

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

Public health 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

Overview	7
Who is it for?	7
Introduction	8
1 Public health need and practice	9
Government action.....	10
2 Considerations.....	11
Definitions and terms	11
Context.....	12
Inclusion and exclusion criteria	13
Collating and assessing evidence.....	16
Synthesising the evidence	17
Cost effectiveness	18
3 Recommendations	20
Introduction	20
What the guidance covers	20
What the guidance does not cover	20
Two recommendation categories	21
Prerequisites underpinning the recommendations	22
Factors to consider when planning and delivering the recommended interventions and services	23
Who should take action?	25
Recommendations.....	25
4 Implementation.....	32
5 Recommendations for research	33
Recommendation 1: prevention.....	33
Recommendation 2: evaluation.....	34
Recommendation 3: return-to-work programmes and interventions.....	35
Recommendation 4: cost effectiveness	36

6 Updating the recommendations	37
7 Related NICE guidance.....	38
8 Glossary	39
Access to Work	39
Behavioural-graded activity	39
Bio-psychosocial model	39
Case management	39
Case worker/s	40
Cognitive behavioural therapy	40
Condition management	40
Counselling.....	40
Employment and support allowance (ESA).....	40
Expert Patients' Programme	41
Functional capacity assessment.....	41
Incapacity benefit.....	41
Intervention	41
Jobcentre Plus.....	41
Job interview guarantee.....	42
Job introduction scheme.....	42
Long-term sickness absence (including recurring long-term sickness absence)	42
Manual therapy.....	42
Mindful employer.....	42
Multimodal programme	42
New Deal for Disabled People (NDDP).....	43
NHS Regional employability programmes	43
Operant conditioning behavioural approach.....	43
Presenteeism	43
Progressive goal attainment programme.....	43

Rehabilitation	43
Return-to-work credit.....	44
Shift.....	44
Short-term sickness absence (including recurring short-term sickness absence).....	44
Statutory sick pay (SSP)	44
Stress	44
Usual care and treatment	45
Vocational rehabilitation	45
Worklessness.....	45
9 References.....	46
Appendix A: Membership of the Programme Development Group, the NICE project team and external contractors.....	49
The Programme Development Group	49
NICE project team	50
External contractors.....	51
Appendix B: Summary of the methods used to develop this guidance	53
Introduction	53
Guidance development	53
Key questions	53
Reviewing the evidence of effectiveness	55
Economic analysis	61
Expert papers.....	61
Fieldwork.....	61
How the PDG formulated the recommendations.....	62
Appendix C: The evidence	64
Evidence statements	65
Economic analysis	72
Fieldwork findings	74

Appendix D: Gaps in the evidence.....	77
Appendix E: Supporting documents	80
Changes after publication.....	82
About this guidance.....	83

Overview

This guideline covers how to help employees return to work after long-term sickness and how to help people receiving benefits return to employment (paid or unpaid).

NICE has also produced a guideline on [managing health in the workplace](#).

Who is it for?

- Employers and commissioners
- Employees
- People receiving benefits
- Members of the public

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance for primary care services and employers on the management of long-term sickness absence and incapacity for work.

The guidance is for employers, NHS (particularly primary care services and occupational health professionals) and other professionals and managers who have a direct or indirect role in – and responsibility for – the management of long-term sickness absence and incapacity. This includes those working in local authorities and in the community, voluntary and private sectors. It will also be of interest to workplace representatives and trades unions, as well as employees and those on incapacity benefit.

The guidance complements and supports, but does not replace NICE guidance on: workplace activities to encourage employees to be physically active and to stop smoking, promoting mental wellbeing through productive and healthy working conditions, low back pain, anxiety and depression, and computerised cognitive behavioural therapy (CCBT). (For further details, see [section 7](#).)

The Programme Development Group (PDG) developed these recommendations on the basis of the reviews of the evidence, an economic analysis, expert papers, stakeholder comments and fieldwork.

Members of the PDG are listed in [appendix A](#). The methods used to develop the guidance are summarised in [appendix B](#). Supporting documents used to prepare this document are listed in [appendix E](#). Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE [website](#), along with a list of the stakeholders involved and NICE's supporting process and methods manuals.

1 Public health need and practice

It is widely recognised that being employed can help improve a person's health and wellbeing and help reduce health inequalities (Department for Work and Pensions 2005a; DH 2004; Health, Work and Wellbeing Programme 2008; Waddell and Burton 2006). Conversely, unemployment is linked to higher levels of mortality and psychological morbidity (McClean et al. 2005). However, being employed in some jobs may still have a worse impact on health than having no job at all. For example, poor quality, low paid and insecure employment (such as temporary casual work and unregulated work) may be no better for health than unemployment (Bartley and Ferrie 2001; Benach et al. 2002; Broom et al. 2006).

The quality and accuracy of data on absence and sickness absence is variable (Barham and Begum 2005; Barham and Leonard 2002). In 2007, UK employees were absent for an average 3.5% (about 8 working days) of the time they were due to spend working. Sixty six per cent of absences involved 7 days or less, 16% involved between 8 days and 4 weeks, and 20% lasted for 4 weeks (20 working days) or longer (Chartered Institute of Personnel Development 2008). The 2008 Confederation of British Industry survey shows that 95% of absences last less than 20 days, but the remaining 5% account for 40% of all lost time (Confederation of British Industry 2008).

In 2006, an estimated 175 million working days were lost in Britain due to sickness absence (Health, Work and Wellbeing Programme 2008). The review of the health of Britain's working-age population by Dame Carol Black estimated that the annual costs of sickness absence and worklessness associated with working-age ill health were over £100 billion. This is greater than the annual budget of the NHS (Health, Work and Wellbeing Programme 2008).

The most common causes of long-term sickness absence among manual workers (across all sectors in the UK) are acute medical conditions followed by back pain, musculoskeletal injuries, stress and mental health problems. Among non-manual workers (across all sectors) the most common causes are stress, acute medical conditions, mental health problems (such as depression and anxiety), musculoskeletal injuries and back pain (Chartered Institute of Personnel and Development 2008). In Scandinavian countries musculoskeletal problems are the most common cause (Shiels et al. 2004).

Sickness absence rates vary by gender, age, occupation, sector, region and the size of the workplace (Barham and Begum 2005; Chartered Institute of Personnel and Development 2008).

Individuals who are out of work for long periods of time due to sickness experience a drop in incomes which can result in poverty and social exclusion. In addition, the longer someone is not

working the less likely they are to return to work (DH 2004; Ministerial Task Force for Health, Safety and Productivity 2004). Someone who has been off sick for 6 months or longer has an 80% chance of being off work for 5 years (Waddell and Burton 2006).

Government action

Government benefits available when a worker falls ill include incapacity benefit, employment and support allowance (ESA) and statutory sick pay (SSP).

About 2.7 million people receive incapacity benefit (Department for Work and Pensions 2005a; 2005b; 2006a; 2006b). Those claiming this benefit for 12 months will, on average, continue to claim for 8 years. After 2 years they are more likely to die or retire than return to work (HM Government 2005b).

A number of national policies, strategies and initiatives have been implemented to help people aged over 16 remain in – or return to – work after sickness absence or after receiving incapacity benefit. (For details see: Department for Work and Pensions 2003; 2004; 2005b; 2006a; 2006b; DH 2008a; 2008b; Health and Safety Commission 2003; HM Government 2005b; 2007; HM Treasury 2004; House of Commons Work and Pensions Committee 2006; Office of the Deputy Prime Minister and Social Exclusion Unit 2004.)

For example, in 2007 the government set a target to reduce the number of people claiming incapacity benefit by one million over the next decade. The government also has targets to increase the proportion of the working population who are in work, reduce health inequalities and eradicate child poverty. Helping people who are off sick and on incapacity benefit to resume work and draw a full salary will help achieve these targets (Department for Work and Pensions 2007). More recently, the review of Britain's working-age population made a number of proposals to help achieve these targets (Health, Work and Wellbeing Programme 2008). In addition, they are supported by a recent review of vocational rehabilitation interventions (Waddell et al. 2008).

2 Considerations

The PDG took account of a number of factors and issues when developing the recommendations.

Definitions and terms

- 2.1 The evidence reviews that inform this guidance identified any relevant interventions, policies, strategies or programmes to help people return to work after sickness absence and/or incapacity. For the purposes of this guidance, the term 'intervention' has also been used to cover policies, strategies and programmes. 'Incapacity' has been used to mean long-term inability to work because of illness or disability.
- 2.2 The original DH referral asked NICE to develop public health guidance for managing long-term sickness and incapacity. However, there is no consensus in the literature on how to define long- or short-term sickness absence. For this guidance, short-term sickness absence has been defined as absences from work of up to (but less than) 4 weeks, and long-term sickness absence as lasting 4 or more weeks. The criteria for qualifying for incapacity benefit have changed over time. In October 2008, a new employment and support allowance (ESA) was introduced which will eventually replace incapacity benefit and income support on grounds of incapacity. To ensure potentially relevant studies were not missed, the terms short-term sickness absence, long-term sickness absence and sickness absence were all used in the literature search. Studies that included participants receiving incapacity benefit or a similar benefit were also included.
- 2.3 The PDG recognised that people who take significant cumulative absences (such as multiple short-term sickness absences linked to a specific condition) are probably more at risk of long-term sickness absence than those taking occasional single day absences. It also noted that the causes of short-term and long-term sickness absence are likely to differ; some conditions, for example back pain, are more likely to result in long-term sickness absence and acute medical conditions are more likely to result in short-term sickness absence.
- 2.4 The lack of studies clearly defined as covering 'long-term sickness absence', 'short-term sickness absence' or 'recurring short- or long-term sickness absence' has meant that the PDG has not always been able to produce recommendations that distinguish between these terms. In future studies, it will

be important for researchers to define the terms they use and use them consistently. In particular, it is important to clarify the duration of long and short-term sickness absences, for both full and part-time employees.

Context

- 2.5 The recent review of the health of Britain's working-age population was based on the premise that work has inherent benefits for people's health. It also recognised gaps in the evidence on how effective and cost-effective work-based interventions and health interventions are in promoting a return to work (Health, Work and Wellbeing Programme 2008). This guidance complements the proposals identified in the review and reiterates the importance of addressing the gaps in the evidence base for this topic.
- 2.6 An individual's health is the result of a set of complex interactions between multiple biological and social factors, including, for example, their:
- sex, biological predisposition and genetic traits
 - socioeconomic position
 - access to information, services, support and resources
 - exposure to risk, including environmental risk factors
 - degree of control over their own life circumstances
 - access to (and their interaction with) the healthcare system (Marmot and Wilkinson 2005).

All these factors affect people's ability to withstand the stressors – biological, social, environmental, psychological and economic – that can trigger ill health (Marmot and Wilkinson 2005). If an individual is absent from work for a prolonged period of time due to health reasons, then it is likely that more than one of these factors will have contributed to their absence. Furthermore, the number of people claiming incapacity benefit is greater in areas of higher unemployment, slower economic growth and higher socioeconomic deprivation (Beatty and Fothergill 2005; Norman and Bamba 2007). People receiving incapacity benefit are less likely to have academic or professional qualifications than those in work (McCormick 2000). As a result, they are likely to need education and training before they can achieve sustainable employment.

This suggests that health is only one of the factors that will need to be addressed when helping someone return to work (Black 2008).

- 2.7 The PDG recognised that the workplace, including employer and employee practices, may contribute to or cause someone's absence from work due to sickness. (An example of such practices includes those which discriminate against certain groups or which do not adequately protect people's health and safety.) Consequently, both employers and employees have an important role in helping people get back to employment after long-term sickness absence and incapacity. This includes ensuring recruitment and selection practices do not exclude or discriminate against those who have experienced long-term sickness absence and incapacity. It may also include an assessment of the person's current fitness for employment and making workplace adjustments as required by health and safety legislation and the Disability Discrimination Act (HM Government 1995/2005). It may also include the provision of any re-training as needed. Campaigns and schemes such as '[Job introduction scheme](#)', '[Job interview guarantee](#)', '[Shift](#)' and '[Mindful employer](#)' aim to overcome stereotypes and stigma about disability, ill health and its effect on employment and employment opportunities. The PDG noted that specialist job advisers, such as Jobcentre Plus staff, may also be able to offer advice and support. It also noted that the [Access to Work Scheme](#) can help fund reasonable adjustments to the workplace for employees with disabilities.
- 2.8 Different types of employer (such as large, small or public and private organisations) are likely to have different policies and practices on sickness absence, which means the criteria and trigger points for intervening may differ. For example, the number of days of sickness absence before a sickness absence policy is triggered may vary. Consequently, employers implementing the recommendations may need to consider adjusting their employment contracts and/or organisational policies.

Inclusion and exclusion criteria

- 2.9 Study design was a key component of the inclusion criteria for the evidence reviews. A wide range of studies that assessed data measures before and after delivery of the intervention were included. They ranged from randomised controlled trials, before and after studies (with and without controls) and case-control, cohort studies to expert papers (see [appendix B](#)). These are the most appropriate study designs for determining causality between intervention

and effect. Given the limited time frame, descriptive studies examining the relationship between ill health and sickness absence or incapacity were excluded. Similarly, qualitative studies (such as in-depth interviews and focus group data describing participants' views and experiences) were excluded. The PDG was aware, however, that such studies might provide data that would complement the effectiveness and cost-effectiveness data (for example, information on the barriers to and facilitators of delivery for specific interventions).

2.10 To ensure the literature searches and evidence reviews used to inform the guidance corresponded with the referral received (and to work within available resource) a number of exclusion criteria were applied (see [appendix B](#)). For example, the following were excluded:

- research not published in English
- dissertations, books and book chapters (however, the findings from such sources may also be available in journal publications)
- interventions assessing the effectiveness of private health insurance schemes – although an intervention delivered by private health insurance companies would be included if it involved a workplace or primary care partner
- interventions assessing 'ill-health retirement' and their outcomes
- studies on fiscal policies, such as evaluations of disability working allowance and its impact on return-to-work outcomes
- studies assessing the effectiveness of statutory or occupational pay schemes or studies assessing interventions which aim to prevent the first occurrence of sickness absence (primary prevention).

2.11 The evidence review covering interventions for people receiving incapacity or similar benefits was restricted to UK studies. There may be relevant international studies but differences in national policy, legislation and the benefits system mean it would not necessarily be feasible to implement the interventions in the UK.

2.12 The PDG identified a number of implications related to the inclusion and exclusion criteria:

- Three of the evidence reviews used as the basis of the guidance were restricted to studies that only covered absences recorded as sickness and excluded studies on other absences (for example, maternity leave). Some studies that did cover sickness absence may have been excluded because of the lack of consistency in how employers record absences or lack of detail on the reasons for the absence.
- All the evidence reviews were limited to interventions that involved employers and primary care providers (although they did not need to be the only providers involved, and the interventions could be delivered in various settings). A few studies were excluded because they did not describe explicitly who was involved in the intervention.
- There may be studies covering population groups that were not specified in the inclusion and exclusion criteria or explicitly searched for, but which might have been useful to consider. Examples include: people who are employed but receiving incapacity benefit because they are no longer eligible for employers' sickness benefits; or interventions for those who are unemployed and receiving jobseekers allowance (or previous forms of this benefit) such as regional employability programmes.
- Studies involving mixed population groups (such as self-employed and employed people or those experiencing sickness absence or other types of absence) would not have been included if it was not possible to disaggregate the data into a form that met the inclusion criteria. The PDG noted that the recommendations may also help self-employed and unemployed people return to work.
- Similarly, mixed study designs (such as quantitative and qualitative) would not have been included for the same reason.
- Interventions involving the clinical diagnosis, treatment and management of conditions that have resulted in sickness absence and/or incapacity were excluded as they were not part of the remit of this guidance. As a result, studies that also provided data on non-clinical interventions may have been excluded because the data presented were not sufficiently disaggregated.
- Studies that did not report on return-to-work or work-related outcomes were excluded. A large number of studies were excluded from the evidence reviews for this reason.
- Studies of return-to-work interventions that were planned, designed, delivered, managed or funded solely by local authorities were excluded. Similarly studies of return-to-work interventions that operate without any primary care or workplace

involvement were excluded. (For example, this included some mental health-orientated strategies and studies on 'New deal for disabled people'.)

- Although not part of the inclusion criteria for this guidance, it was noted that studies which examine the prevention of the first occurrence of sickness absence could prove valuable.

Collating and assessing evidence

2.13 A number of methodological issues were identified:

- Some of the evidence considered originated from interim evaluations. When final evaluations of these activities are published, they may fill part of the gap in the evidence.
- Work-related outcomes (rather than health) were the primary outcomes of interest for this guidance. However, improvements in work-related outcomes were not the primary outcomes or the main aim of some of the included studies (such as expert patient programmes). Consequently, data such as detailed statistics on return-to-work outcomes were often not reported.
- A wide range of work-related outcomes would have been considered in the evidence review focusing on incapacity (such as return to paid and unpaid work, job seeking behaviour, increase in work experience or vocational training). However, the majority of the identified studies in the incapacity review only reported on outcomes associated with a return to paid work. Very few reported on other outcomes of interest.
- Details were often not given about the content of the intervention, at what point during a person's sickness absence it was delivered, by whom, in what setting and how often and for how long. This made comparison across the different types of interventions difficult. It also made it difficult to identify exactly which elements of the intervention (for example, delivering it early in the absence) influenced its effectiveness.
- Some studies lacked control groups.
- Very few studies presented any cost or economic data.
- Follow-up periods were variable (from weeks to months to years) and often details on the sustainability of interventions (1 year and beyond) were not reported.

- Some studies involved multiple components and did not always report the differential effectiveness of each component.

2.14 A review commissioned by the Vocational Rehabilitation Task Group (Waddell et al. 2008) was published following the evidence consultation phase on this guidance. This review provides important evidence which will be considered (alongside any further published evidence) when this guidance is updated. (NICE guidance is usually updated every 3 to 5 years.)

Synthesising the evidence

2.15 Most of the evidence came from non-UK studies (in particular Scandinavian countries) and, where this is the case, the question of its applicability to England must be taken into account. Particular international variations include:

- 'treatment as usual', which was used as the comparator in many studies
- provision of financial incentives or compensation (for example, sickness benefits); these factors also vary between different types of employer
- qualifications, roles and responsibilities or specific occupations (such as social workers) between countries
- welfare benefits and their eligibility criteria
- the descriptors used to report the reasons for sickness absence and incapacity; for example, the same condition might be categorised as linked to 'musculoskeletal disorders' in one country and 'stress-related' in another.

2.16 The PDG primarily relied on effect size and statistical significance to determine which interventions to include in the recommendations. However, in many studies the effect size and/or statistical significance at a 95% or 99% confidence interval was not reported. In such situations, if outcome data indicated general positive trends, the PDG considered making recommendations for practice.

2.17 Some of the studies reviewed indicated that intervening at an 'early' stage during sickness absence contributed to the success of the intervention. However, there is no universal definition of 'early' in terms of days, weeks or months. Consequently, where possible, the recommendations outline possible time periods to intervene. The Health and Safety Executive has produced a

[ready reckoner guide](#), which outlines the average lengths of absence by illness, by sector and by occupation, to help employers assess when to intervene. It may be useful for employers to refer to this guide alongside this guidance document.

- 2.18 Emerging evidence on the Expert Patients' Programme (expert paper 1) and condition management (expert paper 2) was considered. Both highlighted the need to help people overcome psychological or physical barriers before they can return to work. Condition management, when combined with informal employment advice, increased confidence levels about finding work and led to some increases in the number of people on incapacity benefit who returned to work. However, the PDG recognised that longer-term follow-up and evaluation was needed.
- 2.19 Relatively little evidence was identified on the effectiveness and cost effectiveness of interventions (such as those focusing on stress and mental illness or psychological interventions for specific population groups). Either they had not been evaluated or the evaluations were not publicly available. The PDG noted that the absence of evidence should not be taken as an indication that such interventions should be stopped (if they help to improve work-related or treatment outcomes). It also noted that some interventions may cause harm, even though there is no evidence to prove this. (See [appendix D](#) for further information on the evidence gaps.)
- 2.20 The experience, training and competencies of those coordinating or delivering the intervention/s – and their access to supervision and consultation with more skilled and higher qualified professionals – may affect the long-term effectiveness and cost effectiveness of any intervention.
- 2.21 Improving the quality of the evidence is a continuing process. Better evaluation processes are needed to help improve the available evidence base for this area (see [section 5](#), research recommendations).

Cost effectiveness

- 2.22 Evidence on cost effectiveness was generally sparse. Most of the interventions dealt with musculoskeletal conditions and, in particular, lower back pain. Where evidence existed, it showed that such interventions were cost effective from both an NHS/personal social services perspective and a societal perspective.

The analysis from the employer's perspective showed that, for the average employer, most of the effective interventions would, in the long run, reduce their costs. Usually this would be achieved through production increases attributable to earlier and/or a more effective return to work. These results can probably be applied to most employers (see [appendix C](#) for further details).

- 2.23 The cost effectiveness modelling for this guidance relates to interventions for those with a long-term sickness absence, excluding those in receipt of incapacity benefit. It was carried out at a time of relatively full employment. It assumed as a 'base case' that the average length of time it takes to replace someone who is on long-term sick leave was 10 weeks. In October 2008, a sharp increase in unemployment was forecast and the PDG recognised that, as a result, it may take less time to replace someone temporarily. Furthermore, when there is a larger pool of unemployed people there may be less of an imperative to get people back to work. As a result, interventions aimed at getting people back to work earlier will probably not be as cost effective as indicated in the modelling, which assumed conditions of low unemployment.
- 2.24 The PDG recognised that in times of severe or very severe economic downturn, these interventions will become less cost effective (that is, there will be a higher cost per QALY gained) than when there is full employment. However, it was not possible to determine whether they would be still be sufficiently cost effective to be a good use of government funds in times of relatively high unemployment. It also recognised that the probability of a return to work for those receiving incapacity benefits would decrease when there is high unemployment.

3 Recommendations

Introduction

This is NICE's formal guidance on managing long-term sickness absence and incapacity for work. When writing the recommendations, the Programme Development Group (PDG) (see [appendix A](#)) considered the evidence of effectiveness (including cost effectiveness), expert papers, fieldwork data and comments from stakeholders. The PDG also drew on its expertise to help interpret the evidence. Where this has occurred the recommendations are marked as being based on 'inference derived from the evidence' (IDE) in [appendix C](#). Full details are available [online](#).

The evidence statements underpinning the recommendations are listed in [appendix C](#).

The evidence reviews, supporting evidence statements, expert papers and economic analysis are available [online](#).

What the guidance covers

The guidance presents recommendations, based on evidence of effectiveness and cost effectiveness, for [interventions](#) that aim to:

- prevent or reduce the number of employees moving from short-term to long-term sickness absence (including the prevention of [recurring short-term sickness absence](#))
- help employees on long-term sickness absence return to work
- reduce the number of employees who take long-term sickness absence on a recurring basis
- help people receiving incapacity benefit or similar benefits return to employment (paid and unpaid).

What the guidance does not cover

As the focus of this guidance is the management of long-term sickness absence and incapacity for employers and primary care services it has drawn on evidence on return-to-work outcomes. The guidance does not cover prevention of sickness absence before it occurs (primary prevention) or treatment of conditions that cause sickness absence and incapacity. For recommendations on treatment see the following:

- NICE technology appraisal guidance 51 on computerised cognitive behaviour therapy for depression and anxiety [Replaced by [NICE technology appraisal guidance 97](#)]
- NICE clinical guideline 22 on anxiety [Replaced by [NICE clinical guideline 113](#)]
- NICE clinical guideline 23 on depression [Replaced by [NICE clinical guideline 90](#)]
- NICE clinical guideline 88 on [low back pain](#) (2009)

The guidance does not cover government legislation on employers' legal responsibilities. Both employers and employees may wish to refer to:

- The Disability Discrimination Act (DDA) 1995/2005 (HM Government 2005a)
- The Health and Safety at Work etc. Act 1974 (HSWA) and its associated regulations (HM Government 1974)
- The Employment Rights Act 1996 (HM Government 1996)
- Data Protection Act 1998 (HM Government 1998).

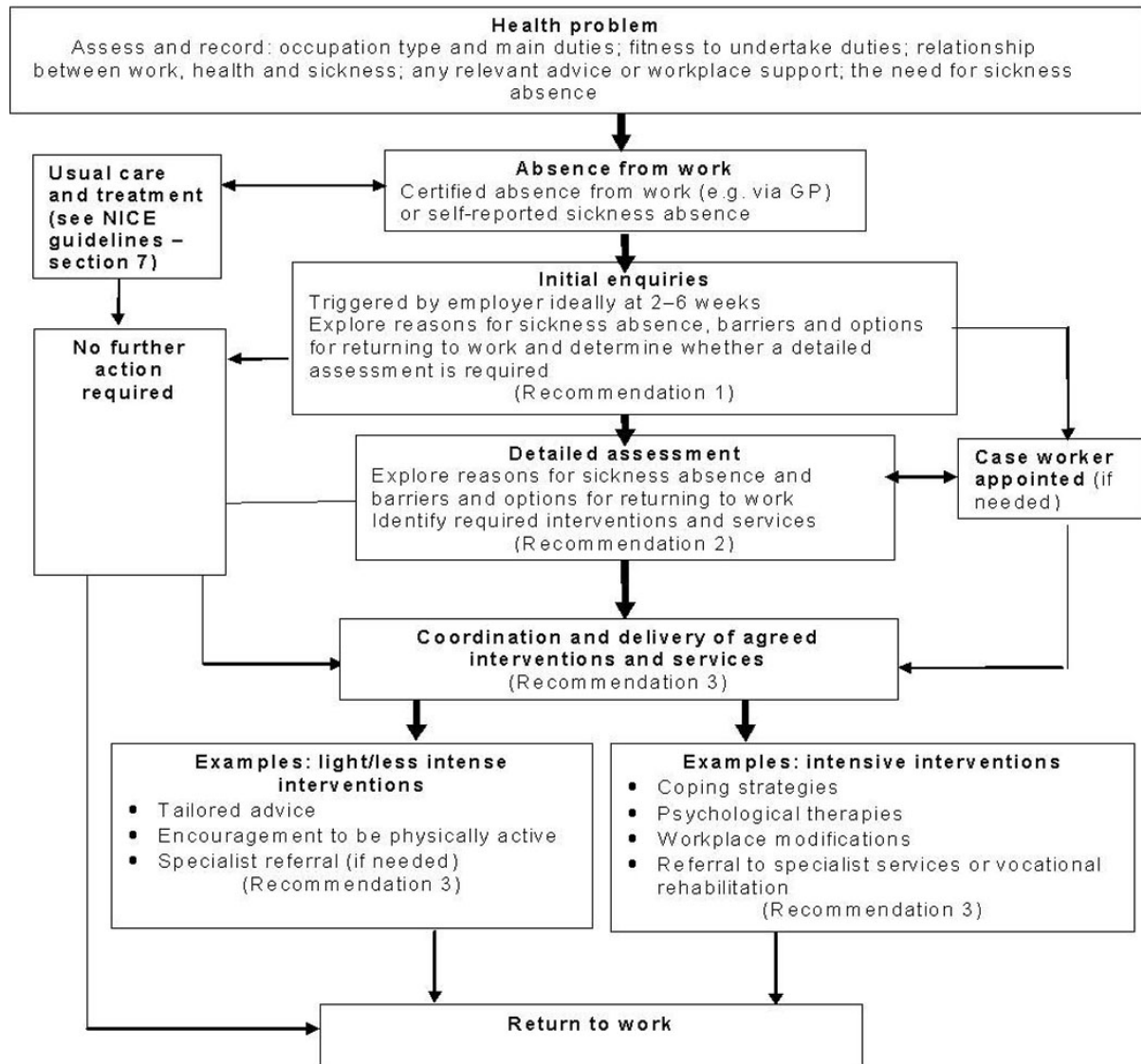
Two recommendation categories

The recommendations fall into two categories (please note, the way they are numbered does not imply a hierarchy of importance):

- Recommendations 1–3 cover activities which relate to employees who experience long-term sickness or recurring long- or short-term sickness absence. These aim to encourage a well-managed return to work which will be of mutual benefit to both the employee and their employer.
- Recommendation 4 relates to activities for those who are unemployed and in receipt of incapacity benefit (or other similar benefits such as employment and support allowance [ESA]).

The diagram illustrates the various stages in the sickness absence pathway and how this relates to the recommendations.

Pathway for managing long-term or recurring short- or long-term sickness absence



Prerequisites underpinning the recommendations

The following prerequisites have been identified from the evidence considered. These underpin and support effective implementation of the recommendations:

- Primary care trust commissioners (or other commissioners) have ensured:
 - referral mechanisms are available to GPs and any other specialists (such as occupational health physicians and nurses)
 - any interventions or services identified as a result of following recommendations 1 to 4 are commissioned and available.

- Those responsible for managing certification (such as GPs) have considered the advice given in 'Patients, their employment and their health – how to help your patients stay in work' (Department for Work and Pensions 2008). For example, they should balance the immediate health benefits of prescribing time away from work and the potential long-term disadvantages for the patient.
- Agreement has been reached with the person experiencing sickness absence or receiving incapacity benefit about what confidential information can be shared with whom and for what purpose.
- The person experiencing sickness absence or incapacity and the employer are in regular contact and work together to plan and put into practice any agreed activities.
- The person experiencing sickness absence or incapacity has received the appropriate treatment.
- The person planning, coordinating or delivering the intervention/s or service/s has the relevant experience, expertise and credibility. For example, they might need training in communications skills. They may need access to supervision and consultation with more skilled professionals. They may also need access to sources of employment and health and safety advice and discrimination law.
- The proposals outlined in 'Dame Carol Black's review of the health of Britain's working age population. Working for a healthier tomorrow' (Health, Work and Wellbeing Programme 2008) are taken forward.

Factors to consider when planning and delivering the recommended interventions and services

The following factors need to be considered when implementing the recommendations.

Planning

- The person's age and gender, the condition that led to the sickness absence, their prognosis for returning to work and the type of work they are involved in all needs to be taken into account. These factors may influence their speed of recovery and ability to return to work.
- The appropriateness of the proposed intervention in relation to the person's specific characteristics, such as their sex/gender, age, race/ethnicity, disability, sexual orientation, religion or belief.

- Any incentives or financial implications which may encourage or discourage a return to work (for example, whether or not the absence has had any impact on their pay).
- Local job market, availability of jobs or alternative work or another role within the original workplace.
- Organisational structure and culture.
- The multi-faceted nature of long-term sickness absence: that is, sickness absence and incapacity associated with one condition (for example, back pain) may lead to further complications (for example, a stress-related condition).
- The valuable role that trades union and employee representatives can play in helping employers to develop guidance and policies on the recommended interventions. They may also have a role as advocates for – and supporters of – staff wanting to return to work.

Delivery

- Activities need to be tailored to the individual's condition, their prognosis for returning to work and any perceived (or actual) barriers to returning to work.
- A multi-disciplinary or multi-agency approach needs to be adopted. For example, employment specialists could be used or the organisation could work in partnership with Jobcentre Plus staff to help find suitable jobs,
- The timing, length, frequency and intensity of interventions needs to be determined (early intervention may improve effectiveness).
- It is important to establish the employee's confidence and trust in the person delivering the intervention (or the confidence and trust of the person in receipt of incapacity benefit). For example, if a member of a statutory service is helping deliver an intervention and has a responsibility to inform state benefit services, this may affect the person's confidence in their impartiality.
- Organisational sickness absence policies and appropriate health and safety practices should be established and implemented.
- Evidence suggests that 'actively doing something with people' (for example, physiotherapy) can be more effective than 'advising them to do something' (for example, advising them to undertake regular physical activity) or 'encouraging them to do it for themselves' (for example, providing them with contact details for another organisation).

Who should take action?

For each recommendation a list of 'Who should take action?' is provided. Furthermore, in the 'What action should be taken' sections, various specialists and professionals are suggested as people who may be involved in the delivery of the intervention or service. This is not a definitive list and responsibility often involves a team approach (across the NHS and with external organisations).

Recommendations

Employees on sickness absence

Recommendation 1: initial enquiries

Who is the target population?

Employees experiencing long-term sickness absence or recurring short- or long-term sickness absence, particularly those with musculoskeletal disorders or mental health problems.

Who should take action?

Employers (this may have been devolved to line managers, human resource [HR] professionals or occupational health specialists).

What action should they take?

- Identify someone who is suitably trained and impartial to undertake initial enquiries with the relevant employees (see above). As an example, they could be an occupational health physician or nurse or a human resource specialist.
- Within 12 weeks (ideally between 2 and 6 weeks) of a person starting sickness absence (or following recurring episodes of short- or long-term sickness absence) ensure that initial enquiries are undertaken in conjunction with the employee. The aim is to:
 - determine the reason for the sickness and their prognosis for returning to work (that is, how likely it is that they will return to work) and if they have any perceived (or actual) barriers to returning to work (including the need for workplace adjustments)
 - decide on the options for returning to work and jointly agree what, if any, action is required to prepare for this.

- If action is required consider identifying:
 - whether or not a detailed assessment is needed to determine what interventions and services are required and to develop a return-to-work plan (see recommendation 2)
 - whether or not a case worker/s is needed to coordinate a detailed assessment, deliver any proposed interventions or produce a return-to-work plan.
 - If necessary, appoint a case worker/s (see recommendation 2).

Recommendation 2: detailed assessment

Who is the target population?

Employees experiencing long-term sickness absence or recurring short- or long-term sickness absence, particularly those with musculoskeletal disorders or mental health problems.

Who should take action?

- Employers (this may be devolved to line managers, HR professionals or occupational health specialists).
- Case workers (if appointed).

What action should they take?

- If indicated by the initial enquiries, arrange for a more detailed assessment to be undertaken. The assessment could be coordinated by a suitably trained case worker/s. The case worker does not necessarily need a clinical or occupational health background but should have the skills and training to act as an impartial intermediary. (Note: it may not be an appropriate role for the person's line manager).
- Arrange for the relevant specialist/s to undertake the assessment (or different components of it) in conjunction with the employee. It could include one or more of the following:
 - referral via an occupational health adviser (or encouragement to self-refer) to a GP with occupational health experience or another appropriate health specialist (such as a physiotherapist). The aim is to diagnose and treat the employee and determine any need for further tests or sick leave
 - use of a screening tool to determine the prognosis for returning to work

- a combined interview and work assessment by one or more appropriate specialists (such as a physician, nurse or another professional specialising in occupational health, health and safety, rehabilitation or ergonomics). This assessment should also involve the line manager
- a return-to-work plan.
- If a combined interview and work assessment is needed it should evaluate:
 - the person's health, social and employment situation, any barriers to returning to work (for example, work relationships) and their perceived confidence and ability to overcome these barriers
 - their current or previous rehabilitation experiences
 - the tasks they carry out at work – and their functional capacity to perform them (dealing with issues such as mobility, strength and fitness)
 - any workplace or work equipment modifications that are needed in line with the Disability Discrimination Act (including ergonomic modifications).
- If a return-to-work plan is needed it should determine the level, type and frequency of interventions and services needed, including any psychological support (see recommendation 3). A return-to-work plan could also identify if any of the following is required:
 - a gradual return to the original job using staged increases in hours and days worked (for example, starting with shorter hours and/or less days and gradually increasing them)
 - a return to partial duties of the original job or temporary/permanent redeployment to another job.
- Ensure those assessing which psychological support or interventions to offer are trained in psychological assessment techniques.

Recommendation 3: interventions and services

Who is the target population?

Employees experiencing long-term sickness absence or recurring short- or long-term sickness absence, particularly those with musculoskeletal disorders or mental health problems.

Who should take action?

- Employers (this may be devolved to line managers, HR professionals or occupational health specialists).
- Case workers (if appointed).

What action should they take?

- Coordinate and support the delivery of any planned health, occupational or rehabilitation interventions or services and any return-to-work plan developed following initial enquiries or the detailed assessment. People who have a poor prognosis for returning to work are likely to benefit most from more 'intensive' interventions and services; those with a good prognosis are likely to benefit from 'light' or less intense interventions and services. Liaise with everyone involved (such as line managers and occupational health staff).
- Where necessary, arrange for a referral to relevant specialists or services. This may include referral via an occupational health adviser (or encouragement to self-refer) to a GP, a specialist physician, nurse or another professional specialising in occupational health, health and safety, rehabilitation or ergonomics. It could also include referral to a physiotherapist.
- Where necessary, employers should appoint a case worker/s to coordinate referral for, and delivery of any required interventions and services. This includes delivery of the return-to-work plan, if required (including modifications to the workplace or work equipment). The case worker/s does not necessarily need a clinical or occupational health background. However, they should have the skills and training to act as an impartial intermediary and to ensure appropriate referrals are made to specialist services.
- Ensure employees are consulted and jointly agree all planned health, occupational or rehabilitation interventions or services and the return-to-work plan (including workplace or work equipment modifications).
- Encourage employees to contact their GP or occupational health service for further advice and support as needed.
- Consider offering people who have a poor prognosis for returning to work an 'intensive' programme of interventions. For example, offer a programme of multi-disciplinary interventions over several weeks combined with usual care and treatment. Examples may include one or more of the following:
 - cognitive behavioural therapy (CBT) or education and training on physical and mental coping strategies for work and everyday activities (this may be combined with exercise programmes)

- counselling about a return to work
 - workplace modifications
 - referral to physiotherapy services or vocational rehabilitation (including training).
- Consider offering more intensive, specialist input when there is recurring long-term sickness absence or repeat episodes of short-term sickness absence.
 - Consider offering 'light' or less intense interventions, along with usual care and treatment, to those with a good prognosis for returning to work. Examples might include short sessions providing one or more of the following, as appropriate: individually tailored advice on how to manage daily activities at home and at work (this could include advice on the benefits of being physically active and on relaxation techniques); encouragement to be physically active; referral to a physiotherapist or psychological services.
 - Ensure psychological interventions and services are evidence-based. Also ensure they are delivered by suitably trained and experienced practitioners. These may be health professionals (such as physicians, nurses or others specialising in occupational health, rehabilitation or ergonomics); social workers; clinical or occupational psychologists; specialist counsellors or therapists.
 - Consider helping people to develop problem solving and coping strategies using evidence-based psychological interventions. The aim is to overcome any barriers they have to returning to work and to support them to return. Examples which have been proven to be effective for certain groups and conditions are listed below:
 - women with musculoskeletal pain: CBT in small groups (involving 5–6 people), with one-to-one telephone follow-up
 - men and women with stress-related conditions: CBT and contact with the employer
 - men and women experiencing low back pain: CBT in small groups (involving 5–6 people) combined with one-to-one sessions of behavioural-graded activity and liaison with the workplace to discuss a return-to-work plan (for guidance on treatment see NICE clinical guideline on patients with chronic [longer than 6 weeks] non-specific low back pain [2009]).
 - men and women with psychological or musculoskeletal problems: solution-focused group sessions (using, for example, 'The road ahead course' format)

- men and women with whiplash injuries: progressive goal attainment programmes combined with physiotherapy or multimodal programmes.
- Consider providing a multi-disciplinary back management programme to help employees with this condition return to work. It could be delivered by a GP with occupational health experience, a specialist professional (such as a physiotherapist) or a combination of others specialising in occupational health, health and safety, rehabilitation or ergonomics. As an example, a programme could comprise:
 - one intensive session covering attitudes to health, structure and function of the back and posture and the link to symptoms, stress and coping strategies, posture exercises and relaxation training
 - optional sessions to recap on learning and to discuss the experience of putting it into practice.

For guidance on treatment, see NICE clinical guideline on patients with chronic (longer than 6 weeks) non-specific low back pain (2009).

Unemployed people on incapacity benefit

Recommendation 4: returning to work

Who is the target population?

People with health problems who are unemployed and claiming incapacity benefit or ESA.

Who should take action?

- Department for Work and Pensions.
- Other bodies or organisations which may commission services for those who are unemployed and claiming incapacity benefit or ESA.

What action should they take?

- Commission an integrated programme to help claimants 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, including that offered by 'New deal for disabled people' (for example, help producing a curriculum vitae, 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
 - financial measures to motivate them to return to work (such as return-to-work credit)
 - support before and after returning to work: this may include one or more of the following: mentoring, a job coach, occupational health support or financial advice.
- Evaluate the programme (including any specific components) in line with research recommendation 2 (see section 5 for research recommendations).

The PDG considers that all the recommended measures are cost effective.

For the research recommendations and gaps in research, see section 5 and appendix D respectively.

4 Implementation

NICE guidance can help:

- Employers and employees fulfill their duties according to the Health and Safety at Work etc Act 1974 and associated Health and Safety Executive regulations, Disability Discrimination Act 1995/2005 and Employment Rights Act 1996.
- Employers to improve management systems to reduce sickness absence as part of good management practice to promote positive workplace morale, increase productivity and support sustained employment.
- Employers to demonstrate they are exemplars of healthy workplaces and good occupational health practices (HM Government 2005b).
- NHS organisations meet DH standards for public health as set out in '[Standards for better health](#)' (updated in 2006). Performance against these standards is assessed by the Healthcare Commission, and forms part of the annual health check score awarded to local healthcare organisations.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, and to make best use of available resources.

NICE has developed [tools](#) to help organisations implement this guidance.

5 Recommendations for research

The PDG has made the following recommendations to fill the most important gaps in the evidence.

These recommendations are aimed at:

- Research councils.
- Government departments including the Department for Work and Pensions.
- Local and regional authorities and primary care trusts.
- National and other research commissioners and funders such as the National Institute for Health Research.

Recommendation 1: prevention

What action should they take?

Commission or undertake research to identify activities which can prevent the first occurrence of sickness absence or reduce further occurrences of sickness absence. These may include:

- pre-employment health assessments to identify existing health problems
- workplace adjustments
- application of the Disability Discrimination Act (HM Government 1995/2005)
- health, safety and wellbeing interventions for example: risk assessment and control strategies covering chemical, physical, biological and psychological hazards; health promotion; and health and safety training
- occupational health services, for example, physiotherapy, counselling, health assessments, health surveillance and biological monitoring (such as biological assessments for musculoskeletal disorder or mental health assessments) and the use of screening tools
- human resource strategies such as flexible working practices, the provision of parental or carers' leave and dignity at work policies and practices.

Recommendation 2: evaluation

What action should they take?

Commission evaluations to establish the effectiveness of interventions to help people return to work (paid or unpaid) after experiencing long-term sickness absence or recurring short- or long-term sickness absence. This includes interventions aimed at those in receipt of incapacity benefit or employment and support allowance (ESA). It also includes treatment-related interventions.

Evaluations should:

- Use combined quantitative and qualitative methods to consider the context, process, content and experience of those involved and the impact (including the costs and health effects) of the intervention. Barriers and facilitators should also be investigated. For complex interventions, use the approach recommended in the Medical Research Council guidelines (2008).
- Consider using a bio-psychosocial model of health to develop any research questions.
- Where possible, use longitudinal designs and comparison/well-matched control groups to measure impact. Evaluations should be sufficiently powered to assess a sustained return to work (rather than other end points). They should also avoid selection bias. Drop-out and follow-up numbers should be measured.
- Describe the theoretical links between the context, process, structure and impact of the interventions.
- Describe the primary reasons or conditions causing the sickness absence or incapacity and the duration of the absence. Use definitions of health conditions that encapsulate symptom patterns as well as diagnostic paradigms.
- Describe in detail the content of the intervention, when it was delivered, by whom, in what setting and at what point during the individual's absence or incapacity. Describe how health and safety or other policies were applied.
- Define and collect appropriate process and outcome measures for baseline and follow-up (across a series of time points) of intended and unintended, short, intermediate and long-term impacts (positive and negative). Ensure follow-up periods are long enough for any improvements in work-related outcomes to be evaluated – in particular, to cover a sustained return to paid or unpaid work in a temporary or permanent new job or in the same job (albeit with modifications). Use validated outcome measures, where possible.

- Use 'presenteeism' (in addition to absenteeism) as an outcome measure along with quality of working life measures and other work-related outcomes.
- Where multi-component interventions are used, identify whether the outcome is due to one or a combination of components.
- Determine if interventions are more effective for particular groups (groups could be defined by sex/gender, age, race/ethnicity, socioeconomic status, disability, sexual orientation, religion/belief or any other characteristic). Ensure there is a wide representation of population groups and health conditions.
- Consider the perceived advantages and disadvantages of any compulsory versus voluntary components of the intervention, taking into account both the views of those delivering it and recipients.
- Ideally publish in peer-reviewed scientific literature and not just as evaluation reports.

Recommendation 3: return-to-work programmes and interventions

What action should they take?

Determine if the following help those experiencing long-term or recurring short- or long-term sickness absence or recipients of incapacity benefit (or ESA) return to work. Commission independent evaluations to achieve this. The evaluations should take into account the content of research recommendation 2.

- Expert Patients' Programme.
- Conditions Management Programme.
- Regional NHS Employability schemes.
- Job retention schemes.
- Fit for work schemes.
- Pathways to Work and any other similar programmes or interventions, such as rehabilitation or psychosocial interventions which aim to promote a return to work.
- Clinical combined with return-to-work interventions for low back pain, musculoskeletal disorders and mental health problems.

- Multi-disciplinary interventions which aim to prevent the occurrence of long-term or recurring short-term sickness absence or the move from short- to long-term sickness absence.

Recommendation 4: cost effectiveness

What action should they take?

Gather evidence on the costs and benefits of interventions to help those experiencing long-term sickness absence or recurring short- or long-term sickness absence return to work (paid or unpaid). This should include interventions aimed at those in receipt of incapacity benefit and ESA. In particular:

- Where appropriate, include economic evaluation as an integral part of funded evaluation studies.
- Where possible, use validated long-term outcome measures to assess the impact on health and a sustained return to work, alongside any other benefits.
- Consider the time that should elapse before outcomes are measured (public health outcomes often require long follow-up periods).
- Take careful account of the costs of delivering (or not delivering) the intervention or, in the absence of cost information, identify the level of resources used.
- Ensure evaluations are not limited to the costs to, and benefits for, the NHS.

More detail on the gaps in the evidence identified during development of this guidance is provided in [appendix D](#).

6 Updating the recommendations

This guidance will be updated as needed. Information on the progress of any update will be posted [online](#).

7 Related NICE guidance

Promoting physical activity in the workplace. NICE public health guidance 13 (2008).

Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007).

Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal 97 (2006).

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE clinical guideline 22 (2004). [Replaced by [NICE clinical guideline 113](#)]

Depression: management of depression in primary and secondary care. NICE clinical guideline 23 (2004). [Replaced by [NICE clinical guideline 90](#)]

Low back pain: early management of persistent non-specific low back pain. NICE clinical guideline 88 (2009).

Promoting mental wellbeing at work. NICE public health guidance 22 (2009).

Depression in adults with a chronic physical health problem: Treatment and management. NICE clinical guideline 91 (2009).

8 Glossary

The terms in the guidance are all used in a generic manner unless it is otherwise clear in the text that they are linked to a single example.

Access to Work

Access to Work is a service for people with disabilities and their employers. It can offer advice and support, including grants towards equipment, adapting the premises, or a support worker. It can also pay towards the cost of getting to work. It is available for people with disabilities who are in a paid job, unemployed and about to start work, or self-employed.

Behavioural-graded activity

A behavioural intervention that aims to increase a person's activity levels gradually. Typically, people with back problems attend 15 1-hour sessions covering activities that are relevant to them. A further three sessions are dedicated to back education and lifting instructions delivered by an occupational therapist.

Bio-psychosocial model

The bio-psychosocial (BPS) model proposes that biological, psychological and social factors all play a significant role in human responses to illness or disease. It is contrasted with the traditional, reductionist biomedical model of medicine. The latter suggests that every disease process can be explained in terms of an underlying deviation from normal function (such as a pathogen, genetic or developmental abnormality or injury). BPS general principles underpin a number of approaches to and treatments for complex physical and mental health conditions. The concept informs (to varying degrees) work in areas such as psychiatry, medicine, nursing, clinical and health psychology, occupational health and sociology.

Case management

Case management is a collaborative process of assessment, planning, facilitation and advocacy. The aim is to provide options and services that meet an individual's health needs.

Case worker/s

An individual/group of people responsible for managing an assessment and coordinating delivery of interventions and services to help a person return to work.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is a psychological treatment where people work with a therapist to look at how their problems, thoughts, feelings and behaviour fit together. CBT can help people to challenge negative thoughts and change any behaviour that causes problems. It may be delivered in one-to-one or group sessions.

Condition management

Non-treatment programmes designed to help people better manage their health condition with a view to returning to work.

Counselling

The overall aim of counselling is to provide an opportunity for the client to work towards a more satisfying and resourceful life. Counselling involves a relationship between a trained counsellor and an individual. The objectives will vary according to the client's needs. They may include addressing and resolving specific problems, making decisions, coping with crisis, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships. A distinction needs to be made between counselling and counselling skills. Many health service and other professionals routinely and appropriately use counselling and basic human relationship skills as part of their work. This is distinct, however, from more formal counselling which involves a clearly defined professional relationship.

Employment and support allowance (ESA)

Employment and support allowance (ESA) is a two-tier system of benefits. All claimants who are out of work due to ill health or a disability are entitled to the ESA basic benefit (paid at the same rates as unemployment benefit – job seeker's allowance). Those judged (via a medically administered 'work capability' test) unable to work, or with limited capacity to work due to the severity of their physical or mental condition, receive a higher support allowance, with no conditionality. Those who are deemed 'sick but able to work' only receive additional employment support if they participate in employability initiatives such as Pathways to Work.

Expert Patients' Programme

The Expert Patients' Programme provides group-based support to help people manage their long-term condition. The groups are led by non-professionals with experience of the condition. The programme is aimed at people with a wide range of long-term conditions, whatever their age or ethnicity. It offers a toolkit of techniques to improve their quality of life. They learn to develop their communication skills, manage their emotions and their daily activities and plan for the future. They also learn how to use the healthcare system, find health resources, understand the importance of exercising and healthy eating, and manage fatigue, sleep, pain, anger and depression.

Functional capacity assessment

An evaluation which includes a medical, physical therapy, a psychological examination and an assessment of the individual's work situation.

Incapacity benefit

A weekly benefit for people who are not able to work due to illness or disability while under state pension age. From 27 October 2008, employment and support allowance (ESA) replaced incapacity benefit and income support claimed on the grounds of incapacity by new claimants. Between 2010 and 2013, existing claimants will be brought into the new system.

Intervention

This generic term has been used in the guidance to describe an intervention, programme, strategy or policy. It involves a single action (or set of actions) to alter the outcome of a situation. For example, in the case of long-term sickness absence from work, it could involve implementing an organisation's sickness absence policy to help an individual to return to work.

Jobcentre Plus

Jobcentre Plus is a government agency that helps people of working age move from welfare benefits into work and helps employers to fill their vacancies. Jobcentre Plus is part of the Department for Work and Pensions. It plays a major role in supporting the Department's aim to 'promote opportunity and independence for all through modern, customer-focused services'.

Job interview guarantee

A scheme to encourage people with disabilities to apply for jobs. People who meet the definition of disability under the Disability Discrimination Act are guaranteed an interview for a post if they meet the essential criteria for doing it.

Job introduction scheme

JIS pays a weekly grant to a disabled employee's employer for the first 6 weeks of their employment to help towards their wages or other employment costs.

Long-term sickness absence (including recurring long-term sickness absence)

Long-term sickness absence has been defined in the literature as an absence lasting more than 2 weeks. For the purposes of this guidance, it is defined as 4 or more weeks. This is half-way between the usual minimum of 2 weeks in the literature, and the 6-week period after which the chance of an early return to work starts to diminish. In addition, 4 weeks is commonly used as a cut-off in the international literature. Recurring long-term sickness absence has been defined as more than one episode of long-term sickness absence, with each episode lasting more than 4 weeks

Manual therapy

A general term for treatments that involve physical manipulation, such as osteopathy and physiotherapy.

Mindful employer

An initiative aimed at increasing awareness of mental health at work and providing support for businesses recruiting and training staff who have mental health issues.

Multimodal programme

A programme to manage back pain with input from different professionals. It covers relaxation training, exercises to reduce cervical and lumbar lordosis (curvature of the spine) and psychological support to reduce anxiety. It also includes eye fixation exercises and manual treatment of the cervical spine, using techniques such as massage and mobilisation.

New Deal for Disabled People (NDDP)

A programme of advice and practical support to help people move from disability and health-related benefits into paid employment. The programme is delivered through a network of 'job brokers' from a range of organisations. Each one offers different services which can be tailored to individual needs. NDDP is only available in some areas of the UK. Similar help and advice is provided elsewhere by Pathways to Work.

NHS Regional employability programmes

NHS training and work experience placements which are designed to enhance the skills and employment prospects of unemployed people and encourage NHS employers to develop supportive recruitment and training practices.

Operant conditioning behavioural approach

A type of behavioural therapy.

Presenteeism

Presenteeism is the opposite of absenteeism. It can describe being in work despite health problems. It also describes someone's attendance at work without performing all of their usual tasks (regardless of the reason). 'Suboptimal performance' is often used interchangeably with presenteeism in the literature: it describes a scenario where employees do not function fully leading to losses in productivity. Presenteeism can also make health problems worse.

Progressive goal attainment programme

A standardised psychosocial rehabilitation programme that aims for a gradual increase in daily, goal-directed activity by overcoming any psychological obstacles to such activity. The main components are education and reassurance.

Rehabilitation

The action of restoring someone to a previous condition, status or some degree of normal life.

Return-to-work credit

This credit provides financial support during the first year of work after someone has had a health condition or disability and has been receiving a relevant benefit. It is a tax-free payment paid on top of wages for up to 52 weeks. It is a means-tested allowance available to anyone who works 16 hours or more a week.

Shift

Shift is an initiative which aims to tackle the stigma and discrimination surrounding mental health issues in England. Working with the National Social Inclusion Programme, it aims to create a society where people who experience mental health problems enjoy the same rights and opportunities as other people.

Short-term sickness absence (including recurring short-term sickness absence)

Short-term sickness absence has been defined in the literature in days or weeks. For the purposes of this guidance, it is defined as an absence lasting up to (but less than) 4 weeks. Recurring short-term sickness absence has been defined as more than one episode of short-term sickness absence, each lasting less than 4 weeks.

Statutory sick pay (SSP)

Employers pay SSP to employees who are unable to work because of sickness. It is paid for a maximum of 28 weeks.

Stress

There is no simple definition of stress, but there is consensus that it is caused by a person's appraisal of a situation and how their mind and body prepares to respond. Stress is a natural but sometimes distressing reaction leading to a psychological and physiological tension which is referred to as the 'flight or fight' response. It may be positive (for example, as part of preparation for a sporting event or in response to an exciting work challenge). It may also be negative (for example, it may be a response to bereavement or to excessive pressure). It leads to an increase in heart rate and blood pressure and may result in frequent, intrusive thoughts and accompanying feelings of fear or excitement. Stress may occur in response to a single event experienced over a short period of time (for example, unexpected increases in workload). Alternatively, it may occur in response to multiple events over long periods of time (for example, in response to protracted

periods of treatment for an illness). In the majority of cases (and with appropriate intervention) people will adapt and cope. However, there are some occasions when this does not occur.

Usual care and treatment

This refers to the usual health, social and other interventions used to treat and manage a condition which has caused the sickness absence.

Vocational rehabilitation

This involves helping 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 the usual tasks.

Worklessness

A term that is broader than the traditional definition of unemployment. It is used to describe people of working age who are not in formal employment but who are looking for a job (the unemployed). It is also used to describe people of working age who are not formally employed and are not looking for employment (also known as the 'economically inactive').

9 References

- Barham C, Begum N (2005) Sickness absence from work in the UK. Labour market trends. London: Office for National Statistics
- Barham C, Leonard J (2002) Trends and sources of data on sickness absence. Labour market trends. London: Office for National Statistics
- Bartley M, Ferrie J (2001) Unemployment, job insecurity and health. *Journal of Epidemiology and Community Health* 55: 776–81
- Beatty C, Fothergill S (2005) The diversion from 'unemployment' to 'sickness' across British regions and districts. *Regional Studies* 39: 837–54
- Benach J, Amable M, Muntaner C (2002) The consequences of flexible work for health: are we looking in the right place? *Journal of Epidemiology and Community Health* 56: 405–6
- Broom D, D'Souza R, Strazdins L et al. (2006) The lesser evil: bad jobs or unemployment? A survey of mid-aged Australians. *Social Science and Medicine* 63: 575–86
- Chartered Institute of Personnel and Development (2008) Annual survey report 2008: absence management. London: Chartered Institute of Personnel and Development
- Confederation of British Industry (2008) CBI/AXA absence and labour turnover survey. London: Confederation of British Industry
- Department for Work and Pensions (2003) Pathways to work: helping people into employment. The government's response and action plan. London: Department for Work and Pensions
- Department for Work and Pensions (2004) Building capacity for work. A UK framework for vocational rehabilitation. London: Department for Work and Pensions
- Department for Work and Pensions (2005a) Exploring how general practitioners work with patients on sick leave, research report 257. Leeds: Corporate Document Services
- Department for Work and Pensions (2005b) Department for Work and Pensions five year strategy. Opportunity and security throughout life. London: The Stationery Office

Department for Work and Pensions (2006a) A new deal for welfare: empowering people to work. London: The Stationery Office

Department for Work and Pensions (2006b) Welfare reform bill. London: The Stationery Office

Department for Work and Pensions (2007) Ready for work: full employment in our generation. London: The Stationery Office

Department for Work and Pensions (2008) Patients, their employment and their health – how to help your patients stay in work.

Department of Health (2004) Choosing health – making healthy choices easier. London: Department of Health

Department of Health (2008a) High quality care for all. NHS next stage review. Final report. London: Department of Health

Department of Health (2008b) NHS next stage review: our vision for primary and community care. London: Department of Health

Health and Safety Commission (2003) A strategy for workplace health and safety in Great Britain to 2010 and beyond. London: Health and Safety Commission

Health, Work and Wellbeing Programme (2008) Dame Carol Black's review of the health of Britain's working age population. Working for a healthier tomorrow. London: The Stationery Office

HM Government (1974) Health and Safety at Work Act.

HM Government (1995) The Disability Discrimination Act.

HM Government (1996) Employment Rights Act.

HM Government (1998) Data Protection Act 1998.

HM Government (2005a) The Disability Discrimination Act.

HM Government (2005b) Health, work and wellbeing – caring for our future. A strategy for the health and wellbeing of working age people.

HM Government (2007) Welfare Reform Act. London: The Stationery Office

HM Treasury (2004) 2004 spending review. Public service agreements 2005–2008. London: The Stationery Office

House of Commons Work and Pensions Committee (2006) Incapacity benefits and pathways to work. London: The Stationery Office

Marmot M, Wilkinson R (editors) (2006) Social determinants of health. Oxford: Oxford University Press

McCormick J (2000) On the sick: incapacity and inclusion. Edinburgh: Scottish Council Foundation

Mclean C, Carmona C, Francis S et al. (2005) Worklessness and health – what do we know about the causal relationship? Evidence review. London: Health Development Agency

Medical Research Council (2008) Developing and evaluating complex interventions: new guidance.

Ministerial Task Force for Health, Safety and Productivity and the Cabinet Office (2004) Managing sickness absence in the public sector. London: Health and Safety Executive

Norman P, Bambra C (2007) The utility of medically certified sickness absence as an updatable indicator of population health. *Population, Space and Place* 13: 333–52

Office of the Deputy Prime Minister and Social Exclusion Unit (2004) Jobs and enterprise in deprived areas. Social Exclusion Unit report. London: Office of the Deputy Prime Minister

Shiels C, Gabbay MB, Ford FM (2004) Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice* 54 (499): 86–91

Waddell G, Burton A (2006) Is work good for your health and wellbeing? London: The Stationery Office

Waddell G, Burton A, Kendall N (2008) Vocational rehabilitation what works, for whom, and when? London: The Stationery Office

Appendix A: Membership of the Programme Development Group, the NICE project team and external contractors

The Programme Development Group

PDG membership is multidisciplinary. It comprises researchers, practitioners, stakeholder representatives and members of the public as follows:

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Expert co-optees to the PDG:

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External contractors

NICE commissioned a mapping review, three evidence reviews, an economic analysis and a further report, following the consultation.

External reviewers: mapping and evidence reviews

- Mapping review: 'Guidance for primary care services and employers on the management of long-term sickness and incapacity: mapping review'. This review was carried out by the Institute for Employment Studies (IES) and Sheffield University's Institute of Work Psychology (IWP) and School of Health and Related Research (SchARR). The principal authors were: Sue Hayday, Jo Rick, Chris Carroll and Nick Jagger.
- Review 1: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work'. This review was carried out by IES and Sheffield University's IWP and SchARR. The principal authors were: Jim Hillage, Jo Rick, Hazel Pilgrim, Nick Jagger, Chris Carroll and Andrew Booth.
- Review 2: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis'. This review was carried out by IES and Sheffield University's IWP and SchARR. The principal authors were: Jo Rick, Chris Carroll, Jim Hillage, Hazel Pilgrim and Nick Jagger.
- Review 3: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to help recipients of incapacity benefits return to employment (paid and unpaid)'. This review was carried out by IES and Sheffield University's IWP and SchARR. The principal authors were: Sue Hayday, Jo Rick, Chris Carroll, Nick Jagger and Jim Hillage.

- Consultation report: 'Responses to the evidence consultation on long-term sickness absence and incapacity'. This report was carried out by IES and Sheffield University's IWP and ScHARR. The principal authors were: Jim Hillage, Jo Rick and Hazel Pilgrim.

External reviewers: expert papers

- Expert paper 1: 'Expert patients' programme' produced by Ann Rogers, National Primary Care Research and Development Centre, Primary Care Research Group, School of Community-based Medicine, University of Manchester.
- Expert paper 2: 'Condition management' produced by Fiona Ford, School of Public Health and Clinical Sciences, University of Central Lancashire.
- Expert paper 3: 'Discrimination in the labour market' produced by Peter Riach, Institute for the Study of Labour (IZA), University of Bonn.
- Expert paper 4: 'Regional employability programmes' produced by Vanessa Roberts, Directorate of Human Resources, Sheffield Teaching Hospitals NHS Foundation Trust.
- Expert paper 5: 'Evaluation of Camden GP surgery pilot' produced by Roy MacGregor, James Wigg Practice, Tomorrows People Partnership.

External reviewers: economic analysis

The economic analysis 'Modelling the cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees on sickness absence' was carried out by ScHARR (with support from IWP and IES). The principal authors were: Hazel Pilgrim, Chris Carroll, Jo Rick, Nick Jagger and Jim Hillage.

Fieldwork

The fieldwork 'Testing NICE draft guidance: managing long-term sickness absence and incapacity to work' was carried out by Inclusion.

Appendix B: Summary of the methods used to develop this guidance

Introduction

The reports of the reviews, expert papers and economic analysis include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it. The minutes of the PDG meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in [appendix E](#) and are available [online](#).

Guidance development

The stages involved in developing public health programme guidance are outlined in the box below.

1. Draft scope released for consultation meeting
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews and economic analysis undertaken
6. Evidence and economic analysis released for consultation
7. Comments and additional material submitted by stakeholders
8. Report of additional material produced (screened against inclusion criteria used in reviews)
9. Evidence and economic analysis submitted to the PDG
10. PDG produces draft recommendations
11. Draft guidance released for consultation and for field testing
12. PDG amends recommendations
13. Final guidance published on website
14. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching questions were:

- What work or primary care-based interventions, programmes, policies or strategies are effective and cost-effective in
 - preventing or reducing 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.
 - helping employees who have been on long-term sickness absence to return to work?
 - helping to reduce the number of employees who take long-term sickness absence on a recurring basis?
- What UK work or primary care-based interventions are effective and cost effective in helping people receiving incapacity benefit to return to full or part-time employment (paid and unpaid)? 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.

The subsidiary questions were:

1. What is the frequency, content, length and duration of an effective intervention, programme, policy or strategy?
2. Which are the most effective, cost effective and acceptable interventions, programmes, policies or strategies for different groups (for example, age, conditions, gender, ethnic groups or social classes)?
3. Does the effectiveness of an intervention, programme, policy or strategy depend on who or what organisation is leading it (that is, internal or external occupational health provision or counselling support)?
4. What are the barriers to, and facilitators of, effective implementation?
5. Does the intervention, programme, policy or strategy lead to any adverse or unintended (positive and negative) outcomes?
6. Which interventions, programmes, policies or strategies are ineffective and/or are not cost effective?

These questions were made more specific for each review (see reviews for further details).

Reviewing the evidence of effectiveness

A mapping review and three evidence reviews (covering the four main research questions) were conducted.

Identifying the evidence

The following databases were searched for review-level studies and primary studies published from 1990 onwards:

- AMED (Allied and Complementary Medicine)
- ASSIA (Applied Social Science Index and Abstracts)
- Business Source Premier
- British Nursing Index
- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- Cochrane Central Register of Controlled Trials
- Cochrane Database of Systematic Reviews (CDSR)
- Current Contents.
- Database of Abstracts of Reviews of Effectiveness (DARE)
- Econlit
- EMBASE
- Health Economics Evaluation Database (HEED)
- HMIC (Health Management Information Consortium – King's Fund Database and DH-Data database)
- MEDLINE
- National Research Register
- NHS EED (NHS Economics Evaluation Database)
- NHS HTA (NHS Health Technology Assessment)

- PsycINFO
- Science Citation Index
- SIGLE (International System for grey literature)
- Sociological Abstracts
- Social Science Citation Index

The following websites were also searched:

- [Advisory Conciliation and Arbitration Service \(ACAS\)](#)
- [Centre for Longitudinal Studies](#)
- [Department for Business, Enterprise and Regulatory Reform](#)
- [Department for Work & Pensions](#)
- [Employment Studies Research Unit](#)
- [Health and Safety Executive](#)
- [Institute of Occupational Health](#)
- [Institute for Public Policy & Research](#)
- [Oxford Health Alliance](#)
- [National Audit Office](#)
- [Xpert HR](#)

The reference lists of all review-level studies identified by the database and website searches were reviewed to identify additional potential references. Also, experts in the topic area (including PDG members) were contacted and asked to submit potentially relevant references. The reference lists for all primary studies that met the inclusion criteria were examined to identify any additional primary studies, and the citations of all included primary studies were also searched using Web of science and CINAHL.

Further details of the databases, search terms and strategies are included in the review reports.

Selection criteria

Studies were included in the two effectiveness and cost effectiveness reviews covering sickness absence if:

- they were based in developed countries or in Organisation for Economic Co-operation and Development (OECD) countries
- they were delivered in a primary care and/or workplace setting and/or planned, designed, delivered, managed or funded in collaboration with primary care providers and/or employers; the interventions could be delivered by a number of providers (such as voluntary, private, statutory sectors) and/or in various settings as long as they were fully or co-planned, designed, delivered, managed and/or funded in collaboration with employers and primary care settings
- the population comprised people aged 16 or older in full- or part-time employment, both paid and unpaid and had experienced short-term sickness and/or long-term sickness (which may be defined as 'short-term absence' or 'long-term absence' or 'sickness absence' in the research)
- they involved employers in the public, private or 'not for profit' sectors
- they reported on work-related outcomes such as a return to work, job seeking behaviour or reduced sick absence
- they covered an intervention that aimed to:
 - prevent or reduce the number of employees moving from short- to long-term sickness absence or prevent the recurrence of short-term absence
 - support return to work from, and/or reduce the length of, long-term sickness absence
 - help reduce recurrence of long-term sickness absence
- the study design was randomised controlled trials (RCTs) or longitudinal intervention studies (that is, there is at least one follow-up measure after baseline) or randomised controlled trials (RCTs) with cost effectiveness, cost consequences, cost benefit, cost utility, cost minimisation or net monetary (cost) benefit data.

Studies were excluded if:

- they were set in developing or non-OECD countries
- the population comprised

- self-employed people
- pregnant women who have taken sickness absence related to their pregnancy
- unemployed people
- they covered an intervention that:
 - aimed to prevent the first occurrence of short- or long-term sickness absence (primary prevention)
 - targeted pregnant women exclusively and/or which focused on illnesses associated with pregnancy, during the course of a pregnancy
 - tackled workplace absences which are not reported and/or recorded as sickness absence (for example, maternity leave)
 - was delivered outside the workplace or primary care settings
 - dealt solely with the effectiveness of private health insurance schemes and/or claiming of statutory or occupational sick pay; preventing ill-health retirement ; the provision of clinical diagnosis, treatment for existing conditions (including pharmacological or therapeutic interventions) and management of conditions associated with short- and/or long-term sickness
- if they described the relationship between health or ill health and short- or long-term absence (that is, correlate studies or non-evaluative studies of an intervention, policy, programme or strategy); descriptive studies of participants' views and experiences and cross-sectional studies (that is, with only one data collection point) were also excluded
- was a dissertation, thesis, book or book chapter or was a non-English language study.

Studies were included in the one remaining effectiveness and cost-effectiveness review covering incapacity if:

- they were based in the UK
- they were delivered in a primary care setting and/or workplace setting and/or planned, designed, delivered, managed or funded in collaboration with primary care providers and/or employers; these interventions, policies, programmes or strategies could be delivered by a number of providers (such as voluntary, private, statutory sectors) and/or in various settings as

long as they were fully or co-planned, designed, delivered, managed and/or funded in collaboration with employers and primary care settings

- the population comprised people over age 16 who were unemployed because of long-term incapacity and receiving incapacity benefit or other similar benefits
- they reported on work-related outcomes, for example, a return to work (paid/unpaid) or job seeking behaviour
- they covered an intervention that aimed to help people (over 16) who are unemployed and in receipt of incapacity benefit (or a previous form of incapacity benefit or similar benefit) return to work (paid/unpaid) or prepare for work (paid/unpaid)
- the study design was RCTs or longitudinal intervention studies (that is, there is at least one follow-up measure after baseline) or RCTs with cost effectiveness, cost consequences, cost-benefit, cost-utility, cost-minimisation or net monetary cost and benefit data.

For the incapacity review, studies were excluded if:

- they were not based in the UK
- the population was:
 - people over age 16 in full- or part-time employment, both paid and unpaid
 - people over age 16 not in receipt of incapacity benefit (or a previous version of the benefit)
- the intervention:
 - was delivered outside a workplace or primary care setting, with no primary care or employer involvement in the planning, design, delivery, management or funding
 - dealt solely with drug treatment; the effectiveness of the incapacity benefit system, private health insurance schemes or statutory or occupational sick pay or preventing ill-health retirement
- they described the relationship between health or ill health and incapacity (that is, correlates studies or non-evaluative studies of an intervention); descriptive studies of participants' views and experiences and cross-sectional studies (that is, with only one data collection point) were also excluded
- it was a dissertation, thesis, book, book chapter or was not published in English.

Inclusion and exclusion criteria for each review varied slightly and details are included in the review reports.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see [appendix E](#)). Each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study type

- RCTs (including cluster RCTs).
- Individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies.
- Case reports or case series.

Study quality

++ All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.

+ Some criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter.

The main reasons for studies being assessed as (-) were:

- lack of details in terms of study design features, such as method recruitment to study or randomisation
- lack of detail about the study participants
- lack of details in terms of content of the intervention such as who delivered the intervention, in what setting, what the intervention involved
- limited statistical data presented on work-related outcomes

- short follow-up periods for the participants from baseline to post intervention.

The studies were also assessed for their applicability to the UK.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

The findings from the studies included in the reviews were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements were prepared by the external contractors (see [appendix A](#)). The statements reflect their judgement of the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Economic analysis

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The results are reported in: 'Modelling the cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees on sickness absence'.

They are available on the NICE [website](#).

Expert papers

Five expert papers, covering expert patients' programmes; condition management; discrimination in the labour market; regional employability programmes and an evaluation of Camden GP surgery pilot were also produced.

Fieldwork

Fieldwork was carried out to evaluate how relevant and useful NICE's recommendations are for practitioners and how feasible it would be to put them into practice. It was conducted with practitioners and commissioners who are involved in managing long-term sickness absence and incapacity services. They included those working in the NHS (particularly primary care services and occupational health professionals), local authorities, community, voluntary and private sectors and workplace representatives and trade unions.

The fieldwork comprised:

- Six stakeholder workshops involving 120 representatives from the public, private, voluntary and community sectors.
- Eight focus groups involving 30 professionals from Jobcentre Plus, NHS HR managers and incapacity benefit and sickness absence experts.
- Telephone interviews with three GPs and one other professional who were unable to attend a focus group.

The fieldwork was commissioned to ensure there was ample geographical coverage. The main issues arising are set out in [appendix C](#) under fieldwork findings. The full fieldwork report 'Testing NICE draft guidance: managing long-term sickness absence and incapacity to work' is available [online](#).

How the PDG formulated the recommendations

At its meetings in February, April, May, June, September and October 2008, the PDG considered the evidence of effectiveness and cost effectiveness, expert reports and the economic analysis to determine:

- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal
- where there is an effect, the typical size of effect.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope.
- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.

- Ease of implementation and any anticipated changes in practice.

The PDG noted that the effectiveness of some interventions could vary according to the context in which they were delivered. For example, the country in which the study was delivered may well have a different policy and fiscal structure which needs to be considered.

Where evidence was lacking, the PDG also considered whether a recommendation should only be implemented as part of a research programme.

Where possible, recommendations were linked to an evidence statement(s) (see [appendix C](#) for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in August 2008. At its meeting in October 2008, the PDG amended the guidance in light of comments from stakeholders and experts, the consultation report and the fieldwork. The guidance was signed off by the NICE Guidance Executive in December 2008.

Appendix C: The evidence

This appendix lists the evidence statements from three reviews and a consultation report provided by external contractors (see [appendix A](#)) and links them to the relevant recommendations. (See [appendix B](#) for the key to quality assessments). The evidence statements are presented here without references – these can be found in the full review (see [appendix E](#) for details). It also links two of the five expert papers to the recommendations (the other three contribute to 'IDE') and sets out a brief summary of findings from the economic analysis and the fieldwork.

The three evidence reviews of effectiveness and cost effectiveness and the consultation report are:

- Review 1: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work'.
- Review 2: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis'.
- Review 3: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to help recipients of incapacity benefits return to employment (paid and unpaid)'.
- Consultation report: 'Responses to the evidence consultation on long-term sickness absence and incapacity'.

Evidence statement number ER1.1 indicates that the linked statement is numbered 1 in the 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work'. **Evidence statement ER2.1** indicates that the linked statement is numbered 1 in the 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis'. **EP1** indicates that the recommendation is linked to expert paper 1 'Expert patients' programme' and **EP2** indicates that the recommendation is linked to expert paper 2 'Condition management'. **CR1** indicates that the recommendation is linked to the consultation report: 'Responses to the evidence consultation on long-term sickness absence and incapacity'.

The reviews, expert papers, economic analysis, consultation report and fieldwork report are available [online](#). Where a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence).

Recommendation 1: evidence statements ER1.2, ER1.23, ER1.26, ER1.40, ER2.1; EP1, EP2.

Recommendation 2: evidence statements ER1.2, ER1.21, ER1.23, ER1.24, ER1.26, ER1.40, ER1.45, ER1.50, ER1.52, ER1.54, ER2.1, ER2.7, ER2.10; EP1, EP2; IDE.

Recommendation 3: evidence statements ER1.2, ER1.8, ER1.11, ER1.12, ER1.13, ER1.16, ER1.17, ER1.20, ER1.21, ER1.23, ER1.24, ER1.26, ER1.28, ER1.30, ER1.33, ER1.40, ER1.45, ER1.50, ER1.52, ER2.1, ER2.7, ER2.10; IDE.

Recommendation 4: evidence statements ER3.2, CR1.1, CR1.2, CR1.3.

Evidence statements

Evidence statement ER1.2

One RCT study in Norway (+) found evidence that workers, aged between 18 and 60, on long-term sick leave with lower back pain who receive consultations with a physician (specialising in physical medicine and rehabilitation) and a physiotherapist to improve skills to cope with their condition may be effective at helping workers return to work up to a year after they start sick leave than comparable people who were treated in primary care. In the consultation, patients received information, reassurance and encouragement to engage in physical activity as normal as possible and reports were sent to their primary care physician and local national insurance office. However, there was no significant difference between the groups in terms of return to work in the second or third year. Although the study found significant differences in the average number of sick leave days at the 12-month point between the intervention group and the control group, there was no significant difference between the groups in the proportions experiencing further sickness episodes over the 3 year period.

Evidence statement ER1.8

There is limited evidence from a longitudinal before-and-after comparison study (-) that attendance at a back school programme (for up to 6 hours over a period of a year) by 200 bus drivers in Holland may be effective at reducing long-term sickness absence.

Evidence statement ER1.11

An RCT study (+) found a significant decrease in the days on 'short-term' sick leave(that is, for between 2 and 6 months) for 36 women employees in Sweden who took part in a cognitive behavioural return-to-work programme compared with a group of 36 similar women employees over a period of 6 months. The average age among the two groups was 46. However, there was no significant effect for women on long-term sick leave.

Evidence statement ER1.12

One RCT study (+) found a significant difference in the proportion of 45 employees (27% female) in the Netherlands on long-term sick leave, for up to 20 weeks, with low back pain who had returned to work after 12 months following an intervention involving behavioural-graded activity and education supplemented by problem-solving therapy (for around 3 hours a week for 15 weeks) compared with 39 comparable employees who just received behavioural-graded activity and education.

Evidence statement ER1.13

One RCT study (+) found a significant positive difference in the proportion of 109 employees (34% female) who returned to work at a Dutch post and telecommunications company 3 months after at least 2 weeks' sick leave with symptoms of mental distress after undergoing a three-stage cognitive behavioural therapy (CBT) intervention compared with 83 comparable employees who received usual care.

Evidence statement ER1.16

One RCT study (-) found no significant difference in the proportion of 53 employees (76% female, average age 38) in Oslo, Norway who had returned to work from long-term sickness absence related to psychological or muscle skeletal disorders after attending a solution-focused group-based intervention (with 8 weekly sessions, lasting 3 to 4 hours, focusing on coping strategies) compared with 50 comparable employees receiving treatment as usual.

Evidence statement ER1.17

In a controlled before-and-after study (+) significantly more of the 70 male and female (54% of the total) employees with whiplash injuries in Canada who attended a 10-week Progressive Goal Attainment Programme (PGAP) (for an hour a week) in addition to the usual physical therapy, had

returned to work 4 weeks after the intervention compared with a sample of 70 comparable employees who received physical therapy only.

Evidence statement ER1.20

One RCT study (+) found that a behavioural medicine rehabilitation programme and its two constituent components: behaviour-oriented physiotherapy (for 4 weeks) and cognitive behavioural therapy (for 4 weeks) was effective compared to 'treatment as usual' in securing faster returns to work among 214 employees aged 18 to 60 (average age 43 and 55% female) long-term sick-listed for non-specific spinal pain for between 1 and 6 months in an unspecified area of Sweden for women, but not for men.

Evidence statement ER1.21

A prospective randomised control study (+) found that a graded activity programme (including workplace visits, a 'back school' and individual graded exercise for 3 days a week until return to work) was effective speeding up return to work among 51 car workers (23% female) sick listed for 8 weeks with low back pain compared with a similar group of 50 sick-listed employees in Volvo in Goteborg, Sweden.

Evidence statement ER1.23

Three linked studies (+) from an RCT involving 664 employees in Bergen Norway sick-listed for musculoskeletal pain found that a screening tool could be effectively developed to classify patients by their likelihood of returning to work. The studies show that an intensive (five, 6-hour sessions a week for 4 weeks) intervention multidisciplinary rehabilitation regime (including cognitive behavioural modification, education, exercise and 'occasional' workplace intervention) can be effective for patients with extensive problems (and a low propensity to return to work); those with a stronger likelihood of return to work benefit just as much from usual care as from a low or high intensity intervention. The studies also show that men and women respond differently to different types of treatment.

Evidence statement ER1.24

A Dutch RCT study (+), among 196 men and women aged between 18 and 65 who had been on sick leave for between 2 and 6 weeks due to lower back pain, found that a multi-stage return to work programme (involving a workplace assessment and work modifications based on participative ergonomics and counselling the employee about return to work) was effective at getting them back to work sooner than if they had just had usual care. There is also evidence that the workplace

intervention was effective in reducing the total number of days taken as sick leave among the study population and that the clinical intervention (in combination with usual care or the workplace intervention) did not have a positive effect, although the clinical intervention was only adhered to by 65% of cases.

Evidence statement ER1.26

There is evidence from an RCT study (-) involving 137 workers (58%t female) off sick in Sweden for at least a week with musculoskeletal disorders that an early intervention involving a work rehabilitation interview and a workplace assessment can be effective at significantly reducing the number of days off sick in the subsequent year, although the generalisability of the study to the UK may be limited as the results of the study may have been influenced by the operation of the Swedish sick pay regulations.

Evidence statement ER1.28

A Canadian RCT study (-), among 104 workers who had been on sick leave for between 4 and 13 weeks due to lower back pain, found that a multi-stage return to work programme (involving a combination of workplace and clinical and rehabilitative interventions) was effective at speeding up their rate of return to work and in minimising the total number of days taken as sick leave.

Evidence statement ER1.30

One RCT study (-) found that a multimodal treatment (including relaxation training, psychological support and manual therapy, provided in ten 1-hour sessions over 2 weeks) was effective at securing a return to work for 60 patients (42% female) suffering from whiplash injury who were recruited within 2 months of sustaining a neck injury in and around Ancona in Italy.

Evidence statement ER1.33

There is limited evidence from a controlled before and after study (-) that a therapeutic return to work intervention which linked graded work exposure with functional restoration therapy for people aged 18 to 65 years (52% female) suffering from chronic low back pain and off sick for over 90 days in Quebec, Canada, compared with just functional restoration therapy, community services without any rehabilitation intervention or usual care (for patients denied access to the intervention by the local Compensation Board).

Evidence statement ER1.40

There is evidence from econometric secondary data analysis (+) of survey and administrative data from 1685 sick-listed (for 3 to 12 weeks) employees (56 of whom were female) randomly drawn from across Denmark that a case management approach (in which sick-listed employees are interviewed by a person or team who can direct health and occupational services to help the interviewee back to work) is effective at helping people return to work.

Evidence statement R1.45

There is evidence from one Norwegian cost benefit evaluation based on a randomised controlled trial (++) that an examination at a primary care spine clinic by physician and physiotherapist and provision of information and individual instruction, as well as advice on how to stay active, is likely to be cost effective compared to primary care treatment in returning employees back to work following sickness absence due to low back pain.

Evidence statement ER1.50

There is evidence from two economic evaluations (one Norwegian, one Swedish, both [+]) that multidisciplinary treatment is likely to be cost effective in improving return to work and reducing sickness absence for people with low back pain. The net present value of productivity gains is equal to £352,953 (2007) for light and extensive multidisciplinary treatment (results not provided individually within the paper) and the cost-benefit results of behaviour-oriented physiotherapy, cognitive behavioural therapy and the combination of these is £62,294; £98,197 and £154,475 respectively for females. The interventions are not considered cost effective for males individually; however combined the cost-benefit of behaviour-oriented physiotherapy and CBT for males is £71,024.

Evidence statement ER1.52

There is evidence from one Dutch economic RCT evaluation (+) that a multi-stage return to work programme (involving usual care plus a workplace assessment and work modifications based on participative ergonomics and counselling the employee about return to work) is likely to be cost effective in reducing the re-occurrence of absence due to low back pain when measured against usual care as outlined by Dutch occupational physician guidelines for lower back pain. The cost per return to work day gained is estimated to be £17 and the cost per quality-adjusted life year (QALY) gained is estimated to be dominating (-£1294) in comparison to usual care. However, based on the analysis, it is unlikely that physiotherapy based on operant behavioural principles provided

following eight weeks of other ineffective treatment in terms of return to work is cost effective in comparison to the provision of Dutch usual care for the same indication).

Evidence statement ER1.54

There is evidence from one Canadian cost-benefit and cost-effectiveness analysis (+) based on an RCT that the clinical intervention, the occupational intervention and the Sherbrooke model (a combination of clinical and occupational interventions) is likely to be cost effective in comparison to standard care for back pain. The analysis suggests that the combination of the clinical and occupational interventions (the Sherbrooke model) is likely to better value for money than the two interventions individually.

Evidence statement ER2.1

One RCT study in Norway (+) found evidence that workers, aged between 18 and 60, on long-term sick leave with lower back pain who receive consultations with a physician (specialising in physical medicine and rehabilitation) and a physiotherapist to improve skills to cope with their condition may be effective at helping workers return to work up to a year after they start sick leave than comparable people who receive were treated in primary care. In the consultation, patients received information, reassurance and encouragement to engage in physical activity as normal as possible and reports were sent to their primary care physician and local national insurance office. Although the study found significant differences in the average number of sick leave days at the 12-month point between the intervention group and the control group, there was no significant difference between the groups in the proportions experiencing further sickness episodes over the three year period. Therefore there is insufficient evidence from this study to suggest that this intervention was effective in preventing the re-occurrence of sickness absence in the long term.

Evidence statement ER2.7

A Dutch RCT study (+), among 196 men and women aged between 18 and 65 who had been on sick leave for between 2 and 6 weeks due to lower back pain, found that a multi-stage return to work programme (involving a workplace assessment and work modifications based on participative ergonomics and counselling the employee about return to work) was effective at getting them back to work sooner than if they had just had usual care. There is also evidence that the workplace intervention was effective in reducing the total number of days taken as recurring sick leave among the study population and that the clinical intervention (in combination with usual care or the workplace intervention) did not have a positive effect, although the clinical intervention was only adhered to by 65% of cases.

Evidence Statement ER2.10

There is evidence from one Dutch economic RCT evaluation (+) that work modifications based on participative ergonomics and counselling the employee about return to work are likely to be cost effective in reducing the re-occurrence of absence due to low back pain when compared against usual care as outlined by Dutch occupational physician guidelines for lower back pain. Within this study patients are randomised to receive a clinical intervention or usual care at 8 weeks if they have not returned to work and therefore this may confound the results; although the authors have tried to calculate an adjustment for this. The cost per return to work day gained is estimated to be £17 and the cost per QALY gained is estimated to be dominating (-£1295) for the workplace intervention in comparison to usual care. However, based on the analysis, it is unlikely that graded exercise based on operant behavioural principles provided for those who remain on sickness absence after 8 weeks of receiving either the workplace intervention or usual care in terms of return to work is cost effective in comparison to the provision of Dutch usual care for the same indication.

Evidence Statement ER3.2

There is limited evidence from a non-randomised controlled trial (+) that a programme comprising attendance at a work-focused interview and access to return to work support (including further interviews, help with managing their health condition, financial support and in-work occupational health and personal support) could be effective at increasing the chances of people on incapacity benefit (IB) being in work 18 months after initially enquiring about accessing IB. The employment effects appear to be stronger for women than men, those aged under, rather than over, 50 and people without rather than with mental illness.

Evidence Statement CR1.1

There is limited evidence from a before and after evaluation study (-) using econometric analysis that a programme comprising attendance at a work-focused interview plus up to five further interviews with trained advisers and access to return to work support (including further interviews, employability training, help with managing their health condition, financial support and in-work occupational health and personal support) can be effective at increasing the chances of existing claimants of incapacity benefit (IB) being in work 18 months after the programme of intervention began.

Evidence Statement CR1.2

There is limited evidence from a before and after comparison evaluation (-) that an intervention in North East England designed to help people off incapacity benefit and into work by providing access to health and condition management, advice from a health caseworker, employment advice and a range of employability support from an employment case worker can lead to beneficiaries gaining sustained employment (that is, for at least 3 months).

Evidence Statement CR1.3

There is evidence from one UK cost benefit analysis (+) that the 'Pathways to work' intervention, comprising attendance at a work-focused interview and access to return to work support (including further interviews, employability training, help with managing their health condition, financial support and in-work occupational health and personal support), is likely to be cost saving compared to no such intervention in returning people currently receiving incapacity benefit to work if the effectiveness evidence reported by Bewley et al. (2007) on which this analysis is based is accepted.

Expert papers

- Expert paper 1: 'Expert patients' programme'.
- Expert paper 2: 'Condition management'.
- Expert paper 3: 'Discrimination in the labour market'.
- Expert paper 4: 'Regional employability programmes'.
- Expert paper 5: 'Evaluation of Camden GP surgery pilot'.

Economic analysis

The economic literature on interventions showing a return-to-work outcome for people on long-term sickness absence is relatively sparse.

The first evidence review 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work' identified 11 economic studies. Ten of these focused on back pain or musculoskeletal pain/disorders. One focused on minor mental health disorders. All 11 studies were covered in the effectiveness component of the evidence review.

The second evidence review 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis' identified three economic studies. (These also appeared within the 11 studies identified in the first review.) All three focused on back pain.

From these two reviews, several of the 10 studies on people with back pain show that various combinations of physical activity advice, physiotherapy, CBT and workplace assessment are cost effective, compared with usual care. The mental health study (from the Netherlands) found that an intervention where social workers help people to adopt problem-solving strategies and encourage them to resume work was cost effective, compared with usual care.

The third evidence review, 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to help recipients of incapacity benefits return to employment (paid and unpaid)', identified only one economic study on the 'Pathways to Work' scheme. This was carried out for the Department for Work and Pensions and assessed the cost effectiveness of an intervention covered in the effectiveness section of this review.

The economic analysis of the pathways scheme showed that for four initiatives targeted at recipients of new and repeat incapacity benefit, the benefits exceed the costs (from the perspective of the individual, the public sector and society). This analysis did not include any of the quality of life benefits that people may experience as a result of returning to work. The pathways scheme was more effective for women; people aged under 50 and those who did not have a mental illness. However, the reasons for being in receipt of incapacity were not given.

Other than the Pathways to Work analysis, all the economic studies from the three reviews took place outside the UK and so need to be treated with caution because of the differences in benefits systems and what is regarded as 'usual care'.

Economic modelling was carried out on:

- a physical activity and education (including CBT) intervention (it cost £2800 per QALY compared with usual care)
- a workplace-based intervention (which dominates usual care)
- a physical activity, education (including psychological component) intervention combined with a workplace visit for musculoskeletal disorders. (This combination of treatments dominates usual care.)

All three of the above interventions were found to be cost effective ways of helping people return to work when compared with usual care.

A number of assumptions had to be made to determine whether or not mental health interventions were cost effective. For example, whether the quality-of-life gain for someone with mental health problems when they returned to work was the same as for someone who had been off work with musculoskeletal problems. If the same assumptions are made for both these groups, in terms of the cost and the effect of an intervention, then cost effectiveness will not depend on the condition. Hence, what is cost effective for musculoskeletal interventions will automatically be cost effective for mental health interventions.

A further analysis was undertaken of the potential cost-effectiveness of using an initial assessment and/or case worker/manager/team. It found that, if this results in at least a 1% improvement in the return-to-work rate – and costs less than about £900 per employee, then it is likely to be cost effective at a threshold of £20,000 per QALY.

No economic modelling was undertaken for Pathways to Work, because this had already been carried out in the report prepared for the Department for Work and Pensions (see above). It estimated that Pathways to Work would have a favourable benefit to cost ratio for finding employment for people on incapacity benefit.

However, in a climate of increasing unemployment, the length of time it would take for participants to find a job would substantially increase. This would, in turn, reduce the benefits of programmes and interventions to encourage this group of people to return to work. Thus Pathways to Work is less likely to be cost effective. The PDG believed employers would probably be more likely to screen out applications from such recipients when there was relatively high unemployment.

Fieldwork findings

Fieldwork aimed to test the relevance, usefulness and the feasibility of putting the recommendations into practice. The PDG considered the findings when developing the final recommendations. For details, go to the fieldwork section in [appendix B](#) and 'Testing NICE draft guidance – managing long-term sickness absence and incapacity to work'.

Participants work with people experiencing sickness absence on a long-term or recurring basis, including those in receipt of incapacity benefit.

Overall, they welcomed the development of NICE guidance on this subject. However, many felt that the recommendations did not take sufficient account of the non-medical factors that might lead to sickness absence. Examples might include interpersonal relationships (both within and outside work) and social and cultural issues.

More detail was needed about how the recommendations would be paid for in practice – and on the responsibilities and choices that employees should be offered. Participants felt that the employee was viewed as a passive recipient rather than an active partner in the process of getting them back to work. Good practice case studies and flow charts depicting, for example, the 'client journey', would have helped to outline how the recommendations could impact on both employees and employers.

There was support for a multi-disciplinary (occupational health, psychologists and GPs) and multi-agency (health care providers and Jobcentre Plus staff) approach. But clearly, good communications would be essential, given the wide-ranging issues and conditions involved.

Although there was support for the use of case workers, there was no consensus on who should take on that role. The confidential nature of information held about an individual was an issue that needed careful consideration. Some participants felt the line manager would be best placed to carry out the role, others felt that they would not be impartial enough.

However, there was consensus that the roles of each profession should be made more explicit. Similarly, the recommendations need to make it clear whether or not an assessment should be undertaken within or outside the employing organisation (or even, whether it was necessary at all for employees with an acute health condition and a known return-to-work date).

While stakeholders, practitioners and commissioners did not believe the recommendations offered an entirely new approach, some interventions may have not been implemented universally, due to lack of service availability.

Wider and more systematic implementation would be achieved if:

- it was clear who would pay for the assessments and interventions recommended
- both employers and employees had access to relevant resources and information
- it was clear who should take action and which organisation or agency should take the lead

- the employee was acknowledged as a partner in the return-to-work process (by including them in the recommendations as part of the 'who should take action' list).

Appendix D: Gaps in the evidence

The PDG identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence, stakeholder comments and expert papers and fieldwork. These gaps are set out below.

1. Limited evidence was identified on interventions that:
 - aim to prevent employees moving from short- to long-term sickness absence
 - attempt to reduce the number of employees taking repeated short- or long-term sickness absence.
2. There was very limited, UK-based evidence that met the inclusion criteria for this guidance on interventions that help those receiving incapacity (or similar benefit) return to work. The evidence that was available either only demonstrated a small effect size or did not provide detailed information about the different population groups that benefited from the interventions.
3. There was limited evidence on interventions that help people with mental health problems return to work after sickness absence.
4. Evidence on biopsychological interventions was limited in terms of the range of therapies covered. For example, other 'talk therapies' like counselling were not identified. Also, very few studies examined or described the wider social context of sickness absence (part of a bio-psychosocial approach).
5. The following details were often missing from descriptions of interventions:
 - a definition of the sickness absence period, the primary reasons for or details of the conditions causing the sickness absence period or incapacity and duration of the sickness absence and the point when the employee was ready to return to work
 - content, when it was delivered, by whom, in what setting, at what point during the individual's absence or incapacity, how frequently and for how long?
 - any variation in effectiveness and cost effectiveness in relation to characteristics such as gender/sex, age, race/ethnicity, disability, sexual orientation and religion or belief

- whether or not a particular component of a multi-component intervention was responsible for effectiveness/cost effectiveness – and the differential impact of each component
 - the perceptions of both those delivering the intervention and the recipients of the benefits of, and barriers to, taking in part in compulsory versus voluntary components
 - a control or comparison element
 - statistical data for reported intended and unintended outcomes
 - the economic costs and benefits
 - follow-up periods and sustainability.
6. There was a lack of evidence on specific components that make an intervention effective. For example, few studies provided data to answer questions such as: 'Does effectiveness depend on the intervener?' or 'Does the intensity or duration influence effectiveness or duration of effect'?
 7. Few studies evaluated the factors that hinder or help someone to return to work following sickness absence or incapacity (for example, whether mandatory compared to voluntary components help or hinder effectiveness).
 8. Few studies described the barriers experienced by those planning, designing, delivering or managing the interventions. None described how to overcome these barriers.
 9. Long-term return-to-work or quality of working life outcomes for a number of potentially relevant interventions were not always available (for example, they were not available for the Expert Patients' Programme and condition management programmes).
 10. There was a lack of robust evaluations of recent interventions using employment case managers.
 11. Routine data collection (such as the collection of details on occupation, sickness certification and sickness absence) was not standardised, recorded and made accessible for research.
 12. There is no standardised database (such as that used by GPs) which links across government departments.
 13. Routine health care data collection does not include information on occupation or employment status. This information is needed to assess progress in tackling health

inequalities. For example, to assess whether people from different occupational groups receive the same interventions or whether their recovery time and any sustained return to work is comparable.

The Group made four recommendations for research. These are listed in [section 5](#).

Appendix E: Supporting documents

Supporting documents are available [online](#). These include the following.

- Reviews of effectiveness and cost effectiveness:
 - Mapping review: 'Guidance for primary care services and employers on the management of long-term sickness and incapacity: mapping review'.
 - Review 1: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who move from short-term to long-term sickness absence and to help employees on long-term sickness absence return to work'.
 - Review 2: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees who take long-term sickness absence on a recurring basis'.
 - Review 3: 'Review of the effectiveness and cost effectiveness of interventions, strategies, programmes and policies to help recipients of incapacity benefits return to employment (paid and unpaid)'.
- Expert papers:
 - Paper 1: 'Expert patients' programme'.
 - Paper 2: 'Condition management'.
 - Paper 3: 'Discrimination in the labour market'.
 - Paper 4: 'Regional employability programmes'.
 - Paper 5: 'Evaluation of Camden GP surgery pilot'.
- Economic analysis: 'Modelling the cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees on sickness absence'.
- Consultation report: 'Responses to the evidence consultation on long-term sickness absence and incapacity'.
- Fieldwork report: 'Testing NICE draft guidance: managing long-term sickness absence and incapacity to work'.

- A [quick reference guide](#) for professionals whose remit includes public health and for interested members of the public.

For information on how NICE public health guidance is developed, see:

- '[Methods for development of NICE public health guidance \(second edition, 2009\)](#)'
- '[The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public \(second edition, 2009\)](#)'.

Changes after publication

February 2012: minor maintenance.

January 2013: minor maintenance.

About this guidance

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

This guidance was developed using the NICE [public health programme](#) guidance process.

Tools to help you put the guidance into practice and information about the evidence it is based on are also [available](#).

Your responsibility

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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