for work.

(Also see the section on keeping in touch with people on sickness absence). **[2019]**

1.3.2 Consider the following to support the person who is currently not fit for work and plan for their return to the workplace:

- Seek information and advice on what support they might need, such as from an occupational health service or online resources, or telephone advice from external bodies.
- If any ongoing health needs are anticipated for when the person returns to work, discuss with them what adjustments or other support might be needed. If adjustments need approval, discuss these with decision makers to gain sign-off. **[2019]**

1.3.3 When a statement of fitness for work indicates that a person may be fit for work, contact them as soon as possible:

- Discuss what adjustments (such as flexible working, phased return, reduced hours, changes to workstations or duties) might help them return to work. Use any recommendations in the statement of fitness for work as a starting point.

- Involve the employee and line managers in these discussions initially, and occupational health services if needed.
- Human resources, trade unions or occupational health services (if not already participating) may also be involved if the circumstances or adjustments are more complex. **[2019]**

1.3.4 If adjustments suggested by a medical practitioner in the statement of fitness for work or requested by the employee cannot be made, explain the reasons clearly in writing to the employee. With their consent, send a copy to the certifying medical practitioner. **[2019]**

1.3.5 If a person may be fit to return to work with adjustments but those adjustments cannot be made, the person should continue to be treated as 'not fit for work', in line with the Department for Work and Pensions' guidance for employers. In such cases:

- Advise the person that they should return to work only when they have sufficiently recovered and are able to perform their regular duties.
- Discuss and jointly agree a plan for keeping in touch during their extended absence. Discuss any actions that may support them in making a full recovery and returning to their regular duties, and agree to regularly review these (see the section on early intervention). **[2019]**

To find out why the committee made the 2019 recommendations on statement of fitness for work and how they might affect practice, see rationale and impact.

1.4 Making workplace adjustments

1.4.1 When any work adjustments have been agreed with a person returning from sickness absence:

- Arrange risk assessments if needed. Guidance on these is available on the Health and Safety Executive website.
- Without breaking confidentiality, decide whether colleagues could be informed to help them understand the need for the adjustments, and discuss any concerns that colleagues may have. **[2019]**

1.4.2 Record any workplace adjustments agreed with the employee, and how long these are expected to last, in a written return-to-work plan for the employee and their line manager. **[2019]**

1.4.3 Monitor any workplace adjustments that have been put in place to see if they are meeting the needs of both the employee and employer. Review this regularly, within a timeframe agreed by the employee and line manager in the written return-to-work plan.

- Encourage the employee to raise any issues related to the workplace adjustments and who to raise them to. This may be an independent, impartial person. If necessary, think about making changes to the return-to-work plan.
- Ensure the employee is aware of other interventions that may be available to support them in their workplace (see the section on early intervention). **[2019]**

To find out why the committee made the 2019 recommendations on making workplace adjustments and how they might affect practice, see rationale and impact.

1.5 Keeping in touch with people on sickness absence

1.5.1 Ensure the organisation regularly keeps in touch with people who are 'not fit for work' during periods of sickness absence, including people with a chronic health condition or a progressive illness or disability covered by the Equality Act 2010. **[2019]**

1.5.2 Make contact as early as possible, and within 4 weeks of them starting sickness absence, depending on the circumstances. **[2019]**

1.5.3 When contacting the employee:

- Be sensitive to their individual needs and circumstances.
- Be aware that communication style and content could affect the person's wellbeing and decision to return to work.

- Ensure that they are aware that the purpose of keeping in touch is to provide support and help them return to the workplace when they feel ready.
- If an early referral to support services, for example physiotherapy, is available through the organisation's occupational health provider, discuss if this may be helpful.
- Discuss how they would like to be contacted in future, how frequently and by whom. If the line manager is not the most appropriate person to keep in touch, offer alternatives.
- Provide reassurance that anything they share about their health will be kept confidential, unless there are serious concerns for their or others' wellbeing. **[2019]**

1.5.4 Ensure members of staff responsible for keeping in touch with people on sickness absence:

- Are aware of the need for sensitivity and discretion at all times.
- Understand the organisation's policies or procedures on managing sickness absence and returning to work.
- Are competent in relevant communication skills and are encouraged to access online or other resources and advice to improve these skills. **[2019]**

To find out why the committee made the 2019 recommendations on keeping in touch with people on sickness absence and how they might affect practice or services, see rationale and impact.

1.6 Early intervention

1.6.1 In organisations that offer access to early interventions such as an employee assistance programme, ensure that all employees are aware of its availability and remit. **[2019]**

1.6.2 Assure employees that all contact with the employee assistance programme is confidential and that information is not shared with the employing organisation. **[2019]**

1.6.3 For employees whose sickness absence is expected to continue beyond 4 weeks, in organisations with access to an occupational health provider:

- discuss the possibility of a referral to occupational health for an assessment of fitness for work **or**
- discuss the suitability for early referral to support services; if referral is appropriate, ensure this takes place as early as possible. **[2019]**

1.6.4 Where occupational health services or an employee assistance programme are not available, encourage employees whose sickness absence is expected to continue beyond 4 weeks to discuss with their GP any options for referral to support services such as physiotherapy, counselling or occupational therapy. **[2019]**

To find out why the committee made the 2019 recommendations on early intervention and how they might affect practice, see rationale and impact.

1.7 Sustainable return to work

1.7.1 For people who have been absent for 4 or more weeks because of a musculoskeletal condition, consider interventions to help them return to work. For example:

- A programme of graded activity delivered by someone with appropriate training (for example, a physical or occupational therapist).
- Problem-solving therapy.
- A worksite assessment by a suitably qualified professional to review and discuss with the employee, together with a representative of the employer, the suitability of work tasks or any adjustments that could be made.
- A meeting between the employee and their line manager, facilitated by an impartial person, to agree the key barriers to returning to work and

what modifications could be made to the work environment to overcome these. **[2019]**

1.7.2 For people who resume work after an absence of 4 or more weeks for a common mental health condition, consider a 3-month structured support intervention to reduce the likelihood of a recurrence of absence. Involve the line manager in this process, which could be led by an impartial person. The intervention may include:

- Meeting the person to identify any issues encountered since their return to work, and exploring possible solutions and support needs.
- Developing an action plan to implement, which is agreed with the person's line manager.
- Regular follow-up meetings with the person and their line manager to evaluate progress. **[2019]**

To find out why the committee made the 2019 recommendations on achieving a sustainable return to work and how they might affect practice, see rationale and impact.

1.8 People with a health condition or disability who are not currently employed

1.8.1 Commission an integrated programme to help people receiving benefits who have a health condition or disability to enter or return to work (paid or unpaid). The programme should include a combination of interventions such as:

- an interview with a trained adviser to discuss the help they need to return to work
- vocational training (for example help producing a CV, interview training and help to find a job or a work placement)
- a condition management component run by local health providers to help people manage their health condition

- support before and after returning to work that may include 1 or more of the following: mentoring, a job coach, occupational health support or financial advice. **[2009]**

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary or, for public health and social care terms, the Think Local, Act Personal Care and Support Jargon Buster.

Condition management

Programmes delivered by healthcare professionals that do not treat the underlying condition, but that focus on improving the likelihood of people being able to return to, or stay in, work. These programmes may aim to improve a person's understanding of their condition, increase their confidence and improve their ability to function in the workplace, through for example, pain or stress management and building self-esteem and confidence.

Employee assistance programme

An employer-funded programme offering services such as confidential counselling and advice on a range of work and personal issues.

Employment and support allowance

Employment and support allowance (ESA) is a 2-tier system of benefits that will be replaced by the introduction of Universal Credit. All claimants who are out of work because of ill health or a disability are entitled to claim ESA (paid at the same rates as job seeker's allowance). Those deemed capable of work at some time in the future (by a medically administered 'work capability' test) are placed in a work-related activity group. Those deemed not capable of work because of the severity of their physical or mental condition are placed in a support group with no conditions (and until April 2017 received a higher support allowance).

Graded activity

Graded activity aims to increase a person's activity levels gradually using a behavioural approach. Typically, people with musculoskeletal conditions attend

individually focused training sessions with a gradually increasing exercise programme.

Long-term sickness absence

Long-term sickness absence is sometimes defined as an absence lasting more than 2 weeks, but for this guideline it is defined as 4 or more weeks (as per the scope of this guideline and previous NICE guidance). Recurring long-term sickness absence has been defined as more than 1 episode of long-term sickness absence, with each episode lasting more than 4 weeks.

Micro-, small- and medium-sized enterprises

Organisations employing fewer than 250 people. Micro-sized organisations employ between 0 and 9 people, small organisations employ between 0 and 49 people and medium-sized organisations employ between 50 and 249 people.

Presenteeism

Presenteeism can describe being in work despite health problems, or someone's attendance at work without performing all of their usual tasks (regardless of the reason). 'Suboptimal performance' is often used interchangeably with presenteeism: it describes employees not functioning fully, leading to losses in productivity. Presenteeism can make health problems worse.

Problem-solving therapy

Therapy that involves learning or reactivating problem-solving skills.

Short-term sickness absence

For this guideline it is defined as an absence lasting up to (but less than) 4 weeks. Recurring short-term sickness absence is defined as more than 1 episode of short-term sickness absence, each lasting less than 4 weeks.

Vocational rehabilitation

Helps those who are ill, injured or who have a disability to access, maintain or return to employment or another useful occupation. It may involve liaison between occupational health, management, human resources and other in-house or external

facilitators. It may result in transitional working arrangements, training, social support and modifications to tasks.

Recommendations for research

The guideline committee has made the following recommendations for research.

As part of the 2019 update, the guideline committee made 5 additional research recommendations. Four of these relate to a UK focus on effective and cost effective interventions to: support return to work after long-term sickness absence; support return to work after recurrent short-term sickness absence; reduce long-term sickness absence in people with common mental health conditions; and reduce recurrent short-term sickness absence in people with common mental health conditions. The other is on the views of UK employers and employees, on the challenges and potential solutions to managing sickness absence and return to work in micro-, small- and medium-sized enterprises. The committee removed 4 research recommendations from the original guideline on: preventing sickness absence; evaluating interventions; return to work interventions and programmes; and cost effectiveness. The committee considered that the new research recommendations capture any research questions that still need to be addressed.

Key recommendations for research

1 Interventions after long-term sickness absence

What interventions are effective and cost effective in supporting return to work, in all workplaces including micro-, small- and medium-sized enterprises, after long-term sickness absence in the UK?

To find out why the committee made the research recommendation on interventions after long-term sickness absence see the rationale and impact section for workplace culture and policies and the rationale and impact section for early intervention.

2 Interventions after recurrent short-term sickness absence

What interventions are effective and cost effective in supporting return to work after recurrent short-term sickness absence in the UK?

To find out why the committee made the research recommendation on interventions after recurrent short-term sickness absence see rationale and impact

3 Interventions after long-term sickness absence for mental health conditions

For people with common mental health conditions, what interventions are effective and cost effective in reducing long-term sickness absence in the UK?

To find out why the committee made the research recommendation on interventions after long-term sickness absence for mental health conditions see rationale and impact.

4 Interventions after recurrent short-term sickness absence for mental health conditions

For people with common mental health conditions, what interventions are effective and cost effective in reducing recurrent short-term sickness absence in the UK?

To find out why the committee made the research recommendation on interventions after recurrent short-term sickness absence for mental health conditions see rationale and impact.

5 Views of employees and employers

What are the views of UK employees and employers in micro-, small- and medium-sized enterprises on the challenges and possible solutions (barriers and facilitators) to ensuring sickness policy is managed effectively and facilitating return to work where access to additional services may not be readily available (for example, employee assistance programmes or occupational health services)?

To find out why the committee made the research recommendation on views of employees and employers see rationale and impact.

Other recommendations for research

Interventions to reduce sickness absence where employees are not centrally located

Which interventions are effective and cost effective in supporting people working in organisations where employees are not centrally located to return to work after long-term sickness absence in the UK?

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Workplace culture and policies

Recommendations 1.1.1 to 1.1.9

Why the committee made the recommendations

Evidence from the UK showed that workplace policies on sickness absence and return to work may help to reduce uncertainty around the process of enabling return to work for employees and employers, but only if they are properly implemented. The committee agreed that it is important for all sizes of organisation to clearly communicate policies and procedures to staff. However, smaller organisations may not have formal policies in place. The committee agreed that in these situations it is important that all employees are aware of the procedures for reporting and managing sickness. This means that employees, line managers and their employing organisations know what is expected of one another during an episode of sickness absence and during the process of a person returning to work. Regularly reviewing these policies and procedures would be good practice to ensure that they are appropriately applied and fit for purpose.

The committee discussed testimony from experts in occupational health and in employment research. The expert in occupational health was asked how the occupational health service in their NHS trust had contributed to achieving and maintaining a relatively low sickness absence rate and the barriers and facilitators to

doing so. The expert in employment research was asked about common and more innovative measures used by organisations to reduce sickness absence rates. The testimony provided by the experts identified that a commitment to employee health and wellbeing, proactively and strategically led from the top levels of management, should underpin sickness absence and return-to-work policies. The committee discussed the importance of these policies being part of a wider culture that values and promotes employee health and wellbeing. They noted that inappropriately applied return-to-work policies can result in presenteeism or longer absences from work. They highlighted the importance of ensuring that everyone is treated fairly. For this reason, the committee thought it important to regularly review how policies are implemented across the organisation, to ensure that those who are off work or planning a return to work are treated consistently.

There is a small amount of low-quality evidence that employers providing early access to interventions, for example through an occupational health provider or employee assistance programme, can benefit both employees and employers. There is also some similarly limited evidence that accessing interventions early may help to reduce sickness absence rates and promote a more sustainable return to work. Testimony from an expert in occupational health supported the evidence that was found on providing early access to interventions, when appropriate. Furthermore, the committee noted that guidance for employers on commissioning an occupational health service is available from the Society of Occupational Medicine. The committee discussed the limitations in the evidence and, in particular they noted that micro-, small- and medium enterprises are not represented in the evidence and may not have access to such services.

The committee also heard from experts, particularly the expert in occupational health, that organisations that are considered to be examples of good practice collect detailed data on trends in sickness absence according to factors such as job type and location. This detailed data can help the organisation target specific interventions and resources where they are most needed. This data may also help to highlight any inequalities and identify policies or procedures that may need to be reviewed or amended.

The evidence seen by the committee focused almost entirely on supporting people to return to work after a period of long-term sickness absence (4 or more weeks). No evidence was found on preventing recurrent short-term sickness absence (of less than 4 weeks per episode) or on preventing people moving from short to long-term sickness absence. Although there was no direct evidence the committee agreed that, in practice, interventions that were effective in supporting people to return to work after long-term sickness absence may also help to prevent recurrent short-term absences and to prevent people moving from short to long-term sickness absence. This is because they may have to overcome similar barriers and need similar support when returning to work. The recommendations therefore do not distinguish between supporting people returning from long-term or recurrent short-term sickness absences.

Because no evidence was found on preventing short-term sickness absence, the committee made a research recommendation. They also made a research recommendation on supporting people to return to work after long-term sickness absence in a UK context. This is because most of the evidence they considered is not from the UK, but from countries with different systems for managing sickness absence. The committee therefore agreed there was a need for more directly applicable evidence.

Although there was no evidence on preventing the move from short-term to long-term sickness absence, the committee did not make a research recommendation in this area. This is because they acknowledged the potential difficulties of identifying people with short-term sickness absence that may become long-term sickness and the feasibility of recruiting them to take part in research trials before they cross the 4 week threshold into long-term sickness absence.

How the recommendations might affect practice

The recommendations reflect good practice. Larger organisations are more likely to already have formal policies and procedures, but they may need to develop procedures for regularly reviewing the implementation of these policies and enabling review of them.

The resource implications are likely to be greater for micro-, small- and medium-sized organisations that don't have formal policies or provide access to occupational health or employee assistance programme services. Larger organisations are more likely to have these in place, but the committee heard from an expert in employment research that this may not always be the case. The committee noted from their experience that it would be good practice for smaller organisations, which do not currently have access to such services, to explore where additional services (such as occupational health) may be available to provide support, as part of a proactive approach to promoting employee health and wellbeing.

If recommendations are widely implemented, it may result in a larger number of employers having appropriate policies and procedures in place and may help to encourage the spread of good practice. Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Assessing and certifying fitness for work

Recommendations 1.2.1 to 1.2.5

Why the committee made the recommendations

There was evidence from a small number of UK studies that showed there can be challenges for GPs in completing fit notes. They may feel that they do not have the occupational health experience or the knowledge of the workplace needed to make suggestions about workplace adjustments. The committee agreed that the best person to complete the fit note is the medical practitioner with the most relevant recent knowledge of the person's situation. In many cases this will be a GP, but it could also be a person's specialist in secondary care. They may be able to provide more information on the anticipated effects of treatment, timeframes for rehabilitation, and adjustments for when the person returns to work. The committee

concluded that when someone returns to work a fit note is likely to be the most use to both employee and employer if it has the most complete and up-to-date information.

There was evidence from a small number of UK studies that showed it is important to avoid people becoming disconnected from work during their absence. Keeping in touch regularly with the workplace is important for building the person's confidence to return, monitoring their recovery and maintaining a focus on the goal of returning to work. This evidence also suggested and the committee agreed that the GP may be well placed to refer people on long-term sickness absence to rehabilitation and support services, particularly if these are not offered by the employer as part of occupational health provision. The committee did not specifically recommend keeping in touch regularly with the GP, because this may have a resource impact that had not been assessed.

The committee noted that reasons for sickness absence can be complex and agreed that GPs primarily view their role as a patient advocate. GPs are therefore well placed to explore whether sickness absence is exacerbated by aspects of the person's job, home life (such as caring responsibilities), or workplace relationships that the person feels unable to discuss with their employer (such as poor relationships with line managers). If the medical practitioner anticipates that the absence is likely to be long term (4 or more weeks), they could consider referral to rehabilitation and support services.

There is evidence from a small number of UK studies suggesting that patients believe the GP advice on fit notes can empower them in negotiating changes at work. But, there is also evidence that employers can find fit notes unsatisfactory. In particular, employers have reported that fit notes may not give enough useful information on how the person’s health condition may affect their ability to do their job. This can make employers wary of any risks associated with someone returning to work, if they are not fully recovered. The committee therefore agreed that it is important to encourage medical practitioners to state clearly how the person's health condition or treatment might affect them in their workplace, so that appropriate support and adjustments can be considered. However, this type of detail on the fit note needed to be added only with the person’s agreement. The committee also

discussed that unless the GP has specific knowledge about a person's workplace or role, it may be difficult for them to understand the implications of someone's condition on their ability to do their job.

How the recommendations might affect practice

If specialists certify sickness absence to employers, rather than referring them to their GP, this would free up GP appointment time and may provide more useful information for employers. However, there may then be an impact on specialists' time. The committee agreed that it is part of the GPs role to refer people on sickness absence to rehabilitation and support services and so this should not incur an additional cost. However, there may be an additional impact on support services, such as physiotherapy and counselling.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Statement of fitness for work

Recommendations 1.3.1 to 1.3.5

Why the committee made the recommendations

Some UK studies showed that employers think fit notes can provide useful information to support managers in communicating with people who are absent. They can help managers understand the employee's health condition and what support they might need when they return to work. This can enable them to plan for suitable adjustments to ensure a safe and sustainable return to work. The committee agreed that when an employer receives a fit note, they should start a confidential record that notes the reason for, and the anticipated length of, absence and any comments from the medical practitioner about how the person's condition may affect their capability to work. They agreed that it would be good practice to do this for every absence for which a fit note is received, not just when it is anticipated that the person will be taking a long-term sickness absence. This is because it may not be immediately clear when an absence may become long term, because there may be

subsequent fit notes received for the same episode of absence. In addition, keeping such records may also help to identify recurrent sickness absence.

The committee agreed it is good practice to be proactive and plan ahead how to support someone once they are ready to return to the workplace. Although there was no evidence identified on planning ahead, the committee made a recommendation encouraging employers to do so, based on good practice. The committee were aware that various online information and advice resources are available to help managers understand the effects of particular health conditions or treatments, if the employing organisation does not have its own occupational health adviser. Although they had not reviewed these resources and they were conscious they may change over time, the committee noted that information from reputable organisations, such as Public Health England, may be helpful.

The committee noted that it is important to discuss adjustments that may be helpful with the returning employee, because they may have already discussed this with their medical practitioner. In many cases this discussion may involve only the employee and their line manager, and if necessary, occupational health. The evidence suggests that being able to have such a conversation may depend on a good relationship between line manager and employee. The committee heard evidence from experts in occupational health and from a mental health support service, which showed that if relationships are difficult, or adjustments are more complex, it can be helpful to involve an impartial party to help reach an agreement.

The committee noted that recommendations for adjustments that a medical practitioner makes on a ‘may be fit for work’ note are advisory. Evidence shows that employers may have concerns about employee expectations and the possibility of conflict, if adjustments can’t be accommodated. Also, the evidence suggested and the committee discussed that some GPs and patients have reported feeling undermined when their suggestions to employers are not acted on. The committee agreed that guidance on what employers should do, if adjustments cannot be agreed, would minimise conflict. They recommended that the person should be treated as ‘not fit for work’ and noted the importance of maintaining contact with them. They also noted that when suggested adjustments can’t be made it would be helpful to provide GPs, with the employee's consent, with feedback, so that they are

aware of the person's continuing absence and are better informed about their particular workplace context.

The committee noted that if someone has a chronic or progressive illness or disability covered by the Equality Act 2010, the employer has a legal obligation to make reasonable adjustments in the workplace. This applies to all employees with an illness or disability covered by the Act, not just those returning from sickness absence.

How the recommendations might affect practice

Larger organisations are more likely to already have formal policies and procedures in place for making return-to-work plans.

Resource implications are likely to be greater for micro-, small- and medium-sized organisations, which may not have capacity to plan ahead for someone returning to work, or the capacity or resources to make adjustments to the workplace or duties.

Providing feedback to medical practitioners when adjustments they have recommended cannot be accommodated would be good practice. However, the committee were aware that a mechanism for providing this feedback would need to be developed and maintained and that for some organisations, particularly micro-, small- and medium- sized organisations, this may not be sustainable.

Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity. If the resource input makes returning to work part of a proactive approach to supporting employee health and wellbeing, this investment may help to reduce the costs of sickness absences in the longer term.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Making workplace adjustments

Recommendations 1.4.1 to 1.4.3

Why the committee made the recommendations

The committee were aware that it is a legal requirement for employers to carry out risk assessments to ensure a healthy and safe environment in the workplace and that guidance on these is available from the Health and Safety Executive[1]. They discussed and agreed from their experience and expertise that it is good management practice to undertake an additional risk assessment for a person returning from sick leave and before making workplace adjustments. It is important not only to minimise potential risk to the returning person's health, but also to identify and manage risks to the health and safety of other staff.

There is a small amount of low-quality UK evidence to suggest that some colleagues may resent adjustments being made to the returning person's role or workload. However, other similarly limited evidence noted that other staff members can be understanding about workplace and role adjustments and assist with supporting their colleagues' return to work. The committee noted that to maintain relationships and productivity in the wider team it may be helpful to explain the reasons for the adjustments and give colleagues the opportunity to raise any concerns. It is important that this is done without breaking confidentiality.

The committee agreed that it is important to keep a written record of the adjustments that have been agreed and to regularly review these to ensure they continue to meet the person's needs as their recovery progresses and to amend them if necessary. It can also be helpful, when reviewing how the adjustments are working, to remind the person of any other interventions the employer may provide, if these are available.

How the recommendations might affect practice

Larger organisations are more likely to already have formal policies and procedures in place for making return-to-work adjustments. They may need to develop additional procedures and provide resources or training for risk assessment of return-to-work

[1] See Regulation 3 of the Health and Safety Executive's Management of Health and Safety at Work Regulations 1999.

plans, developing written return-to-work plans and monitoring how well workplace adjustments are working.

Resource implications are likely to be greater for micro-, small- and medium-sized organisations, which may not have capacity to make adjustments.

The committee noted that the capacity of organisations to provide risk assessment training may need to be considered.

Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Keeping in touch with people on sickness absence

Recommendations 1.5.1 to 1.5.4

Why the committee made the recommendations

Evidence from UK studies shows that keeping in touch with people who are on extended periods of sick leave can help them feel supported, valued and more confident about returning to work. The committee agreed that a positive commitment to keeping in touch should form part of the organisation's sickness absence and return-to-work policies.

The committee discussed that managers may have concerns about contacting and keeping in touch with those who are off work, and that employees may feel that this is putting additional pressure on them to return to work. Evidence from UK studies supported this discussion. The committee also noted that if people are absent for reasons that relate to an illness or disability that is covered by the Equality Act 2010, managers may feel additional concern about the appropriateness of contacting them. The committee noted that these concerns may lead to those who have an illness or disability covered by the Act being disadvantaged compared with others, if their

employers do not contact them for fear it may be inappropriate to do so. The committee agreed that policies on keeping in touch should be followed with everyone who takes sickness absence, because the benefits of keeping in touch were considered to outweigh the risks.

The timing of initial contact should take into account the personal circumstances of the employee and their reason for, and anticipated length of, absence. In addition to making the employee feel supported, the aim is to help prevent a short-term absence becoming a long-term absence. For this reason, the committee recommended getting in touch as soon as possible and within 4 weeks. However, they were mindful of the need to keep this flexible, particularly when sickness absences may be planned or when recovery will clearly take longer than 4 weeks. For example, for recovery from surgery or cancer treatments.

Some low-quality evidence shows that keeping in touch also helps employers with workforce planning and understanding what, if any, workplace adjustments might best support the person when they return to work.

The committee discussed the limitations in the evidence, but noted that it has shown that relationships with managers are an important factor in people's decisions about returning to work. The committee noted that this may be particularly pertinent when there is a mental health component to the absence. It is therefore important to establish from the employee’s perspective whether the line manager is the best person to keep in touch with them.

The committee noted that it is important to reassure people that anything they share about their health will remain confidential. However, they acknowledged that in circumstances when there are serious concerns for the wellbeing of the employee or others, information may have to be disclosed in order to meet an employers’ duty of care, or to meet professional or legal obligations.

The evidence suggested, and the committee agreed, that the communication style of the person with responsibility for keeping in touch with the employee and the content of the communication can affect the employee's wellbeing and decisions about returning to work. For this reason, the committee recommended that organisations should provide those with keeping in touch responsibilities access to communication

skills training and encourage them to access online resources and advice to ensure they are competent and confident in this area. Resources to help employers with this include the NHS Employers website - maintain contact, and resources from Public Health England.

How the recommendations might affect practice

Micro-, small- and medium-sized organisations may find it more difficult to offer alternatives to the line manager as a contact person for people on sickness absence. They may be less likely to have formal procedures or policies on keeping in touch with people on sickness absence.

Resource implications are likely to be minimal and focus mainly on communication skills training. Formal training may be more likely to be offered by larger organisations, but there are useful online resources and advice that can be used by and adapted for smaller organisations.

Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Early intervention

Recommendations 1.6.1 to 1.6.4

Why the committee made the recommendations

There was a small amount of low-quality evidence from UK studies that providing free-to-access employee assistance programmes and occupational health services is regarded as good employer practice. It is valued by employees as an indication that the organisation cares about the health and wellbeing of the workforce. However, the evidence suggested that employees are not always aware that these services are available or what their remit is. This possible lack of awareness was discussed by the committee and also identified by the expert testimony from the

occupational health expert. Particular reference was made to employee assistance programmes, for which there may be a misperception that programmes focus only on mental health and there can be stigma associated with this. In reality, employee assistance programmes can also offer practical advice on other issues such as debt counselling. The committee further discussed that employees may have concerns about the confidentiality of these services. Within this discussion the committee noted the importance of employees having the information on how to access the services independently and without needing to ask their employer.

The committee discussed evidence and expert testimony from the occupational health expert that early access to interventions offered by occupational health providers are regarded positively by employers and employees, and may help to reduce sickness absence rates and support sustainable return to work. These can include fast-tracked access to physiotherapy or counselling sessions. Although it was unclear whether the interventions included in the economic model were provided at an early stage, the model suggested that providing specific interventions was cost saving. The committee noted that it is important that the potential benefits and decision to refer to occupational health are discussed and agreed between the employee and their manager to avoid it being perceived as a punitive response to absence.

The committee were aware that services such as these tend to be offered by larger employers and that people working in micro-, small- and medium-sized organisations may not have access to them. They were aware from the government policy paper on Improving lives - the future of work health and disability that around 43% of employees in the UK are employed by small- or medium-sized enterprises. They made a research recommendation to determine effective and cost effective ways to support people to return to work after sickness absence, in UK workplaces of all sizes, including micro-, small- and medium-sized enterprises. In addition, they made a research recommendation to determine the views of UK employers and employees on the particular challenges faced by smaller organisations and possible solutions.

How the recommendations might affect practice

Larger organisations are more likely to already fund services providing early intervention opportunities, whereas micro-, small- and medium-sized organisations

may not be in a position to fund external occupational health provision or provide employee assistance programmes.

Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity. For example, providing 'fast track' or early access to interventions may incur an additional cost. However, this may be included as part of an occupational health service that an organisation provides, as part of a proactive approach to supporting employee health and wellbeing, and this investment may help to reduce the costs of sickness absences in the longer term.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Sustainable return to work

Recommendations 1.7.1 to 1.7.2

Why the committee made the recommendations

The committee discussed that musculoskeletal conditions and common mental health conditions are the most frequent causes of long-term sickness absence among employees. Evidence from a small number of non-UK studies in people with musculoskeletal conditions suggested that interventions to strengthen a person's physical and mental health, and to focus on reducing potential barriers in the workplace, may increase return-to-work rates. Although the committee noted the limitations in the evidence, they agreed that for employers with occupational health access, it would be useful to have the option of arranging a therapeutic programme of graded activity or problem solving for employees who are absent for 4 or more weeks because of musculoskeletal conditions. The committee noted that these types of interventions could be cost saving, even though the economic analysis focused only on changes in absenteeism, because of a lack of data on other outcomes, such as productivity, staff turnover and wellbeing.

The committee discussed the evidence that the time people take to return to work after absence because of a musculoskeletal condition may be reduced if flexible adjustments are agreed between employee and employer, as part of a planned return-to-work process. The committee heard from an occupational health expert and an expert from a mental health support service that it can be helpful for an impartial person (who may or may not be part of the organisation) to facilitate discussions between the employee and employer, to help agree adjustments that are acceptable to both. The committee noted that there may be a number of people who could fill this role, examples include people from occupational health services, occupational therapists and vocational rehabilitation consultants.

A study of people who had returned to work after absence related to mental health conditions showed a supportive monitoring and problem-solving intervention delivered over 3 months to be associated with a reduced risk of recurrent absence. This intervention was estimated to be cost saving in the economic analysis, even though the analysis only considered the impact on absenteeism. Although the evidence was limited, in that it was based on 1 low-quality study, the committee also heard from an expert who supports people with mental health conditions that have resulted in them being absent from work or struggling to remain in work. Their testimony described the use of individual support plans and supportive monitoring. Based on this evidence and their expertise, the committee noted that such interventions are considered to be good practice for people with long-term absence because of common mental health conditions.

The committee noted that although there are substantial limitations in the evidence on supporting people to return to work after absence because of musculoskeletal or mental health conditions, particularly the lack of UK-based studies, it is important to not discourage what is considered to be good practice.

The committee agreed that interventions for those with common mental health conditions should be a research priority. This group may experience recurrent and long-term sickness and there is a lack of evidence on supporting their return to work. The committee recognised that reasons why a person may take sickness absence may be complex. They therefore agreed that research studies should aim to capture the context of the sickness absence and the preferences of participants in supporting

them to return to work, alongside data on whether they have been able to return to work.

How the recommendations might affect practice

The recommendations made in this area reflect good practice but some may currently be more accessible to people working in larger organisations. For example, organisations may buy in occupational health services that provide access to physiotherapy, counselling or ergonomic assessment of worksites.

Not all organisations have access to such services, particularly micro-, small- and medium-sized enterprises. But they may be able to access them with minimal resource implications, for example by being part of a local or sector association that subscribes to these services.

There may be resource implications if everyone returning to work after absences of 4 or more weeks because of a common mental health problem is offered a 3-month programme of structured support. Economic modelling indicated that such an approach could be cost saving. The committee considered that these interventions could offer value for money and in the long run could reduce their costs. In the model these were achieved through savings associated with reduced absenteeism. The committee were mindful of other potential benefits not captured in the model, such as increased productivity as a result of early or sustained return to work and reductions in the costs associated with staff turnover.

Implementing the recommendations may need resource input initially, but over time may result in a reduction in the costs of sickness absence and improved productivity.

Full details of the evidence and the committee's discussion are in evidence review C: facilitating return to work from long-term sickness absence and reducing risk of recurrence.

Return to recommendations

Context

Although absence management processes can help people return to work after long-term sickness absence, many do not go back. Among claimants of Employment and

Support Allowance who had worked in the 12 months before their claim, 45% took a period of sickness absence before they left work.

Between 2010 and 2013 there were around 960,000 long-term sickness absences (of 4 weeks or more) a year in Britain. Stress and acute conditions are responsible for many long-term absences, followed by mental ill health, musculoskeletal injuries and back pain. Employers spend around £9 billion a year on sick pay and associated costs.

Since the NICE guideline on managing workplace sickness absence was published in 2009, there have been several changes to policy and practice designed to help people return to work and reduce the social and economic burden of long-term sickness absence from the workplace. There have also been changes to legislation, including the replacement of the Disability Discrimination Act (1995) by the Equality Act 2010. In light of these, and new evidence, it was decided to update this guideline.

The 'fit note'

In 2008 Working for a healthier tomorrow - work and health in Britain (Department for Work and Pensions) challenged the perception that it is inappropriate to be in work unless 100% fit. It shifted the emphasis from what a person cannot do to what they can do and led to a move from the 'sick' to the 'fit' note. But a review suggests that there are too many fit notes stating that someone is 'unfit for work', rather than 'may be fit for work' if adjustments are made to help them return to work.

Occupational health support

A report in 2016 noted that the recruitment of occupational health physicians has been declining since 2003. In 2011, only 38% of employees had access to occupational health services and this is less likely among smaller organisations. However in 2016, over 99% of private sector organisations had less than 50 employees and this was the sector in which there had been the most growth.

Support for mental ill health

In England, 19% of long-term sickness absence is attributed to mental ill health. In 2009, the Department for Work and Pensions added employment advisers to some

Improving Access to Psychological Therapies (IAPT) services. In 2019 the NHS Long Term Plan identified stable employment as a major factor in maintaining good mental health and set out plans for investing in further employment support in IAPT.

Employee assistance programmes, many of which provide counselling, are increasingly being offered as an employee benefit. In 2017 Thriving at work: a review of mental health and employers proposed core mental health standards that can be implemented by organisations of all sizes, and enhanced standards for larger organisations or those that are able to do more.

Who is covered

Everyone aged over 16 in full-time or part-time employment (paid or unpaid), who has had a long-term sickness absence (4 or more weeks) or recurring short-term sickness absences (less than 4 weeks each) and so may be at risk of moving from short- to long-term sickness absence. Everyone aged over 16 who is unemployed and gets benefits because of a long-term condition or disability that prevents them from working.

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see our web page on workplaces.

Update information

2019

This guideline is an update of NICE guideline PH19 (published 2009) and will replace it.

We have reviewed the evidence on reducing recurrent short-term sickness absence, preventing or reducing moving from short-term to long-term sickness absence, returning to work after long-term sickness absence, and reducing recurrence of long-term sickness absence.

Recommendations are marked **[2019]** if the evidence has been reviewed.

Recommendations that have been deleted or changed

All of the recommendations from the 2009 guideline that related to the questions reviewed in this partial update have been deleted. The committee agreed that the new evidence review and updated methods for developing NICE guidance meant that the new evidence review, committee discussion and development of recommendations should supersede the recommendations from 2009.

For the review question that was not updated, the recommendation has been carried forward into this guideline (this is recommendation 1.8.1 and is marked [2009]).

This recommendation has undergone minor editorial changes; these have not changed the meaning of this recommendation. The committee agreed these editorial changes.

See also the previous NICE guideline and supporting documents.