# Action Plan 14/14
## Managing Long Term Sickness
### NICE PH19
### June 2014

<table>
<thead>
<tr>
<th>Title:</th>
<th>Action Plan 14/14 Managing Long Term Sickness NICE PH 19 (Published 03/2009)</th>
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<tbody>
<tr>
<td>Prepared by:</td>
<td>David Boyle, Clinical Development Officer</td>
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<td>Presented by:</td>
<td>David Boyle, Clinical Development Officer</td>
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<td>Main aim:</td>
<td>To provide assurance that SWASFT complies with all relevant NICE guidance</td>
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<tr>
<td>Recommendations:</td>
<td>The CEG is requested to discuss these papers and to agree actions as outlined.</td>
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<td>Previous Forum:</td>
<td>None</td>
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This report references:

<table>
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<tr>
<th>Board Assurance Framework</th>
<th>e.g. BAF01-11, BAF02-11 (the BAF includes reference to Board Self Certs, COs and CQC)</th>
<th>Directorate Business Plans</th>
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1. **Introduction**

1.1 NICE PH 19 outlines management and measures for the management of Long Term sickness. After a review by the Clinical Development Officer (East), sections relating to NHS staff were deemed relevant for action. See table 1, paragraph 3 for the breakdown of the guidance relevant to the Trust.

1.2 The Clinical Development Officer (East) liaised with the Trust's health and wellbeing manager, and with the National Nurse Manager for Capita Health and Wellbeing (the Trust’s Occupational Health provider) to provide assurance of compliance with this guideline.

2. **Compliance with Guidance**

2.1 **Capita Occupational Health**

2.1.1 The following reply was received from Capita;

2.1.2 “I've double checked this guidance and made some notes and references below. The vast majority of the document really refers to what we would consider to be accepted OH best practice and is what we work towards as ‘standard’. But – I have pulled out some of the sections and made specific reference if this is helpful? There are some sections that really relate to what happens at the non-OH end or ongoing management of the individual – though from our experience, SWAST generally adhere to these principles in supporting staff back to work and always aiming for successful rehabilitation where this is possible.

2.1.3 Definition of long and short term (more than 4 weeks) – some customers use 3 weeks as a marker and we generally accept the employer definition and I think the recommendation in relation to early intervention in referral is probably a HR/management question as we cannot really control

2.1.4 The below would form part of standard clinical history during assessment:

- sex, biological predisposition and genetic traits
- socioeconomic position
- access to information, services, support and resources
- exposure to risk, including environmental risk factors
degree of control over their own life circumstances
access to (and their interaction with) the healthcare system (Marmot and Wilkinson 2005).
Positive impact of work upon improved psychological wellbeing

2.1.5 This is a standard part of our ethos and values. When reports are audited – they are assessed for the value they contribute to a case, or ability to support a manager to make decisions and the value of being in work forms a specific component of this.

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

2.1.7 The above references to NICE guidelines are our reference points when assessing whether the care that an individual is receiving is clinically appropriate. I have double checked our pathways and they do broadly follow this as suggested whereby self-help/advice / health promotion is considered in conjunction with referrals for workplace assessment/ergonomic/ other interventions such as physiotherapy / counselling / CBT etc. may also be relevant.

2.1.8 OH advice is given in conjunction with SWAST policies (and partnership) as per guidance and consideration of alternative duties/phased return to work programmes etc. are always considered - there is much info re cost effectiveness of such interventions or additional support. This decision is usually left to SWAST – as ultimately – they are in a better position to make business decisions in relation to cost effectiveness.

Chris Rhodes
National Nurse Manager

Organisational health, Health and wellbeing, Capita”

2.2 SWASFT Human Resources

2.2.1 The following reply was received from the Trust’s Health and Wellbeing lead:

2.2.2 “From an HR policy perspective we follow NICE guidelines:
2.2.3 Recommendation One
We utilise OH as the impartial and suitably trained professional to undertake initial enquiries about their long term absence. HR and line managers are also mapped into this process in the form of welfare meetings, informed by the earlier OH assessment. Welfare meetings are for the purpose of facilitating a manageable return to work.

2.2.4 Recommendation Two
If the absence is stress related, HR will advise that a stress risk assessment is carried out in an attempt to facilitate a return to work by taking reasonable steps to remedy some of the stressors.

2.2.5 In addition to this, we work in conjunction with our OH who will provide detailed advice and guidance to our managers. The HR Business Partner for the particular area the employee works in will act as the case worker, considering OH advice and also discussions had at welfare meetings. The HRBP will also help the manager develop a suitable RTW plan, taking into consideration the advice from OH, which may involve a phased return.

2.2.6 Recommendation Three
HR Business Partners and line managers are encouraged to be familiar with the Trust’s Health and Wellbeing Handbook, which details the support available to them currently, including OH, the employee assistance programme, how to access physiotherapy, osteopathy or chiropractic services etc. In addition to this, specialist therapies or treatments can be proposed by OH in certain circumstances as an alternative to the core framework we procure from them.
As with Recommendation Two, the HRBP will act as the case worker with the line manager to ensure the member of staff receives the appropriate care.

Sam Fraser
Health and Wellbeing and Equality Lead
SWASFT

2.3 HR Policies
2.3.1 The Trust’s “Sickness Absence Policy” refers to the recommended timeframes for categorisation of long term and multiple short term absences, which fall within NICE guidance. (See query in paragraph 2.1.3, and recommendation 1 in the policy below) The policy also reflects and further clarifies the Trust’s approach to the management of sickness absence and the procedures to be followed when sickness absence occurs.
# Action Plan

## 3.1 The following table outlines the paragraphs from the Clinical Guideline relevant to the Trust.

## 3.2 Table 1: Action Plan; NICE PH19 paragraphs relevant to the Trust

<table>
<thead>
<tr>
<th>ID</th>
<th>Recommendation</th>
<th>Action Required</th>
<th>Target Date</th>
<th>Person Responsible</th>
<th>Date Achieved</th>
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<tbody>
<tr>
<td>Recommendation 1</td>
<td>Identify someone who is suitably trained and impartial to undertake initial enquiries with the relevant employees (see above). As an example, they could be an occupational health physician or nurse or a human resource specialist. Within 12 weeks (ideally between 2 and 6 weeks) of a person starting sickness absence (or following recurring episodes of short- or long-term sickness absence) ensure that initial enquiries are undertaken in conjunction with the employee. The aim is to: determine the reason for the sickness and their prognosis for returning to work (that is, how likely it is that they will return to work) and if they have any perceived (or actual) barriers to returning to work (including the need for workplace adjustments) decide on the options for returning to work and jointly agree what, if any, action is required to prepare for this. If action is required consider identifying: whether or not a detailed assessment is needed to determine what interventions and services are required and to develop a return-to-work plan (see recommendation 2)</td>
<td>None: see correspondence from SWASFT HR and Capita OH above; Trust sickness policy</td>
<td>N/A</td>
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| Recommendation 1 ctd | whether or not a case worker/s is needed to coordinate a detailed assessment, deliver any proposed interventions or produce a return-to-work plan. 
If necessary, appoint a case worker/s (see recommendation 2). |  |  |

| Recommendation 2 | If indicated by the initial enquiries, arrange for a more detailed assessment to be undertaken. The assessment could be coordinated by a suitably trained case worker/s. The case worker does not necessarily need a clinical or occupational health background but should have the skills and training to act as an impartial intermediary. (Note: it may not be an appropriate role for the person's line manager). 
Arrange for the relevant specialist/s to undertake the assessment (or different components of it) in conjunction with the employee. It could include one or more of the following: 
referral via an occupational health adviser (or encouragement to self-refer) to a GP with occupational health experience or another appropriate health specialist (such as a physiotherapist). The aim is to diagnose and treat the employee and determine any need for further tests or sick leave 
use of a screening tool to determine the prognosis for returning to work 
a combined interview and work assessment by one or more appropriate specialists (such as a physician, nurse or another professional specialising in occupational health, health and safety, rehabilitation or ergonomics). This assessment should also involve the line manager 
a return-to-work plan. | None: see correspondence from SWASFT HR and Capita OH above; Trust sickness policy | N/A |
If a combined interview and work assessment is needed it should evaluate:

- the person's health, social and employment situation, any barriers to returning to work (for example, work relationships) and their perceived confidence and ability to overcome these barriers
- their current or previous rehabilitation experiences
- the tasks they carry out at work – and their functional capacity to perform them (dealing with issues such as mobility, strength and fitness)
- any workplace or work equipment modifications that are needed in line with the Disability Discrimination Act (including ergonomic modifications).

If a return-to-work plan is needed it should determine the level, type and frequency of interventions and services needed, including any psychological support (see recommendation 3). A return-to-work plan could also identify if any of the following is required:

- a gradual return to the original job using staged increases in hours and days worked (for example, starting with shorter hours and/or less days and gradually increasing them)
- a return to partial duties of the original job or temporary/permanent redeployment to another job.
Ensure those assessing which psychological support or interventions to offer are trained in psychological assessment techniques.

**Recommendation 3**

Coordinate and support the delivery of any planned health, occupational or rehabilitation interventions or services and any return-to-work plan developed following initial enquiries or the detailed assessment. People who have a poor prognosis for returning to work are likely to benefit most from more 'intensive' interventions and services; those with a good prognosis are likely to benefit from 'light' or less intense interventions and services. Liaise with everyone involved (such as line managers and occupational health staff).

Where necessary, arrange for a referral to relevant specialists or services. This may include referral via an occupational health adviser (or encouragement to self-refer) to a GP, a specialist physician, nurse or another professional specialising in occupational health, health and safety, rehabilitation or ergonomics. It could also include referral to a physiotherapist.

Where necessary, employers should appoint a case worker/s to coordinate referral for, and delivery of any required interventions and services. This includes delivery of the return-to-work plan, if required (including modifications to the workplace or work equipment). The case worker/s does not necessarily need a clinical or occupational health background. However, they should have the skills and training to act as an impartial intermediary and to ensure appropriate referrals are made to specialist services.

Ensure employees are consulted and jointly agree all planned health, occupational or rehabilitation interventions or services and the return-to-work plan (including workplace or work equipment modifications).

None: see correspondence from SWASFT HR and Capita OH above; Trust sickness policy

N/A
Recommendation 3 ctd

Encourage employees to contact their GP or occupational health service for further advice and support as needed.

Consider offering people who have a poor prognosis for returning to work an 'intensive' programme of interventions. For example, offer a programme of multi-disciplinary interventions over several weeks combined with usual care and treatment. Examples may include one or more of the following:

- cognitive behavioural therapy (CBT) or education and training on physical and mental coping strategies for work and everyday activities (this may be combined with exercise programmes)
- counselling about a return to work
- workplace modifications
- referral to physiotherapy services or vocational rehabilitation (including training).

Consider offering more intensive, specialist input when there is recurring long-term sickness absence or repeat episodes of short-term sickness absence.

Consider offering 'light' or less intense interventions, along with usual care and treatment, to those with a good prognosis for returning to work. Examples might include short sessions providing one or more of the following, as appropriate: individually tailored advice on how to manage daily activities at home and at work (this could include advice on the benefits of being physically active and on relaxation techniques); encouragement to be physically active; referral to a physiotherapist or psychological services.
Ensure psychological interventions and services are evidence-based. Also ensure they are delivered by suitably trained and experienced practitioners. These may be health professionals (such as physicians, nurses or others specialising in occupational health, rehabilitation or ergonomics); social workers; clinical or occupational psychologists; specialist counsellors or therapists.

Consider helping people to develop problem solving and coping strategies using evidence-based psychological interventions. The aim is to overcome any barriers they have to returning to work and to support them to return. Examples which have been proven to be effective for certain groups and conditions are listed below:

- **women with musculoskeletal pain:** CBT in small groups (involving 5–6 people), with one-to-one telephone follow-up
- **men and women with stress-related conditions:** CBT and contact with the employer
- **men and women experiencing low back pain:** CBT in small groups (involving 5–6 people) combined with one-to-one sessions of behavioural-graded activity and liaison with the workplace to discuss a return-to-work plan (for guidance on treatment see NICE clinical guideline on patients with chronic [longer than 6 weeks] non-specific low back pain [2009].
- **men and women with psychological or musculoskeletal problems:** solution-focused group sessions (using, for example, ‘The road ahead course’ format)
- **men and women with whiplash injuries:** progressive goal attainment programmes combined with physiotherapy or multimodal programmes.
<table>
<thead>
<tr>
<th>Recommendation 3 ctd</th>
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<td>Consider providing a multi-disciplinary back management programme to help employees with this condition return to work. It could be delivered by a GP with occupational health experience, a specialist professional (such as a physiotherapist) or a combination of others specialising in occupational health, health and safety, rehabilitation or ergonomics. As an example, a programme could comprise:</td>
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<tr>
<td>one intensive session covering attitudes to health, structure and function of the back and posture and the link to symptoms, stress and coping strategies, posture exercises and relaxation training</td>
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<td>optional sessions to recap on learning and to discuss the experience of putting it into practice.</td>
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4 Recommendation

4.1 The group is asked to note this report for assurance

David Boyle

Clinical Development Officer (East)