

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

PUBLIC HEALTH DRAFT GUIDANCE

Issue date:

Managing long-term sickness absence and incapacity for work

NICE public health guidance x

Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE or the Institute) 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, low back pain, anxiety, depression, and computerised cognitive behavioural therapy (CCBT). (For further details, see section 8.)

The Programme Development Group (PDG) has considered both the reviews of the evidence and the economic analysis.

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This document sets out the preliminary recommendations developed by the PDG. It does not include all the sections that will form part of the final guidance. The Institute is now inviting comments from stakeholders (listed on the NICE website at: www.nice.org.uk).

Terms in **bold** are defined in the glossary (section 9). Click on the term to link to the glossary.

Note that this document does not constitute the Institute's formal guidance on managing long-term sickness absence and incapacity. The recommendations made in section 4 are provisional and may change after consultation with stakeholders and fieldwork.

The process the Institute will follow after the consultation period (which includes fieldwork) is summarised below. For further details, see 'The public health guidance development process: an overview for stakeholders including public health practitioners, policy makers and the public' (this document is available on the Institute's website at: www.nice.org.uk/phprocess).

- The PDG will meet again to consider the consultation comments, the fieldwork reports and the stakeholder evidence.
- After that meeting, the PDG will produce a second draft of the guidance.
- The draft guidance goes to the NICE Guidance Executive for final sign off.

The key dates are:

Closing date for comments: 17 September 2008.

Next PDG meeting: 15–16 October 2008.

Details of membership of the Programme Development Group are given in appendix A and key supporting documents used in the preparation of this document are listed in appendix E.

This guidance was developed using the NICE public health programme process.

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1 Key priorities

This section will be completed in the final document.

2 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 (DH 2004; Department for Work and Pensions 2005a; 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).

The quality and accuracy of available data on absence and sickness absence is variable (Barham and Begum 2005; Barham and Leonard 2002). In 2008, 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 are 7 days or less, 16% are between 8 days and 4 weeks, and 20% are 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).

The most common causes of [long-term sickness absence](#) for manual workers (across all sectors) 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 stress and anxiety), musculoskeletal injuries and back pain (Chartered Institute of Personnel Development 2008).

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

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An estimated 175 million working days were lost in Britain in 2006 through sickness absence (Health, Work and Well-being Programme 2008). Sickness absence costs the British economy an estimated £12 billion each year (HM Government 2005).

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). Once someone has been off sick from work for 6 months or longer, they have an 80% chance of being off work for 5 years (Waddell and Burton 2006).

Government benefits that are available when a worker falls ill include [incapacity benefit](#). About 2.7 million people receive incapacity benefit (Department for Work and Pensions 2005a; 2005b; 2006a; 2006b). Among people who have been claiming incapacity benefit for 12 months, the average duration of their claim will be 8 years, and after 2 years on incapacity benefit people are more likely to die or retire than return to work (HM Government 2005).

A number of national policies, strategies, targets 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 (Department for Work and Pensions 2003; 2004; 2005b; 2006a; 2006b; DH 2008a; 2008b; Health and Safety Commission 2003; Health, Work and Well-being Programme 2008; HM Government 2005; 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. Supporting 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).

Where the evidence permits, this guidance covers [interventions](#), policies, programmes or strategies that aim to help:

- prevent employees moving from short-term to long-term sickness absence (including the prevention of [recurring short-term sickness absence](#));
- 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).

3 Considerations

The PDG took account of a number of factors and issues in making the recommendations.

Context

3.1 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.

3.2 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 4 weeks, and long-term sickness absence as absences of 4 or more weeks. The criteria for qualifying for incapacity benefit have also changed over time. (From October 2008 onwards a new Employment and Support Allowance (ESA) will replace incapacity benefit and income support on grounds of incapacity – initially this will be for new claimants only). In order to ensure that 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. 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.

- 3.3 The original DH referral asked NICE to develop guidance for managing long-term sickness and incapacity. However, the lack of studies clearly defined as covering 'long-term sickness absence', 'short-term sickness absence' or 'recurring sickness absence' has meant that the PDG has not always been able to produce recommendations that distinguish between these terms.
- 3.4 There was a lack of evidence of a sufficient quality to demonstrate the effectiveness of interventions that help people receiving incapacity benefit (or similar benefits) return to employment (paid and unpaid). As a result, the PDG has not made a recommendation on this. Instead, it has highlighted the need for further research (see 'Appendix D').
- 3.5 The PDG considered 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. They 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.

- 3.6 Different types of employers (such as large, small or public and private employers) are likely to have different policies and practices for dealing with sickness absence. For example, criteria and trigger points (such as number of days of sickness absence before a sickness absence policy is triggered or before salary is reduced) for intervening may differ. Consequently, employers implementing the recommendations may need to consider adjusting their employment contracts and/or organisational policies.
- 3.7 The recent 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, which is greater than the annual budget of the NHS. The above review was based on the premise that work has inherent benefits for people's health. It also recognised that there are gaps in the evidence on how effective and cost-effective work-based interventions and health interventions are in promoting a return to work.
- 3.8 Employers have an important role in helping people get back to employment after long-term sickness absence and incapacity. This may include 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 need for any re-training. Campaigns and schemes such as '[Job interview guarantee](#)' and '[Mindful employer](#)' aim to overcome stereotypes and stigma about ill health and its effect on employment opportunities.
- 3.9 Some of the evidence was linked to specific populations groups and/or specific conditions such as low back pain. When drafting some of the recommendations, the PDG extrapolated this evidence to the general population. Such recommendations do not refer to specific

groups or communities, and they are marked as ‘inference derived from the evidence’ (IDE) in appendix C.

- 3.10 The number of people claiming incapacity benefit is greater in areas of higher unemployment, slower economic growth and greater socioeconomic deprivation. People receiving incapacity benefit are less likely to have academic or professional qualifications than those in work. This suggests that health problems associated with incapacity are only part of a complex interplay with other socioeconomic factors that need to be considered when making individual plans to help a person return to work. For example, many claimants are likely to need education and training before they can achieve sustainable employment.
- 3.11 The numbering of the recommendations does not imply a hierarchy of importance.

Collating and assessing the evidence

- 3.12 The guidance has drawn on a wide range of research using quantitative methods including randomised controlled trials, before and after studies (with and without controls), case–control and cohort studies (see appendix B).
- 3.13 Study design was a key component of the inclusion criteria for the evidence reviews. Only randomised controlled trials and longitudinal studies (that is, where measures are assessed before and after intervention) were included as these are the most appropriate study designs for determining causality between intervention and effect. Given the limited time frame and available resources, descriptive studies examining the relationship between ill-health and sickness absence or incapacity were excluded. Similarly, qualitative studies 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.

3.14 A number of methodological issues were identified:

- Work-related outcomes (rather than health) were the primary outcomes of interest for this guidance. However, work-related outcomes were not the primary outcomes or the main aim of some of the included studies. Consequently, data such as detailed statistics on return to work were often not reported.
- 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 also not reported.
- Some studies involved multiple components and did not always report the differential effectiveness of each component.

3.15 A range of evidence was identified using the methods outlined in appendix B, and evidence statements to guide development of the recommendations were developed from it (see appendix C).

However, to ensure the guidance was delivered to deadline and within financial resources, pragmatic decisions were made and a number of exclusion criteria were identified (see appendix B). For example, the following were excluded:

- research not published in English

- dissertations, theses, 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.

3.16 The evidence review covering interventions for people receiving incapacity or similar benefits was restricted to studies in the UK. 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 they cover in the UK.

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

- Three of the evidence reviews 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 specificity in how the study describes 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

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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 also 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 those who are unemployed and receiving jobseekers allowance (or previous forms of this benefit).
- Studies involving mixed population groups (such as self-employed and employed people or those experiencing sickness absence or other types of absence), or mixed study designs (such as quantitative and qualitative) may have been missed if it was not possible to disaggregate the data into a form that met the inclusion criteria.
- 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 through local authorities or 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'.)

Synthesising the evidence

3.18 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.

3.19 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), may have a significant impact on return to work or work related outcomes; 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.

3.20 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

(www.hse.gov.uk/costs/ill_health_costs/ill_health_costs_intro.asp)

- 3.21 No evidence was identified on the effectiveness and cost effectiveness of some interventions in current practice (such as some interventions that focus on stress and mental illness). This was because they had either 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.)
- 3.22 Evidence for the cost effectiveness of interventions was generally sparse but, where it existed, it showed that such interventions were cost effective from both an NHS/personal social services perspective and a societal perspective. The results from these two perspectives were similar. 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 through production increases attributable to earlier and/or more effective return to work. These results were clear-cut for the average employer, so they can probably be applied to most employers.
- 3.23 In some cases, it was not possible to determine which interventions were cost-effective. In particular, it was not possible to determine whether or not mental health interventions were cost effective.

- 3.24 It is important to note that an intervention may be cost effective even if it only has a small effect (which may not be statistically significant), if the cost is low enough.
- 3.25 The experience, training, skills and competencies needed by the person who delivers the intervention may also affect the long-term effectiveness and cost effectiveness of any intervention.
- 3.26 There appear to be conflicting views on the use of [manual therapy](#) in relation to return-to-work outcomes. The evidence suggests that manual therapy can be effective for some conditions. However, the committee noted that some treatment guidelines (not NICE clinical guidelines) caution against the use of manual therapy. The committee considered that practitioners should decide, in collaboration with the recipient, which if these interventions are most appropriate.
- 3.27 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 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.
- 3.28 The PDG identified from the evidence a number of additional factors that are important to consider when implementing the recommendations. These include:
- the age and sex of the person receiving the intervention, the condition that led to the sickness absence, and prognosis, which may influence speed of recovery and ability to return to work
 - whether the proposed intervention is appropriate for a person in relation to specific characteristics such as their age, ethnicity and gender

- whether there are any incentives or financial benefits to encourage return to work, such as loss of full pay
- tailoring the delivery of the intervention to the individual's condition and prognosis for returning to work
- the experience, expertise and credibility of the person delivering the interventions and whether a multi-disciplinary approach is required
- the organisational structure and culture in which the interventions are to be delivered
- when to deliver the interventions; early intervention may improve effectiveness
- the need to develop ongoing contact with the person and involve the employer and the employee in the planning, design and delivery of interventions
- the level of involvement of the person delivering and receiving the intervention; the evidence suggests that 'doing something to people' (such as physiotherapy) helps improve effectiveness compared with 'telling them to do something' (such as undertake regular physical activity), or 'getting them to do it for themselves' (such as providing contact details for other professionals or organisations that may be able to help)
- the duration, frequency and intensity of the intervention
- sickness absence associated with one condition, such as back pain, may lead to another condition such as psychological illness
- the need for follow-up periods long enough for any improvements in work-related outcomes to be evaluated – in particular, sustained return to work
- the importance of confidence and trust in the experience and skill of the person delivering the intervention, whether from a clinical or non-clinical background; if a statutory service involved in delivering an intervention has a responsibility to inform state

benefit services, this may affect the patient's confidence in the objectivity of its staff.

4 Recommendations

When writing the recommendations, the PDG (see appendix A) considered the evidence of effectiveness and cost effectiveness. Note: this document does not constitute the Institute's formal guidance on this programme. The recommendations are preliminary and may change after consultation.

The evidence statements underpinning the recommendations are listed in appendix C. The evidence reviews, including the supporting evidence statements, and economic analysis are available on the Institute's website at www.nice.org.uk/guidance/index.jsp?action=byID&o=11674

Assessment

Recommendation 1

Target population

Employees experiencing recurring or long-term sickness absence, particularly those with musculoskeletal disorders (including back pain and chronic widespread pain) or mental health problems (such as stress or stress-related conditions).

Who should take action?

- Employers (including line managers and human resources [HR] departments).
- GPs.
- Specialist professionals such as physiotherapists.
- Physicians, nurses or other professionals specialising in occupational health, health and safety, rehabilitation or ergonomics.
- Benefits agencies.

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What action should they take?

- Within 12 weeks (ideally between 2 and 6 weeks) of a person starting sick leave ensure they are assessed. The assessment should be undertaken in conjunction with the employer and carried out by a suitably trained person (for example, a GP or a specialist such as occupational health nurse or physician). The assessment could be undertaken by a suitably trained [case worker/manager/team](#) (see recommendation 2).
- The assessment should include:
 - initial enquiries to determine the reason for the sickness
 - identifying whether a case worker/manager/team is needed if they have not already been appointed (see recommendation 2)
 - screening questions to determine:
 - ◇ the person's prognosis for returning to work (that is, how likely it is that they will return to work)
 - ◇ the level of interventions required, and their type and frequency (see recommendations 3 to 5)
 - discussion and agreement with the employee about the proposed interventions. People who have a poor prognosis for returning to work are likely to benefit most from more intensive interventions; those with a good prognosis for returning to work should be offered either usual care or less intensive interventions (see recommendation 3).
- The assessment could also include one or more of:
 - an examination by a GP or appropriate specialist to determine the person's diagnosis, treatment and need for further tests or further sick leave
 - use of a screening tool (in addition to the screening questions) to determine the prognosis for returning to work
 - a combined interview and workplace assessment to evaluate the person's:

- ◇ current social and employment situation
 - ◇ current or previous rehabilitation experiences
 - ◇ work tasks and their functional capacity to perform them (covering issues such as mobility, strength and fitness)
 - ◇ need for any work modifications, including ergonomic modifications
 - developing a rehabilitation plan which may include psychological support (see recommendation 4).
- Ensure those assessing which psychological interventions to offer are trained in assessment techniques.
 - Arrange for a specialist (such as an occupational health professional) and the employer to be involved more in the assessment if the person has had recurring episodes of long-term sickness absence or repeat episodes of short-term sickness absence.

Appointing a case worker/manager/team

Recommendation 2

Target population

Employees experiencing recurring or long-term sickness absence, particularly those with musculoskeletal disorders or mental health problems (such as stress or stress-related conditions).

Who should take action?

- Employers (including line managers and HR departments).
- GPs.
- Specialist professionals (such as physiotherapists).
- Physicians, nurses or other professionals specialising in occupational health, health and safety, rehabilitation or ergonomics.

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- Benefits agencies.

What action should they take?

- If indicated by the assessment (see recommendation 1), appoint a case worker/manager/team to plan and coordinate the delivery of any health, occupational or rehabilitation interventions. The case worker/manager/team) should liaise with the employee, the employer and anyone else involved such as the GP, specialists (such as occupational health or physiotherapists) or benefits agency, and identify:
 - possible options for returning to work
 - the level and type of intervention needed (see recommendations 3 to 5).
- The case worker/manager/ team does not need to have a clinical or occupational health background but should have the skills and training to able to act as an intermediary among the people involved.

Delivering interventions and services

Recommendation 3

Target population

Employees experiencing recurring or long-term sickness absence, particularly those with musculoskeletal disorders (including back pain and chronic widespread pain) or mental health problems.

Who should take action?

- Employers (including line managers and HR departments).
- Case workers/managers/teams.
- GPs.
- Specialist professionals (such as physiotherapists).

- Professionals, physicians or nurses specialising in occupational health, health and safety, rehabilitation or ergonomics.
- Union representatives.

What action should they take?

- Ensure the coordination and delivery of the interventions is jointly agreed between the employee and the employer. (This should involve identifying what level, type and frequency of interventions are needed.) This could be done by a case worker (or case manager), if appointed, or by another suitably trained person (for example, a GP or a specialist such as an occupational health nurse or physician).
- Examples of ‘light’ interventions include usual care plus short sessions providing, where appropriate, one or more of the following:
 - tailored information
 - advice and training
 - encouragement to be physically active
 - referral to physiotherapists and/or psychology services.
- Examples of ‘intensive’ interventions include usual care plus a programme of multidisciplinary interventions over several weeks (for example, daily sessions for 4 weeks) including one or more of the following:
 - [cognitive behavioural therapy](#)
 - education on physical and mental coping strategies for work and everyday activities
 - exercise
 - workplace modifications.
- The following types of intervention could be included:
 - a return-to-work or rehabilitation programme, which could involve:
 - ◇ a gradual return to the person’s original job using staged increases in hours and days worked (for example, starting

- with shorter hours and/or less days and gradually increased)
- ◇ a return to partial duties of the original job or temporary/permanent redeployment to another job
 - modifications to the workplace or work equipment (including ergonomic modifications).
- Consider the following interventions, where appropriate:
 - individually tailored information and advice on how to manage daily activities at home and at work; this could include advice on, and encouragement to take part in, suitable physical activities (such as daily walks) and relaxation techniques
 - exercise programmes (such as a '[Swedish back school](#)' programme or programmes using an '[operant-conditioning behavioural approach](#)')
 - counselling about returning to work
 - physiotherapy
 - referral to vocational rehabilitation (including training).
 - Arrange more specialist input when there is recurring long-term sickness absence or repeat episodes of short-term sickness absence. Employees should be encouraged to contact their employer, GP or occupational health service for further advice and support as needed.
 - Coordinate and deliver these interventions to reduce the risk of further sickness absence.

(See also NICE clinical guideline on managing patients with chronic back pain at www.nice.org.uk/guidance/index.jsp?action=byID&o=11645 [in development, due May 2009]).

Recommendation 4

Target population

Employees experiencing recurring or long-term sickness absence, particularly those with musculoskeletal disorders (including those experiencing pain) or mental health problems (such as stress or stress-related conditions).

Who should take action?

- Employers (including line managers and HR departments).
- Case workers/managers/teams.
- GPs.
- Professionals, physicians or nurses or psychologists specialising in occupational health, health and safety, rehabilitation or ergonomics.
- Union representatives:

What action should they take?

- Ensure the psychological interventions and services provided to improve coping strategies and support a return to work are evidence-based and delivered by trained practitioners. (The practitioners involved in delivering the interventions and services may include social workers, psychologists, GPs, occupational physicians or nurses, or specialist counsellors or therapists. Examples of evidence-based interventions are given below.)
- Consider using the following psychological interventions which have been proven to be effective for the specific groups listed below:
 - cognitive behavioural therapy (CBT) for women with musculoskeletal pain
 - CBT and contact with the employer for women and men with [adjustment disorder](#) or stress
 - CBT or [problem-solving therapy](#) combined with [behavioural graded activity](#) and liaison with the workplace

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to discuss 'a return to work' plan for women experiencing low back pain

- group sessions focused on finding solutions (based on, for example, [‘The road ahead course’](#)) for people with psychological or musculoskeletal pain
- [progressive goal attainment programmes](#) combined with physiotherapy or [multimodal programmes](#) for those with whiplash injuries.

(See also NICE technology appraisal guidance 51 on computerised cognitive behaviour therapy for depression and anxiety at www.nice.org.uk/TA051; NICE clinical guideline 22 on anxiety at www.nice.org.uk/CG022 NICE clinical guideline 23 on depression at www.nice.org.uk/CG023)

Recommendation 5

Target population

Employees experiencing recurring or long-term sickness absence due to back pain (for example, this may include those with driving as a significant component of their work).

Who should take action?

- Employers (including line managers and HR departments).
- Case workers/managers/teams.
- GPs.
- Specialist professionals (such as physiotherapists).
- Professionals, physicians or nurses specialising in occupational health, health and safety, rehabilitation or ergonomics.
- Union representatives.

What action should they take?

- Consider providing a multi-disciplinary 'back school' programme. The programme could comprise:
 - an initial intensive session (lasting up to 3 hours) covering definitions and attitudes to health; how the structure and function of the back and posture is related to the symptoms; stress and coping strategies; posture exercises and relaxation training
 - two shorter, voluntary follow-up sessions (up to 1 hour) during the next year to recap on the learning and discuss the person's experience of putting it into practice.

(See also NICE clinical guideline on the acute management of patients with chronic (longer than 6 weeks) non-specific low back pain [due May 2009] at www.nice.org.uk/guidance/index.jsp?action=byID&o=11645)

5 Implementation

NICE guidance can help:

- NHS organisations meet DH standards for public health as set out in the seventh domain of '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.
- NHS organisations, social care and children's services meet the requirements of the DH's 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.
- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Government's 'The new performance framework for local authorities and local authority partnerships'.

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- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for children's trusts, health and wellbeing partnerships and other multi-sector partnerships working on health within a local strategic partnership.

NICE will develop tools to help organisations implement this guidance. Details of the tools will be available on our website after the guidance has issued (www.nice.org.uk/PHxxx).

6 Recommendations for research

This section will be completed in the final guidance. More detail on the evidence gaps identified during the development of this guidance is provided in appendix D.

7 Updating the recommendations

This section will be completed in the final guidance.

8 Related NICE guidance

Published

Workplace health promotion: how to encourage employees to be physically active. NICE public health guidance 13 (2008). Available from www.nice.org.uk/PH013

Workplace health promotion: how to help employees to stop smoking. NICE public health guidance 5 (2007). Available from: www.nice.org.uk/PHI005

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Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal 97 (2006). Available from www.nice.org.uk/TA097

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). Available from www.nice.org.uk/CG022

Depression: management of depression in primary and secondary care. NICE clinical guideline 23 (2004). Available from www.nice.org.uk/CG023

Under development

Low back pain: the acute management of patients with chronic (longer than 6 weeks) non-specific low back pain. NICE clinical guideline (due May 2009).

Guidance for employers on promoting mental wellbeing through productive and healthy working conditions. NICE public health guidance (due June 2009).

9 Glossary

Adjustment disorder

A diagnostic category which refers to a collection of symptoms that together result in an inability to adapt to stressful life events. Responses may be linked to a single event (bereavement or accident) or multiple events occurring over a period of time (such as financial difficulties or living in a stressful or hostile environment). Symptoms must occur within 3 months of the event and persist for at least 6 months.

Behavioural graded activity

A behavioural treatment that aims to gradually increase a person's activity levels. The person attends 15 1-hour sessions, which cover activities that are relevant to them, and another 3 sessions dedicated to back education and lifting instructions delivered by an occupational therapist. (Van den Hout et al.

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2003 referred to in the evidence review at:

www.nice.org.uk/guidance/index.jsp?action=download&o=40657)

Case worker/manager/team

An individual/team responsible for managing any assessments and the co-ordination of intervention delivery to help a person return to work. The frequency and number of these assessments may vary over time depending on the service provider and availability. Where appropriate services are tailored to individuals.

Cognitive behavioural therapy

A range of evidence-based therapies based on psychological models of human cognition, learning and behaviour. Approaches range from structured one-to-one individual psychotherapy to self-help books or web-based programmes.

Incapacity benefit

A weekly benefit for people who become incapable of work due to illness or disability while under state pension age (see www.dwp.gov.uk for further information).

Intervention

This term has been used to describe an intervention, programme, strategy or policy. This involves a single action or set of actions initiated with the intention of altering the outcome of a situation. For example in the case of long-term sickness absence from work, any action (such as implementing an organisation's sickness absence policy) to help an individual to return to work.

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 (DDA) are guaranteed an interview for a post if they meet the essential criteria for doing it.

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Long-term sickness absence

Long-term sickness absence has been defined as anything from 2 weeks to 6 weeks onwards. As there is no universally accepted definition, for this guidance a length of 4 or more weeks has been chosen. 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. This definition may change in the future as further research evidence or international consensus emerges.

Manual therapy

A general term for treatments such as osteopathy or physiotherapy that involve physical manipulation, such as massage, soft tissue and joint mobilisation (Aure et al 2003, referred to in the evidence review at: www.nice.org.uk/guidance/index.jsp?action=download&o=40657)

Mindful employer

An initiative aimed at increasing awareness of mental health at work and providing support for businesses recruiting and training staff (further details can be found at /www.mindfulemployer.net/).

Multimodal programme

A programme to manage back pain with input from different professionals focusing on relaxation training on breathing, exercises to reduce cervical and lumbar lordosis (curvature of the spine), psychological support to reduce anxiety, eye fixation exercises and manual treatment of the cervical spine such as massage and mobilisation (Provinciali 1996, referred to in the evidence review at: www.nice.org.uk/guidance/index.jsp?action=download&o=40657).

Operant conditioning behavioural approach

A type of behavioural therapy.

Problem-solving therapy

A type of cognitive-behavioural therapy that teaches problem-solving skills. It comprises ten 90-minute group sessions with two therapists. The therapy focuses on training people to apply these new skills not just to pain management but also to other areas of their daily life. Homework assignments are given between sessions and discussed during the next session. (Van den Hout et al. 2003, referred to in the evidence review at:

www.nice.org.uk/guidance/index.jsp?action=download&o=40657)

Progressive goal attainment programme

A standardised psychosocial rehabilitation program that aims to gradually increase daily involvement in goal-directed activity. The main components of the programme are education and reassurance, keeping an activity log, planning activity, walking for 15 minutes a day, increasing the amount of activity a person does, and overcoming psychological obstacles to them doing this (Sullivan et al. 2006, referred to in the evidence review at:

www.nice.org.uk/guidance/index.jsp?action=download&o=40657).

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

Short-term sickness absence has been defined as anything from period less than 7 days up to 4 weeks. As there is no universally accepted definition, for this guidance a period of up to but less than 4 weeks has been chosen.

Recurring short-term sickness absence has been defined as frequent sickness absences from work of up to 4 weeks.

The road ahead course

A programme of 8 weekly sessions of 3–4 hours each, focusing on coping strategies, support between participants and developing goals and solutions for the future. Half the time is spent in plenary sessions, half in small group work, and participants have access to individual counseling and follow-up (Nystuen et al. 2006, referred to in the evidence review at:

www.nice.org.uk/guidance/index.jsp?action=download&o=40657)

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Swedish back school

A training course covering basic anatomy, the functions of muscles and treatments for back and low back pain. Ergonomic examples are presented. It includes a workplace component which involves observing and discussing the individual's working postures and techniques. The advantages of physical activity – and the damaging effects of immobilization – on muscles, tendons, joints and discs are emphasised.

Worklessness

A term that is broader than the traditional definition of unemployment. It is increasingly being used to describe people of working age who are not in formal employment but who are looking for a job (the unemployed), together with people of working age who are neither formally employed nor looking for formal employment (the economically inactive).

10 References

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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:

Ms Kathy Bairstow Senior Advice and Information Officer, Epilepsy Action

Dr Clare Bamba Lecturer in Public Health Policy, University of Durham

Professor David Croisdale-Appleby (Chair) Professor, Wolfson Research Institute and the School of Medicine and Health, University of Durham

Dr Mark Gabbay Head of Division of Primary Care, University of Liverpool

Ms Linda Hughes Freelance Consultant and Volunteer, Tomorrow's People

Mr Bob Johnson National Official, National Association Schoolmasters Union
Women Teachers

Professor Sayeed Khan Chief Medical Adviser, Engineering Employers'
Federation, the Manufacturers' Organisation

Ms Gillian McCarthy Area Director, Advisery, Conciliation and Arbitration
Service, North West England

Ms Helen Macdonald Freelance Consultant Cognitive-Behavioural
Psychotherapist and Chartered Health Psychologist

Professor Ceri Phillips Professor, Swansea University

Dr Richard Preece Freelance Consultant, Occupational Medicine

Dr Peter Riach Freelance Consultant, Prison Service Pay Review Body

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Ms Vanessa Roberts, Employment Projects Manager, Sheffield Teaching Hospitals

Ms Claire Saunders Strategic Health and Safety Adviser, Essex County Council

Dr Sian Williams Consultant in Occupational Medicine, Royal Free Hampstead NHS Trust and Director of the Occupational Health Clinical Effectiveness Unit, Royal College of Physicians

Expert cooptees to the PDG:

Mr Robert Campbell Disability Management Consultant (retired)

Ms Maureen Edwards Senior User/Human Resources Director, NHS Electronic Staff Record

Dr Fiona Ford Senior Lecturer, University of Central Lancashire

Mrs Louise Knox Chief Executive, Pentreath

Dr Jacquie Halliday-Bell Medical Inspector of Health and Safety, Health and Safety Executive

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Karen Peploe

Analyst

Sarah Dunsdon

Project Manager

Palida Teelucknavan

Coordinator

External contractors

NICE commissioned a mapping review, three evidence reviews and an economic analysis.

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 of Employment Studies (IES) and Sheffield University's Institute of Work Psychology (IWP) and School of Health and Related Research (SchHARR). 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 SchHARR. 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'.

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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.

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 IES and Sheffield University's IWP and ScHARR. The principal authors were: Hazel Pilgrim, Chris Carroll, Jo Rick, Nick Jagger and Jim Hillage.

Appendix B Summary of the methods used to develop this guidance

Introduction

The reports of the reviews 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 from the NICE website at: www.nice.org.uk/guidance/index.jsp?action=byID&o=11674

The guidance development process

The stages of the guidance development process are outlined in the box below.

1. Draft scope
2. Stakeholder meeting
3. Stakeholder comments
4. Final scope and responses published on website
5. Reviews and economic analysis
6. Reviews and economic analysis (including executive summaries and evidence tables) circulated to stakeholders for comment
7. Comments and additional evidence submitted by stakeholders
8. Review of additional evidence submitted by stakeholders (screened against inclusion criteria used in reviews)
9. Revised reviews and economic analysis submitted to the PDG
10. The PDG produces draft recommendations
11. Draft recommendations published on website for comment by stakeholders and for field testing
12. The PDG amends recommendations
13. Responses to guidance comments consultation published on website
14. Final guidance 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 facilitated the development of recommendations by the PDG. The overarching research 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 secondary research questions are:

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?

Reviewing the evidence of effectiveness and cost effectiveness

A mapping review and three evidence reviews (covering the four main research questions) of effectiveness and cost effectiveness 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)

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- 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): www.acas.org.uk/
- Centre for Longitudinal Studies: www.cls.ioe.ac.uk/
- Department for Business, Enterprise and Regulatory Reform: www.dti.gov.uk/index.html
- Department for Work & Pensions: www.dwp.gov.uk/
- Employment Studies Research Unit: www.uwe.ac.uk/bbs/research/esru/wps.shtml
- Health and Safety Executive: www.hse.gov.uk/index.htm
- Institute of Occupational Health: www.bham.ac.uk/ioh
- Institute for Public Policy & Research: www.ippr.org.uk/
- Oxford Health Alliance: www.oxha.org/
- National Audit Office: www.nao.org.uk/
- Xpert HR: www.xperthr.co.uk/

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.

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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
- 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:

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- 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:

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- 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 return to work outcomes
- 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

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- 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 were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect 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 at:

www.nice.org.uk/guidance/index.jsp?action=byID&o=11674

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Fieldwork

This section will be completed in the final document.

How the PDG formulated the recommendations

At its meetings in February, April, May, and June 2008, the PDG considered the evidence of effectiveness and cost effectiveness, 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 population health and/or reducing inequalities in health.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and the anticipated extent of change in practice that would be required.

The PDG noted that the effectiveness of some interventions could vary according to the context in which they were delivered.

The PDG also considered whether a recommendation should only be implemented as part of a research programme where evidence was lacking.

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).

Appendix C The evidence

This appendix sets out the evidence statements taken from three reviews and links them to the relevant recommendations (see appendix B for the key to study types and 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 sets out a brief summary of findings from the economic appraisal.

The three evidence reviews of effectiveness and cost effectiveness 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)'.

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'.

The reviews and economic analysis are available on the NICE website (www.nice.org.uk/guidance/index.jsp?action=byID&o=11674). Where a Long-term sickness absence and incapacity - consultation draft

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).

Where the PDG has considered other evidence, it is linked to the appropriate recommendation below. It is also listed in the additional evidence section of this appendix.

Recommendation 1: 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

Recommendation 2: evidence statement ER1.40; IDE

Recommendation 3: evidence statements ER1.2, ER1.20, ER1.21, ER1.23, ER1.24, ER1.26, ER1.28, ER1.33, ER1.40, ER1.45, ER1.50, ER1.52, ER2.1, ER2.7, ER2.10

Recommendation 4: evidence statements ER1.11, ER1.12, ER1.13, ER1.16, ER1.17, ER1.30

Recommendation 5: evidence statement ER1.8; IDE

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 Long-term sickness absence and incapacity - consultation draft

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 Long-term sickness absence and incapacity - consultation draft

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.

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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

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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 be 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 Long-term sickness absence and incapacity - consultation draft

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.

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 Long-term sickness absence and incapacity - consultation draft

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.

Several of the 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.

One mental health study from the Netherlands found that 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: the Pathways to Work scheme. This was carried out for the Department for Work and Pensions. (The study is based on the Bewley and co-workers paper covered in the effectiveness section of this review). An economic analysis 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 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 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) and
- a physical activity, education (including psychological component) intervention combined with a workplace visit for muscular-skeletal disorders. (This combination of treatments dominates usual care.)

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

No economic modelling was undertaken for Pathways to Work.

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.

These gaps are set out below.

1. Limited evidence was identified on interventions that:
 - a. aim to prevent employees moving from short- to long-term sickness absence
 - b. attempt to reduce the number of employees taking repeated short- or long-term sickness absences.
2. Similarly there is very limited UK-based evidence on interventions that help those receiving incapacity benefit return to work, and the evidence that was available did not demonstrate effectiveness.
3. There is limited evidence on interventions for people with mental health problems.
4. Details on the following components of an intervention were often missing:
 - a. definitions for the sickness absence period, the primary reasons or conditions for the sickness absence period or incapacity and duration of sickness absence
 - b. the content of the intervention, when it was delivered, by whom, in what setting, at what point during the individuals absence or incapacity was the intervention delivered and the frequency or duration of its delivery
 - c. details on any variations in effectiveness and cost effectiveness in relation to characteristics such as gender, age, ethnicity, disability, sexual orientation and religion

- d. if a particular component of the multi-component intervention was responsible for the effectiveness/cost-effectiveness
 - e. the control or comparison element of the study
 - f. statistical data for reported intended and unintended outcomes
 - g. the economic costs and benefits of any of the interventions
 - h. follow-up periods and sustainability of interventions
 - i. the differential effectiveness for each component.
5. There is a lack of evidence on the specific components that make an intervention effective. For example, few studies provided data to answer the secondary research questions such as: 'Does effectiveness depend on the intervener?' or 'Does the intensity or duration influence effectiveness or duration of effect'?
6. Few studies evaluated factors that hinder or promote the interventions' success in achieving return to work following sickness absence or incapacity. In addition, few studies describe the barriers experienced by those planning, designing, delivering or managing the interventions and none described how to overcome these barriers.

Appendix E Supporting documents

Supporting documents are available from the NICE website (www.nice.org.uk/guidance/index.jsp?action=byID&o=11674). These include the following.

- Evidence reviews:
 - 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)’.
- Economic analysis: ‘Modelling the cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees on sickness absence’.

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

- ‘Methods for development of NICE public health guidance’ available from: www.nice.org.uk/phmethods

- 'The public health guidance development process: an overview for stakeholders including public health practitioners, policy makers and the public' available from: www.nice.org.uk/phprocess