NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

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

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces PH19.

This guideline should be read in conjunction with NG13.

Overview

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

NICE has also produced a guideline on workplace health: management practices.

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

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 guideline on workplace health: management practices, the NICE guideline on low back pain and sciatica in over 16s and the NICE guideline on mental wellbeing at work.

This guideline focuses on managing sickness absence among all employees, regardless of whether they have a disability or long-term condition covered by the Equality Act 2010. It should be considered alongside the legal requirements for employers in relation to health and disability, and it is not a substitute for the law or relevant codes of practice.

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 clear 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 and accessible procedures for reporting and managing sickness are in place and are explained to all new and existing employees. **[2019]**

1.1.4 Ensure that all employees know the workplace policies or procedures for notifying and managing sickness absence, and for return to work. Make this part of the induction process for new employees and ensure that they know the sickness absence reporting system is confidential. **[2019]**

1.1.5 When developing workplace policies for managing sickness absence and return to work, ensure that these are part of a broader, strategically led approach to promoting employees' health and wellbeing (see recommendation 1.1.1). **[2019]**

1.1.6 Consider using a confidential and accessible 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 non-identifiable data that can enable the sickness absence profile and changing trends to be monitored across the organisation. The data should include information on:

- the duration and frequency of absence
- the cause of absence (and whether work related)
- factors that may be associated with sickness absence such as job role, salary band, department and location of workplace. **[2019]**

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

- areas in which intervention may be needed to support employees' health and wellbeing **and**
- policies or procedures that may need to be reviewed or amended. **[2019]**

To find out why the committee made the 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 GP or secondary care specialist. **[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:

- referral to health rehabilitation and support services, such as physiotherapy, counselling or occupational therapy
- signposting them to other possible expert sources of vocational advice and support relevant to their condition. **[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 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 To support the person who is currently not fit for work and plan for their return to the workplace, consider:

- taking into account any additional information provided (for example from an allied health professional's health and work report) about how their condition may affect their ability to do their role
- seeking information and advice on what support they might need, such as from an occupational health service or from other possible expert sources of vocational advice and support relevant to their condition (this may include online resources, or telephone advice from external bodies)
- discussing with them what adjustments or other support might be needed if any ongoing health needs are anticipated for when they return to work; 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, especially 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 informed 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 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 additional risk assessments if needed. Guidance on these is available on the Health and Safety Executive website.
- Discuss with the returning person whether colleagues could be informed about the adjustments to help them understand the need for them. Seek the person's informed consent and, if it is given, explain the reasons why the adjustments are being made. Discuss with colleagues any concerns that they may have about the impact of adjustments. [2019]

1.4.2 Record any workplace adjustments agreed with the employee, including a

timeframe for their implementation and how long they 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 discuss who to raise them with. This may be an independent, impartial person. If necessary, think about making changes to the return-to-work plan.
- Ensure that 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 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 that 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 their 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, counselling or occupational therapy) 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 that 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 signposted to and encouraged to use online or other resources and advice to improve these skills. **[2019]**

> To find out why the committee made the 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 rehabilitation, counselling or an employee assistance programme) ensure that all employees are aware of their availability, remit and confidentiality. **[2019]**

1.6.2 Assure employees that all contact with the employee assistance programme is confidential. **[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 that this takes place as early as possible. [2019]

1.6.4 If 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 or secondary care specialist any options for referral to support services such as physiotherapy, counselling or occupational therapy. [2019]

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

1.7 Sustainable return to work and reducing recurrence of absence

Sustainable return to work for people with a musculoskeletal condition

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]

Reducing recurrence of absence for people with a common mental health condition

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 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.

Common mental health condition

Common mental health conditions include conditions such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder.

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 confidential services such as counselling and advice on a range of work and personal issues. Although the employer may receive an indication of numbers of employees taking up the service, no personal information is shared with the employer that would enable them to identify which employees access the service or their reason for doing so.

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 organisations

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

Inappropriately continuing to go to work despite health problems. It also describes someone's attendance at work without performing all of their usual tasks (regardless of the reason). When employees feel the need to attend work although they are not functioning fully, it can result in losses in productivity. Presenteeism can also 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.

Wellbeing

Wellbeing is the subjective state of being healthy, happy, contented, comfortable and satisfied with one's quality of life.

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 healthcare and

rehabilitation practitioners; 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 and support return to work in people with common mental health conditions; and reduce recurrent short-term sickness absence and support return to work in people with common mental health conditions. The other is on the challenges and potential solutions for UK employers and employees in managing sickness absence and return to work in micro-, small- and medium-sized organisations. 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 organisations, 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 and supporting return to work 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 and supporting return to work 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 Challenges and potential solutions for smaller employers

What are the challenges and potential solutions for UK employers and employees in micro-, small- and medium-sized organisations (which may not have easy access to additional services such as employee assistance programmes or occupational health services) in ensuring sickness policy is managed effectively and facilitating return to work?

To find out why the committee made the research recommendation on the challenges and potential solutions for smaller 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. 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.

The committee discussed 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, they 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.

The focus of this guideline is on managing sickness absence among all employees, regardless of whether they have a disability or long-term condition covered by the Equality Act 2010. Although the committee were aware that organisations should also have policies and procedures in place for managing disability leave, this area is not included within the scope of this guideline. The committee noted that there are legislative requirements about health and disability for employers and that the recommendations in this guideline should be considered alongside those requirements.

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-sized organisations 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 non-identifiable data can help the organisation target specific interventions and resources where they are most needed. It 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-term to long-term sickness absence.

Despite the lack of 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 recurrent short-term sickness absence, the committee recommended research in this area (see research recommendation 2). They also agreed that research is needed on supporting people to return to work after long-term sickness absence in a UK context (see research recommendation 1). Most of the evidence they considered was not from the UK, but from countries with different systems for managing sickness absence. The committee therefore agreed there was a need for more evidence that was directly applicable to the UK population. The committee considered that alongside data on supporting return to work it would be helpful if studies collected data on the impact of absenteeism and presenteeism.

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 of 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 them and how they have been implemented.

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 that do not currently have access to such services to explore where additional services (such as occupational health) may be available to provide support. This would be 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.

Return to recommendations

Assessing and certifying fitness for work

Recommendations 1.2.1 to 1.2.5

Why the committee made the recommendations

The committee were aware that the government is considering changes to allow other healthcare professionals to complete fit notes in addition to medical practitioners (see the government policy paper Improving lives: the future of work, health and disability). However, fit notes are currently only completed by medical practitioners and the recommendation reflects the situation at the time of publication (November 2019).

There was evidence from a small number of UK studies that showed there can be challenges for GPs in completing fit notes. GPs 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 discussed that other medical practitioners were also likely to experience the same challenges and 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. The specialist may be able to provide more information than the GP on the anticipated effects of treatment, timeframes for rehabilitation and adjustments for when the person returns to work.

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 suggested and the committee agreed that the GP may be particularly well placed to refer people on long-term sickness absence to rehabilitation and support services, especially if these are not offered by the employer as part of occupational health provision. They noted that specialists may also refer people under their care to some rehabilitation services. They also noted that it may be helpful to signpost people to other possible expert sources of vocational advice and

support relevant to their condition. This may include advice and support from the voluntary sector.

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.

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 it would be good practice to start a confidential record 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 there are various potential sources of expert advice available to help managers understand the effects of health conditions or treatments. These can be particularly useful if the employing organisation does not have its own occupational health adviser. This may include online information and resources that give vocational advice and specific advice relevant to the employee's particular condition.

Although the committee had not reviewed these resources and they were conscious they may change over time, they noted that information from organisations, such as Public Health England, and some voluntary sector organisations may be helpful.

The committee noted that it is important to discuss adjustments that may be helpful with the

returning employee. 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 informed 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's recommendations on making adjustments to support people to return to work focus on all employees. But they 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 legal obligation applies to all employees with an illness or disability covered by the Act, not just those returning from sickness absence. But the committee noted that particular consideration may need to be given to adjustments when an employee with a disability or condition covered by the Act is returning from sickness leave, to provide them with the best possible support.

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. The committee noted that if an employee has a disability or a long-term condition that makes it difficult for them to do their job, organisations may find it helpful to explore whether they are eligible for funding to support making adaptations to the workplace.

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 it 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.

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.

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 help 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 only done after discussion with the returning person and with their informed consent.

The committee agreed that it is important to keep a written record of the adjustments that have been agreed in a written return-to-work plan. This should be based on the individual employee's needs and their role in the organisation and as such there will need to be some flexibility in terms of what the plan covers. The committee agreed it is important to regularly review the return-to-work plans to ensure that 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 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.

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. 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.

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 with the employee 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.

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 that they are competent and confident in this area. Resources to help employers with this include the NHS Employers website - maintain contact, and 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.

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, they 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 employee assistance programmes. Within this discussion the committee noted that the services provided by these programmes are confidential. They also recognised the importance of employees having information on how to access the programmes 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 organisations.

The committee agreed that research is needed 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 organisations (see research recommendation 1). In addition, they agreed there is a need for research on the challenges and potential solutions for UK employers and employees in managing sickness absence and return to work in smaller organisations where access to additional services may not be readily available (see research recommendation 5).

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.

Return to recommendations

Sustainable return to work and reducing recurrence of absence

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. Although 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 noted that these types of interventions could be cost saving.

The committee discussed evidence which showed 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. Although the economic analysis only considered the impact on absenteeism, this intervention was estimated to be cost saving.

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 due to 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 due to 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 (see research recommendation 3 and research recommendation 4).

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 organisations. 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 condition 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.

Return to recommendations

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

Context

Absence management processes can help people return to work after long-term sickness absence, but 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 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. For example, the government consultation Health is everyone's business: proposals to reduce ill health-related job loss, encourages early action by employers to support employees with a disability or long-term condition to remain in work. Since 2009, 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. A review in the government policy paper Improving lives: the future of work, health and disability suggests that there are too many fit notes stating 'not fit for work', when people 'may be fit for work' as long as appropriate workplace adjustments are made.

Occupational health support

The 2016 Occupational medical workforce crisis report by the All Parliamentary Group on Occupational Safety and Health 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 2019 over 99% of private sector organisations had fewer than 50 employees.

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 the government's 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

You can see everything NICE says on workplace health: long-term sickness absence and capability to work in our interactive flowchart on managing long-term sickness absence and capability to work.

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

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see resources to help you put guidance into practice.

Update information

November 2019: 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. These recommendations are marked **[2019]**.

The recommendation marked **[2009]** last had an evidence review in 2009. Minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

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