NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH PROGRAMME GUIDANCE

SCOPE

1 Guidance title

Guidance for primary care services and employers on the management of long-term sickness and incapacity

1.1 Short title

Guidance on the management of long-term sickness and incapacity for work

2 Background

(a) The National Institute for Health and Clinical Excellence (‘NICE’ or ‘the Institute’) has been asked by the Department of Health to develop guidance on a public health programme aimed at managing long-term sickness and incapacity.

(b) NICE public health programme guidance supports implementation of the preventive aspects of national service frameworks (NSFs) where a framework has been published. The statements in each NSF reflect the evidence that was used at the time the framework was prepared. The public health guidance published by the Institute after an NSF has been issued will have the effect of updating the framework.

(c) This guidance will support a number of related government policy documents and legislation including:

- ‘A new deal for welfare: empowering people to work’ (DWP 2006a)
- ‘Incapacity benefits and pathways to work’ (House of Commons Work and Pensions Committee 2006)
- ‘Welfare reform bill’ (DWP 2006b)

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• ‘Department for Work and Pensions five year strategy. Opportunity and security throughout life’ (DWP 2005a)
• Disability Discrimination Act (2005)
• ‘Health, work and wellbeing – caring for our future. A strategy for the health and wellbeing of working age people’ (HMG 2005)
• ‘Choosing health – making healthy choices easier’ (DH 2004)
• ‘Building capacity for work. A UK framework for vocational rehabilitation’ (DWP 2004)
• ‘Jobs and enterprise in deprived areas’ (ODPM 2004)
• ‘Pathways to work: helping people into employment. The government’s response and action plan’ (DWP 2003)
• ‘A strategy for workplace health and safety in Great Britain to 2010 and beyond’ (HSC 2003).

(d) This guidance will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness. It is aimed at professionals and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. This includes occupational health professionals, employers, workplace representatives and trades unions, as well as employees themselves.

3 The need for guidance

a) It is widely recognised that being employed can help improve an individual’s health and wellbeing and reduce health inequalities (DH 2004; DWP 2005b). Conversely, unemployment is linked to higher levels of mortality and psychological and psychiatric
morbidity (Mclean C et al. 2005). Since 1997 the UK has seen rising employment (DWP 2006b). The Department of Health estimates that 7.5% of the ‘working age’ population is ‘out of work’ due to a health condition or disability (DH 2004).

b) The quality and accuracy of available data on absence and sickness absence is variable (Barham and Leonard 2002; Barham and Begum 2005). In 2006, UK employees were absent for an average 3.5% of the time they were due to spend working. Sixty percent of absences are short term (up to 7 days), 20% are medium term (8 days to 4 weeks) and 20% are long term (4 weeks/20 working days or longer) (CIPD 2006). An estimated 40 million working days are lost each year in Britain due to ill health and injury. Sickness absence costs the British economy an estimated £12 billion each year (HMG 2005).

c) On average, in 2006, 1% of the UK workforce was absent from work due to long-term sickness. It is estimated that 12% of employees on long-term leave are covered by the ‘Disability discrimination act’ (CIPD 2006). Back pain, musculo-skeletal injuries, acute medical conditions, mental ill health and stress are the most common causes. In the public sector, mental ill health and stress were identified as the main causes of long-term sickness absence for non-manual workers; musculo-skeletal injuries and back pain most affected manual workers (CIPD 2006).

d) Sickness absence rates, including long-term sickness absence rates, vary by gender, age, occupation, sector, region and size of workplace (Barhum and Begum 2005, CIPD 2006).

e) It is widely recognised that prolonged sickness absence can lead to job losses. A wide range of benefits are available when a worker falls ill, including incapacity benefit. Although the number of people in receipt of incapacity benefit has fallen by a third since the 1990s, 2.7 million people still receive it (DWP 2005a; 2006a). The longer
someone is signed off, the less likely they are to return to work (DH 2004; Ministerial task force for health, safety and productivity and the Cabinet Office 2004). If someone has been claiming incapacity benefit for 12 months, the average duration of their claim will be 8 years. After 2 years they are more likely to die or retire than return to work (HM Government 2005).

f) Many national strategies, targets and initiatives focus on how employers and primary care services can help adults over 16 remain in – or return to – work. Examples include those listed in section 2, page 1 of this document.

4 The guidance

a) Public health guidance will be developed according to NICE processes and methods. For details see section 5.

b) This document is the scope. It defines exactly what this guidance will (and will not) examine, and what the guidance developers will consider. The scope is based on a referral from the Department of Health (see appendix A).

4.1 Populations

4.1.1 Groups that will be covered

- All adults over age 16 in full or part-time employment, both paid and unpaid.

- All adults over age 16 who have experienced long-term sickness (for 20 working days or longer) or re-occurring short-term sickness (less than 20 working days) and/or are in receipt of incapacity benefit.

- All employers in the public, private and ‘not for profit’ sectors.

4.1.2 Groups that will not be covered

- Self-employed individuals.

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• Pregnant women who have taken sickness absence related to their pregnancy, during the course of their pregnancy.

• Unemployed individuals who are not sick or in receipt of incapacity benefit.

4.2 Areas

4.2.1 Areas that will be covered

The activities to be considered by this guidance are:

a) Work or primary care-based interventions, programmes, policies or strategies to prevent or reduce the number of employees moving from short to long-term sickness absence. This includes activities to prevent or reduce the re-occurrence of short-term sickness absence episodes. Examples may include:

- trigger mechanisms to identify frequent short-term sickness absence
- risk assessments, modifications and reasonable adjustments to the physical and organisational work environment
- training for line managers in handling and monitoring sickness absence.

b) Work or primary care-based interventions, programmes, policies or strategies to help employees who have been on long-term sickness absence to return to work. Examples may include:

- return to work interviews following a period of sickness absence
- rehabilitation and retention programmes
- provision of information, training and support networks
- training, advice and support for GPs and other primary care staff.
c) Work or primary care-based interventions, programmes, policies or strategies that help reduce the re-occurrence of long-term sickness absence. Examples include:

- linking management performance to the way they deal with long-term sickness absence
- where appropriate, early referral of employees on long-term sickness absence to occupational health professionals, general practitioners or organisations offering Employee Assistance Programmes
- flexible working/work-life balance policies for employees (including carers’ and special leave for family problems)
- stress counselling.

d) UK work or primary care-based interventions, programmes, policies or strategies which help those in receipt of incapacity benefit to return to full or part-time employment. These could be delivered by a number of sectors (such as the voluntary or education sectors) in collaboration with, and/or funded by, employers and primary care services. Examples may include Pathways to Work, New Deal and Access to Work schemes.

4.2.2 Areas that will not be covered

The activities not considered by this guidance are interventions, programmes, policies and strategies which:

- aim to prevent the first occurrence of sickness absence (primary prevention) or aim to prevent sickness absence episodes of less than 20 working days
- target pregnant women exclusively and/or which focus on illnesses associated with pregnancy, during the course of a pregnancy
- tackle workplace absences which are not reported and/or recorded as sickness absence (for example, maternity leave)
- are delivered outside the workplace or primary care

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• involve the clinical diagnosis, treatment (including pharmacological treatment) and management of conditions associated with short and/or long-term sickness or incapacity (for example, low back pain)
• look at the effectiveness of private health insurance schemes, the incapacity benefit system and/or the claiming of statutory sick pay.

4.3 Comparators
Interventions, programmes, policies and strategies will be examined, where possible, against relevant alternative work or primary care-based options and/or no option.

4.4 Outcomes
Primary outcomes to be considered as evidence of effectiveness may include

• maintained levels of physical and mental health among employees which enable participation in work/employment
• improvements in individual and/or population-level health status which enable a return to work/employment and/or staying in work following sickness absence episodes or incapacity
• reduction in morbidity and mortality rates resulting in more people being available for work/employment.

Intermediate outcomes may include:

• reduction in number and duration of reported and/or recorded sickness absences associated with (but not limited to) the following:
  - musculo-skeletal injuries including back pain
  - acute and/or recurring medical conditions
  - stress
  - mental illness
  - drink or drug-related problems
  - other long-term conditions and chronic conditions
• reduction in number and duration of reported and/or recorded sickness absences associated with home and family responsibilities
• increase in number of people who return to work following absence due to long-term sickness or incapacity and/or stay in work. (This includes people who return to their previous or an alternative post)
• increase in number of employers that have introduced policies and procedures to monitor sickness absence
• increase in number of employers who have made reasonable adjustments in the workplace to enable people to return to work
• increase in number of employees who are appropriately referred to an occupational health service when they are on long-term sick leave
• increase in number of people on long-term sick leave who liaise with general practitioners and/or physiotherapists about their ability to return to work
• reduction in the incidence of personal injury claims stemming from workplace accidents
• reduction in the number of people who feel the need to bring claims under the Disability Discrimination Act 2005
• increase in number of people who liaise with job centres to discuss and identify appropriate work opportunities
• increase in number of employers or primary care services that run rehabilitation schemes to help staff return to employment after long-term sickness and/or incapacity.

4.5 Key questions

The following key questions will be addressed:

• Which interventions, programmes, policies or strategies are effective and cost effective in helping to prevent and/or reduce the number of employees who move from short to long-term sickness absence?

• Which interventions, programmes, policies or strategies are effective and cost effective in helping employees on long-term sick leave (20 working days or longer) to return to work?
• Which interventions, programmes, policies or strategies are effective and cost effective in helping to reduce the number of employees who take short or long-term sickness absence on a recurring basis?

• Which interventions, programmes, policies or strategies are effective and cost effective in helping those in receipt of incapacity benefit to return to full or part-time work?

Subsidiary questions may include:

• What is the frequency, content, length and duration of an effective or cost effective intervention, programme, policy or strategy?

• Which are the most effective, cost effective and acceptable interventions, programmes, policies or strategies for different groups? (For example, different groups may include males and females, people of different ages, those with a disability, and people from different ethnic groups or social classes.)

• Does the effectiveness of an intervention, programme, policy or strategy depend on the person leading it? (What are the significant characteristics of an effective leader: what training and skills are required?)

• What are the barriers to – and facilitators of – effective implementation?

• Does the intervention, programme, policy or strategy lead to any adverse or unintended (positive or negative) outcomes?

• Which interventions, programmes, policies or strategies are ineffective and/or are not cost effective?

Effectiveness and cost effectiveness will be examined over the short term (6 to 12 weeks), medium term (12 weeks to 1 year) and long term (1 year and beyond), where evidence allows.
Where there are insufficient effectiveness or cost-effectiveness studies, the reviews will focus on the links between interventions, programmes, policies and strategies and a reduction in sickness absence episodes.

4.6 **Target audiences and settings**

The guidance will be aimed at professionals and managers working in the NHS, in other public sector organisations, and the private, voluntary and community sectors who have a direct or indirect role in – and/or responsibility for employees or those in receipt of incapacity benefit. This includes occupational health professionals, employers, workplace representatives and trades unions, as well as employees themselves.

4.7 **Status of this document**

This is the final scope, incorporating comments from a 4-week consultation period which included a stakeholder meeting on 19 February 2007.

5 **Further information**

The public health guidance development process and methods are described in ‘Methods for development of NICE public health guidance’ (NICE 2006) and ‘The public health guidance development process: an overview for stakeholders, including public health practitioners, policy makers and the public’ (NICE 2006) available at [www.nice.org.uk/page.aspx?o=300576](http://www.nice.org.uk/page.aspx?o=300576)

6 **Related NICE guidance**

Much of NICE guidance, both published and in development, is concerned with tackling the diseases and illnesses which can result in long-term sickness absence and incapacity. For a list of the relevant publications go to: [www.nice.org.uk/guidance](http://www.nice.org.uk/guidance)
Appendix A Referral from the Department of Health

The Department of Health asked the Institute to:

‘Produce guidance for primary care and employers on the management of long-term sickness and incapacity.’
Appendix B References


Guidance on the management of long-term sickness and incapacity for work


